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

Council Meeting

December 6, 2023

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

NOTICE OF MEETING OF COUNCIL

AVIS DE RÉUNION DU CONSEIL

A meeting of the College of Midwives of Ontario will take place on Wednesday, December 6, 2023 from 9:30 AM to 1:30 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 for access details.

L'Ordre des sages-femmes de l'Ontario tiendra une réunion par vidéoconférence, de 9 h 30 à 13 h 30, le 6 décembre, 2023.

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.

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 to 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.

Strategic Framework
2021–2026

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

The 2021-2026 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, December 6, 2023 | 09:30 am to 1:30 pm
Meeting via video-conference.

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
1.	Call to Order: Welcome & Land Acknowledgement	C. Ramlogan-Salanga	9:30	INFORMATION	-	-
2.	Conflict of Interest	C. Ramlogan-Salanga	9:35		-	-
3.	Review and Approval of Proposed Agenda	C. Ramlogan-Salanga	9:37	MOTION	3.0 Agenda	3
4.	Consent Agenda - Draft Minutes of October 12, 2023 Council Meeting Q2 reports of: - Inquiries, Complaints - and Reports Committee Report - Registration Committee - Quality Assurance Committee - Discipline Committee - Fitness to Practise Committee - Client Relations Committee	C. Ramlogan-Salanga	9:40	MOTION	4.0 Draft Minutes of October 12, 2023 4.1 ICRC report 4.2 RC report 4.3 QAC report 4.4 DC report 4.5 FTP report 4.6 CRC report	7
5.	IN CAMERA		9:45	MOTION	-	-
6.	Chair Report	C. Ramlogan-Salanga	10:00	APPROVAL	6.0 Chair report	30
7.	Registrar's Report	K. Dobbin	10:15	APPROVAL	7.0 Registrar's report	32
8.	Executive Committee Report	C. Ramlogan-Salanga	10:45	APPROVAL	8.0 EC report 8.1 Q2 SOP 8.2 Revised Assessment of External Auditor Tool 8.3 2023-2024 Committee Composition	37

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
	I. Council Evaluation	N. Gale			8.4 Briefing Note 8.5 2023 Council Evaluation Report	67
	BREAK 11:30					
9.	Equity, Diversity and Inclusion Report	Z. Grant	11:45	APPROVAL	9.0 Briefing Note 9.1 Self-Assessment Results 9.2 HPRO EDI Organizational Self-Assessment	80
10.	Quality Assurance Committee	A. Singh	12:30	APPROVAL		
	I. Waiver Policy - Standards				10.0 Briefing Note 10.1 Waiver Policy Standards	119
	II. Vaginal Birth After Caesarean Section and Choice of Birthplace Position Statement				10. 2 Briefing Note 10.3 VBAC Position Statement	123
	III. Course on Administering Controlled Substances for Midwives				10.4 Briefing Note 10.5 Appendiz A: Administration of Controlled Substances Course	128
11.	Slate of Council	ALL	1:00	APPROVAL	*will be added post by-election	
12.	Housekeeping		1:20			
	Adjournment	C. Ramlogan-Salanga	1:30	MOTION	-	-
	Next Meetings: March 26-27, 2024 June 25-26, 2024 October 1-2, 2024 December 10-11, 2024			INFORMATION		

MINUTES OF COUNCIL MEETING

Held on October 12, 2023, 9:30 am to 12:30 pm
Hybrid: Zoom & College of Midwives of Ontario Boardroom
21 St. Clair Avenue East

Chair:	Claire Ramlogan-Salanga, RM;
Present:	Don Strickland; Isabelle Milot, RM; Judith Murray; Marianna Kaminska; Hardeep Fervaha, RM; Alexia Singh, RM; Maryam Rahimi-Chatri, RM; Tina Walia-Rao
Regrets:	Edan Thomas, RM; Jyothy Nair, RM; Jacqueline Morrison (Absent);
Staff:	Kelly Dobbin; Nadja Gale; Nancy Tran; Michele Pieragostini; Victoria Marshall; Lieran Docherty; Megan McCarrell; Abinaya Kalanandan
Observers:	Deborah Bonser (AOM)
Recorder	Zahra Grant

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

   Claire Ramlogan-Salanga, Chair called the meeting to order at 9:31 am and welcomed all present and offered a land acknowledgement.

2. Declaration of Conflict of Interests

   No conflicts of interest were declared.

3. Proposed Agenda

   MOTION: That the proposed agenda be approved as presented.
   Moved: Hardeep Fervaha
   Seconded: Marianna Kaminska
   CARRIED

4. Consent Agenda

   MOTION: That the consent agenda consisting of:

- Draft Minutes of June 27, 2023 Council Meeting
- Draft Minutes of July 31, 2023 Council Meeting
- Quarter 1 Reports of:
    - Inquiries, Complaints and Reports Committee
    - Registration Committee
    - Quality Assurance Committee
    - Discipline Committee
    - Fitness to Practise Committee
    - Client Relations Committee

Be approved as presented.
Moved: Alexia Singh
Seconded: Hardeep Fervaha

5. IN CAMERA

Pursuant to the Health Professions Procedural Code of the Regulated Health Professions Act, 1991, section 7(2)(b)

MOTION: Be it resolved that Council move in-camera at 9:47 am.
Moved: Donald Strickland
Seconded: Isabelle Milot

MOTION: Be it resolved that Council move out of in-camera at 10:18 am.
Moved: Marianna Kaminska
Seconded: Tina Walia-Rao
CARRIED

6. Chair Report

Claire Ramlogan-Salanga, Chair introduced the Chair report and provided highlights. The content of the report provided relevant updates regarding work that continues to be underway as well as the summary of feedback received from the training sessions and meeting held since the last report. Council approved the Chair report as presented.

MOTION: That the Chair Report to Council be approved as presented
Moved: Tina Walia-Rao
Seconded: A lexia Singh
CARRIED

7. Registrar's Report

Kelly Dobbin. Registrar & CEO introduced the Registrar report and provided highlights.

The 2022-2023 Annual report appended in the materials has been submitted to Ministry which documents and reports the work accomplished over the fiscal year and our progress on Strategic Goals.

Equity work continues to progress. The Health Profession Regulators of Ontario (HPRO) anti-racism project that included the development of tools and resources to support health regulatory Colleges in their equity work is complete. The tools include a self-evaluation which the College completed. A report and recommendations from the self-assessment will be shared with Council at the December meeting. In addition, an Equity framework has been developed that will guide the College to ensure we are centering equity in our work and as an organization. A webpage to provide front-facing information, updates, and resources is also under development and is intended to be launched in December.

Legislative Updates regarding all regulations currently with Ministry were provided. Of note, the proposed Drugs and Substances Regulation approved at the special meeting of Council in July was submitted. The Ministry is expected to post the proposed regulation to its Regulatory Registry in the coming days.

An update on the Competency Based Assessment Program Pilot was provided. Work is currently underway, and a final report by the consultant group is expected by the end of the calendar year.

The digitization project is now complete is complete with all paper records having been digitized and stored online.

MOTION: That the Registrar's Report be approved as presented

Moved: Marianna Kaminska
Seconded: Judith Murray
CARRIED

8. Executive Report

Claire Ramlogan Salanga, Chair, introduced the Executive Committee report summarizing activities of the Committee.

One of the main roles of the Committee is engagement with the external financial auditor which includes an assessment using the External Auditor review tool. The Committee is recommending adjustments to be made the tool so that the annual review be reduced to include questions that are specific and targeted and should be used as a tool for the Executive Committee to remain risk-aware during the audit. Recommendations will be brought forward to Council at the next meeting.

MOTION:

I. That the Executive Committee Report be approved as presented.

II. That the conclusion and recommendations of the annual assessment of the auditor summary report be approved.

III. That Hilborn, LLP be appointed as the auditor for the 2023-2024 fiscal year.

Moved: Marianna Kaminska
Seconded: Hardeep Fervaha
CARRIED

9. Budget Reforecast

Lieran Docherty led Council through the revised budget for the 2023-24 fiscal year. It was revised due to postponed and delayed spending from the previous fiscal year as well as some newly anticipated overspending and underspending in some key areas. The Executive Committee in their role as finance committee has reviewed the proposed budget by examining the projected revenues and expenses against updated workplans. The Executive Committee recommends that Council approve the revised budget.

MOTION: That the Council approve the revised Budget for the 2023-24 fiscal year
Moved: Hardeep Fervaha
Seconded: Marianna Kaminska
CARRIED

10. Sexual Abuse Prevention Policy (SAPP)

The Client Relations Committee introduced the Sexual Abuse Prevention Policy (SAPP) which was reviewed and revised in accordance with the College's policy review cycle. Suggested revisions were made to define any terms that may have been vague within the policy to provide clarity although there is no evidence to indicate difficulty on the part of registrants in understanding the SAPP.

MOTION: That the Sexual Abuse Prevention Policy be approved as revised.

Moved: Alexia Singh
Seconded: Claire Ramlogan-Salanga
CARRIED

11. Proposed Registration Regulation, Fetal Health Surveillance

The Registration Committee introduced the proposed Registration Regulation that has been revised to add Fetal Health Surveillance training ("FHS") as a new registration requirement for entry-to-practise and approved by Council in April. The proposed draft was circulated for public consultation for a period of 60 days. The Committee reviewed the feedback before making their final recommendation to Council. Council approved the draft as proposed.

MOTION: THAT Council approve the inclusion of the fetal health surveillance competency requirement for general class registration in the Proposed Registration Regulation to replace Ontario Regulation 168/11 made under the Midwifery Act, 1991, and direct an amended submission to the Ministry of Health.
Moved: Claire Ramlogan-Salanga
Seconded: Don Strickland
IN FAVOUR (5 Professional; 4 Public)
CARRIED

12. Election of Executive Committee

Four positions, Chair, Vice Chair (Professional), Vice Chair (Public), and member at large (Professional) were acclaimed. The public member at large was filled with a nomination from the floor, which was also acclaimed.

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

Moved: Tina Walia-Rao
Seconded: Claire Ramlogan-Salanga
CARRIED

13. ADJOURNMENT

MOTION: That the meeting be adjourned at 12:30 pm.
Moved: Maryam Rahimi-Chatri
Seconded: Tina Walia-Rao
CARRIED

INQUIRIES, COMPLAINTS & REPORTS COMMITTEE

REPORT TO COUNCIL – Quarter 2

General

Committee Members

Chair	Samantha Heiydt
Professional	Hardeep Fervaha, RM; Karen McKenzie, RM; Edan Thomas, RM
Public Council	Marianna Kaminska, Judith Murray
Non-Council	Jillian Evans; Emily Gaudreau, RM; Samantha Heiydt; Sarah Kirkland, RM; Nadine Robertson; Maureen Silverman, RM

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held	5	6	–	–	11
Number of Committee Meetings Held	0	0	–	–	0
Number of Trainings	0	0	–	–	0

Notes:
Q1: Five panel meetings were held by videoconference regarding nine COINs
Q2: Four panel meetings were held by videoconference regarding eleven COINs, one panel meeting was held by email, and one oral caution was isssued.

Caseload Work of the ICRC

	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Files Carried Over from previous reporting period	25	24	–	–	N/A	0	0	–	–	N/A
New files	9	8	–	–	17	0	1	–	–	1
Closed files	10	8	–	–	18	0	0	–	–	0
Active files at end of reporting period	24	24	–	–	N/A	0	1	–	–	N/A

Notes:
Q1: Nine new complaint files were a result of receiving seven complaints. Two complaints involved more than one midwife.
Q2: Eight new complaint files were a result of receiving eight individual complaints.

Source of New Matters

	Complaints					Reports				
Source of New Matters	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Client	7	6	–	–	13	0	0	–	–	0
Family Member	1	1	–	–	2	0	0	–	–	0
Health Care Provider	0	1	–	–	1	0	0	–	–	0
Info rec'd from MR/SR	0	0	–	–	0	0	1	–	–	1
Another Midwife	1	0	–	–	1	0	0	–	–	0

Outcomes/Completed Cases

Number of Resolved Cases and Outcomes	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
ADR Resolution	4	0	–	–	4	N/A				
Complaints Withdrawn	0	0	–	–	0	N/A				
Frivolous and Vexatious	0	0	–	–	0	N/A				
No Action	5	11	–	–	16	0	0	-	-	0
Advice & Recommendations	0	2	–	–	2	0	0	–	–	0
Specified Continuing Education or Remediation Program (SCERP)	0	0	–	–	0	0	0	-	-	0
Oral Caution	0	0	–	–	0	0	0	–	–	0
SCERP AND Oral Caution	1	0	–	–	1	0	0	–	–	0
Referral to Discipline Committee	0	0	–	–	0	0	0	–	–	0
Referral to Fitness to Practise Committee	0	0	–	–	0	0	0	–	–	0
Acknowledgement & Undertaking	0	0	–	–	0	0	0	–	–	0
Undertaking to Restrict Practise	0	0	–	–	0	0	0	–	–	0
Undertaking to Resign and Never Reapply	0	0	–	–	0	0	0	–	–	0

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

Themes of New Matters

	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Advertising	0	0	–	–	0	0	0	–	–	0
Billing and fees	0	0	–	–	0	0	0	–	–	0
Communication	4	1	–	–	5	0	0	–	–	0
Competence /Patient Care	7	6	–	–	13	1	0	–	–	1
Fraud	0	0	–	–	0	0	0	–	–	0
Professional Conduct & Behaviour	3	2	–	–	5	1	0	–	–	1
Record Keeping	0	0	–	–	0	0	0	–	–	0
Sexual abuse /Harassment / Boundary Violations	0	0	–	–	0	0	0	–	–	0
Unauthorized Practice	0	0	–	–	0	0	0	–	–	0

Notes:
Category of themes are based on the current methodology set out by the Ministry for the College Performance Measurement Framework (CPMF) Reporting Tool. These categories may change in the next reporting period to reflect any changes to CPMF reporting requirements and/or categories the College wishes to track.
Some complaints involve more than one theme.

Themes of Completed Matters where action was taken by the ICRC

	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Competence /Patient Care	1	0	–	–	–	0	0	–	–	–
Communication	1	2	–	–	–	0	0	–	–	–
Conduct/Ethical Behaviour	1	0				0	0			
Record Keeping	0	2	–	–	–	0	0	–	–	–

Notes:
Matters where the ICRC referred specified allegations to the Discipline Committee or did not take any action are not included. Outcomes in this category are the result of the ICRC issuing advice or recommendations, and/or ordering a SCERP.
Category of main themes are based on the current methodology set out by the Ministry for the College Performance Measurement Framework (CPMF) Reporting Tool. Sub categories represent the concern of the ICRC that required remediation. These categories may change in the next reporting period to reflect any changes to CPMF reporting requirements and/or categories the College wishes to track.
Outcomes of some complaints involve more than one theme. Some complaints may involve more than one midwife.

Timelines

Closed cases	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Number of files closed by ADR <60 days	4	0	–	–	4	0	0	–	–	0
Number of files closed by ADR between 60 & 120 days	0	0	–	–	0	0	0	–	–	0
Number of files closed <150 days	3	1	–	–	4	0	0	–	–	0
Number of files closed between 150 days and 210 days	1	7	–	–	8	0	0	–	–	0
Number of files closed >210 days	2	0	–	–	2	0	0	–	–	0
Average: (reported in number of days)	207	169	–	–	–	0	0	–	–	0
Median: (reported in number of days)	155	204	–	–	–	0	0	–	–	0
Average: for ADR cases (reported in number of days)	75	n/a	–	–						

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
New Files Eligible for ADR	3	2	–	–	5
New files referred to ADR	3	2	–	–	5
Files closed with Resolution Agreement	4	0			4
Files returned to ICRC due to timeframe	0	0	–	–	0
Files returned to ICRC due to unsuccessful mediation	0	1	–	–	1
Files returned to ICRC - Registrar did not ratify the agreement	0	0	–	–	0

Appeals

Complaint Matters	Q1	Q2	Q3	Q4	Total
Open HPARB appeals (Appeals carried over)	4	6	-	-	-
New HPARB appeals	4	0	-	-	4
Completed HPARB appeals - Confirmed	1	3	-	-	4
Open HPARB appeals (at end of reporting period)	6	3	-	-	-

Notes:
Open files: All appeals are by Complainants.

Q1 *Lance v Pelletier CanLII 55218 (ON HPARB)*
Q2 *HG v Bulstrode CanLII 85941 (ON HPARB)*
Q2 *H.G. v Rostam CanLII 85939 (ON HPARB)*
Q2 *H.G. v Murray CanLII 85952 (ON HPARB)*

Respectfully Submitted,

Samantha Heiydt, Chair

REGISTRATION COMMITTEE

REPORT TO COUNCIL – Quarter 2

General

Committee Members

Chair	Isabelle Milot, RM
Professional	Robyn Berman, RM
Public	Jacqueline Morrison (appointed September 28, 2022)
Non-Council	Anna Boudria; Samantha Heiydt; Maryam Rahimi-Chatri, RM; Jessica Raison, RM; Nadine Robertson

Activities of the Committee

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

*Registration Committee meeting held electronically.

Following Council's direction to circulate the amendment to the proposed Registration Regulation related to fetal health surveillance, the College launched a consultation period from May 1 to June 30, 2023.

After reviewing feedback received from the consultation process, the Registration Committee agreed to present them to Council. In addition, the Registration Committee approved making the recommendation to Council that the results be shared with the Ministry of Health, as an amendment to the College's Proposed Registration Regulation package submitted May 1st, 2023.

Registrant changes and statistics follow:

Midwives by class of registration	#				%
	Q1 (1090)	Q2 (1104)	Q3 (-)	Q4 (-)	Total
General	757	774	-	-	70
General with new registrant conditions	86	77	-	-	7
Supervised practice	2	0	-	-	0
Inactive	245	253	-	-	23
Transitional	0	0	-	-	0

New midwives by class of registration	#					%
	Q1 (34)	Q2 (26)	Q3 (-)	Q4 (-)	Total (60)	Total
General	0	1	-	-	1	2
General with new registrant conditions	29	21	-	-	50	83
Supervised practice	0	1	-	-	1	2
Inactive	0	3	-	-	3	5
Transitional	5	0	-	-	5	8

New midwives by route of entry	#					%
	Q1 (34)	Q2 (26)	Q3 (-)	Q4 (-)	Total (60)	Total
McMaster University graduates	20	8	-	-	28	47
Toronto Metropolitan University graduates	14	14	-	-	28	47
Out of province certificate holders (midwife applicants) from other Canadian	0	4	-	-	4	6

regulated midwifery jurisdictions						
Former registrants	0	-	-	-	0	0

Panel Referrals	Q1	Q2	Q3	Q4	Total
Total Number of referrals to a panel of the Registration Committee	8	8	-	-	16

Files Reviewed at Panel by Category	Q1 (13)	Q2 (8)	Q3 (-)	Q4 (-)	Total (21)
Application for registration[1]	0	0	-	-	0
Class change – Inactive to General[2]	9	7	-	-	16
Active practice requirements shortfall[3]	3	0	-	-	3
Re-issuance of a Supervised Practice certificate of registration[4]	0	0	-	-	0
Reinstatement within one year following revocation[5]	0	0	-	-	0
Variation of terms, conditions and limitations[6]	1	0	-	-	1
Other[7]	0	1	-	-	1

Panel Outcomes by Category					
Panel Outcomes by Application for Registration[1]	Q1 (0)	Q2 (0)	Q3 (-)	Q4 (-)	Total (0)
Application approved – Registrar directed to issue certificate of registration	0	0	-	-	0
Application approved – Registrar directed to issue a certificate of registration if the applicant successfully completes examinations set or approved by the panel	0	0	-	-	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

Application approved – Registrar directed to impose terms, conditions and limitations on certificate	0	0	-	-	0
Application not approved – Registrar directed to refuse to issue certificate	0	0	-	-	0
Panel Outcomes by Class change – Inactive to General[2]	Q1 (6)	Q2 (8)	Q3 (-)	Q4 (-)	Total (14)
Requalification program approved – General certificate to be re-issued	3	5	-	-	8
Requalification program approved – General certificate to be issued with terms, conditions, or limitations	3	1	-	-	4
Requalification program approved with supervision required – Supervised Practice certificate to be issued	0	1	-	-	1
Panel Outcomes by Active Practice Requirements Shortfall[3]	Q1 (1)	Q2 (0)	Q3 (-)	Q4 (-)	Total (1)
Exception granted – extenuating circumstances demonstrated	0	0	-	-	0
Shortfall plan required	0	0	-	-	0
Shortfall plan and undertaking imposing terms, conditions and limitations	1	0	-	-	1
Panel Outcomes by Re-issuance of a Supervised Practice certificate of registration[4]	Q1 (0)	Q2 (0)	Q3 (-)	Q4 (-)	Total (0)
Re-issuance approved – supervised practice extended	0	0	-	-	0
Re-issuance not approved	0	0	-	-	0
Panel Outcomes by Reinstatement within one year following revocation[5]	Q1 (0)	Q2 (0)	Q3 (-)	Q4 (-)	Total (0)
Requalification program approved – no supervised practice required	0	0	-	-	0
Requalification program approved – supervised practice required	0	0	-	-	0
Panel Outcomes by Variation of terms, conditions and limitations[6]	Q1 (1)	Q2 (0)	Q3 (-)	Q4 (-)	Total (1)
Application refused	0	0	-	-	0

Registrar directed to remove any term, condition or limitation imposed on the certificate of registration	0	0	-	-	0
Registrar directed to modify terms, conditions or limitations on the certificate of registration	1	0	-	-	1

Panel Outcomes: Other[7]	Q1 (1)	Q2 (0)	Q3 (-)	Q4 (-)	Total (1)
Request approved	0	1	-	-	1

Timelines: from referral to a panel, to a written decision	Q1 (8)	Q2 (8)	Q3 (-)	Q4 (-)	Total (16)
Files closed within 30 days	2	4	-	-	6
Files closed within 60 days	3	4	-	-	7
Files closed beyond 60 days	3	0	-	-	3
Median: (reported in number of days)	42	23	-	-	32.5
Average: (reported in number of days)	48	30	-	-	39

Registration Decisions appealed to the Health Professions Appeal and Review Board (HPARB)	Q1 (0)	Q2 (0)	Q3 (-)	Q4 (-)
Open HPARB appeals as of quarter end	0	0	-	-
New HPARB appeals	0	0	-	-
Completed HPARB appeals	0	0	-	-
Open HPARB appeals at quarter end	0	0	-	-

Of those appeals completed, the number of registration decision appeals that:	Q1 (n/a)	Q2 (n/a)	Q3 (-)	Q4 (-)
Confirmed the decision	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	-	-
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	-	-
Were referred back for further consideration	n/a	n/a	-	-

Attrition[8]	#	%
Q1	6	1
Q2	12	1
Q3	-	-
Q4	-	-

Respectfully Submitted,

Isabelle Milot, RM, Chair

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. *Under section 8(1.1.) of the Registration Regulation (Ontario Regulation 168/11), a panel of the Registration Committee must first specify the education or training an applicant must complete before attempting the qualifying examination (CMRE) for a fourth time. In this particular case, the individual was already registered with the College but sought request from the panel to approve an educational/training plan because they were required to successfully complete the CMRE due to an undertaking.*

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

QUALITY ASSURANCE COMMITTEE

REPORT TO COUNCIL – Quarter 2

General

Committee Members

Chair	Lilly Martin, RM (Non-Council)
Professional	Alexia Singh, RM
Public Council	Marianna Kaminska; Donald Strickland
Non-Council	Sabrina Blaise, RM; Kristen Wilkinson, RM

Activities of the Committee

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

Items

Designated Drugs Regulation

The Committee reviewed the final draft of the Designated Drugs and Substances Regulation and proposed amendments. The Committee made the decision to submit the revised final draft of the Designated Drugs and Substances Regulation to Council for approval to submit it to the Ministry of Health without a 60-day public consultation.

