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

# Regulatory Performance Review

2020/2021

## Executive Summary

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

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

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

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

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

## Domain 1: Regulatory Policy

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

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

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

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

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

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Work undertaken to take into account:<br>- Findings from the literature review<br>- Developments in the area of professional regulation in Ontario and other jurisdictions<br>- College data (investigations and hearings data; learnings from quality assurance and registration; surveys with midwives and members of the public)<br>2. Evidence that regulatory policy is reviewed and revised at regular intervals. | 1. New regulatory initiatives or proposals considered by Council or a committee in the reporting period<br>2. Schedule for reviewing public facing documents. |

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

## Review procedure to test compliance with the standards

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

## Comments/observations

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

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

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

1. Standards Review: Phase 2, including the proposals to:
    a. Rescind
        i. The Consultation and Transfer of Care Standard (CTCS)
        ii. When a Client Chooses Care Outside Midwifery Standards of Practice
        iii. Delegation, Orders and Directives
    b. Implement
        i. The Midwifery Scope of Practice

c. Amend
    i. The Professional Standards for Midwives to set minimum expectations for midwives after a transfer of care and include additional standards on delegation
    ii. The Guideline on Ending the Midwife Client Relationship to provide guidance to midwives in situations when a client chooses care that falls below a standard of the profession.

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

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

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

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

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

| | | |
|---|---|---|
| 4 | Requirements for issuance and ongoing requirements for classes of registration | The regulatory impact assessment for classes of registration was conducted in 2020. The initial recommendations by the Registration Committee were reviewed by Council in March 2021. This proposal is still in progress and will be finalized in 2021. |

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

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

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

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Engagement and discussions with relevant partner organizations on all regulatory changes is undertaken<br>2. Proposed changes are circulated to the public, stakeholders and the membership for consultation before they are approved<br>3. The College allows a reasonable period for genuine comment<br>4. The College provides a written response to all consultations. Where a survey was conducted, evidence that results & analysis were formally circulated | 1. Number of formal and informal consultations conducted in the reporting period<br>2. Responses provided to all consultations and survey findings are shared with midwives and the public as appropriate<br>3. Average consultation length |
| Conclusion against this standard: Met x | Partially met ☐ Not met ☐ |

**Review procedure to test compliance with the standard**

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

**Comments/observations**

Open and effective consultation is a critical part of our policy-making. Effective consultation allows us to identify any potential unintended effects and to hear

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

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

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

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

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

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

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

As part of the consultation the following was provided:

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

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

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

Practice environment survey with midwives

The survey about midwifery practice environments was conducted in October 2020 to understand if the College's standards that apply to practice owners are enough or if there is a need for additional standards or guidance to support positive environments. The information from the survey will be analyzed in 2021. Any recommendations will be brought to the Quality Assurance Committee and Council as needed.

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

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

## STANDARD 4: Policy decision-making is open and transparent

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Council briefing materials, including the rationale and evidence supporting any recommendations, are posted on the College website in advance of every Council meeting | 1. Dates and links to Council materials<br>2. Notices and implementation dates |

| | |
|---|---|
| 2. Council meetings are open to the public<br>3. Notice of all new regulatory initiatives given to midwives and the public prior to the implementation date. | |
| Conclusion against this standard: Met x | Partially met ☐ Not met ☐ |

**Review procedure to test compliance with the standard**

Website audit

**Comments/observations**

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

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

| Initiative | Briefing Materials Available to the Public | Notices to midwives (also posted to the website) | Other activities to help midwives understand the new standards/requirements |
|---|---|---|---|
| Standards Review: Phase 2 | March 2020 (agenda item 7)<br>December 2021 (agenda item 10) | - Notice sent to midwives on February 25, 2021<br>- Webpage created for midwives to help them understand the changes and impact on their practice | - Two webinars with midwives<br>- Practice advice<br>- Presentations to midwifery students |

| | | | |
|---|---|---|---|
| Clinical currency | December 2021 (agenda item 11) | Not approved/In progress | N/A |
| New registrant Conditions | March 2021 (agenda item 9) | Not approved/In progress | N/A |
| Classes of registration | March 2021 (agenda item 9) | Not approved/In progress | N/A |