Attachments;

None

Respectfully Submitted,

Lilly Martin, Chair

DISCIPLINE COMMITTEE

REPORT TO COUNCIL – Quarter 2

General

Committee Members

Chair	Judith Murray
Professional	Robyn Berman, RM (until August 21, 2023); Hardeep Fervaha, RM; Karen McKenzie, RM; Isabelle Milot, RM; Jyothy Nair, RM; Alexia Singh, RM; Edan Thomas, RM
Public Council	Marianna Kaminska, Jacqueline Morrison, Oliver Okafor, Donald Strickland,
Non-Council	Anna Boudria, Lilly Martin, RM

Activities of the Committee

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

Items

The Committee did not conduct any business this quarter.

Respectfully Submitted,

Judith Murray, Chair

FITNESS TO PRACTISE COMMITTEE

REPORT TO COUNCIL – Quarter 2

General

Committee Members

Chair	Judith Murray
Professional	Robyn Berman, RM (Until August 21, 2023); Hardeep Fervaha, RM; Karen McKenzie, RM; Isabelle Milot, RM; Jyothy Nair, RM; Alexia Singh, RM; Edan Thomas, RM
Public Council	Marianna Kaminska, Jacqueline Morrison, Oliver Okafor, Donald Strickland,
Non-Council	Anna Boudria, Lilly Martin, RM

Activities of the Committee

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

Items

The Committee did not conduct any business this quarter.

Respectfully Submitted,

Judith Murray, Chair

CLIENT RELATIONS COMMITTEE

REPORT TO COUNCIL – Quarter 2

General

Committee Members

Chair	Donald Strickland
Professional	Jyothy Nair, RM
Public Council	Judith Murray
Non-Council	Emily Gaudreau, RM

Activities of the Committee

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

The Client Relations Committee (CRC) met on September 25, 2023

In Q2, the CRC addressed the following:

Terms of Reference

The CRC reviewed and approved updated Terms of Reference (TOR), as part of a standard bi-annual review for all committees. All TOR's will be brought forward to Council for approval this fiscal year. The key changes were updating to standardize with all other College Committees and changing the Administrative Duties from "meet at least one (1) time per year" to meet on an "as needed basis", and subject to a revision in the College bylaw.

Review and Update to Sexual Abuse Prevention Policy

The CRC reviewed updates to the Sexual Abuse Prevention Policy which were implemented immediately. The review was part of the College's regular review schedule for documents, and the guide was last reviewed in 2018. The RHPA's definition of "spouse" was added to the policy, but no other substantive changes were made, Council approved this policy at its October Council meeting.

Review and Update to The Guide on Funding For Therapy And Counselling, Forms and Internal Policy For Processing Applications

The CRC reviewed updates to the Guide on Funding for Therapy and Counselling which were implemented immediately. The review was part of the College's regular review schedule for documents. The guide was last reviewed in 2018. Updates included clarifying the application review process (discussed below). The associated application forms were updated to align with other public facing forms at the College.

An internal policy was developed by staff and presented to the Committee to reduce wait times for clients who apply for funding. The policy allows staff to approve funding applications that meet the established criteria on behalf of the Committee without the need to convene a CRC meeting.

Review and Update to The Guideline for Reporting Sexual Abuse

The CRC reviewed updates to the Guideline for Reporting Sexual Abuse which were implemented immediately. The review was part of the College's regular review schedule of documents. The guideline was last reviewed in 2018. Changes included a clarification in the wording on the consequences of failing to make a report and the addition of references to additional College resources about mandatory reporting.

Review and Update to Sexual Abuse Complaints Guide

The CRC reviewed updates to the Sexual Abuse Complaints Guide which were implemented immediately. The review was part of the College's regular review schedule of documents. The guide was last reviewed in 2018. The revisions aim to better manage client's expectations in a kind and compassionate way, including providing more information about the funding for therapy and counselling available. A clarification was added to clarify what is not sexual abuse. For example, in the course of providing clinical care, a midwife may, with client consent, touch a client in a way that is appropriate to the service being provided. For example, conducting an internal examination to assess cervical dilation. This conduct is very different from touching a client in a sexual manner.

Applications For Funding

The College received no applications for funding this quarter.

Respectfully Submitted,

Donald Strickland, Chair

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).

CHAIR'S REPORT

REPORT TO COUNCIL – Nov 17, 2023
Prepared by: Claire Ramlogan-Salanga, RM

1. General Highlights

   Once again, I had the privilege of attending the Canadian Network of Agencies of Regulation (CNAR) conference in Vancouver. At this year's event I was able to partake in sessions that discussed human rights, compassionate regulation, and governance modernization. This conference was useful in that it provided an overview of regulation across the country, specifically with a focus on health profession regulation modernization. I was also able to attend the Canadian Midwifery Regulators Council annual board meeting. This two-day event focused on issues facing each regulator with regard to the health human resource crisis, scopes of practice, and EDI efforts. Overall, that week of regulatory education and dialogue has inspired future work here at the College and our Council.

2. Governance

   In October, Council participated in three in-person training sessions. The first was led by Rania El-Muggamar, Anti-Oppression Consultant and Liberation Educator. This session aimed to guide our Council in implementing measurable, goal-oriented, and long-term equity, meaningful inclusion and anti-oppressive practices. Thank you to Council members who completed the pre-session learning needs survey as it provided her with a picture of where we were at on our EDI journey.

   The second training was led by Isabelle Milot, RM and long-time Council member. She shared with Council the popularity of alternative models of midwifery care in the province. In her region, she specifically shared insights including the challenges of operating a postpartum clinic for the past two years. This presentation provided a view into the realities of midwifery work and the potential for new and exciting paths for improving access to midwifery care.

   Our third training was led by Erica Richler, SML Law, where we engaged in a robust discussion about conflicts of interest. Through the use of case studies, Council was able to work through scenarios that we could apply to our setting. Ms. Richler also provided us with future trends for addressing conflicts of interest as Council members.

3. Council Governance Quality Improvement

   Council evaluations of training and Council days occur as part of our quality improvement initiatives. Overall, comments on the training sessions were positive and Council members all took away key messages for their own learning. The desire to have more time to discuss topics in more depth remains challenging, however, it does indicate engagement by

Council members. As we move forward with training day scheduling, staff will consider ways to promote the application of our training day content.

Keeping with our aim to improve governance and modernization of Council, the following are highlights of the areas that are being planned:

A. Continuous improvement regarding Equity, Diversity, and Inclusion
   - Targeted training days and time to apply the lessons learned.
   - Ensuring Council is accessible digitally and physically.
   - Council "Buddy system" evaluation.
   - Unconscious bias training.

B. Enriching Council's understanding of its governance role
   - Training regarding financial literacy for not-for-profit organizations.
   - Training regarding Chair and Committee engagement and decision making.
   - Succession planning including the implementation of Co-Chairs.

C. Ongoing Reform of the College's Governance Policies and Processes
   - Piloting collection of competencies and demographics from council members to better identify our resources and gaps.
   - Review and revisions to regulatory impact assessment and decision-making tools.
   - Review of College By-laws.
   - Planning for future governance modernization initiatives.

4. Stakeholder Engagement

1. CNAR Conference Oct 16-18, 2023
2. CMRC Board Meeting Oct 19-20, 2023
3. AOM/CMO Meeting Oct 13, 2023
4. OMSC Meeting Nov 1, 2023
5. QAC meeting – Ex Officio Nov 7, 2023

REGISTRAR-CEO QUARTERLY REPORT

REPORT TO COUNCIL – December 2023
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

Equity, Diversity & Inclusion
The HPRO Anti-Racism project previously reported to Council is now complete and we have piloted the organizational self-assessment tool to identify the strengths and gaps of our EDI-related work. In addition, the College has developed a framework to give structure to our ongoing and planned equity work. More detailed information can be found under agenda item 9.

Legislative and Regulatory Updates
We have no recent updates to provide regarding proposed changes to the Professional Misconduct Regulation 388/09, under the *Midwifery Act, 1991*, which was formally submitted in 2017.

On March 27, 2023, we submitted to the Ministry the list of laboratory tests, approved at the March Council meeting, to be included in Schedule 2 of the General Regulation (O. Reg. 45/22) under the *Laboratory and Specimen Collection Centre Licensing Act*. The Ministry has indicated that they agree to some of the additions, however, they have questions in regard to some others. We are preparing a written response and hope to meet with them before the end of the calendar year to discuss any outstanding issues.

Following Council's decision to include fetal health surveillance competency requirement for general class registration in the Proposed Registration Regulation, the College will be submitting an addendum to its May 1, 2023 submission.

The Ministry posted Council's proposed Designated Drugs and Substances Regulation to its Regulatory Registry in October, requesting public feedback by November 13th. Now that the consultation period is over, we expect to hear back from the Ministry in regard to any changes that may be proposed in light of the feedback received as well as next steps. Prior to the consultation

period, we were expecting changes to the regulation to come into effect as early as February 1, 2024.

2. Development and Achievement of Goals

Registration Renewal 2023
The renewal period has concluded, yielding a total of 1,090 registration renewals. Since the launch of the renewal period on August 1, the College has received 23 resignations. As of November 21, 2023, there are 1,091 current registrants, comprising 243 inactive and 848 practising professionals.

National Collaboration on a Competency-Based Assessment Program
Since the last update, the assessment tool was created, consisting of eight case scenarios intended for delivery through a structured oral examination format. The case scenarios underwent a rigorous process of review and validation. In addition, a fairness review was conducted aimed at ascertaining inclusivity, avoiding perpetuating stereotypes, and guaranteeing that the scenarios accurately reflected the terminology and circumstances inherent to the profession.

The final phase of the project involved piloting the tool to measure its effectiveness and solicit feedback for refining the overall process. Trained pilot assessors conducted eight assessments throughout November.

Each assessment, spanning approximately three hours, consisted of a panel of three assessors and a participant. The participant was selected either because they were a former registrant or a registrant whose file was recently reviewed by the registration panel due to a class change request or a shortfall in active practice requirements.

As the project concludes, the final report with recommendations will be presented to the Registration Committee at their next meeting early in the new year.

Orientation and Assessment Program
The application period has closed for the second cohort of internationally educated applicants. Although there is a lower volume of applications and program interest compared to the inaugural cohort, this is expected given that the program ran twice in a single year. In contrast, the International Midwifery Pre-Registration Program was only delivered once a year. Enrolment figures and trends will guide the College in determining the program's frequency post-pilot.

Simultaneously, the module content is undergoing a thorough review and the in-person intensive is scheduled to run in mid-April. Given the modest enrollment, the intensive is projected to span six days.

In preparation for first cohort applications, the Registration Committee endorsed a policy to evaluate clinical experience for those who successfully completed the Orientation and Assessment Program. International applicants who successfully completed the program can anticipate registration either with a Supervised Class certificate or under General class certificate with new registrant's conditions. Each application will undergo an individual assessment, factoring in clinical experience gained outside of Canada.

Waiver Policy - Standards
The Quality Assurance Committee has reviewed the Standards' Waiver Policy as part of its regular policy review cycle. There have been no applications for waivers since Council approved changes to the Second Birth Attendant Standard in 2022. To anticipate future changes within the healthcare landscape, the Committee agreed that the policy has not outlived its usefulness and may be needed in the future. The Committee is asking Council to renew the policy with minor edits. Please see agenda item 10 for details.

Vaginal Birth After Caesarean Section and Choice of Birthplace Position Statement
The Quality Assurance Committee has reviewed the Vaginal Birth After Caesarean Section and Choice of Birthplace Position Statement as part of its regular policy review cycle. In an effort to draw continued focus to the midwifery Scope of Practice and the Professional Standards for Midwives, the Quality Assurance Committee recommends that Council rescind the 2018 position statement since it is both redundant and reflects only one of many situations where midwives are expected to centre the client as the primary decision maker in their health decisions. Committee members acknowledged that targeted and clear communications must be provided to midwives, the public, and other partners to ensure that the reason for rescinding is clear and that the College continues to expect midwives to offer a choice of birthplace to clients experiencing a trial of labour after caesarean section. Please see agenda item 10 for details.

Course on Administering Controlled Substances for Midwives
The Quality Assurance Committee recommends that Council approve the College's course on Administering Controlled Substances for Midwives in preparation for changes to the Designated Drugs and Substances Regulation that are expected in early 2024. This course will provide the necessary information on the legislative and regulatory framework that serves to protect the public in regard to the administration of controlled substances. Midwives who will administer controlled substances will be able to satisfy the regulation's requirements of knowledge skills and judgment to maintain public safety following completion of this course (unless they have already satisfied this requirement through Registrar-approved formal education and training). Please see agenda item 10 for details.

3. Reputation and Relationship Management

Communications with Registrants and the Public
Regular communications with registrants and the public continue to take place via email, social media, telephone, and on our website. Our LinkedIn channel is continuing to grow with popular posts about the Orientation and Assessment Pilot Program and the news about the expanding list of drugs and substances that midwives can prescribe and administer.

The College was approached by a journalist from the Canadian Press looking for information on the proposed changes to the Designated Drugs Regulation. I spoke with Allison Jones about the College's position on the changes and the article was in several publications including the National Post.
The Ministry of Health launched their consultation on the Designated Drug Regulation in late October and we sent out two emails to our subscriber list to advise registrants and members of the public of the opportunity to provide feedback. The Association of Ontario Midwives launched a

campaign encouraging midwives and the public to comment on the challenges of prescribing and administering to a list of drugs and to oppose the Ministry-imposed restriction of prescribing oxytocics and prostaglandins only for the purposes of preventing and treating postpartum hemorrhage, inducing or augmenting labour, cervical ripening and for the management of spontaneous early pregnancy loss or retained placental tissue, thereby excluding its use for the purposes of planned terminations. This feedback is in line with our previously articulated concerns, however, Council also supported expanding the list as an interim step recognizing that additional drugs and substances would result in improved client care while we worked with the Ministry on a long-term and sustainable solution.

We launched a survey on practice hours, to collect baseline data on how midwives in Ontario practise. We have conducted this survey for the third time in order to track how responses have changed against a set of baseline questions that were asked in the previous annual surveys. At the time of writing this report, there had been 279 responses to the survey and one final email reminder for registrants has been scheduled.

Meetings with Partners
In October, the College held one of our regular meetings with the Association of Ontario Midwives (AOM) and shared updates and news about upcoming projects each organization is taking on.

The Ontario Midwifery Strategy Council (OMSC) met in early November to discuss issues of common interest, including an increase in reports of unauthorized practitioners. The OMSC includes representatives from the College, the Association of Ontario Midwives, the Midwifery Education Program, the birth centres, and the Provincial Council for Maternal and Child Health.

Student Engagement Strategy
Work continues on the College's Student Engagement Strategy, and we expect to send a survey to midwifery students and new registrants before the end of the year. The feedback we receive will inform our decisions on which tools to use to reach midwifery students most effectively. We will also consult with faculty and preceptors.

Celebrating 30 Years of Midwifery Regulation
The College of Midwives of Ontario was established on January 1, 1994 and next year will mark 30 years of regulating the profession in the public interest. We are preparing communications pieces to share with registrants and the public to celebrate the many milestones we have accomplished over the past 30 years.

4. Financial Accountability and Management

Statement of Operations
The Q2 Statement of Operations was approved by the Executive Committee at its last meeting and is presented under the Executive Committee's report to Council for your information. The Q2 Statement of Operations reflects the revised budget that was approved at the October 2023 Council meeting.

Assessment of External Auditor

The annual assessment report of the external auditor was presented and approved at the October 2023 Council meeting. The Executive Committee has approved and is bringing forward proposed changes to the assessment tool and process. The Executive Committee is proposing a condensed annual assessment to increase effectiveness and reduce repetitiveness. As a result of the condensed nature of the annual assessment, the Executive Committee is also proposing that the comprehensive assessment be undertaken every three years rather than every five years.

5. People and Organizational Leadership

The College has finalized dates for collective bargaining with AMAPCEO. Bargaining will get underway in November 2023.

The College is developing an internal Learning and Development strategy. The purpose of the strategy is to provide a detailed plan that guides our learning goals and initiatives. The strategy will also help ensure that our learning goals and initiatives are aligned with strategic priorities and organizational needs.

6. Council Governance and Engagement

Council Updates

A by-election is currently running from November 1, 2023 to November 30, 2023, to fill a vacancy for a professional member position on Council. There are two nominees: Naa Yoyo Nartey-Khama and Maureen Silverman. The successful candidate will commence their term at the first Council meeting post-election (December 6, 2023) and will end October 2025.

The Annual Council Evaluation was launched immediately following the October 12 Council meeting. Results and summary of findings were presented to the Executive Committee in November and discussion was had on using the evaluation process to improve and reinforce good governance behaviours and identify continuous improvement priorities. More information can be found in the Executive Report under agenda item 8.

We are pleased to report that three public non-Council committee member applications were received. These individuals are included in the recommendations for committee term appointments. In addition, three current public non-Council appointees who are eligible for reappointment are also included. Six professional non-Council appointees are eligible for re-appointment. No new professional member applications were received although it should be noted that Maureen Silverman is a current professional non-Council member interested in re-appointment but also running in the by-election. A more detailed description of the committee appointment recommendations is included in the Executive committee report under agenda item 8.

Attachments: N/A

EXECUTIVE COMMITTEE

REPORT TO COUNCIL – December 2023

General

Committee Members

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

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Committee Meetings Held	3	2	1		6
Number of Trainings	0	0	0		0

Committee Meetings

November 15, 2023 | Videoconference

Items

Q2 Statement of Operations

The Committee reviewed and approved the Q2 Statement of Operations. The statement is attached for reference.

Revisions to the Assessment of the External Auditor Tool

In their report to Council in October, the Executive Committee proposed recommendations to amend the process and cycle of the external auditor assessment. An assessment will continue to be conducted annually. The annual assessment will still be conducted in May with a presentation to Council in October. The revisions include a condensed annual assessment tool to provide key probing questions and assess 1) Three quality factors: Independence, objectivity and professional skepticism 2) Quality of the engagement team 3) Quality of communications and interactions with external auditor. The other revision is that a comprehensive assessment be conducted every three years instead of every five. The Committee approved the revised tool and process for implementation. A copy of the tool is attached for reference.

Annual Council Evaluation

The Committee reviewed the results of the 2023 year-end Council evaluation, noting that College staff assumed administration of the evaluation from the external consultant who was unable to complete the process due to unexpected circumstances. Overall, the results of the evaluation are positive with good feedback. The Committee discussed potential strategies to keep Council engaged in between meetings as well as the possibility of more in-person meetings, which are vital to fostering culture and connection as a collective. Succession and leadership development was discussed as key continuous improvement priorities for the College. A copy of the evaluation report and a briefing note are attached for reference.

Staff recommended updates to the Council evaluation process and these recommendations are being brought forward to Council in a separate briefing note attached.

Committee Appointment Recommendations

The Committee reviewed the proposed committee appointments and discussed the importance of appointing new chairs with the intention of building leadership and capacity within our governance structure. The Committee is recommending two co-chair positions for Registration and Quality Assurance. Co-chairs will consist of a previous chair of the Committee and a first-time chair. The purpose of the co-chair relationship is to provide mentorship and support to the chair role in the interest of succession planning and leadership development.

Co-Chairs will work together and share chair responsibilities for six months as a transition period. During this time, both chairs will be compensated for their time.

Three new public non-Council committee appointment applications were received, and they are included in the recommendations. Three of the four current public non-Council committee appointees have submitted interest in reappointment and continue to be eligible and are therefore included in the recommendations, giving a total of six public non-Council committee applicants being recommended for appointment. In addition, six professional non-Council committee appointments are being recommended to Council; all are eligible reappointments.