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

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

## Domain 2: Suitability to Practise

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

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

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

## Review procedure to test compliance with the above standard

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

## Comments/observations

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

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

Initial applications for registration

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

Table 1: New Midwives by Class of Registration

| | |
|---|---|
| General | 52 |
| Supervised practice | 11 |
| Inactive | 1 |
| Transitional | 0 |
| Total | 64 |

Table 2: New Midwives by Route of Entry

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

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

Class change applications

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

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

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

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

### STANDARD 6: Midwives continually demonstrate suitability to practise

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Checks are carried out to ensure that clinical currency and other ongoing requirements (*renewal, active practice, NR conditions/supervised practice/QAP) are met<br>2. Action is taken in cases where midwives are not able to meet ongoing suitability to practise requirements or if concerns are identified<br>3. Mechanisms used to regularly assess how midwives are performing beyond annual registration renewal and quality assurance program reporting. | 1. Number of members who met all requirements at registration annual renewal and action taken where the requirements were not met<br>2. Number of midwives who met active practice requirements and action taken where the requirements were not met<br>3. Number of new registrants and supervised midwives whose conditions were lifted / supervised practice was complete<br>4. quality assurance program compliance rate and action taken in all cases of non-compliance<br>5. Number of peer assessments undertaken, and action taken where a midwife's knowledge, skills and judgment were found unsatisfactory |
| Conclusion against this standard: Met x | Partially met ☐ Not met ☐ |

**Review procedure to test compliance with the above standard**

1. Select and review 50% of midwives who did not complete renewal by October 1 to confirm that appropriate actions were taken by the College in accordance with internal policies and procedures
2. Select and review 5% of midwives who met their active practice requirements to confirm the requirements set out in the Registration Regulation were met.

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

### Comments/observations

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

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

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

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

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

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

Annual renewal

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

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

Table 3: Renewal 2020/2021

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

Quality Assurance Program (QAP) Reporting

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

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

Table 4: Outcomes for 2020/2021 QAP reporting

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

Table 5: Exemptions from the QAP requirements[3]

| | |
|---|---|
| Granted | 11 |
| Not granted | 0 |
| Total | 11 |

Table: 6 QAP Non-compliance Outcomes

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

Active Practice Reporting

Each midwife's active practice report submitted online is reviewed by staff to ensure compliance with the requirements set out in regulations and College policies. Midwives who meet their active practice requirements are notified and their subsequent active practice reporting due date becomes available in the online portal. If after a review it is determined that a midwife has a shortfall, they are referred to a panel of the Registration Committee for consideration of a shortfall plan, existence of extenuating circumstances or the need for a term, condition or limitation to be imposed on their certificate of registration. The level of risk will inform the panel's decision-making and panels use a risk assessment tool to ensure consistency in decision-making. The results of the file review showed that appropriate regulatory action was taken in situations where the requirements were not met.

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

Table 7: Active Practice Reporting for 2020/2021

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

Table 8: Panel Outcomes for Active Practice Requirements Shortfall

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

Monitoring new registrant conditions and completion of supervision plans

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

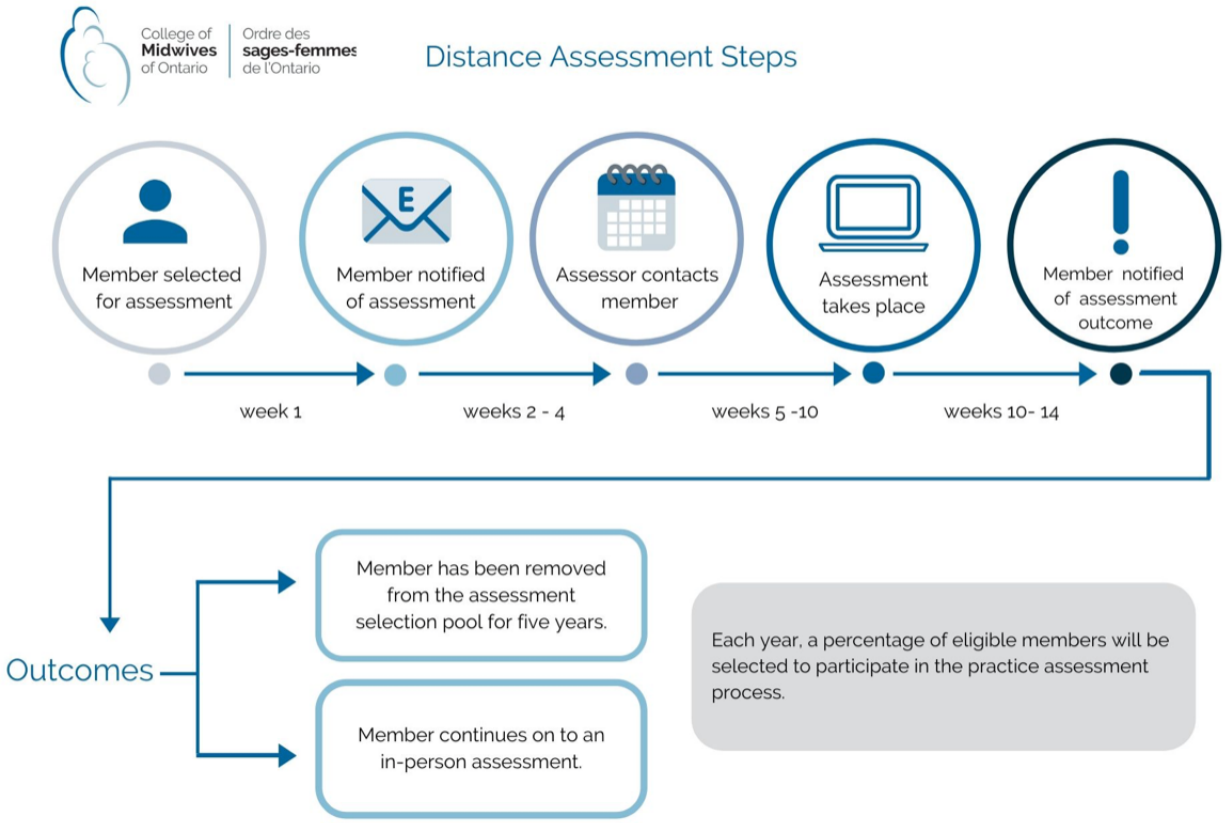
Peer and Practice Assessments

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

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

spectrum of midwifery professional practice, including non-technical competencies such as communication and interprofessional care.

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




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

Table 9: Peer and Practice Assessments

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

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

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

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

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

### Review procedure to test compliance with the standard

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

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

## Comments/observations

Under the framework set out in legislation, we must investigate every complaint filed with the College. Once a complaint has been received in an appropriate form, it is immediately assessed for any risks to the public that need to be acted upon expeditiously by making an interim order and as to whether it could be referred to the College's Alternative Dispute Resolution (ADR) program. The criteria for identifying cases that warrant an interim order at intake and throughout the investigative process are set out in the College's ICRC Procedures Manual. The eligibility criteria for ADR are set out in the Alternative Dispute Resolution Eligibility Policy. Based on the results of the review, we are satisfied that the complaints considered eligible for ADR met the eligibility criteria.