The following motions are being brought forward for approval:

I. That the Executive Committee report be approved as presented.
II. That the proposed committee composition for 2023-2024 be approved and that the terms of current non-Council appointees Jillian Evans (public) and Sarah Kirkland (professional) be extended to January 2024 so they can complete unresolved panel work*

**Note: Dependent on outcome of by-election, committee composition will change.*

Attachments;

1. Q2 Statement of Operations
2. Revised Annual & Comprehensive Assessment of the External Auditor by the Executive Committee Tool
3. 2023-2024 Committee appointment recommendations

Respectfully Submitted,

Claire Ramlogan-Salanga, Chair

The College of Midwives of Ontario

Q2 Statement of Operations (Fiscal April 1, 2023-March 31,2024)

April 1, 2023 - Sept 2023

	F24 Projected Revenue Budget	F24 Projected Revenue to end of Q2	Q2 Revenue F24	Q2 Revenue F23	Percentage Variance Against Budget
REVENUE					
Membership Fees	$ 2,703,230	$ 1,351,615	$ 1,325,465	$ 1,314,716	49%
Administration & Other	$ 81,097	$ 40,549	$ 94,294	$ 29,872	116%
Project Funding - Birth Centres	$ 65,063	$ 32,532	$ 32,532	$ 26,870	50%
O & A Program	$ 98,750	$ 49,375	$ 48,030	$ -	49%
Competency Based Assessment Program	$ 14,688	$ 7,344	$ 14,688	$ 26,840	100%
TOTAL REVENUE	**$ 2,962,828**	**$ 1,481,414**	**$ 1,515,008**	**$ 1,398,299**	**51%**

	F24 Budget Expenses	F24 Budget to end of Q2	Q2 Spending F24	Q2 Spending F23	Percentage Variance Against Budget
EXPENSES					
Salaries & Benefits	$ 1,694,658	$ 847,329	$ 683,325	$ 570,876	40%
Professional Fees	$ 327,275	$ 163,638	$ 168,821	$ 60,884	52%
Council and Committee	$ 150,431	$ 75,216	$ 50,593	$ 62,225	34%
Office & General	$ 119,288	$ 59,644	$ 48,761	$ 29,853	41%
Information Technology, Security & Data	$ 135,291	$ 67,646	$ 62,180	$ 50,400	46%
Rent & Utilities	$ 157,517	$ 78,759	$ 100,571	$ 96,426	64%
Conferences, Meeting Attendance & Membership Fees	$ 84,652	$ 42,326	$ 62,899	$ 61,821	74%
Panel & Programs	$ 308,088	$ 154,044	$ 36,393	$ 18,957	12%
Birth Centre Assessment & Support	$ 65,063	$ 32,532	$ 30,858	$ 32,919	47%
O & A Program Expenses	$ 98,145	$ 49,073	$ 42,660		43%
Competency Based Assessment Program Expenses	$ 91,849	$ 45,925	$ 66,538		72%
Capital Expenditures	$ 30,000	$ 15,000	$ 15,416	$ 21,531	51%
TOTAL EXPENDITURES	**$ 3,262,257**	**$ 1,631,129**	**$ 1,369,014**	**$ 1,005,891**	**42%**
PROJECTED GAIN / (LOSS)	**$ (299,429)**	**$ (149,715)**	**$ 145,994**	**$ 392,407**	

ADDITIONAL NOTES

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

Total Accrual	$ 70,643
Accrual Budget to end of Q2	$ 35,321
Accrual Spending to end of Q2	$ 30,704

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

Annual & Comprehensive Assessment of the External Auditor by the Executive Committee[1]

Version Approved by Executive Committee: September 18, 2019
Annual schedule revised by Executive Committee November 2021
Schedule and annual assessment revised by Executive Committee November 2023

[1] The tools and templates provided by the Chartered Professional Accountants of Canada (CPA) to businesses looking to conduct both annual and comprehensive audits were used as the base to create this tool.

Introduction

The Executive Committee of the College of Midwives conducts both an Annual Assessment of the external auditor prior to reappointment, and a Comprehensive Audit Assessment in place of an Annual Assessment every three years (at minimum).[2] Assessments are conducted to align with best practices as laid out under the Enhanced Audit Quality Initiative put forward by the Chartered Professional Accountants of Canada (CPA). This process allows the Committee to produce quality improvement recommendations for the external auditor annually, recommend the auditor for tender or reappointment periodically, as well as note any concerns.

It should be noted that the Annual Assessment's purpose is to help the Committee identify areas for improvement for the audit firm, and not to decide if the external audit should be put out for tender. In the event that the Committee finds real concerns, they could choose to recommend tender early, but normally this would be a decision made at the time of the Comprehensive Assessment.

Following the Comprehensive Assessment, the Executive Committee will either reassure Council of the quality and objectivity of the incumbent auditor and put that firm forward for re-appointment, or offer Council the recommendation that they should procure a new external auditor.

Tool Currency and Review Cycle

The Tool and associated policies are approved by the Executive Committee.

The Tool (including all appendices) will be formally reviewed the year after the completion of the Comprehensive Audit Assessment (i.e. at least every three years). Between review cycles the Committee may wish to make modifications to the Tool based on their changing needs and circumstances.

Timelines

The annual audit takes place in May each year. The financial statements are presented for approval to the Council at their June meeting. After presentation of the statements the Executive Committee is in a position to reflect on the audit process and decide on its quality and objectivity. The Executive Committee should begin either the annual or Comprehensive Assessment process at their January/February Executive meeting with the goal of sharing with Council their recommendation at Council's October meeting. In the

[2] It should be noted that the Comprehensive Assessment could be conducted earlier than every three years if the Executive Committee determines it is necessary to do a more fulsome assessment. Reasons might include a major change in corporate structure or a poor auditor assessment in the previous year.

event that it is not recommended that the auditor be reappointed, this allows enough time for a procurement process to be undertaken to secure a new auditor in advance of the annual audit in May.

Annual Schedule

TIME	DELIVERABLE
Jan/Feb Executive Meeting	At this meeting, the Executive Committee will review the previous year's assessment and decide if any changes / altered focus is required in the current year's assessment. The Committee will determine if they will require any additional meetings with the auditor outside of the spring Executive Meeting. Staff will be directed to set meetings and create schedules as required.
May	Executive Committee will attend the audit and begin making notes for the completion of the tool.
Executive Meeting after Council in late June	The formal assessment begins. The Executive will determine if meetings with either the auditor or staff are required and will request those meetings and/or set report deadlines. Draft report writing will commence after the June Council meeting where all materials will be reviewed and a recommendation for Council will be decided regarding Auditor reappointment, and level of assessment for the following year. If recommendations are being made to the auditor or staff, they will need to be delivered to the appropriate party after the meeting.
June/July	Executive Committee will draft the final report to be reviewed
September Executive Meeting	A final report will be created, and any revisions can be made at this meeting. This report will be presented at the October Council meeting.
October Council Meeting	Executive presents their summary report and, in the event of a comprehensive audit, their recommendation to reappoint the auditor or put the audit to tender. They will also inform Council of the recommended assessment structure for the following year (Annual or Comprehensive Assessment). Council approves the recommended assessment choice for the following year, and either reappoints the auditor or decides to go to tender.

ADDITIONAL NOTES REGARDING THE SCHEDULE:

- The Executive Committee may require additional meetings to complete the work, these can be in addition to the schedule above.
- The Committee Chair plays a key role in assisting the Committee to follow an appropriate process for the Annual or Comprehensive Assessment.
- The Chair should consider involving all members of the Executive Committee in the preparation of the Assessment tool for the purpose of training members to take a leadership role in the future.

Assessment Goals

The assessment tools should assess three quality factors of an audit:

1. Independence, objectivity and professional skepticism – Do the auditors approach their work with objectivity to ensure they appropriately question and challenge management's assertions in preparing the financial statements?
2. Quality of the engagement team – Does the audit firm put forward team members with the appropriate industry and technical skills to carry out an effective audit?
3. Quality of communications and interactions with the external auditor – Are the communications with the external auditor (written and oral) clear? Is the auditor open and frank, particularly in areas of significant judgments and estimates or when initial views differ from management?

Assessment Elements

The Annual Assessment will consist of the following elements:

1) Determine the scope, timing and process of assessment
2) Completion of Annual Assessment Tool with input from College personnel
3) Any other elements/processes that the Executive Committee deems necessary
4) Recommendation report prepared for Council (staff support can be provided if needed)
5) Report to Council

The Comprehensive Assessment will consist of the following elements:

1) Determine, scope, timing and process of assessment
2) Obtain information from College personnel
3) Obtain input from the Auditor
4) Executive Committee Analysis
5) Observation of the auditor's performance during Executive and Committee meetings. There is the option to observe part of the audit itself, and Executive would decide if this was necessary at the January/February Committee meeting.
6) Discussions with the auditor (as required) and Auditor Feedback Survey
7) Any other elements/processes that the Executive Committee deems necessary

8) Recommendation report prepared for Council (staff support can be provided for this)
9) Council reappoints the auditor or goes to tender

Annual Assessment Process

1. Determine the scope, timing and process

Before proceeding with the Annual Assessment, the Executive Committee should review the process to ensure that no alterations are required for the current year's audit. If changes are required to the Annual Assessment they should be made before the assessment is undertaken. Changes can be suggested at the January/February Committee meeting after the document review, and staff can be engaged to make the required changes and send the revised document to the Committee members.

Guiding questions:

POINTS TO CONSIDER	OBSERVATION
Have there been significant changes in the organization (CMO) that require changes to the assessment process this year?[3]	
Do the results of the prior-year's assessment indicate areas that should be given particular focus this year?	
What changes need to be made to other sections of this tool to reflect the approach to this year's Annual Assessment?	

2. Annual Assessment Tool

This section includes a number of criteria related to the quality of services and fulfillment of roles and responsibilities. This section should be completed by both College personnel and Executive Committee members. Add a "Y" or "N" in the appropriate box.

[3] Note that it may be appropriate to conduct a Comprehensive Assessment rather than an Annual Assessment of the external auditor if significant issues or changes have already been identified. (e.g. the Director of Operations leaves and a new system is put in place, or the Registrar leaves etc.).

Criteria	OBSERVATION	
	COLLEGE PERSONNEL	EXECUTIVE COMMITTEE
The resources assigned by the auditor to complete the work are sufficient.		
Communication by the auditor is provided in a timely, respectful and professional manner.		
The auditor met the agreed upon performance criteria and deliverables e.g engagement letter, audit scope, financial statements and was available to the Executive committee.		
The auditor fulfilled and reported on the following objectives:		
• Obtained reasonable assurance about whether the financial statements as a whole are free from material misstatement.		
• Evaluation of financial internal controls.		
• Evaluation of accounting policies and practices.		
• Ensuring that the organization is appropriately managing its ability to meet current and future obligations.		

This section includes questions related to the three quality factors. This section should be completed by both College personnel and Executive Committee members.

Independence, Objectivity & Professional Skepticism	OBSERVATION

INPUT FROM COLLEGE PERSONNEL	
Does the external auditor approach their work with objectivity to ensure they question appropriately and challenge management's assertions made when preparing the financial statements?	
INPUT FROM EXECUTIVE COMMITTEE	
Does the external auditor either confirm their independence or inform the Executive Committee about matters that might reasonably be thought to compromise their independence?	
Quality of the engagement team	**OBSERVATION**
INPUT FROM COLLEGE PERSONNEL	
Does the audit firm put forward team members with the appropriate industry and technical skills to carry out an effective audit?	
Communication and interactions	**OBSERVATION**
INPUT FROM COLLEGE PERSONNEL	
Are the communications with the external auditor timely, clear and concise? Is the auditor open and frank regarding judgements or views that may differ from management?	
INPUT FROM EXECUTIVE COMMITTEE	
How candid and complete was the dialogue between the auditor, the Executive Committee and/or the Executive Committee Chair? How well did the auditor explain accounting and auditing issues?	

3. Conclude the Annual Assessment and Communicate Results

Conclude the Annual Assessment and prepare a summary report for Council. See Appendix A. The summary report should include a recommendation on whether the next year's assessment should be an Annual or Comprehensive Assessment.

Points to consider:

- Has sufficient information been obtained to allow the Executive to reach a conclusion and consider the assessment complete?
    - If the preliminary results of the assessment are not satisfactory, the Committee may need to take further action to determine whether its preliminary conclusions are justified and to consult with those affected by its recommendations.
- What recommendations for action should be made to the Council? These would include:
    - Recommendation for the following year's audit assessment type (annual or comprehensive)
    - Any recommended changes to assessment procedures (as needed)
- Does the Committee need to formally discuss the results of the assessment with the Council, or will a written report suffice?

Record items to be raised with the auditor for follow-up or future changes:

ITEM	PERSON RESPONSIBLE FOR FOLLOW-UP

Potential future changes to the Tool or process:

POTENTIAL CHANGE	PERSON RESPONSIBLE FOR FOLLOW-UP

Comprehensive Assessment Process

The Comprehensive Assessment assumes that the Committee has conducted Annual Assessments of the external auditor in the previous years. The Comprehensive Assessment includes all processes listed below. This assessment would cover not just the previous year's audit but would also review all audits that underwent annual assessments since the last comprehensive assessment.

It should be noted that the Executive Committee is responsible for determining the scope, timing and process for the Comprehensive Assessment and not staff or the auditor. Although the staff and the auditor contribute, the process belongs to the Executive Committee. A Comprehensive Assessment should be conducted at least every three years.

As part of the Comprehensive Assessment process the Executive Committee should look for the external auditor to identify any threats to independence and describe safeguards they have put in place. Some factors to consider would be:

a) Number of years the audit firm has served as external auditor
b) Length of service of key audit team members
c) Whether familiarity threats have been identified and if so what safeguards have been put in place
d) The transparency of audit firm and staff interactions and whether the Executive Committee is aware of any interactions that might impair independence.
e) Whether the fees are sufficient to provide for an audit of appropriate quality taking into account changes in the College's business.

1. Additional Information to Determine Scope, Timing, and Process

In addition to the considerations noted in the Annual Assessment process, the Executive may wish to also consider the following:

POINTS TO CONSIDER	OBSERVATION
When was the last Comprehensive Assessment conducted and what period should this assessment cover?[3]	

2. Obtain Input from College Personnel

[3] The Comprehensive Assessment should, as a rule, cover all assessments since the previous Comprehensive Assessment.

This section includes a number of questions the Executive Committee may want to ask College personnel, such as the Registrar and the Director of Operations. The Executive Committee needs to determine whether they wish to obtain input in writing or through discussions.

In advance of the discussion, the Executive Committee will need to request to have the following information made available to them by staff:

- ☐ Relevant Executive Committee meeting minutes and results of Annual Assessments.

- ☐ The College policies for awarding non-audit work and any reports by management on how it has complied with those policies.
- ☐ Whistleblowing policy and associated reports that may have relevance to the relationship with the audit firm.
- ☐ Information about any significant financial reporting matters that have been questioned by regulators or the press that may have relevance for the relationship with the auditor.

QUESTIONS FOR COLLEGE PERSONNEL (Normally the Director of Operations)

POINTS TO CONSIDER	OBSERVATION
RE: INDEPENDENCE, OBJECTIVITY & PROFESSIONAL SKEPTICISM	
How does the external auditor demonstrate integrity, objectivity and professional skepticism, (e.g. by maintaining a respectful but questioning approach throughout the audit)?	
How does the external auditor demonstrate independence (e.g. by proactively discussing independence matters and reporting exceptions to its compliance with independence requirements)?	
How were significant differences in views, if any, between management and the external auditor resolved?	
How did the external auditor adjust the audit plan to respond to changing risks and circumstances?	
How forthright is the external auditor in dealing with difficult situations (e.g. by proactively identifying, communicating and	

resolving technical issues)?	
The auditor and the audit team should have performed risk assessment at the outset of the audit including assessment of fraud risk. Conclude if this process was followed.	
RE: QUALITY OF AUDITOR AND THEIR STAFF	
How would you assess the technical competence and ability of the external auditor to translate knowledge into practice (e.g. by using technical knowledge and independent judgment to provide realistic analysis of issues and by providing appropriate levels of competence across the team)?	
How would you assess the external auditor's understanding of our business and industry (e.g. by demonstrating an understanding of our specific business risks, processes, systems and operations)?	
How sufficient are resources assigned by the external auditor to complete work in a timely manner (e.g. by providing access to specialized expertise during the audit and assigning additional resources to the audit as necessary to complete work in a timely manner)?	
RE: COMMUNICATION AND INTERACTION WITH THE EXTERNAL AUDITOR	
How candid and complete was the dialogue between the auditor and management? How well did the auditor explain accounting and auditing issues?	
How effectively does the auditor provide timely and informative communications about accounting and other relevant developments?	
How does the external auditor communicate about matters affecting the College as a going concern? Note: Going concern is an accounting term for a company that has resources to continue operating indefinitely.	

Provide your overall views on how your relationship with the external auditor contributed to your ability to produce reliable financial reporting throughout the assessment period.	
To what extent does the external auditor keep management informed about the progress of the audit and difficulties encountered?	
To what extent is the external auditor proactive in identifying information requirements and timely in requesting information from management?	
RE: QUALITY OF SERVICE CONSIDERATIONS	
How would you assess the value for money delivered by the external audit (e.g. do the audit fees fairly reflect the cost of the services provided given the size, complexity and risks of the College and a cost-effective quality audit)?	
OTHER INPUT REQUESTED FROM STAFF	

3. Obtain Input from the Auditor

This section includes a number of questions the Executive Committee may want to ask the Auditor. The Executive Committee needs to determine whether they wish to obtain input in writing or through discussions.

In advance of the discussion, the Executive Committee will need to request to have the following information made available to them by the auditor:

- ☐ Analysis of total services provided by the audit firm, covering audit and non-audit services and related fees, since the last Comprehensive Assessment; explanations for differences between actual and estimated fees and between actual audit fees and cost recoveries. Consider obtaining an analysis of other auditors' fees for similar services to comparable entities, where available.
- ☐ Summary of auditor's reports (e.g., consolidated financial statements, subsidiary

financial statements, reports to regulators, special reports).

- ☐ Summary of reports issued to the Executive Committee, including significant matters addressed.
- ☐ A communication from the firm regarding any conflict of interest issues, or independence issues.[5]
- ☐ Summary of reports to management.
- ☐ Summary of key elements of the firm's quality control processes and how they were applied to the College's audit.
- ☐ Annual reports of the audit firm (to confirm the best practices and liquidity of the firm).

QUESTIONS FOR THE AUDITOR

POINTS TO CONSIDER	OBSERVATION
How long has the audit firm been the external auditor? What steps have been taken to address possible institutional familiarity threats?	
What are the firm's expectations as to future partner rotation or other changes to senior audit team personnel?	
How are the resources and size of the audit firm changing?	
What efforts are being made to enhance audit quality within the audit firm generally and the external audit of the College specifically?	
How has the audit firm's relevant expertise in the industries and markets in which the College operates been evolving? What are the audit firm's future plans to serve the College with an audit team with appropriate expertise?	
How has the audit firm considered systemic audit quality issues identified by the Canadian Public Accountability Board (CPAB)	

[5] Canadian auditing standards require the auditor to communicate with the Committee all relationships between the College and the firm that, in the auditor's professional judgment, may reasonably be thought to bear on independence. This includes total fees charged during the period covered by the financial statements for audit and non-audit services and the related safeguards that have been applied to eliminate identified threats to independence or reduce them to an acceptable level.

in its public reports?	
What reputational challenges, if any, are facing the audit firm and how are these being addressed?	
Has the audit firm been disciplined by CPA Ontario since the last Comprehensive Assessment? If so the Executive Committee should review the findings.	
Has the audit firm been subject to reinspection by CPA Ontario since the last Comprehensive Assessment?	
How have significant differences in views, if any, between College management and the firm been addressed?	
OTHER INPUT REQUESTED FROM THE AUDIT FIRM	

4. Executive Committee Analysis

This section includes a number of questions for consideration to be completed by the Executive Committee. This includes questions related to the Auditor responses to the previous section, as well as questions related to the three quality factors.

POINTS TO CONSIDER	**OBSERVATION**
Considerations from Auditor responses	
What institutional familiarity threats has the audit firm identified? What steps have been taken to address them?	
To what extent has the College employed former audit firm staff in key financial positions?	
What personnel changes, if any, in the audit firm or the College could create a perception	

that the external auditor is no longer independent?	
What corporate hospitality has been provided to the audit firm/management by management/the audit firm that could bring the external auditor's independence into question?	
What reputational damage or regulatory action, if any, has the audit firm suffered that could bring into question its professionalism, independence or financial stability?	
Has the non-audit work by the external auditor policy been complied with?	
If the audit firm has been subject to discipline or reinspection from CPA Ontario since the last audit cycle, was there evidence presented by the auditor that mitigated any concerns about their viability as the Colleges auditor	

POINTS TO CONSIDER	OBSERVATION
QUALITY FACTOR: INDEPENDENCE, OBJECTIVITY & PROFESSIONAL SKEPTICISM	
Does the external auditor either confirm their independence or inform the Executive Committee about matters that might reasonably be thought to compromise their independence?	
Did the staff and auditor follow the Policy for Awarding Non-Audit Work to the External Auditor?	
How did the external auditor adjust the audit plan to respond to changing risks and circumstances?	
What steps does the auditor take to ensure that their staff exhibits the values, ethics and attitudes necessary to support a quality audit?	