Table 10: Alternative Dispute Resolution Program in 2020/2021

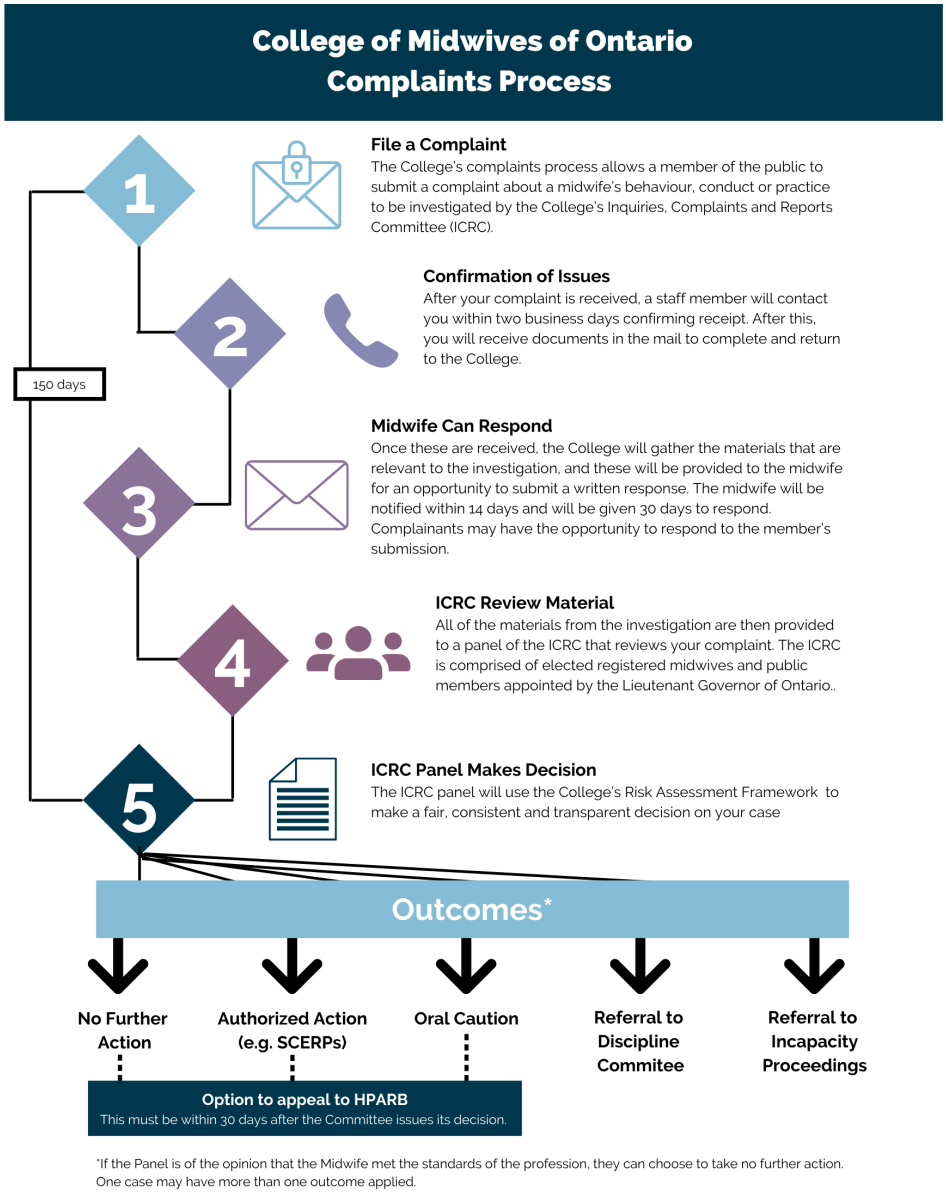
| | |
|---|---|
| Open files with ADR (Files carried over) as of April 1, 2020 | 0 |
| Open files referred to ADR | 0 |
| Closed files within 60 days | 0 |
| Closed files within 120 days | 5 |
| Files returned to ICRC due to timeframe | 0 |
| Files returned to ICRC due to unsuccessful mediation | 0 |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

Table 11: Other ADR-related information

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

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

Figure 2: How the College manages complaints about midwives




This year, the College received and closed the highest number of complaint matters[7] received in a single fiscal year in the College's recent history. This equates to 45 complaint matters received, 55% more than the number of complaint matters received in 2019/2020 (29 new complaints). Similarly, the ICRC closed 51 complaint matters this year, 155% more than last year (when 20 complaint matters were closed).