If Executive is aware of any significant differences in views between management and the external auditor were they resolved?	
What evidence is there that the audit team challenges decisions made by management in preparing the financial statements?	
How has the external auditor addressed potential risks of fraud (e.g. incorporating an element of unpredictability into the audit procedures during the period)?	
Do you have confidence in the professional judgments made by the auditor?	
QUALITY FACTOR: COMMUNICATION AND INTERACTION WITH THE EXTERNAL AUDITOR	
How candid and complete was the dialogue between the auditor, the Executive Committee and/or the Executive Committee chair? How well did the auditor explain accounting and auditing issues?	
How would you assess the external auditor's discussion about the quality of the College's financial reporting, including the reasonableness of accounting estimates and judgments, appropriateness of the accounting policies and adequacy of the disclosures?	
What is your assessment of how the external auditor discussed sensitive issues (e.g. were concerns about management's reporting processes, internal control over financial reporting or the quality of the College's financial management team discussed in a timely, candid and professional manner)?	
If the auditor didn't receive cooperation from staff did they alert the Executive Committee promptly?	
How well did the external auditor inform the Executive Committee of current developments in accounting and auditing standards relevant to the College's financial statements and their potential impact on the	

audit?	
QUALITY FACTOR: QUALITY OF SERVICE CONSIDERATIONS	
During the audit, how well did the external auditor meet the agreed-upon performance criteria (e.g. by meeting agreed-upon performance delivery, being available and accessible to management and the Executive Committee?)	
How did the auditor and audit team ensure that the necessary knowledge and skills (College-specific, industry, accounting, auditing) were dedicated to the audit?	
What evidence was there that the engagement partner (e.g. lead auditor) devoted sufficient attention and leadership to the audit?	
How proactive is the external auditor in identifying opportunities and risks, (e.g by anticipating and providing insights and approaches for potential business issues and improving internal controls)?	
OTHER INPUT REQUESTED FROM THE EXECUTIVE	

5. Additional Information to Conclude the Comprehensive Assessment and Communicate Results

In addition to submitting a report to Council the Executive Committee must also decide if they will recommend the current auditor for reappointment or if they will recommend the College go to tender to explore alternate vendor options.

APPENDIX A -Templates

TEMPLATE: ANNUAL ASSESSMENT REPORT TO COUNCIL

Reporting year:	
Summary observations:	
Recommendations made to the auditor:	
Recommended audit structure for the following year (FOR APPROVAL BY COUNCIL):	☐ Annual Assessment ☐ Comprehensive Assessment
Any recommended changes to the assessment process for future:	

TEMPLATE: COMPREHENSIVE ASSESSMENT REPORT TO COUNCIL

Reporting year:	
Summary observations:	
Recommendation to Council – renew auditor or go to tender (FOR APPROVAL BY COUNCIL):	
Recommended audit structure for the following year (FOR APPROVAL BY COUNCIL):	☐ Annual Assessment ☐ Comprensive Assessment
Any recommended changes to the assessment process for future:	
Recommendations made to the auditor: (In the event that the auditor is to be renewed)	

APPENDIX B -Disclosure of Wrongdoings (Whistleblower Policy)

PURPOSE

To provide an effective process that allows staff to bring concerns or information about illegal activities or other Wrongdoing as defined in this Policy (including improper use of College funds, assets or resources) to the attention of the Registrar for review and resolution without fear of reprisal, to provide that participants in an investigation be treated fairly and appropriately, and to ensure that the College has a process which favors transparency and accountability.

POLICY

The College's internal controls and operating procedures are intended to detect and to prevent or deter improper activities; however, at times these systems may not provide perfect safeguards against improper conduct. Staff owe a duty of loyalty to their employer, which includes a responsibility to bring to the attention of the Registrar instances of Wrongdoing. When an staff member has reasonable grounds to believe that another staff member has committed or is about to commit a financial or other Wrongdoing, as defined in this Policy:

a) the staff member must disclose this information through a clearly defined process;
b) the matter will be reviewed and, if warranted, investigated by the Registrar or Executive Committee;
c) the staff member will be protected from reprisals;
d) the subject of the disclosure will be provided an opportunity to respond to allegations;
e) all parties to an investigation will be treated fairly;
f) confidentiality will be maintained to the greatest extent possible;
g) if Wrongdoing is found, appropriate remedial and disciplinary actions will be taken up to and including dismissal for just cause and civil proceedings or criminal prosecution, as warranted by the situation.

This policy applies to all staff.

RESPONSIBILITY

The Registrar is responsible and should be reported to directly.

In the event that the disclosure is made about the Registrar, the Executive Committee should be contacted. The details of the disclosure should be made by email to the Committee Chair, and the Committee Chair will then take the lead on the investigation.

Staff are responsible to bring to the attention of the Registrar instances of Wrongdoing.

DEFINITIONS

Discloser means a staff member who makes a Disclosure under this Policy. This person is commonly referred to as a "whistleblower".

Protected Disclosure means a disclosure that is made in good faith by a staff member in accordance with this Policy.
Improper Disclosure means a disclosure made in bad faith, which includes but is not limited to providing false information, making disclosures that the Discloser knows are baseless, or making repeated disclosure concerning matters that have been previously examined and determined by the Registrar to be false.
Reprisal means any of the following measures taken against an staff member by reason that the staff member has, in good faith, made a Protected Disclosure or has, in good faith, cooperated in an investigation carried out under this Policy:

a) a disciplinary measure including demotion or termination;
b) any measure that adversely affects the employment or working conditions of the staff member; or
c) a threat to take any of the measures referred to in (a) or (b).

Subject means the person(s) whom the Discloser believes has committed or is about to commit a Wrongdoing that is covered by this Policy.
Wrongdoing for purposes of this Policy means any act or omission that is more than trivial in nature, and that is:

a) Forgery or unauthorized alteration of documents
b) Unauthorized alteration or manipulation of computer files
c) Fraudulent financial reporting and deliberate misrepresentation of financial information, including the failure to record information
d) Pursuit of a benefit or advantage that is a conflict of interest (e.g. receiving gifts of significant value from a potential supplier)
e) Misappropriation or misuse of resources such as funds, supplies, and other assets
f) Authorizing payment for goods not received or services not performed
g) Knowingly directing or counselling a person to commit a wrongdoing as defined here

PROCEDURE
WHISTLEBLOWER PROTECTION

Confidentiality will be maintained to the extent possible, consistent with the procedural requirements of this Policy. No guarantee on confidentiality protection can be made but the attempt will be made to protect the confidentiality of the Discloser unless:

- the person agrees to be identified
- identification is necessary to allow the College or law enforcement officials to investigate or respond effectively to the report
- identification is required by law
- the person accused of fraudulent or dishonest conduct is entitled to the information as a matter of legal right in disciplinary proceedings.

A file will be created when the Disclosure Process is initiated. That Disclosure File will be maintained separately from the personnel files of the Discloser or the Subject and will normally be under the control of the Registrar. Information collected may be subject to considerations such as privacy legislation and the rules governing court or other legal proceedings.

All College staff who participate in or are involved in any way in any process under this Policy will be responsible to:

- keep information relating to any process under this Policy, strictly confidential;
- refrain from discussing any Disclosure or the fact of their involvement, except to the extent required for the purposes of any investigation and resolution.

Any staff member who has reasonable grounds to believe that a reprisal has been taken against them may file a complaint with the Registrar (or in the event that the Registrar is the source of the alleged reprisal then the Executive Committee). Any staff member found to have engaged in retaliation will be subject to disciplinary action, up to and including dismissal with cause.
Provisions for protection from retaliation are not intended to prohibit management from taking appropriate disciplinary or other action against whistle blowing staff members in the usual course of their duties if such action is based solely on valid performance-related factors.

IMPROPER DISCLOSURE

Improper Disclosure will be viewed as misconduct and will be met with appropriate disciplinary action, up to and including termination of employment for cause, where warranted.

APPENDIX C - Policy on Awarding Non-Audit Work to the External Auditor

RESPONSIBLE PARTY

The Executive Committee is responsible for this policy. The Director of Operations is responsible to help enforce compliance with this policy.

PURPOSE

The objective of the policy is to provide guidance on the pre-approval process for the provision of non-audit services provided by the College's external auditor. It is required to ensure the ongoing independence of the external auditor is not compromised through the provision of non-audit services.

SCOPE

This policy applies to all services that could be provided by the external auditor.

POLICY

This policy addresses audit services, audit-related services and non-audit services that could be provided by the College's external auditor. It also explains services that are prohibited to ensure auditor independence.

AUDIT SERVICES

These are audit specific services to be performed by the external auditor pursuant to a written engagement letter, which outlines the scope and nature of the services. An estimated cost of audit services will be outlined in the engagement letter, and the auditor will be required to stay within 20% of the approved audit fee unless additional approval is given by Executive.

AUDIT RELATED SERVICES

Audit related services are assurance and related services that are reasonably and closely related to the performance of the audit of the College's financial statements. Based on the Executive Committee's belief that the provision of audit-related services does not impair independence of the auditor, the Executive Committee grants pre-approval of audit-related services at the time of approving the audit engagement letter. Audit-related services may include, among others, the following:

- Providing feedback and commentary related to accounting, financial reporting or disclosure matters, not classified as "audit services";
- Assistance with understanding and implementing new accounting and financial reporting guidance

- Assistance with all questions related to taxation and government deductions
- Agreed upon or expanded audit procedures required to respond to the needs of the Executive Committee or comply with financial, accounting, or regulatory reporting matters.
- Clarification on amortization and guidance in connection with the development of accounting policies
- Clarification on Council payments and staff payments and all related taxation questions
- New account code creation and reclassification of existing accounts
- Clarification on accounting standards (e.g. rules on record retention, best practice)

If these services individually or in aggregate over the course of the fiscal year exceed 25% of the approved audit fee estimate, there must be additional approval by the Chair of the Executive Committee or the Executive Committee prior to the commencement of the service (see Delegation of Authority section below).

NON-AUDIT RELATED SERVICES

In connection with any engagement for non-audit services the scope, nature, and anticipated fees for such services shall be agreed upon by management and the external auditor, who shall then obtain the consent of the Chair of the Executive Committee or the Executive Committee (see Delegation of Authority section below) to proceed with the proposed engagement. Once consent has been obtained engagement letters for non-audit services may be signed by one of the of the following: Registrar, Director of Operations, or Chair of the Executive Committee.

The requirement for pre-approval shall be waived if the following conditions are satisfied:

a. The cost of the services will be no more than $2,500; and
b. The non-audit services were not previously anticipated by the College at the time of engagement

Examples of Non-Audit Related Services:

- Discussions, opinion and revisions of budget documents to be submitted to the Ministry
- Analysis of lease incentives and lease documents
- Advice related to staff cost of living increases

PROHIBITED SERVICES

The external auditor is not allowed to provide any non-audit services specifically prohibited in the Canadian CPA profession's code of ethics on auditor independence standards.

No staff or previous staff of the audit firm will be employed by the College without consent from the Executive Committee.

DELEGATION OF AUTHORITY

The Executive Committee Chair may approve any engagements listed above on behalf of the full committee provided that such engagements are reported to the full committee at its next scheduled meeting.

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Summary of Council's 2023 Annual Evaluation results, plans for continuous improvement and updating the evaluation process.

Summary

This briefing note summarizes the year end Council survey results and recommendations from the Executive Committee for ongoing continuous improvement. It also includes recommended updates to the annual evaluation process.

Background

Purpose of Evaluations

In keeping with the principles outlined in our Governance Policies (GP1) Council will:

- Commit to ongoing Council development including the orientation of new Council members in Council's governance processes, engage in regular discussion towards governance process improvement and undertake an evaluation process.
- Self-monitor and discuss Council's processes and performance on an annual basis.

In keeping with the process outlined in our Governance Policy (GP10) Council will evaluate its effectiveness on an annual basis.

Accordingly,

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

In addition, Domain 1 of the Ministry's College Performance Measurement Framework (CPMF) focuses on governance. The three standards measured in the CPMF under Domain 1 are:

- Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.
- Council decisions are made in the public interest.
- The College acts to foster public trust through transparency about decisions made and actions taken.

In 2020, the College engaged an independent third-party governance consultant, Sam Goodwin, to review the Council's evaluation process and to administer Council's annual evaluation.

Current Evaluation Process

October – all Council members complete the year end evaluation survey and interviews.
November – draft analysis report reviewed by the Executive Committee.
December – draft report to Council and facilitated discussion held.
March – final evaluation report tabled at Council meeting.

As part of this process and based on the results of the year end evaluation, Council, in collaboration with the governance consultant, identifies continuous improvement priorities for the coming year.

As part of the 2022 Council evaluation process, Council identified and agreed to the following continuous improvement priorities:

- A continuing focus on Diversity, Equity, and Inclusion.
- Enriching Council's understanding of its Governance role.
- Ongoing reform of the College's Governance policies and processes.

Over the last year, work has been ongoing and continues in these areas including:

A continuing focus on Diversity, Equity, and Inclusion.

- Continued Council training and development on equity, diversity, inclusion and justice.
- Piloting collection of Council member competencies and demographics.
- Enhanced recruitment call outs for non-Council members and implementation of the Council election information sessions encouraging racialized midwives to run for Council and non-Council committee appointments by offering safe and inclusive spaces to learn about Council's role and responsibilities.
- Implementation of HPRO anti-racism and equity self-assessment tools.

Enriching Council's understanding of its Governance role.

- Continued Council training and development in the areas of governance, risk-based regulation and defining public interest from an equitable perspective.
- Chair report revised to include section for reporting on continuous improvement progress.
- Introduction of "buddy system" for new Council members.

Ongoing reform of the College's Governance policies and processes.

- Council training with legal counsel on identifying and preventing conflict of interest.
- Review of by-laws and governance policies in relation to conflict of interest and code of conduct.

Council has now completed its annual effectiveness survey, the results are summarized in the attached report. The year end survey was initiated by our external governance consultant but, College staff, in the Governance and Strategy Department, assumed the

administration of the evaluation from the external consultant who was unable to complete the process due to unexpected circumstances.

Staff ensured uptake and completion of the year end survey, summarized the results and presented them to the Executive Committee at their November meeting. Staff did not conduct further interviews with Council members as has been done in the past by the governance consultant, however, the survey had a 100% completion rate.

With the new Governance and Strategy Department at the College, we have an opportunity to not only administer the annual Council evaluation survey but to build on the work implemented by the external consultant and Council regarding Council evaluation, effectiveness and continuous improvement.

Key Considerations & Public Interest Rationale

End of Year Survey Results

The 2023 evaluation results are similar to previous years, overall positive with good comments and suggestions. The survey evaluates Council's effectiveness in the following areas:

1. Governance and Decision Making
2. Leadership
3. Financial Performance and Risk
4. Council Performance
5. Continuous Improvement

In each of the indicators under these categories, Council scored four and above out of five, demonstrating ongoing effectiveness in the execution of their fiduciary role and responsibilities pertaining to the mandate of the College.

Based on the suggestions received via the survey, the following were identified as possible areas for improvement:

- Ways to effectively monitor and anticipate the impacts that our decisions have on marginalized registrants.
- Leadership development, succession planning.
- Better engagement during meetings.
- Financial literacy and skills to develop/assess strategic planning

Council Continuous Improvement Priorities 2024

The Executive Committee acknowledged that work on the continuous improvement priorities is ongoing and that based on this year's survey results, it would benefit Council to remain focused on the previous year's priorities with an enhanced focus on succession planning, leadership and engagement development.

As outlined in the Chair's report, the following are highlights of areas of work already planned to address these continuous improvement priorities:

A. Continuous improvement regarding Equity, Diversity, and Inclusion
   - Targeted training days and time to apply the lessons learned.
   - Ensuring Council is accessible digitally and physically.
   - Council "buddy system" evaluation.
   - Unconscious bias training.

B. Enriching Council's understanding of its governance role
   - Training regarding financial literacy for not-for-profit organizations.
   - Training regarding Chair and Committee engagement and decision making.
   - Succession planning including the implementation of Co-Chairs.

C. Ongoing Reform of the College's Governance Policies and Processes
   - Piloting collection of competencies and demographics from council members to better identify our resources and gaps.
   - Review and revisions to regulatory impact assessment and decision-making tools.
   - Review of College By-laws.
   - Planning for future governance modernization initiatives.

Updates to the Annual Evaluation Process

The Executive Committee considered changes to the Council evaluation process as outlined below. The recommendations build on the evaluation process to help Council further evaluate and reinforce ongoing learning and governance effectiveness across the work of Council and its committees.

Annual Evaluation:

- Continue with the annual Council evaluation process but bring it in-house, based on the success of the 2023 year-end survey administration that was administered by staff and the new capacity that has been established with the implementation of the Governance and Strategy department at the College.
- Continue to implement post-Council meeting and training surveys, with revisions to questions to incorporate performance indicators that reflect the governance principles that Council commits to.
- Implement committee surveys.
- Use housekeeping time of meetings to administer the surveys to improve response rate.
- Use surveys and feedback mechanisms to not only evaluate Council and committee effectiveness but to also reinforce the College's governance principles, strategic priorities and learnings from continuous improvement initiatives.
- Implement meetings with committee Chairs, Executive Committee and staff for feedback, leadership training and development.
- Annual evaluation report to incorporate year-end survey results from both Council and committees with ongoing monitoring and reporting on post-Council meeting and training survey results reported throughout the year.

Further building on the annual evaluation process established by the external consultant and in keeping with the Council evaluation requirements outlined in the Governance Policies and the CPMF, we will engage with our external third-party consultant every three years.

Next Steps

- Staff to work with the Executive Committee and the external governance consultant, to finalize evaluation process and update surveys as needed.
- Staff to work with the Executive Committee to continue succession planning and governance modernization discussions and planning.
- Staff to work with Committee Chairs to implement evaluations.
- Implementation of training plans.

Recommendations

The following motions are submitted for approval:

THAT Council approve the year end Council evaluation report and identified areas for continuous improvement for ongoing work.

THAT Council approve the recommended changes to the Council and committee annual evaluation process.

Implementation Date

The updated evaluation process will be implemented for the 2023-24 governance year.

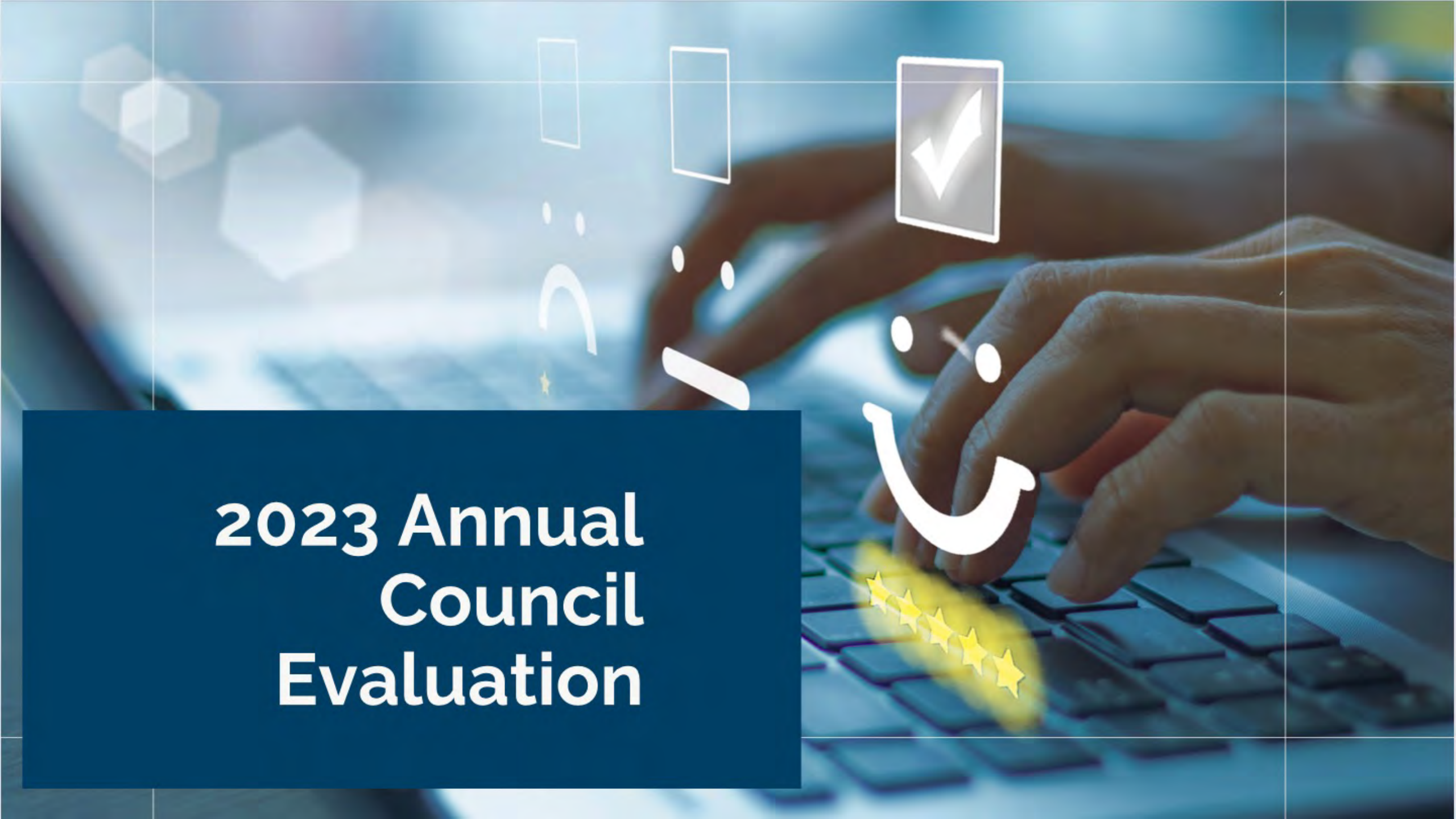
Legislative and Other References

N/A

Attachments

2023 Annual Council Evaluation Report

Submitted by:
Executive Committee



2023 Annual Council Evaluation

Overview

The Process

•Survey initiated after October Council meeting

•Reflection of past year and identification of opportunities for improvement

•College-staff took over administration of survey from external advisor October 20

The Categories

1. Governance and Decision Making
2. Leadership
3. Financial Performance & Risk
4. Council Performance
5. Continuous Improvement

The Results

- 13 responses received
- Nothing drastically different from previous years, overall positive with good comments and suggestions.

1. Governance and Decision Making

1. Council members have a good understanding of the mandate, mission and programs of the College.

4.3
5.0

Overall continue the education & trainings that reinforce roles and responsibilities of Council and committees.

Opportunities for mentorship and buddying between experienced/new Council and committee members.

An annual refresher on structure of College as an organization may be helpful for Council to understand.

2. Council members are aligned on their role as Governors to make decisions in the public interest.

4.8
5.0

The focus on public interest is always a focus during meetings.