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

This is because we were able to resolve more of our older, more complex cases in 2020/2021. For our complaints' caseload in 2020/2021 and other complaints-related information, refer to the below tables.

Table 12: Complaints caseload in 2020/2021

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

Table 13: Who made a complaint in 2020/2021

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

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

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

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

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

**Review procedure to test compliance with the standard**

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

## Comments/observations

Mandatory reporting obligations legally require a midwife to self-report (e.g., findings of professional negligence and malpractice) and provide information about other midwives or other healthcare practitioners to relevant regulators. It is in the public interest that this important information be provided to relevant authorities on a timely basis. Midwives are also allowed to make permissive reports which refers to those instances where midwives are not required to make a report under legislation but choose to do so, in the public interest. Finally, information also comes to our attention through other sources, e.g., from the Office of the Chief Coroner (Coroner's Reports); information received from a client that did not result in a formal complaint; or information received from other regulators.

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

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

Table 14: Mandatory & Other Reports in 2020/2021

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

Table 15: Preliminary Inquiries made in 2020/2021

| | |
|---|---|
| Open inquiries as of March 31, 2020 | 22 |

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

| | |
|---|---|
| New inquiries started | 62 |
| Inquiries closed | 61 |
| Open inquiries as of April 1, 2021 | 23 |

Table 16: Preliminary inquiry outcomes in 2020/2021

| | |
|---|---|
| Reports resulting in a formal investigation by the Registrar | 7 |
| Reports resulting in an educational letter | 20 |
| Reports resulting in no action | 34 |
| Total | 61 |

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

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

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

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

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

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Evidence that the public and midwives have information to identify and report those engaged in unauthorized or illegal practice<br>2. The process of dealing with non-registrants who hold themselves out as midwives is proportionate to the risk being managed.<br>3. Evidence that the College is transparent about those engaged in unauthorized or illegal practice | 1. Website information<br>2. Number of unauthorized practice reports received by the College and action taken<br>3. average length from the receipt of report to final action. |

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

**Review procedure to test compliance with the standard**

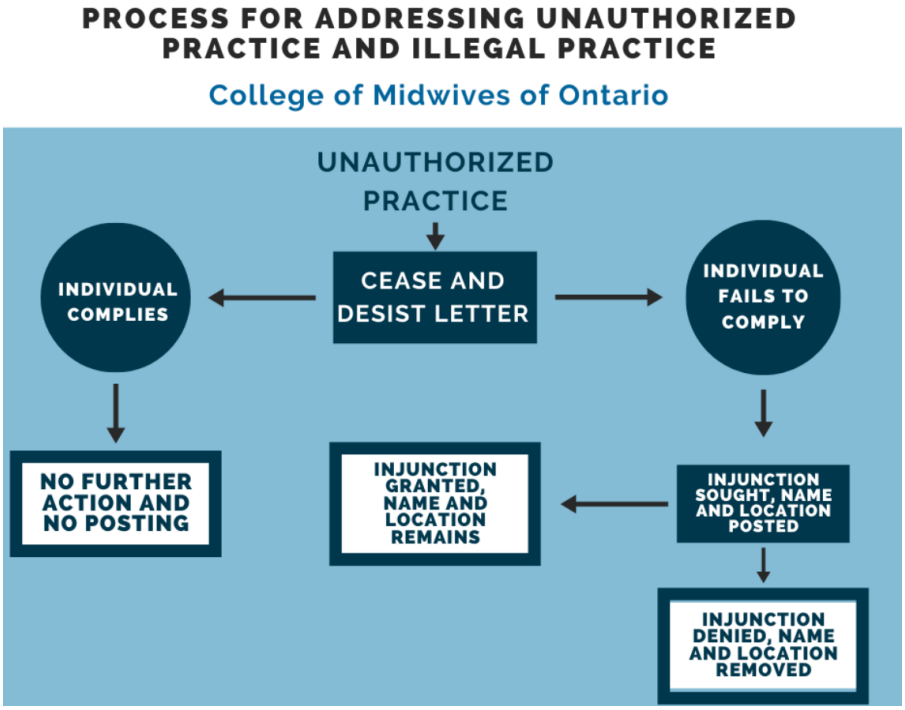
1. Website audit
2. Review all reports of unauthorized practice received from April 1 to March 31, 2020 to ensure that the internal process was adhered to.

**Comments/observations**

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

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

Figure 3: How the College addresses unauthorized practice




The College has a dedicated webpage that defines what unauthorized/illegal practice means and details the College's process for addressing the reports made to the

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

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

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

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

## Domain 3: Openness and Accountability

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

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

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

**Review procedure to test compliance with the standard**

Website audit

### Comments/observations

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

Our What to Expect from Your Midwife brochure outlines the role of the College in regulating midwifery in the public interest, as well as what clients can expect from their midwives. The College sends brochures (in both English and French) to all Midwifery Practice Groups across the province for client distribution.[9] The brochure order form is available on the College's website. In 2020/2021, we created a COVID-19 webpage for the public to provide first-hand information (by way of frequently asked questions) about how the pandemic has changed the way midwifery care is being provided, and to assure midwifery clients that their safety remained our priority. In addition to resources available on the College's website, our Practice Advisor is available to provide practice advice to midwifery clients and the public about midwifery standards. While the vast majority of individuals who contact the College for practice advice are midwives (almost 78%), others approach the College for information, including midwifery clients (8% of total inquiries made in 2020/2021), some of whom are also complainants as well as hospitals, midwifery students, consultants and insurance providers.

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

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

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

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

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

### Standard 11: Public register provides access to information about midwives

| Evidence of compliance | Data source(s) |
|---|---|
| 1. The public register is up to date and in compliance with the legislation and by-laws that set out what should be public<br>2. The public register search is prominently displayed on the website and is accessible at all times<br>3. The public has information to understand how to navigate the public register and how to interpret the information provided<br>4. Information deemed as public is posted within 5 days after the midwife has been notified of the decision<br>5. Non-College information (e.g., charges) is made available within 5 business days after the members has been notified of the College's obligation to post to the register. | 1. Register profiles<br>2. Committee orders (ICRC/discipline, registration and quality assurance) that include information designated as public<br>3. Public register-related webpages, including the glossary of terms |
| Conclusion against this standard: Met ☐ | Partially met x Not met ☐ |

### Review procedure to test compliance with the standard

1. Select and review 20 random register profiles to verify their accuracy (in addition all midwifery files reviewed as part of standards 5 & 6 were also reviewed against this standard)

2. Select and review 5% of committee orders issued in the reporting period that include information designated as public to verify that they were posted to the register within five days after the midwife has been notified of the decision or of the College's obligation to post to the register (for non-College information) and were accurate.

**Comments/observations**

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

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

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

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

Information generated as a result of a College proceeding

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

Personal, practice and other information

This category includes a broad variety of information ranging from a midwife's name, current and past practice location and business address to criminal findings of guilt, criminal charges, bail conditions, findings of professional negligence and malpractice

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

and other similar types of information. Midwives are required to provide this type of information by either updating their profiles in the member portal (that is tied to the public register) or contacting the College in writing. Our website outlines which pieces of information midwives can update in the member and which can only be provided in writing to the College. We cannot guarantee that the information that midwives must provide is indeed provided to the College in a timely manner[11], or at all, and we cannot guarantee that the register is always accurate. We must, however, make every effort to ensure that the information is accurate and complete.