3. Council members are clear and agree on the distinction between Council and Management responsibilities.

4.5
5.0

Acknowledgement that at times deliberations get in the weeds but that it is natural and strong Chairing often gets Council back on track.

4. Council regularly monitors and evaluates progress toward strategic goals and monitors organizational and program effectiveness and performance.

4.6
5.0

Overall good job.

Can be hard to differentiate between monitoring effectively and micromanagement.

Formal review of strategic plan highlighting key initiatives to contributed to goals or a sort of action assessment plan could be helpful.

2. Leadership

5. Council members have opportunities to develop as leaders through rotation of Committee assignments, Chair roles, and other opportunities to lead

4.2
5.0

Council could benefit from more purposeful assignment and development of leadership roles and succession planning.

Need to be proactive as more seasoned members of Council will eventually have terms end.

6. Council leaders (e.g. Exec Committee members, Chairs) provide effective leadership and act in accordance with the College's values and the public interest.

4.8
5.0

Excellent Chairs.

7. Executive Committee has the necessary skills, enthusiasm, and energy to provide leadership to Council.

4.7
5.0

Excellent job overall but would be nice to see enthusiasm from other Council members to join the committees. For example setting expectation that all Council members at some point in their term sit on Exec.

8. Executive Committee has an effective working relationship with the CEO.

4.8
5.0

Committee has good rapport with Kelly and there is an effort to understand how she works and interacts with staff.

3. Financial Performance & Risk

9. Council, including through the Executive Committee, is actively and appropriately involved in setting direction for and approving the financial plan/budget.

4.6
5.0

General agreement but more education and training in financial literacy for non-profit organizations could benefit Council and Exec.

10. Council monitors financial performance regularly and staff are able to explain variances and potential corrective actions, with few or no surprises.

4.9
5.0

Excellent and high quality with solid rationale and preparation.

11. Council ensures timely, independent auditing of finances, and audit results are discussed by Council with the Auditor.

4.9
5.0

12. Council contributes to and is briefed periodically on regulatory and organizational risk management priorities and actions.

4.7
5.0

The College does this very well.

4. Council Performance

13. Council meeting agenda and packages are clear about the key issues and areas for Council consideration.

.

4.9
5.0

Direction from the Chair on what to focus on has been really helpful.

14. Council receives quality background information and material sufficiently in advance to allow for effective preparation.

5.0
5.0

15. Meetings start and end on time with an emphasis on substantive discussion of significant matters by Council.

4.9
5.0

Well run overall but lack of participation and questions from Council can make it seems like rubber stamping.

Ways to build engagement and expectation of questions.

Suggestion to forego hybrid meeting model to foster more meaningful engagement. Consider In-Person twice a year.

16. All necessary skills to conduct Council business are represented on Council.

4.0
5.0

Unsure without an understanding of what those 'necessary skills' are.

Continue to increase diversity.

17. Members proactively ask questions, raise issues, and engage constructively in discussion and debate.

4.0
5.0

Can be improved, seems to have decreased.

Areas for Improvement

- Ways to effectively monitor and anticipate the impacts that our decisions have on marginalized registrants.
- Leadership development, succession planning.
- Better engagement during meetings.
- Financial literacy and skills to develop/assess strategic planning.

CONTINOUS IMPROVEMENT PRIORITIES

A. Equity, Diversity, and Inclusion

- Targeted training days and time to apply the lessons learned.
- Ensuring Council is accessible digitally and physically.
- Council “buddy system” evaluation.
- Unconscious bias training.

B. Enriching Council’s understanding of its governance role

- Training regarding financial literacy and oversight.
- Training regarding Chair and Committee engagement and decision making.
- Succession planning including the implementation of Co-Chairs.

C. Ongoing Reform of the College’s Governance Policies and Processes

- Piloting collection of competencies and demographics from council members to better identify our resources and gaps.
- Review and revisions to regulatory impact assessment and decision-making tools.
- Review of College By-laws.
- Planning for future governance modernization initiatives.

FOR INFORMATION

BRIEFING NOTE FOR COUNCIL

Subject: Equity, Diversity and Inclusion (EDI) Update

Summary

An overview of the College's work in our commitment to equity, diversity and inclusion. What has been achieved, what is currently being done and a vision for future and ongoing work.

Background

In 2021, Council added Equity as a guiding principle in our Strategic Framework. Our principles shape our culture, define how we strive to work as an organization and our relationships with the public, midwives and partner organizations. The equity principle states that: "We identify, remove and prevent systemic inequities." Another one of the six principles is that of accountability to making "fair, consistent, and defensible decisions, incorporating diverse and inclusive views."

To date, the College has engaged in ongoing equity-centered activities to develop knowledge and understanding of systemic inequities, recruit diverse perspectives on Council and committees, and foster a culture of inclusiveness as an organization. Some of these activities include:

<u>Council & Committee</u>

- Continued development and learning on equity-centered topics during Council and committee trainings.
- Encouraging racialized midwives to run for Council and non-Council committee appointments by offering safe and inclusive spaces to learn about Council's role and responsibilities.
- The observance of land acknowledgments at all Council and Executive Committee meetings with members of Council sharing responsibility in offering the land acknowledgement to contribute to individual and collective learning.
- Annual Council evaluation used to identify continuous improvement priorities.
- Piloting the collection of Council competency and skills through self-assessment, as well as surveying demographic information to better understand representation and inclusion specific to our College's needs.

<u>Organizational</u>

- Incorporated EDI statement in job postings and inclusion of EDI-related questions during the interview process for recruitment.
- Opportunity for staff involvement during the recruitment and interview process.
- Introduction of a Governance Officer staff position, a role which includes an equity portfolio to build support and leadership on equity projects, initiatives, and processes for the College.

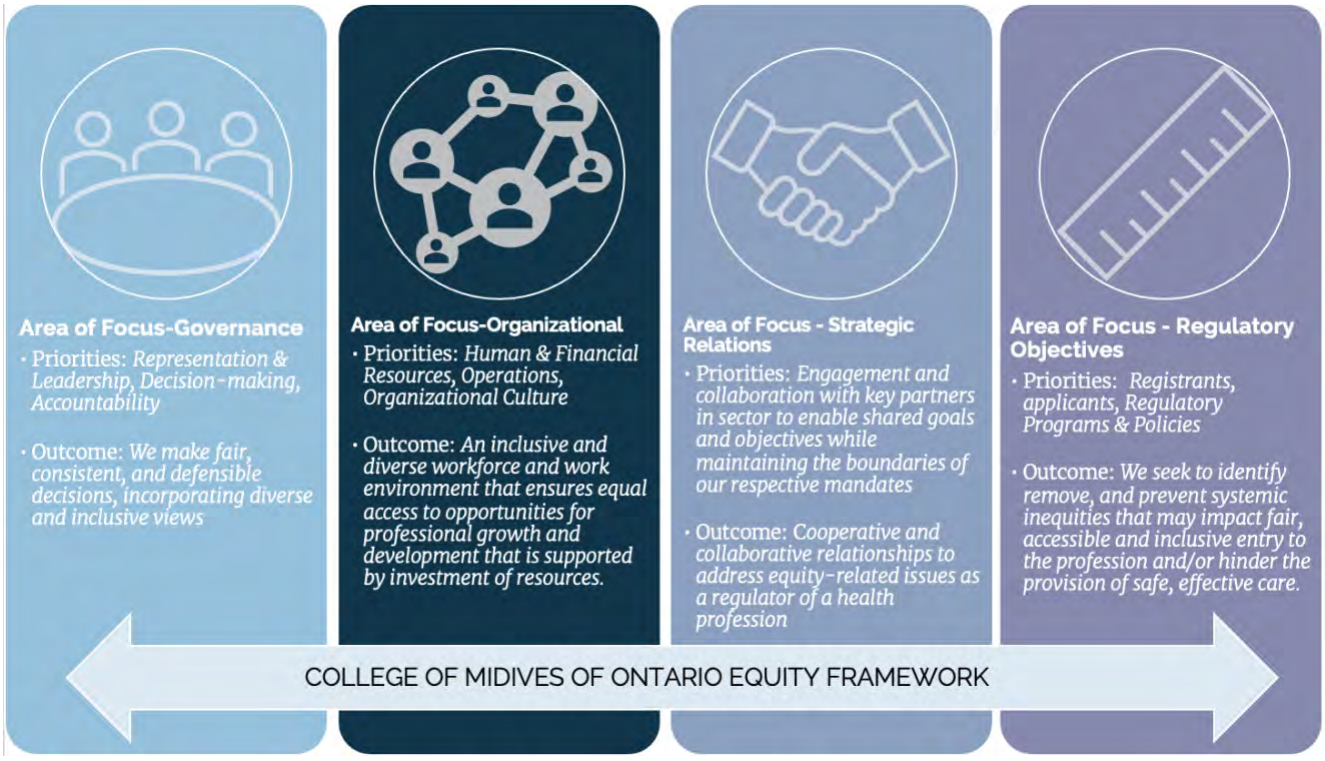
- Staff learning engagement and conversations on days that center, highlight and commemorate diverse communities (i.e. Black History Month, Pride, Indigenous History Month)
- Participation on the steering committee for the Health Profession Regulators of Ontario (HPRO) Anti-Racism Project.

Equity Framework

A College-specific Equity, Diversity and Inclusion framework has been developed to provide a foundation that guides work and any initiatives that may be developed and are ongoing by the College.

The framework is organized by four areas of focus: Governance, Organizational, Sector Relations and Regulatory Objectives. Each area of focus describes its priorities and desired outcomes. The framework is grounded in four principles that inform the work, namely: anti-racism and anti-oppression, accessibility, intersectionality and cultural safety. The outcomes of the framework are based on values and principles already established by the College, including our guiding principles, governance policies and organizational culture statements.

A visual of the framework is included below:



Four grounding principles:

- Anti-Racism/Anti-Oppression: The active process of identifying and eliminating racism by consistently engaging with systems, organizational structures, policies and attitudes with strategies, practices and actions that challenge systems of oppression and power.

- Accessibility: Commitment as a regulatory health college to provide access that is accommodating, safe, and inclusive.

- Intersectionality: The understanding and analysis of power imbalances that operate in relation to individual and group identities and social locations.

- Cultural Safety: The commitment to fostering ways to build trust and safety for all communities interacting with the College with the understanding that within populations of diverse communities there will be differences in experience and access to power and privilege as a result of historical, social and political contexts.

The framework guides and supports the work of the College to ensure centering of equity considerations in a way that is comprehensive and integrative in building culture and practices.

HPRO Anti-Racism Project
An external consulting firm, Graybridge Malkam, supported the project and developed the Equity, Diversity and Inclusion materials. Final materials that have been made available to all health regulatory Colleges include:

- EDI Self-assessment Guide for Year-end 2022 CPMF Reporting
- HPRO EDI Organizational Self-Assessment and Action Guide
- HPRO EDI and Anti-Racism Tools - Briefing outline, Case Studies, FAQs

These tools help Colleges perform an assessment of the strengths and gaps on EDI allowing us to ascertain the degree of organizational commitment and performance in EDI and anti-racism. As a method of measurement, the tool uses a continuum of practices described by four categories: inactive, reactive, proactive, and progressive. The tool was also designed to be in alignment with the Ministry's College Performance Measurement Framework (CPMF) which all Colleges are measured against. The College has piloted use of the tool and completed the organizational self-assessment. A copy of visualized charted results is attached, and a summary of the assessment is described under key considerations below.

Key Considerations

The College is deeply committed to being an equitable and inclusive organization. The governance and strategy department of the College will continue to work at building in the structural support to ensure this work remains an ongoing priority with measurable outcomes.

Equity Framework

The equity framework was developed to provide structure to equity-related initiatives of the College to ensure alignment that is comprehensive in centering equity in decisions as a governing body and as an organization. The domains of the self-assessment are easily incorporated into the relevant areas of focus of the framework. Any of the actions and initiatives identified in relation to the self-assessment have also been organized according to the areas of focus.

HPRO EDI Self-Assessment

The results of the self-assessment are helpful as a perspective that situates our equity work as a College, however, it should also be understood that the tool was developed in consideration of regulatory health colleges that are at varying stages of understanding and action when it comes to equity work. This means that some of the work specific to our College and what we are doing is not necessarily reflected in the self-assessment therefore only gives part of the full picture. A summary of the results of each assessed domain as well as descriptions of recommended initiatives and intended outcomes is included below and have been linked to related areas of focus of the equity framework.

Domain 1: Governance, where the goals of the domain are that "Council and committee members have EDI competence. Decisions are made that encompass diversity of public interest. Transparency about actions fosters trust with a diverse public." Our assessment of this domain had the highest number of indicators represented in the proactive and progressive categories.

Planned Initiatives/Activities:

Framework Area Focus: Governance	
Initiative/Activity	Outcome
Implementation of process for collection of demographic and trait-specific qualities of Council and committee members.	Accurate information and data on who and which communities are represented on Council committees. Can inform process for recruitment and composition of Council and committees.
Consistent and continued learning, training and resource development on equity-related topics.	Council, committee and panel members are consistently engaged in building knowledge and competence.

Domain 2: Resources, which has the goal of "responsible stewardship of financial and human resources dedicated to EDI is demonstrated". Our assessment of this domain had indicators that ranged across the spectrum from inactive to progressive.

Planned Initiatives/Activities:

Framework Area of Focus: Organizational	
Initiative/Activity	Outcome
Specific resource allocation in relation to planned equity-related activities during annual budget development process.	Consistent funding and support for equity initiatives that are clearly defined.

Continue staff learning, engagement and conversations on days that center, highlight and commemorate diverse communities (i.e. Black History Month, Pride, Indigenous History Month)	Fostering and maintaining a welcoming, respectful, diverse, and inclusive work environment that is culturally safe.
Development of policies, guides and resources.	Clear understanding and definitions of concepts, principles, benchmarks, and best practices for being an organization that is equitable, inclusive, diverse, and anti-racist.

Domain 3: System Partners, which has the goal of "There is active engagement with other colleges and system partners regarding EDI. Cooperative and collaborative relationships to progress on EDI are maintained." Most indicators of our self-assessment were leaning toward proactive and progressive. The College will continue to prioritize building and nurturing meaningful relationships for opportunities for learning, collaboration and support.

Planned Initiatives/Activities:

Framework Area of Focus: Strategic Relations	
Initiative/Activity	Outcome
Incorporating targeted equity strategies in consultation processes.	Connection and relationships with public and sector partners to ensure inclusion and consideration of diverse perspectives.
Engagement with Truth & Reconciliation Committee Calls to action in relation to regulatory function of College.	Registrants have access to cultural competency training and resources for provision of culturally safe and inclusive care.
Foster and maintain relationships with Indigenous communities and practitioners.	Support retention of Indigenous health-care providers in Aboriginal communities.
Foster and maintain sector relationships and connections.	Ongoing cross-community and organizational collaboration and support to enable achievement of shared equity initiatives.

Domain 4: Information Management, where the goals are "protection from unauthorized disclosure of EDI data." Our assessment of this domain identified the most indicators in the inactive category and is therefore identified as an area for focus and improvement. This is mainly a reflection of the fact that specific equity related data collection is not yet a consistent practice of the College. As the College's data strategy is implemented, where it intersects with equity goals will be addressed more specifically.

Planned Initiatives/Activities:

Framework Area of Focus: Organizational & Regulatory Objectives	
Initiative/Activity	Outcome

Embed equity, diversity, and inclusion performance metrics in our operations.	The College's Performance Measurement Framework incorporates metrics related to equity, diversity, and inclusion and is reported annually.
Collect equity and human rights-based data including the development of or revisions to policies and/or codes that provide rationale, method and information protection details.	Better understanding demographic trends, identify barriers that some groups may face entering and remaining in the profession, and develop or update programs and initiatives to promote equity, diversity, and inclusion in midwifery regulation.
Data Strategy – determining intersections with equity work to inform priorities.	Evidence-based direction and decision-making.

Domain 5: Regulatory Policies, which has the goal of "The development, review and implementation of policies, standards of practice, and practice guidelines are based on the best available EDI evidence. They reflect current best practices on EDI and are reasonably aligned with changing public expectations on EDI and other College objectives." The College identified the most indicators in the proactive category and will continue to consistently review current policies and initiatives, as well as look for opportunities to develop policies that explicitly state and affirm positions on equity and anti-racism.

Planned Initiatives/Activities:

Framework Area of Focus: Regulatory Objectives	
Initiative/Activity	Outcome
Revisions to policy development process review to incorporate equity impact assessment.	Council and committee members receive materials that have considered an equity impact assessment.
Revisions to decision-making tools.	Council, committee and panel members are able to consider equity-informed points when making decisions.

Domain 6: Suitability to Practise, which has the goal of "Registrants are assessed for competent, safe and ethical practice with patients/clients and colleagues. Continuing competence is assured. Complaints processes are integrated, accessible and supportive of EDI. Activities are prioritized based on a diverse public's risk and actions to protect." The results of the self-assessment showed indicators across the spectrum from inactive to progressive. Department and committee initiatives will be a focus for work-planning in the upcoming year.

Planned Initiatives/Activities:

Framework Area of Focus: Regulatory Objectives

Initiative/Activity	Outcome
Development of professional development resources and consistent review of professional standards to enable equitable and inclusive care.	Expectations and obligations for registrants in relation to EDI are clear.
Ongoing review of professional standards and guidelines.	Registrants have an understanding of equity-centered concepts and expectations as primary care providers serving diverse communities.
Building understanding of trauma-informed practices in approach to regulation.	Regulatory processes that are compassionate and fair.

Domain 7: Measurement, Reporting & Improvement, which has the goal of "College monitors, reports on, and improves its performance." Our assessment for this domain indicated most activities in the reactive and proactive areas.

Planned Initiatives/Activities:

Framework Area of Focus: Regulatory Objectives	
Initiative/Activity	Outcome
Dedicated page on website for public facing information providing updates on equity initiatives, resources and collection of comments/feedback.	Transparency and communication of our values and principles as an equitable health regulator.
Incorporation of equity-related metrics in Council and committee assessments and feedback surveys.	Consistent and ongoing engagement with council and committee members on experience and perceptions of progress.
Development of equity performance indicators.	Measurable progress.

It should be noted that the recommended activities in relation to the self-assessment do not encompass the full extent of the EDI work of the College. Many of the initiatives suggested and described will also require more detailed planning and department consultation that is best determined during a planning process such as operational planning day, where departments and staff will be able to determine and plan how to incorporate goals into a specific workplan.

Accountability to EDI commitments will be adhered to through consistent reporting to Council, the development of metrics to measure success of desired outcomes, consistent collection of feedback and evaluation that engages Council and committee members, registrants, sector partners and the public.

Recommendations

N/A

Implementation Date

N/A

Legislative and Other References

N/A

Attachments

1. College EDI Self-Assessment Visual Results
2. HPRO EDI Organizational Self-Assessment with Indicators

Submitted by: Zahra Grant, Governance Officer

Organizational EDI Self-Assessment

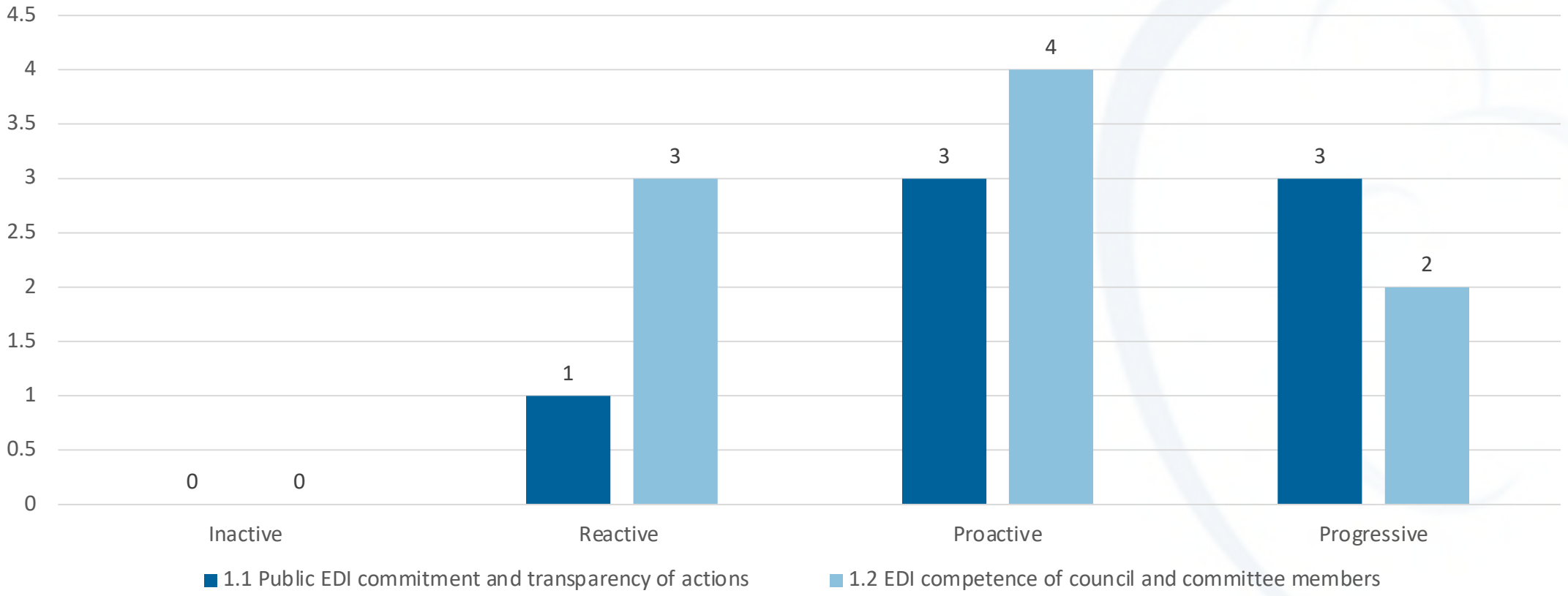
The self-assessment tool is organized along 7 domains in alignment with the Ministry's College Performance Measurement Framework (CPMF). Each domain was assigned to a particular department/staff for response gathering.