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

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

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

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

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

### Review procedure to test compliance with the standard

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

### Comments/observations

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

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

<u>Information and support</u>

The review showed that all parties (or a midwife in a report matter) are provided with relevant information to understand the process and decision-making and are kept informed on the progress of their case. Staff is available to respond to any inquiries throughout the process. The College has a policy that requires staff to acknowledge all

inquiries within two business days and to provide a timeline in which the inquiry can be addressed if it cannot be addressed within that time. All staff of the College are responsible for abiding by this policy and identifying when the standard cannot be met to management. The generic email address: conduct@cmo.on.ca that is used in all formal documents for inquiries relating to complaints, reports, or unauthorized practice and general information about the complaints, discipline or ADR process has an automatic response that indicates the inquiry is received and gives the established timeline of two business days for a response. In addition, practice advice is available at intake and throughout the process if complainants (and midwives) need advice on clinical, ethical, or regulatory issues.

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

Decision-making

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

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

Table 18: ICRC Dispositions [12]

| Dispositions | Complaints | Reports |
|---|---|---|
| | 2020/2021 | 2020/2021 |
| **Number of decisions issued** | **51** | **10** |
| Complaints referred to ADR | 5 | N/A |
| Complaints Withdrawn | 1 | |
| Frivolous and Vexatious | 1 | |
| No Action | 29 | 3 |
| Advice & Recommendations | 13 | 3 |
| Specified Continuing Education or Remediation Program (SCERP) | 3 | 5 |
| Oral Caution | 0 | 1 |
| Referral to Discipline Committee | 1 | 0 |

[12] Some decisions contain more than one disposition (e.g., caution and SCERP). So, the total number of decisions may not equal the total number of dispositions.

| | | |
|---|---|---|
| Referral to Fitness to Practise Committee | 0 | 0 |
| Acknowledgement & Undertaking | 0 | 0 |
| Undertaking to Restrict Practise | 0 | 0 |
| Undertaking to Resign and Never Reapply | 0 | 0 |

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

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

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

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

Compliance monitoring

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

[13] One discipline case may result in more than one finding of professional misconduct and/or penalty component.

Table 20: Compliance Monitoring[14]

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

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

Reviews before the Health Professions Appeal and Review Board

In a complaint matter either party can seek a review of the ICRC's decision unless the decision was to refer the matter to discipline or to an incapacity inquiry. There is no right of review before the Health Professions Appeal and Review Board (HPARB) in a Registrar's report matter. In such cases, the only option for a midwife who is dissatisfied with an outcome is to apply for judicial review to the Divisional Court. HPARB reviews focus on two issues: the adequacy of the investigation and the reasonableness of the decision. HPARB has broad remedial powers. In addition to confirming the decision of the ICRC, it can return the matter to the ICRC to make a new decision with recommendations from HPARB or it can require the ICRC to make a specific decision dictated by HPARB. While the mere fact of a review before HPARB is not indicative of an issue, we closely monitor HPARB reviews. Any matter referred back to the ICRC or any recommendations made to the ICRC will trigger a review and a possible change to internal procedures.

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

Table 21: HPARB appeals in 2021/2022

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

Appeals to the Divisional Court

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

[14] Committee decisions may consist of multiple orders with different prescribed timelines. Accordingly, the total number of orders being monitored may not equal the total number of midwives being monitored.
[15] The ten appeals are representative of six complaint matters. Five complaints involve more than one midwife. All appeals are by complainants.