Each domain has indicators describing practices that organizations can identify as doing or not doing and that are represented by four categories: inactive, reactive, proactive, and progressive. Results have been plotted in a way that show how many indicators of each category were identified as things the College is doing provide an initial assessment of strengths and gaps on EDI and anti-racism related process and practices as an organization.

The goals of each domain are described and some have subdomains for additional self-assessment. Domains with sub-domains are represented by one or more columns for the designated category.

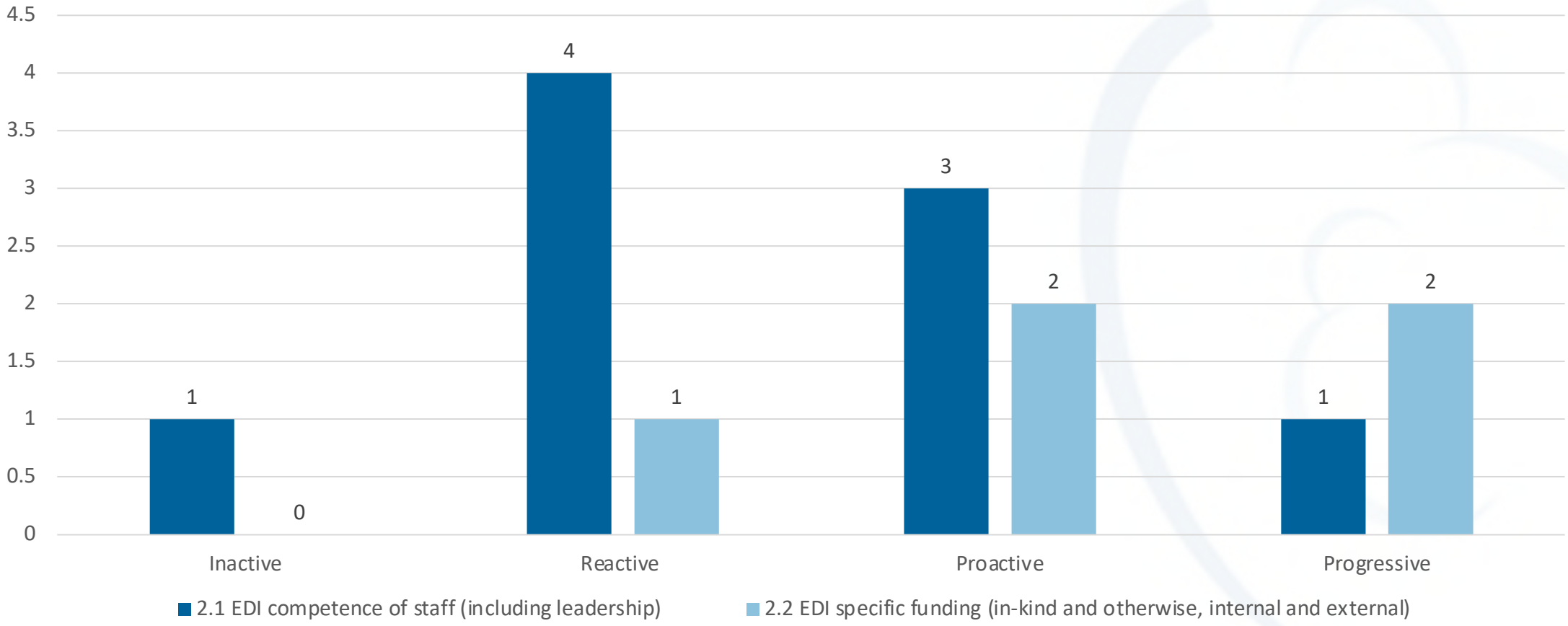
Domain 1: Governance

Goals: Council and committee members have EDI competence. Decisions are made that encompass diversity of public interest. Transparency about actions fosters trust with a diverse public.



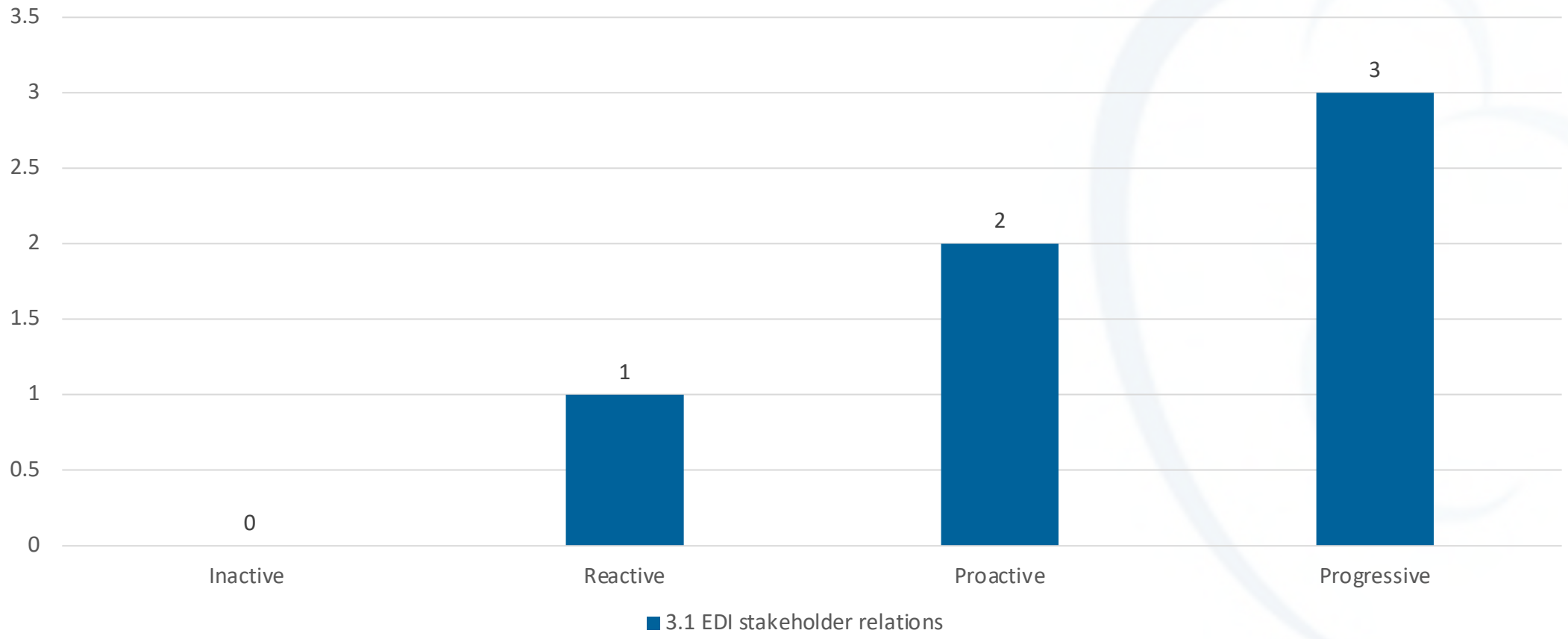
Domain 2 Resources

Goals: Responsible stewardship of financial and human resources dedicated to EDI is demonstrated.



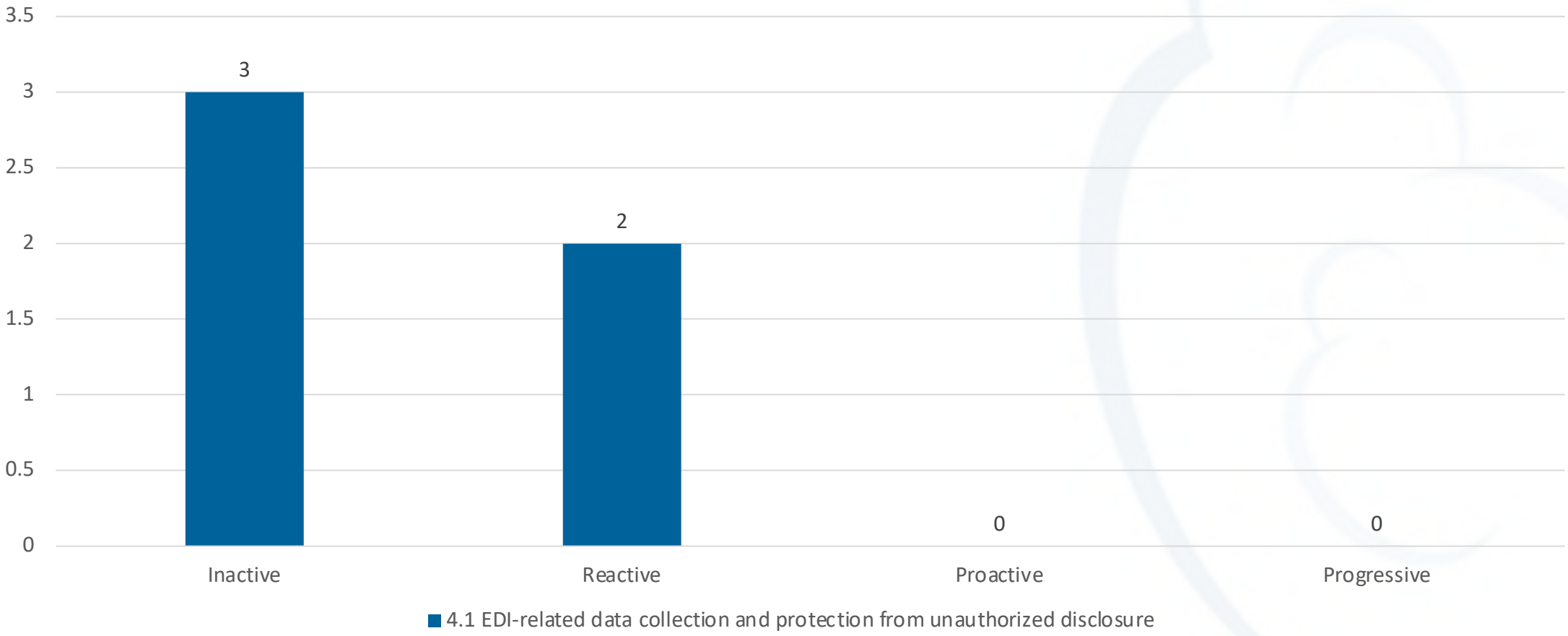
Domain 3: System Partners

Goals: There is active engagement with other colleges and system partners regarding EDI. Cooperative and collaborative relationships to progress on EDI are maintained.



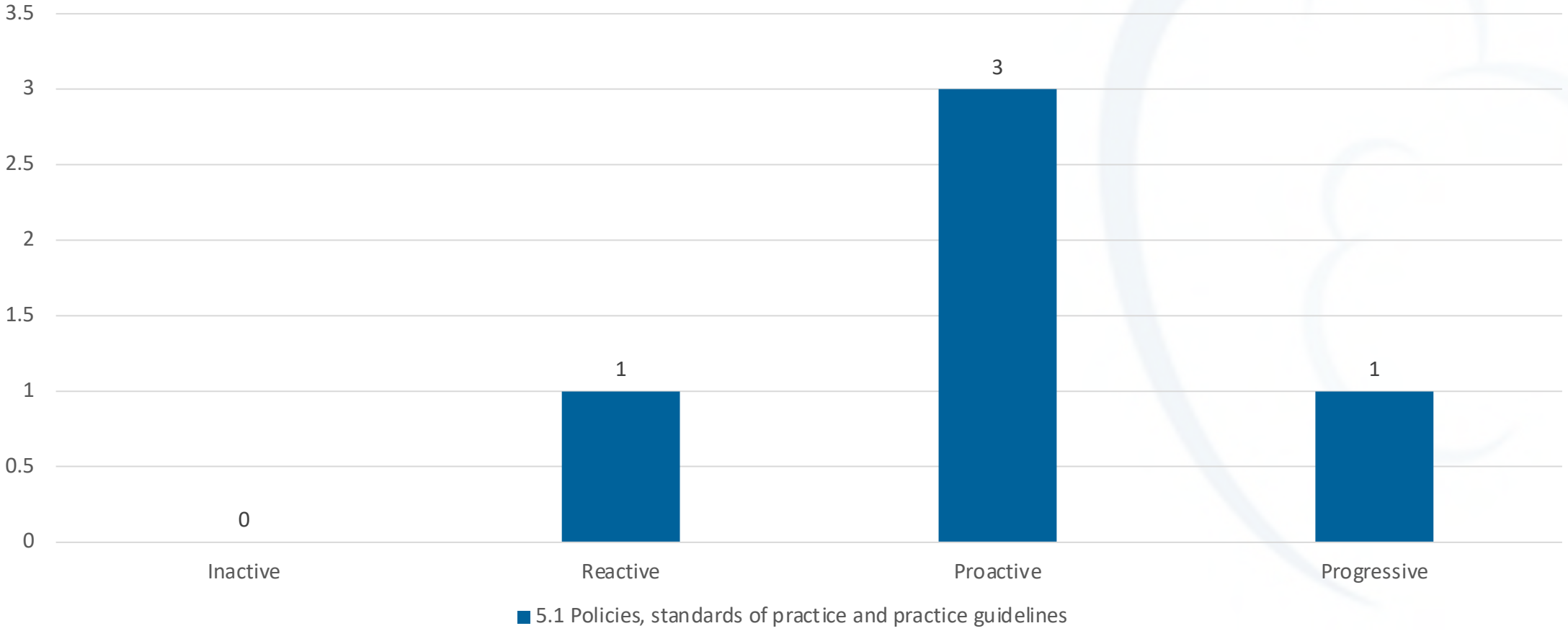
Domain 4: Information Management

INFORMATION MANAGEMENT Goals: There is protection from unauthorized disclosure of EDI data.



Domain 5: Regulatory Policies

REGULATORY POLICIES Goals: The development, review and implementation of policies, standards of practice, and practice guidelines are based on the best available EDI evidence. They reflect current best practices on EDI and are reasonably aligned with changing public expectations on EDI and other College objectives

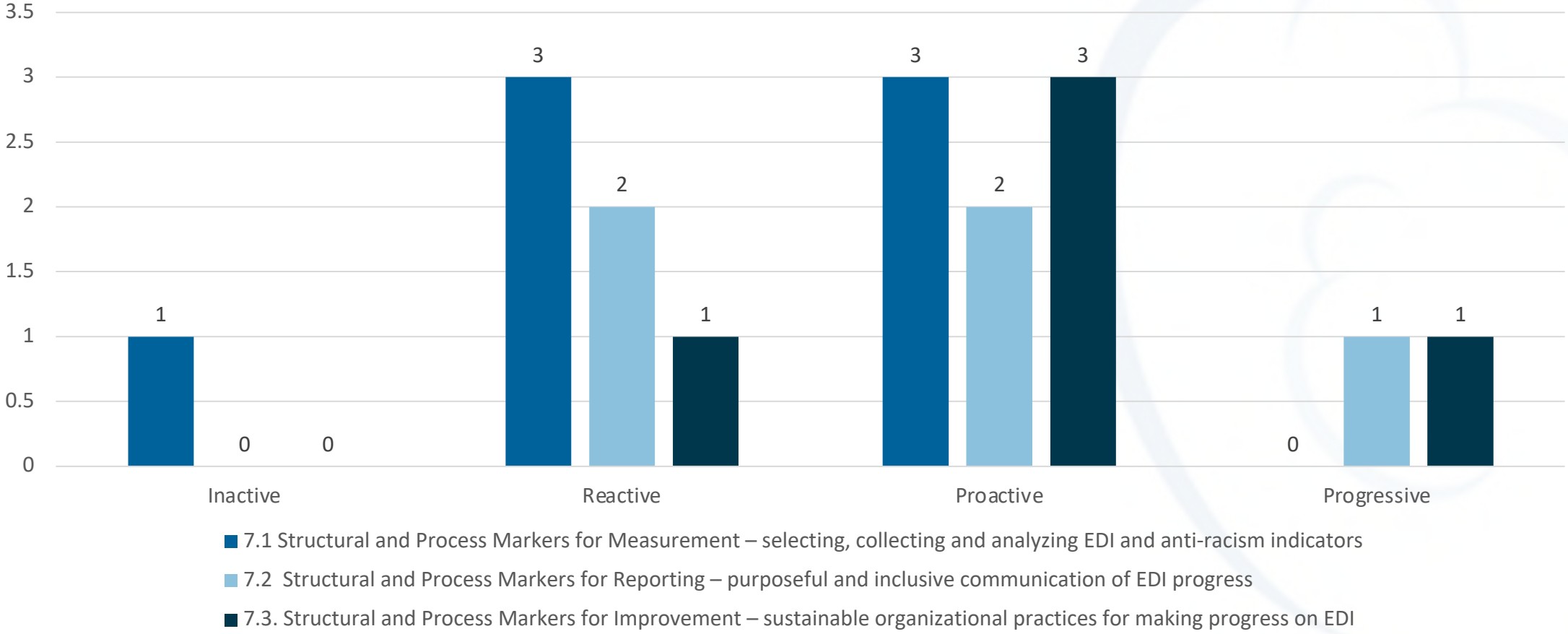


Domain 6: Suitability to Practise

SUITABILITY TO PRACTICE Goals: Registrants are assessed for competent, safe and ethical practice with patients/clients and colleagues. Continuing competence is assured. Complaints processes are integrated, accessible and supportive of EDI. Activities are prioritized based on a diverse public's risk and actions to protect.

Domain 7: Measurement, Reporting & Improvement

MEASUREMENT, REPORTING AND IMPROVEMENT Goals College monitors, reports on, and improves its performance.



SELF-ASSESSMENT DOMAINS AND MARKERS

The **Assessment Markers** are more detailed tables of established good practices that Colleges can use for more comprehensive self-assessment in areas they have identified for early attention. The colour categorization among the various levels in these domain-specific tables is meant to be understood as a representation of a continuum rather than a distinct transition. Each level is interconnected with the adjacent levels; movement along these levels is complex and not necessarily linear in all cases.

DOMAIN 1: GOVERNANCE

GOVERNANCE Goals: Council and committee members have EDI competence. Decisions are made in a diverse public's interest. Transparency about actions fosters trust with a diverse public.

1.1 Public EDI commitment and transparency of actions

Inactive	☐ The College has made no public commitment to EDI. ☐ The College has made no public commitment to anti-racism
Reactive	☐ The College has made a public commitment to EDI (publishing a statement on the College's website). ☐ The College has made a public commitment to anti-racism (publishing a statement on the College's website). ☐ The College has undertaken consultation processes with several groups without being guided by EDI and anti-racism benchmarks and best practices. ☐ The College has developed a basic anti-racism vision, mission, or strategy. The vision, mission or strategy is written in a general manner. ☐ The College has developed a basic EDI vision, mission, or strategy. The vision, mission or strategy is written in a general manner. ☐ The College's commitment to EDI and anti-racism is integrated, albeit somewhat inconsistently, into other public statements, processes, and policies and is linked to long-term EDI and anti-racism objectives, albeit vaguely.

Proactive

- ☐ The College has defined EDI broadly to include some dimensions beyond gender, race, and Indigeneity.
- ☐ The College's commitment to EDI and anti-racism is consistently integrated into other public statements, processes, and policies with limited foresight into how this integration will help or work (in the case of products).
- ☐ The College's public commitment includes high-level goals or action plans that reflect the College's responsibility as a regulated health profession regulator so that the diverse needs of the communities served are met, but with limited EDI and anti-racism-related details.
- ☐ The College has undertaken consultation processes with various equity-seeking groups (e.g. Indigenous, other racialized groups, people disabilities, members of the LGBTQ2+ community) that were guided by EDI and anti-racism benchmarks and best practices.
- ☐ The College has qualitative goals for achieving EDI and anti-racism within the College's mandate that include input from a variety of internal and external interested parties.
- ☐ The College has quantitative goals for achieving EDI and anti-racism within the College's mandates that include input from a variety of internal and external interested parties.
- ☐ The College has examined its organizational policies and procedures to identify opportunities for reducing barriers to equity, diversity, and inclusion.
- ☐ Most of the Council members, registrants, and key system partners are aware that EDI and anti-racism are important to the College.
- ☐ The College's commitment to EDI and anti-racism are communicated widely and frequently, and integrated into most of the College's messaging.

Progressive

- ☐ The College has incorporated EDI and anti-racism concepts as part of the organizational culture, and it is considered in the College's strategic planning.
- ☐ The College regularly undertakes consultation processes with several equity-seeking groups that are guided by EDI and anti-racism benchmarks and best practices.
- ☐ Competencies that help achieve the College's EDI and anti-racism goals and strategy are openly demonstrated by most decision-makers within the College (Executive and Management, Council and committee and tribunal members, etc.).
- ☐ The College regularly reports its progress and achievements in relation to its stated goals in a number of ways suitable to different audiences.
- ☐ The College demonstrates a commitment to lessons learned, adjusts its approach to EDI and anti-racism and its action plan when needed, and integrates updates in its communication channels and in its statements.
- ☐ EDI and anti-racism (featuring an intersectional approach) are embedded in the College's operations as a core value, a source of innovation, and a means to belonging, sustainability and success.
- ☐ The College is frequently acknowledged and benchmarked by others (e.g., health regulatory Colleges, community organizations, or associations) for its EDI and anti-racism accomplishments.
- ☐ The College is proactive and responsive to EDI and anti-racism challenges faced by society.
- ☐ EDI and anti-racism are now ingrained in the College's work culture.

1.2 EDI competence of council and committee members

Inactive	☐ Council and committee members have no or limited understanding of EDI and anti-racism. ☐ The composition of the Council and committees appears to be homogeneous, and is generally unquestioned.
Reactive	☐ Council and committee members have had some training on EDI, anti-racism and unconscious bias. ☐ Council and committee members have some knowledge and awareness of EDI and anti-racism focusing on personal interactions, not yet developing College-specific approaches, policies, procedures, and processes. ☐ Council and committee members are open to making EDI and anti-racism-related adjustments within the College while maintaining the existing systems and processes as they are. ☐ Council and committee members issue a commitment to increasing representation of equity-seeking groups (members of the LGBTQ2+ community, Indigenous groups, other racialized groups, disability groups, ethnic/religious groups, etc.)
Proactive	☐ Council and committee members are actively working on enhancing the diversity to better represent the public the College has a mandate to protect (within the constraints that they are under). ☐ Council and committee members have continuous training on EDI and anti-racism as a means to stay up to date and to keep the EDI and anti-racism lens strong and effective. ☐ Council and committee members use their EDI and anti-racism competencies while making decisions. ☐ Council and committee members are supporters, and several are champions of EDI and anti-racism. ☐ Council and committee members are open and willing to make EDI and anti-racism-related adjustments within the College (flexibility and the willingness to implement recommended changes). ☐ Council and committee members use EDI and anti-racism tools to make some changes to their approaches, projects, working groups, etc., although the changes may be inconsistent.
Progressive	☐ Council and committee members use EDI and anti-racism tools to make consistent and long-term changes to their approaches, projects, working groups, etc. ☐ Council and committee members draw on their EDI and anti-racism resources to make committee and council assignments. ☐ Council and committee members understand the need to and demonstrate support for undertaking EDI and anti-racism assessments within their College. ☐ Council and committee members are champions of EDI and anti-racism and take consistent action to achieve EDI and anti-racism objectives.

DOMAIN 2: RESOURCES

RESOURCE Goals: Responsible stewardship of financial and human resources dedicated to EDI is demonstrated.

2.1 EDI competence of staff (including leadership)

Inactive	☐ Staff have no to very limited awareness of the importance of EDI and how to support it. ☐ Staff have no to very limited awareness of the importance of anti-racism and how to support it. ☐ Diversity among staff members is either non-existent or limited along very few identity factors (e.g., men and women). ☐ Staff are unwilling or do not feel able to take the initiative to inform themselves of EDI. ☐ Staff are unwilling or do not feel able to take the initiative to inform themselves of anti-racism.
Reactive	☐ Staff can identify some aspects of EDI, even if there is not a clear understanding of the implications and complexity of EDI. ☐ Staff can identify some aspects of anti-racism, even if there isn't a clear understanding of the implications and complexity of anti-racism. ☐ Staff assess or implement basic EDI measures (e.g., adjust language references, have one level of equity-markers (e.g., women and men)) ☐ Staff assess or implement basic anti-racism measures (e.g., add language on diversity and send out reminders on the College's stand on racism) ☐ Staff have some knowledge and awareness of EDI and anti-racism focusing on personal interactions, not yet developing College-specific approaches, policies, procedures, and processes. ☐ The diversity of staff members is very limited and cuts across one or two identity factors. ☐ The willingness and ability of the staff to engage, intentionally and consistently, with diversified voices outside those officially staffed by the College is limited, or at best is done in a performative manner (for cases where staff diversity is limited).

Proactive	☐ Staff have access to EDI and anti-racism resources to help guide them. ☐ The diversity of staff members more closely reflects the diversity of the public they are mandated to protect. ☐ Staff have a solid understanding of EDI and the steps that need to be taken to increase EDI. ☐ Staff have a solid understanding of racism and the steps that need to be taken to fight against the various forms of racism and to become anti-racist. ☐ Staff members are assigned to varying tasks based on EDI competencies and an equity lens.
Progressive	☐ Staff are actively and consistently implementing changes to help improve EDI, using an intersectional approach and beyond just responding to a specific situation. ☐ Staff are actively and consistently implementing changes to help decrease racism (against Indigenous and other-racialized groups), beyond responding to a specific situation. ☐ Staff hiring processes incorporate an equity lens. ☐ Staff's performance is assessed through an equity and intersectional lens. ☐ Staff members have the knowledge and expertise to provide some training to committee and council members on EDI. ☐ Staff have the knowledge and expertise to engage appropriate experts to train committees and council members on EDI (in cases where external expertise may be required). ☐ Staff undertakes continuous learning and training on EDI.

2.2 EDI specific funding (in-kind and otherwise, internal and external)

Inactive	☐ The College has not made EDI specific resourcing commitments. ☐ The College has not made ani-racism specific resourcing commitments. ☐ The College has not identified any in-kind or budgetary commitments that it can make to EDI. ☐ The College has not identified any in-kind or budgetary commitments that it can make to anti-racism. ☐ The College draws on freely available resources and does not commit to ensuring in-kind or monetary support for the necessary EDI and anti-racism initiatives/changes.
Reactive	☐ The College has completed the assessment of the availability of the in-kind and monetary resources that it can and will dedicate to EDI and anti-racism. ☐ The College has identified external funding or in-kind potentials that can help it advance on its EDI and anti-racism journey. ☐ The College has assessed the level/quality of its human and financial capacity to implement EDI- and anti-racism-related changes.
Proactive	☐ The College has secured in-kind or financial funding internally for EDI- and anti-racism-related changes. ☐ The College has specifically allocated in-kind or financial funding internally solely for EDI- and anti-racism-related changes. ☐ The College has submitted applications for external funding to support its EDI and anti-racism initiatives. ☐ The College has secured external funding to support its EDI and anti-racism initiatives (including combining resources with other regulatory Colleges).
Progressive	☐ The College has implemented key EDI-related projects, with clearly identified resourcing/funding. ☐ The College has developed an EDI and anti-racism-specific funding mechanism that protects the funds (in-kind and otherwise) from their diversion to other purposes. ☐ The College continuously assesses its budget to maintain the continued funding (in-kind and otherwise) for EDI and anti-racism initiatives that integrate intersectional approaches.

DOMAIN 3: SYSTEM PARTNERS

SYSTEM PARTNER Goals: There is active engagement with other colleges and system partners regarding EDI. Cooperative and collaborative relationships to progress on EDI are maintained.

3.1 Relations with EDI system partners

Inactive	☐ No initiative or effort is undertaken to reach out to other Colleges and partners within the health system regarding the sharing of information on EDI and anti-racism. ☐ No initiative or effort is undertaken to reach out to other colleges and partners within the health system regarding collaborative activity on EDI and anti-racism. ☐ The College considers the work on EDI and anti-racism as a College-based work and as not connected to the rest of the system/process.
Reactive	☐ There is limited engagement about EDI practices with other Colleges within the health system in Ontario. ☐ There is limited engagement with other Colleges about EDI practices within the health system across Canada. ☐ There is limited engagement with other interested parties working on EDI and anti-racism within the health sector in Ontario. ☐ There is limited engagement with other interested parties working on EDI and anti-racism within the health sector across Canada. ☐ Contacts with other interested parties are initiated by external interested parties and the sharing of information is limited and guarded. ☐ Contact with other interested parties (other Colleges and civil society groups) on issues related to EDI and anti-racism is occasional and inconsistent.
Proactive	☐ Various equity groups have been consulted, but consultation is not ongoing ort consistent outside of specific initiatives. ☐ Collaboration with other interested parties on issues related to EDI and anti-racism is completed as part of an initiative and is not ongoing or consistent following the end of a project or an initiative. ☐ There is an updated list of actors to consult, but the consultation process remains selective (always choosing selected groups for consultation rather than undertaking consultations with a wide range of groups).

Progressive

- ☐ The College has established and consistently implements an ongoing plan for consistent and meaningful consultation with various equity groups (e.g., Indigenous, other racialized groups, gender-based groups, LGBTQ2+ groups, disability groups, religious groups, etc.).
- ☐ The College has established and consistently implements an ongoing plan for consultation with other Colleges and actors in the health sector in Ontario.
- ☐ The College has established and consistently implements an ongoing plan for consultation with other Colleges and actors in the health sector across Canada.
- ☐ The College has expanded its reach to outside entities through upstream (universities, educational institutions, certifiers, etc.), downstream (civil society organizations, community groups, advocates, etc.), and horizontal (other Colleges, professional associations) consultations.
- ☐ The College regularly reviews and improves its collaborations efforts on EDI and anti-racism (using an intersectional lens).

DOMAIN 4: INFORMATION MANAGEMENT

INFORMATION MANAGEMENT Goals: There is protection from unauthorized disclosure of EDI data.

4.1 EDI-related data collection and protection from unauthorized disclosure

Inactive	☐ The College's practices for EDI-related data collection and protection are informal. ☐ There has not been collection of any EDI-related data from individuals. ☐ EDI data collection has been very limited. ☐ College staff, council and committee members show little or no awareness of issues related to the management of EDI-related information. ☐ The College's formal practices governing data collection and protection make no reference to particular considerations for EDI-related information.
Reactive	☐ EDI data collection is undertaken for only a very limited number of individual characteristics, generally to respond to specific pressures. ☐ EDI data collection is undertaken within particular initiatives but not on an ongoing basis. ☐ There are processes in place to manage any unauthorized disclosure of individuals' EDI information. ☐ Clear and ongoing communication efforts are in place to minimize individuals' hesitation to self-identify EDI data. ☐ College staff, council and committee members receive training and ongoing support to manage EDI-related information. ☐ There are policies and practices in place to prevent clearly inappropriate (e.g., racist, misogynist, biased) information being shared in the College's social media and public documents. ☐ The College's data analysis and reporting practices explicitly address the risk of individual identities being discoverable due to small group sizes.
Proactive	☐ The College's data collection methods are regularly reviewed to reflect EDI terminology and definitions that are currently recommended by experts and system partners. ☐ The College undertakes regular strategic reviews of its need for EDI-related data and its processes for collecting, securing, analyzing, and reporting it. ☐ Self-identification of a range of EDI-related characteristics (e.g., race, gender, age, disability, etc.) and their intersections is in place with registrants. ☐ Self-identification of a range of EDI-related characteristics and intersections (e.g., race, gender, age, disability, etc.) is in place with individuals other than registrants (e.g., applicants, complainants). ☐ The College's data analysis and reporting practices recognize the potential for causing harm, including groups' discomfort or stigma resulting from reporting of EDI-related data.

Progressive	☐ The College regularly consults with representatives of equity-seeking groups to review and adjust its information management practices. ☐ The College has a robust set of practices for analyzing, interpreting and making decisions on EDI-related data. ☐ There are policies and practices in place to enhance the equity-promoting impact of information being shared in the College's social media and public documents.

DOMAIN 5: REGULATORY POLICIES

REGULATORY POLICIES Goals: The development, review and implementation of policies, standards of practice, and practice guidelines are based on the best available EDI evidence. They reflect current best practices on EDI and are reasonably aligned with changing public expectations on EDI and other College objectives.

5.1 Policies, standards of practice and practice guidelines

Inactive	☐ College staff responsible for professional practice and policies have little experience with practice-related and policy-related issues understood through an EDI lens. ☐ EDI is not a factor in identifying potential new policy or practice standard areas. ☐ The development process for practice standards does not involve an EDI lens. ☐ The College develops policies using a standard approach without considering inclusion and equity. ☐ No input from equity-seeking groups is sought when policies, practice standards, and guidelines are reviewed.
Reactive	☐ The College applies an EDI lens when reviewing individual policies, practice standards, and guidelines where adverse effects have been raised by external interested parties. ☐ The College has issued a statement/policy on EDI including how it relates to practice issues. ☐ The College involves some equity-seeking groups in new policy and practice standards development process.
Proactive	☐ College staff responsible for professional practice and/or policies has demonstrated awareness of unconscious bias, intersectionality and other EDI dynamics and systemic challenges for equity-seeking groups (e.g., racialized, Indigenous, gender non-conforming, people with disabilities, etc.). ☐ The College engages with equity-seeking groups and individuals, as well as relevant interested parties and knowledgeable experts to identify underlying themes and considerations within practice issues and the implementation of policies. ☐ The College has integrated an EDI lens into its policy and practice standard development, review, and launch process. ☐ The College has a formal process for tracking and analysing how practice issues may be caused or affected by discriminatory or biased behaviours. The College consistently acts on findings, e.g., publishing practice advice, revising policies

Progressive

- ☐ The College invests resources to provide practice advice to registrants with an equity and intersectional lens.
- ☐ The College invests in-kind resources working with interested parties in raising awareness and addressing common root causes that negatively affect some registrants (and their patients / clients).
- ☐ The College consistently takes into account intersectionality and the social determinants of health when developing or reviewing policies, practice standards, and guidelines.
- ☐ The College is promoting self-identification, and tracking and analysing multiple identity factors (e.g., Indigenous people, other racialized groups, gender, sexual orientation, disability, etc.) for participants involved in the development and review of policies, practice standards, and guidelines.

DOMAIN 6 SUITABILITY TO PRACTICE

SUITABILITY TO PRACTICE Goals: Registrants are assessed for competent, safe and ethical practice with patients/clients and colleagues. Continuing competence is assured. Complaints processes are integrated, accessible and supportive of EDI. Activities are prioritized based on a diverse public's risk and actions to protect.

6.1 Registration

Inactive	☐ The College's registration committee is not representative of the diversity of applicants or registrants. ☐ The registration process only includes legally required EDI references/questions. ☐ The College does not track identity factors for applicants or registrants.
Reactive	☐ The College is tracking success rates on licensing assessments for domestic and international applicants. ☐ The College communicates its registration policies and procedures. ☐ The College is asking applicants and registrants to self-identify along one or two identity factors. ☐ The College integrates limited EDI identity factors in its formal decisions related to registration practices. ☐ The College has an appeal process.
Proactive	☐ The College has a registration committee that is broadly representative of the diversity of applicants or registrants. ☐ The College is implementing strategies to promote self-identification of applicants and registrants (along multiple identity factors). ☐ The College is tracking and reporting success rates on licensing assessments along multiple identity factors or categories. ☐ The College is supporting efforts by educational institutions to ensure a diversified pool of candidates qualified in competency and experience. ☐ The College engages diverse registrants who self-identify using multiple identity factors to validate assessment tools and identify unintended bias. ☐ The College tracks and reports its appeal data broken down along multiple identity factors. ☐ The College collects, uses and protects applicants' and registrants' identity data following all required legislative, regulatory and industry standards.

Progressive

- The College invests resources to work with other system partners to increase registrant diversity along several intersectional factors.
- The College invests resources working with interested parties in raising awareness and addressing common root causes that have a disproportionate negative impact on the assessments of diverse registrants' physical or mental capacity to practice.
- The College consistently acts upon the findings of differential success rates on licensing assessment for those who self-identify using multiple intersectional identity factors.
- The College engages diverse registrants who self-identify using multiple identity factors to develop inclusive communication materials and preparatory resources, as well as feedback processes, in order to support the success of diverse groups of applicants.
- The College invests resources to identify unintended biases in registration policies, requirements, and assessment tools as part of its defined processes for developing and updating them.
- The College takes action to minimize the impact of unconscious bias and institutional, structural, and systemic inequity and racism on the successful registration outcomes for seeking applicants who are members of equity-seeking groups.

6.2 Quality assurance

Inactive	☐ The College's quality assurance committee is not representative of the diversity of registrants. ☐ The College does not track identity factors related to the quality assurance process, e.g., identity of peer assessors, identity of registrants selected for peer assessments. ☐ The College only addresses mandatory areas of focus (e.g., sexual abuse).
Reactive	☐ The College has explicitly considered the potential impacts of the diversity of peer assessors and QA committee members. ☐ The College asks peer assessors to self-identify using one or two identity factors. ☐ The College asks registrants selected for peer assessments to self-identify on one or two identity factors. ☐ The College includes a reference to equity considerations in its communications about its quality assurance policies and procedures. ☐ The College assesses EDI competency as a 'nice to have' and not as an integral part of continuing development and quality assurance.
Proactive	☐ The College is implementing strategies to promote diversity of peer assessors, including self-identification of multiple identity factors. ☐ The College is tracking and analysing multiple identity factors for registrants selected for peer assessment. ☐ The College is tracking and analysing the decisions on remediation directives broken down by multiple identity factors. ☐ The College is tracking and analysing improvement on re-assessment broken down by multiple identity factors. ☐ The College has a representative quality assurance committee. ☐ The College has intentional practices for reaching out and engaging diverse registrants to act as peer assessors. ☐ The College seeks feedback from diverse peer assessors about its peer assessment process and tools. ☐ The College collects, uses and protects peer assessors and registrants' identity data following all required legislative, regulatory and industry standards.

Progressive

- ☐ The College consistently reports and acts upon the findings of differential rates of selection for peer assessment, remediation directives, and/or improvement upon reassessment by considering multiple identity factors, and intersectional identity breakdowns (numbers permitting).
- ☐ The College invests resources to identify unintended biases in its quality assurance program as part of its defined processes for development and updating it.
- ☐ The College invests in-kind resources working with interested parties in ensuring that remediation 'training' or other supports are inclusive and meeting the needs of diverse registrants.
- ☐ The College provides its registrants with the support/safe space to reflect on and commit to improving their awareness and understanding of EDI and anti-racism.

6.3 Complaints, discipline and fitness to practice

Inactive	☐ The College's Inquiries, Complaints and Report committee (ICRC) is not representative of those involved in complaints, investigations and discipline proceedings (e.g., complainant, registrant, witnesses). ☐ The College's Fitness to Practice committee is not representative of those being assessed for Fitness to Practice. ☐ The College's Discipline committee is not representative of those involved in hearings (e.g., patient / client, registrant). ☐ The College's Patient/Client Relations committee has little or no representation of members of equity-seeking groups (e.g., Indigenous, other racialized groups, member of the LGBTQ2+ community, those with disabilities, etc.). ☐ The College does not track identity factors related to Patient/Client Relations program participants. ☐ The College does not track identity factors related to Fitness to Practice allegations. ☐ The College does not track identity factors for those involved in complaints, investigations and discipline. ☐ The College's complaint, investigation, and tribunal processes have no scope and capacity for addressing EDI and anti-racism issues. ☐ The College's commitment to harassment and discrimination training is limited.
Reactive	☐ The College makes some reference to EDI considerations in its communications about its Patient/Client relations programming. ☐ The College asks those involved in complaints, investigation, and tribunal processes to self-identify along one or two identity factors. ☐ The College asks those applying to the victim compensation fund to self-identify along one or two identity factors. ☐ The College communicates its complaints and discipline policies and procedures. ☐ The College's complaint, investigation, and tribunal processes have limited capacity to protect from bias and address EDI and racism issues. ☐ The College explicitly considers EDI and anti-racism issues in the development of its Patient/Client Relations programming.

Proactive

- ☐ The College is implementing strategies to promote self-identification of complainants, health professionals and witnesses along several identity factors.
- ☐ The College is tracking and analysing multiple identity factors for all involved in the complaints, investigation, and tribunal processes, including the members of the tribunal.
- ☐ The College has representative professional conduct, complaints and discipline committees (ICRC, etc.).
- ☐ Members of the ICRC, Discipline and Fitness to Practice committees (and others involved in complaints and discipline proceedings) have had training or access to learning resources about how unconscious bias, racism, cultural differences, gender bias, and other factors can affect the dynamics of the complaints and discipline process.
- ☐ The College seeks feedback from diverse complainants and registrants about its complaints, patient/client relations, discipline, and fitness to practice processes.
- ☐ The College provides support for addressing biases, humility, and intersectionality during complaints and discipline processes.
- ☐ The College's communications regarding its complaints, patient/client relations, discipline and fitness to practice processes are accessible and inclusive for a diverse population of registrants and the public, for example in various languages and formats, and with consideration of cultural norms, accessibility, and inclusion.
- ☐ The professional conduct committees have demonstrated awareness of unconscious bias and other EDI dynamics and systemic challenges for equity-seeking groups, including racialized, Indigenous, gender non-conforming, people with disabilities, cross-cultural differences, etc.

Progressive

- ☐ The College consistently reports and acts upon the findings of differential rates of complainants, and of health professionals subject to the complaint, by considering the potential impact of intersectional identity factors.
- ☐ Members of the ICRC committee (and others involved in complaints, discipline and fitness to practice proceedings) are knowledgeable and actively consider how unconscious bias, racism, cultural differences, trauma-informed practice, gender bias, and other factors might be affecting the dynamics of the complaints and discipline process.
- ☐ The College invests resources to identify unintended biases in its complaints, investigations and discipline process as part of its development and update processes.
- ☐ The College invests resources to apply an equity and intersectionality lens to its patient / client relations activities.
- ☐ The College invests in-kind resources working with interested parties in identifying, raising awareness, and addressing root causes for common complaints.
- ☐ The College consistently applies EDI and anti-racism principles to its Professional Conduct portfolio.
- ☐ The College consistently reports and acts upon the findings of differential rates of those involved in professional conduct proceedings, using multiple and intersectional identity factors.

DOMAIN 7 MEASUREMENT, REPORTING AND IMPROVEMENT

MEASUREMENT, REPORTING AND IMPROVEMENT Goals College monitors, reports on, and improves its performance.

7. 1. Structural and Process Markers for Measurement – selecting, collecting and analyzing EDI and anti-racism indicators

Inactive	☐ EDI is not clearly defined. ☐ There are no identified EDI-related measurements collected on a regular basis. ☐ There are significant concerns on the part of College staff, leaders, or interested parties about the appropriateness of collecting EDI-related data to inform performance metrics.
Reactive	☐ EDI has been defined at a general level. ☐ There are limited KPIs, typically output / activity measures. ☐ There are occasional reviews of selected policies and practices, measuring against best practice EDI benchmarks, to assess strengths and opportunities for improvement. ☐ The College communicates why the selected indicators are important and how they are measured.
Proactive	☐ EDI has been defined in a comprehensive manner incorporating multiple identity factors – e.g., including anti-racism, gender, Indigeneity, disability, etc. ☐ Measurement methods are designed to be inclusive (in language, cultural norms, accessibility, etc.). ☐ There is some monitoring and measurement of EDI-related outcomes. ☐ There is movement toward integrating the College's EDI-related process and outcome measurements into a logic model showing how activities and results are linked. ☐ Both internal and system-level data are utilized to identify EDI progress. ☐ KPIs and EDI-related indicators are to some extent compared to other relevant indicators such as: comparable regulatory Colleges; population / patient health outcomes; diversity within 'feeder' educational programs; etc. ☐ Relevant interested parties and equity-seeking groups are consulted about data collection purposes and methods. ☐ There is some evidence that EDI and anti-racism policies and practices may be accomplishing their stated goals.

Progressive

- ☐ EDI has been defined in a comprehensive manner incorporating multiple and intersecting identity factors.
- ☐ Strategic plans incorporate EDI and related Key Performance Indicators (KPIs).
- ☐ There is strong evidence that EDI and anti-racism policies and practices are accomplishing their stated goals.
- ☐ Meaningful EDI-related outcomes across the CPMF domains are measured and monitored including quantitative and qualitative metrics such as (illustrative examples):
    - Percentage of registrants (survey) who perceive the College as open to addressing EDI issues; disaggregated by multiple identity factors.
    - Documented perception of interested parties (focus groups) who perceive that the College is a safe place to bring concerns.
    - Percentage of Board / Committee members who (1) feel confident they understand EDI implications of their work; (2) believe the College has fully embraced EDI procedures in actual practice.
    - Geographic distribution of registrants, such as in urban / rural / remote / Indigenous communities; this can be based on their self-identification.
    - Percent of complaints received by College where EDI issues are identified as part of the complaint.
    - Percent of complaints dismissed or no further action taken, disaggregated by identity factors and/or intersections, compared to all dismissed complaints.
    - Percent of surveyed patients / clients reporting being treated fairly in the previous 6 months; disaggregated by identity factors and/or intersections.
- ☐ EDI-related metrics are used to inform the College's consultations with interested parties who are seeking to identify and mitigate barriers or identify under-serviced groups or communities.

7. 2. Structural and Process Markers for Reporting – purposeful and inclusive communication of EDI progress

Inactive	☐ EDI is not clearly defined. ☐ EDI initiatives are not part of organizational reporting. ☐ EDI reporting is focused on demonstrating compliance with requirements such as legislated requirements and Ontario Fairness Commissioner (OFC) standards.
Reactive	☐ EDI reporting is limited to meeting the requirements of the Ontario Fairness Commissioner (OFC). ☐ EDI reporting is consistent with the College's definition(s) of EDI, including aspects such as anti-racism, gender, Indigeneity, disability, etc. ☐ Reporting focuses on a few EDI initiatives. ☐ There are limited performance indicators (KPIs) related to EDI or anti-racism, and typically limited to output / activity measures. ☐ Reporting identifies some equity-seeking groups who may be affected by College activities.
Proactive	☐ There is some reporting of EDI-related outcomes. ☐ There is some reporting of evidence that equity-focused policies and practices are accomplishing the stated goals. ☐ The methods, vehicles, content and timing of EDI and anti-racism reporting activities are intentionally designed to be meaningful and accessible to multiple, diverse audiences. ☐ Reporting and review of relevant indicators takes place at multiple levels of the organization (operational, strategic).
Progressive	☐ EDI-related issues are reflected in other organizational reporting such as risk reviews. ☐ EDI-related Key Performance Indicators (KPIs) are tracked and integrated into ongoing reporting methods (briefings, balanced scorecards, dashboards, etc.). ☐ There is reporting of strong evidence of positive outcomes that EDI and anti-racism policies and practices are accomplishing the stated goals. ☐ Relevant system partners and equity-seeking groups are advised of detailed EDI-related outcomes (measurement results) and engaged in validating and interpreting the findings. ☐ Approaches for creating and delivering College performance reporting are explicitly designed to educate, engage and influence system partners, as part of the College's broad commitment to making progress on EDI and anti-racism.

7.3. Structural and Process Markers for Improvement – sustainable organizational practices for making progress on EDI

Inactive	☐ EDI is not clearly defined. ☐ EDI issues that arise are generally not addressed in a robust manner. ☐ The sole or primary performance standard is the avoidance of legal risk.
Reactive	☐ EDI has been defined at a general level. ☐ Involvement in EDI initiatives is limited and/or compartmentalized without systemic linkages. ☐ KPIs are generally limited to output / activity measures, without a clear linkage to desired improvement in outcomes. ☐ EDI issues are considered at a surface level when they arise; they are resolved as exceptions or discrete events, not as potential indicators of systemic considerations. ☐ Some equity-seeking groups are named as system partners in improvement efforts.
Proactive	☐ There is a clear definition / vision of EDI that compares current state to ideal future across multiple dimensions. ☐ Policies and processes are updated with explicit considerations of EDI aspects. ☐ There is some monitoring and measurement of EDI-related outcomes. ☐ There is a designated individual with accountability for EDI progress and action planning. ☐ There is a formal process for using KPI data to identify areas for improvement. ☐ Representatives of some equity-seeking groups are consulted for their input into selected improvement initiatives. ☐ There is some demonstration to interested parties that changes to policies and practices are having a positive impact.
Progressive	☐ There is a consistent planning and budgeting process for EDI initiatives and progress integrated into business planning. ☐ The strategic plan incorporates EDI and related Key Performance Indicators (KPIs) are tracked and integrated into decision making and future planning. ☐ Potential bias in decision-making about improvement priorities and budgeting is minimized through explicitly designed processes and supporting resources and learning investments. ☐ Partnerships with EDI interested parties are nurtured as strategic partners in identifying, scoping and prioritizing improvement initiatives. ☐ There is strong evidence of positive outcomes from changes introduced to have more inclusive policies and practices. ☐ There is ongoing and transparent communication of high-level KPI results and how the findings have translated into ongoing improvement activities.

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Standards' Waiver Policy Review.

Summary

The Standards' Waiver Policy exists to provide registrants with the means to request a waiver from College Standards of Practice.

At the November 7th QAC Meeting, the Committee decided to renew the Standards' Waiver Policy with minor revisions.

Background

- College standards set minimum expectations that must be met by any midwife in any setting or role.
- Standards guide the professional knowledge, skills and judgment needed to practise midwifery safely and ethically.
- In exceptional circumstances, midwives may not be able to meet certain College standards. In these rare cases, standards may be waived.

The revised Waiver Policy – Standards is attached.

Key Considerations & Public Interest Rationale

College standards may be waived in exceptional circumstances, provided that circumstances of the application are both in the public interest and are sufficiently exceptional to justify a departure from the relevant standards. It is for the midwife to demonstrate that exceptional circumstances exist and must meet the criteria established in the Waiver Policy – Standards.

Since the implementation of this Policy, only midwives who could not meet the Second Birth Attendant Standard submitted applications for waivers, all of which were granted. Since updating the Second Birth Attendant Standard in 2022, the College has not received any new waiver requests. To anticipate future changes within the healthcare landscape, the Committee agreed that the policy has not outlived its usefulness and may be needed in the future. The Committee is asking Council to renew the policy with minor edits.

Recommendations

To approve the Waiver Policy – Standards with minor revisions.

Implementation Date

Dec 6, 2023

Legislative and Other References

None

Attachments

1. Waiver Policy – Standards with tracked changes

Submitted by:

Lilly Martin, RM
Chair, Quality Assurance Committee

WAIVER POLICY – STANDARDS

Purpose

The purpose of this policy is to outline the circumstances in which College standards may be waived.

Scope

This policy applies to all midwives who wish to apply for a waiver of standards.

Definitions

"Code" means the Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991* (RHPA) as amended from time to time.

"exceptional circumstances" means conditions beyond one's control that justify waiving College standards.

Policy Statement

College standards may be waived in exceptional circumstances.

A midwife seeking a waiver of standards must demonstrate to the College that there are exceptional circumstances related to their practice that warrant a departure from the current standards. Every application will be considered on its individual merits.

In all cases a midwife must satisfy the College that the following apply:

1. The waiver will support the public interest which the standards are designed to safeguard
2. A public benefit will be gained by a departure from the standards, and
3. Granting a waiver will not give rise to a risk of harm to the:
    a. clients' interests
    b. regulatory objectives set out in section 3 (1) of the Code, and
    c. College's regulatory outcomes

References (legislative and other)

1. Health Professions Procedural Code, being Schedule 2 to the *Regulated Health Professions Act, 1991*, s. 3(1)
2. Regulatory Outcomes, Strategic Framework 2021-2026, College of Midwives of Ontario

Approved by: Council
Approval date: June 13, 2018
Implementation Date: June 13, 2018
Last reviewed and revised: December 6, 2023

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Vaginal Birth After Caesarean Section (VBAC) and Choice of Birthplace Position Statement.

Summary

The 2018 Vaginal Birth After Caesarean Section and Choice of Birthplace Position Statement is due for review.

Following discussion at its November 7th meeting, the Quality Assurance Committee (QAC) is recommending to Council that the position statement be rescinded.

Background

- Vaginal Birth After Caesarean Section and Choice of Birthplace was first approved by Council in 2013 as a Standard.
- In 2018, QAC considered rescinding it, recognizing that the Professional Standards for Midwives adequately addressed the minimum standard.
- At that time, however, increasing pressure from hospitals was contributing to limiting the choice of birthplace for this population of clients and was placing undue pressure on midwives to recommend hospital birth for clients requesting out-of-hospital birth.
- Council, therefore, approved the Vaginal Birth After Caesarean Section and Choice of Birthplace Position Statement to support the right of choice of birthplace for midwifery clients.
- The position statement is currently scheduled for review, and at this time, it is considered redundant and reflects only one of many situations where midwives are expected to centre the client as the primary decision maker in their health decisions.

Key Considerations & Public Interest Rationale

When the position statement was published, it was meant to protect the public interest in reasserting clients' right to autonomy and primary decision-making.

It is the position of the QAC that the statement is redundant, and its direction is superseded by the Professional Standards for Midwives. Though this may be interpreted as the College changing our stance regarding supporting out-of-hospital birth for this population, in actuality, the College is committed to reinforcing the Professional Standards for Midwives, which thoroughly addresses the obligations of midwives for clients who choose out-of-hospital birth who have a history of prior caesarean section.

Standards related to autonomy in decision-making for clients, clients being the primary decision-makers in their own healthcare, and the midwives' responsibility to provide sufficient evidence to support informed decision-making by the clients, are all clearly represented in the Professional Standards for Midwives.

For example, midwives must meet the following standards:

> *6. Offer treatments based on the current and accepted evidence, and the resources available.*
> *14. Listen to clients and provide information in ways they can understand.*
> *15. Support clients to be active participants in managing their own health and the health of their newborns.*
> *16. Recognize clients as the primary decision-makers and provide informed choice in all aspects of care by:*
>
> > *16.1. providing information so that clients are informed when making decisions about their care*
> > *16.2. advising clients about the nature of any proposed treatment, including the expected benefits, material risks and side effects, alternative courses of action, and likely consequences of not having the treatment*
> > *16.3. making efforts to understand and appreciate what is motivating clients' choices*
> > *16.4. allowing clients adequate time for decision-making*
> > *16.5. ensuring treatment is only provided with the client's informed and voluntary consent unless otherwise permitted by law*
> > *16.6. supporting clients' rights to accept or refuse treatment*
> > *16.7. respecting the degree to which clients want to be involved in decisions about their care.*
>
> *18. Provide clients with a choice between home and hospital births.*
> *19. Provide care during labour and birth in the setting chosen by the client.*
> *28. Consult with or transfer care to another care provider when the care a client requires is beyond the midwifery scope of practice or exceeds your competence, unless not providing care could result in imminent harm.*
> *33. Never abandon a client in labour.*

As shown above, the directive intended by the Vaginal Birth After Caesarean Section and Choice of Birthplace Position Statement is currently reflected in several standards.

Risks of rescinding the position statement include:

- The optics of the College no longer singling out VBAC as a clinical scenario which requires particular focus may be misconstrued by registrants and or by the public as the College reversing or changing course on the position that it took previously.
- Additionally, there is some small amount of risk that rescinding the VBAC position statement could also be misconstrued by clients or unregulated birth attendants as the College limiting autonomy and choice of birthplace for clients.
- A risk that may impact registered midwives is that they no longer feel that they have guidance from the College with regard to this clinical situation.

Risk mitigation strategies include:

- Clear communication about the value of the position statement in the past and the value of the Professional Standards for Midwives now.
- Clear communication to the public and to registrants regarding the application of the Standards to a variety of clinical scenarios including but not limited to clients who choose home birth or out of hospital birth for vaginal birth after caesarean or trial of labour after caesarean.

A structured communication strategy will be required to ensure that risk is mitigated, and that the public and registrants fully understand the reasons for rescinding this position statement.

If we maintain focus on the Professional Standards for Midwives, VBAC will no longer be considered a special case scenario and will instead be part of a larger directive to midwives and an agreement with the public that the midwives' responsibility is to provide informed choice and support decision making by clients. Midwives have a duty of care to provide sufficient information for clients to make informed choices, and clients are then the primary decision maker in their own care. Even when that decision goes against recommendations made by the midwife.

Recommendations

The following motion is submitted for approval:

THAT Council rescind the Vaginal Birth After Caesarean Section and Choice of Birthplace Position Statement.

Implementation Date

January 1, 2024

Legislative and Other References

N/A

Attachments

1. Vaginal Birth After Cesarian Section and Choice of Birthplace Position Statement

Submitted by:

Lilly Martin, RM

Chair, Quality Assurance Committee

POSITION STATEMENT

Vaginal Birth After Caesarean Section and Choice of Birthplace

The College of Midwives of Ontario's mission is to regulate midwifery in the public interest. In keeping with this mission, the College recognizes clients as the primary decision-makers in all aspects of their midwifery care. This means that clients must be supported in making decisions about their care based on their values and preferences as well as the research evidence and current recommendations relevant to their care.

As the primary decision-maker, a client can plan a vaginal birth after a previous caesarean section (VBAC) in all settings, including home. Midwives are required to provide care during labour and birth in the setting chosen by the client. Failure to do so may constitute an act of professional misconduct.

Adopted by the Council on March 21, 2018.

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Course on administering controlled substances for midwives.

Background

In August 2023, the College made its most recent submission to the Ministry proposing changes to the Designated Drugs Regulation. Since then, the College has been working on the necessary materials and processes to be able to effectively implement the regulation when it is approved and comes into force (expected but not confirmed for early 2024).

In 2019, the College submitted a proposed regulation that replaced the specified drug list with broad categories of drugs using a Ministry-proposed classification system called the American Hospital Formulary Service (AHFS). This approach would have provided midwives the authority to prescribe and administer opioids and benzodiazepines for clinical conditions that are in the midwifery scope of practice. At that time, due to the potential risks associated with prescribing opioids and benzodiazepines, the Council approved an online course called Opioids and Benzodiazepines: Safe Prescribing for Midwives offered by the University of British Columbia (UBC) as a mandatory course for midwives. However, the Ministry later decided that using AHFS categories was not the preferred way to draft the regulation and encouraged the College to submit an expanded list of drugs and substances as an interim step while they considered a more effective classification solution.

The proposed expanded list, however, does not include opioid and benzodiazepine prescribing and only permits the administration of four opioids in hospital-only settings which include Fentanyl citrate, Meperidine, Morphine Sulfate and Nalbuphine.

To mitigate the potential risks to the public associated with the administration of these controlled substances, the regulation requires midwives to have sufficient knowledge, skill and judgment to safely and competently administer the controlled substances prior to engaging in the act. The Regulation states that to satisfy this requirement, midwives must have formal education and training approved by the Registrar or Registration Committee or have successfully completed a course approved by the Council. Midwives and applicants who do not satisfy the formal education and training requirements will be able to take the Council-approved course should they wish to administer the controlled substances on their own authority.

Currently, midwives may administer opioids on physician orders in hospital settings, complying with hospital policies and protocols that are in place to ensure community standards and safety. The minimum expectation of any midwife is to administer only those drugs that they are competent to use, meaning that they must have sufficient knowledge, skills, and judgment to use them effectively and safely, even on the order of a physician.

In recognition of this minimum expectation, the College staff proposes to develop a Course that is not clinical in nature but rather reminds midwives of the regulatory framework that

currently exists to maintain public safety. To that end, staff proposes that the Council-approved course meet the following criteria at a minimum:

- Broadly covers controlled drugs and substances in a Canadian context including legislation and regulation
- Relevant to the midwifery scope of practice
- Available to midwives
- Online format with no in-person requirement
- Financially feasible

In July 2023, the Quality Assurance Committee considered the option of making UBC's online course the pre-requisite course for midwives prior to administering controlled substances. Although the UBC course is the only one that satisfies the criteria outlined above, the Committee determined that the course went beyond what Ontario midwives would require because it covered opioid prescribing, which is not permitted in the proposed regulation. Therefore, it was determined that the College should develop its own course that is proportionate to the risk associated with administering opioids in hospital-only settings. Regardless, midwives who have already completed the UBC course will be deemed to have satisfied the formal education and training requirement in the regulation and will not need to take the Course developed by the College.

Key Considerations & Public Interest Rationale

The College's course proposes to inform midwives of the federal and provincial legislation and regulations that permit midwives to access controlled drugs and substances and remind them that they can only administer the four medications listed in the regulation (if clinically indicated) in hospital settings. We will remind them that they must have sufficient knowledge, skills, and judgment to use them effectively and safely and remind them that they must also follow hospital policies and protocols. The course will include relevant existing standards of practice to remind midwives of the minimum expectations that must be met by any midwife administering any drug, including controlled substances. Further details of the course including course description, learning objectives and course outline can be found in Appendix A.

It is important to note that the proposed course is intended to serve as a reminder rather than as a clinical course considering the administration of opioids in labour is not a new competency for midwives. The course will take no more than 1 hour to complete, will not have a formal assessment, and will be offered to all registrants and applicants free of charge. By making this course free of charge, we aim to provide all midwives access to the administration of controlled substances without financial constraints.

Our rationale for developing a reminder course without a formal assessment acknowledges that midwives already possess the required knowledge, skills, and judgment to safely administer substances, even when on the order of a physician. The fact that physician orders exist does not change the fact that the midwives must be competent to administer them, and it would be considered professional misconduct if they acted on physician orders

without sufficient knowledge, skill, or judgment to do so safely. By offering a reminder course, the College not only acknowledges their existing competencies but also safeguards the public by ensuring that midwives remain updated on the legislative and regulatory framework and the College's Standards of Practice. The course is also designed to reinforce the existence of hospital policies and guidelines already in place that serve to protect the public.

Risks associated with the administration of controlled substances are further mitigated as midwives have very few indications that would require administration of controlled substances and there are additional checks and balances in place in hospitals where these medications can be administered. Prohibiting the prescribing of controlled drugs, limiting access to the number of controlled substances, and limiting the administration by injection in hospital-only settings are measures taken to mitigate potential risks associated with misuse and diversion which have contributed to the opioid crisis in Canada. Considering this, the course developed by the College is a proportionate strategy to mitigate the remaining risks to the public.

Recommendations

The following recommendation is submitted for decision:

THAT Council approves the proposed course to be developed by the College on administering controlled substances for midwives.

Implementation Date

When completed. Planned for early 2024 to align with the implementation of the new regulation.

Legislative and Other References

Proposed Designated Drugs and Substances Regulation

Attachments

1. Appendix A: Course outline of the course to be developed by the College on administering controlled substances for midwives.

Submitted by:

Lilly Martin, RM
Chair, Quality Assurance Committee

Appendix A
Course Outline of proposed course to be developed by the College on Administering Controlled Substances for Midwives

Course Title:

Safe Administration of Controlled Substances for Midwives e-Learning Module

Course Duration:

30 minutes – 60 minutes

Course Format:

Self-paced, online video

Assessments:

There are no quizzes or assessments in this course, as it is designed for informational purposes only.

Course Description:

This online module is intended to provide applicants and registered midwives practising in Ontario with guidance on meeting the regulatory requirements to administer on their own authority the following controlled substances by injection in public hospitals: Fentanyl citrate, Meperidine, Morphine Sulphate, Nalbuphine.

This e-learning module does not provide clinical training. Midwives must possess the necessary knowledge, skills and judgment to safely administer any substance, including controlled substances, while also adhering to hospital policies.

Completion of this module satisfies the requirement set out in Section 5 of the (proposed) Designated Drugs and Substances Regulation.

Learning Objectives:

1. Understand the regulatory framework and relevant standards for independently administering controlled substances in Ontario, as set forth in the (proposed) Designated Drugs and Substances Regulation.
2. Apply the standards set out in the College of Midwives of Ontario Professional Standards for Midwives, Prescribing and Administering Standard and Record Keeping Standard with a focus on the administration of controlled substances.

Course Outline:

Section 1: Regulation Overview

This section provides an overview of the legislative and regulatory framework concerning the use of controlled substances within the midwifery scope of practice. It covers the federal *Controlled Drugs and Substances Act*, the *Food Safety Act*, the controlled acts set out in the *Regulated Health Professions Act, 1991* (RHPA) and the (proposed) Designated Drugs and Substances Regulation.

- 1.1 *Controlled Drugs and Substances Act* and *Food Safety Act*
- 1.2 Overview of the *Midwifery Act*, *Regulated Health Professions Act* (RHPA), and the controlled acts authorized to midwives
- 1.3 Overview of the (proposed) Designated Drugs and Substances Regulation
- 1.4 Section 5 of the regulation and its implications

Section 2: Opioid Crisis in Canada

This section addresses the opioid crisis in Canada, presenting high-level data on opioid-related harms. It aims to create awareness of why regulatory control is necessary and includes useful links and resources to be further educated on the situation.

- 2.1 Opioid-related harms in Canada (high-level data)
- 2.2 College's approach to regulation as it applies to controlled drugs and substances
- 2.3 Useful links and resources

Section 3: Standards of Practice

This section focuses on the standards of practice relevant to the safe administration of controlled substances. The standards provide the minimum expectations that must be met by any midwife administering any drug including controlled substances. Standards guide the professional knowledge, skills and judgment needed to practise midwifery safely.

- 3.1 Professional Standards for Midwives
- 3.2 Prescribing and Administering Standard
- 3.3 Record Keeping Standard for Midwives

Section 4: Completion

The last section summarizes the course learning objectives and covers the process of obtaining a Certificate of Completion.

- 4.1 Learning Objectives
- 4.2 Certificate of Completion