Timely resolution of matters

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

Table 22: Timelines: complaint matters and reports

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

The 150-day timeframe set out in legislation is ambitious as there are multiple steps that must be taken to close a case, including giving notice to the midwife along with 30 days to make written submissions (extensions are regularly sought by a member's legal counsel), completing an investigation, bringing the case before a panel of ICRC, their deliberations, and the writing of reasons. Additional steps may be required in complex cases, such as, for example, getting an expert opinion. As shown in Table 23, less than 12% of complaints and 20% of reports were closed within the 150-day timeframe in 2020/2021. Providing meaningful and timely resolutions to complaint and report matters is a key factor in assessing not only the operational efficiency of any system, but also its accessibility, and its ultimate effectiveness. A key metric for many regulators is processing times for regulatory approvals and other processes. Indeed, decisions rendered a year or years after the events in question may no longer be meaningful to the parties involved. At the same time, the quest for simplicity and timeliness cannot be pursued to the detriment of procedural fairness and other principles that we are held to. As an administrative agency we have a duty to ensure that any exercise of power can be justified to the public and midwives in terms of rationality and fairness. Although there may at times be a trade-off between simplicity of process and procedural fairness (and arguably a simpler system that is

more accessible and timelier could lead to greater fairness, particularly for cases that are themselves simpler), this is not always the case.

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

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

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

**Review procedure to test compliance with the standard**

Website audit

**Comments/observations**

Information provided to applicants and midwives

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

The "resources" section of the website provides information and downloadable guidance documents for midwives, including on the various pieces of provincial legislation that apply to healthcare practitioners, including midwives. All College

standards and policies are published on the website (including documents archived after 2018). The "midwives" section of the website provides information about the ongoing requirements that midwives must meet (such as quality assurance requirements and active practice requirements). This section also includes practice advice (in the form of frequently asked questions) and links to relevant documents that midwives must be aware of. In addition, a practice advisor is available to respond to any questions that midwives may have regarding midwifery standards, policies, and regulations.

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

Practice advice

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

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

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

| | |
|---|---|
| • Second Birth Attendants | 6 |
| • Ethical (Conflict over care/Termination of care). | 16 |
| Other Regulations and Guides (e.g., PHIPA, Health Protection and Promotion Act) | 4 |
| Midwife looking for information on website or seeking clarification of standard | 16 |
| Miscellaneous | 23 |
| TOTAL | 184 |

Table 24: People Who Made Inquiries in 2020/2021

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

Support provided to midwives when changes are made

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

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

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

1. Continuing to make information about our ongoing requirements, standards and guidelines available to midwives in an engaging and accessible format.
2. Introducing orientation workshops to help midwives who are new to practice, or new to the province, understand professional issues that will affect them on a daily basis and what it means to be a regulated professional in Ontario.
3. Continuing to work with our midwifery education partners to incorporate regular workshops on professional regulation into their curriculum with the purpose of educating midwifery students about their professional obligations within the Ontario system of regulation and preparing them for entry to practice.
4. Surveying midwives and midwifery students to track their perceptions of the College so we can better understand the impact of our work and how we can communicate more effectively with them.

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

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

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Evidence that all registration files referred to a panel of the Registration Committee are managed in accordance with the requirements set out in legislation and regulations and internal procedures<br>o All midwives and applicants who are subject to a registration proceeding are provided with information to understand the process and make submissions /provide information to support their case<br>o Panel decision-making is proportionate to the risk of harm and reasonable<br>2. Evidence of defined benchmarks for all registration processes and adherence to those<br>3. Satisfactory completion of the Office of the Fairness Commissioner:<br>o Annual Fair Registration Practices Reports<br>o Most recent Registration Practices Assessment Report. | 1. All files closed in the reporting period<br>2. Panel decision-making framework/tools<br>3. Registration panel outcomes<br>4. Data showing that benchmarks are adhered to<br>5. Number of decisions appealed to HPARB and their status<br>6. total number of orders made by the Registration Committee that require monitoring and their status |

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

## Review procedure to test compliance with the standard

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

## Comments/observations

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

Reviews before HPARB

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

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

Office of the Fairness Commissioner (OFC) Reports

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

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

Timeliness

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

Table 25: Timelines: registration matters

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

Despite our overall satisfactory performance against this standard, we only partially met it because we were unable to demonstrate evidence of defined benchmarks and adherence to those. We also note that four registration files referred to a panel of the Registration Committee in December 2020 (for active practice shortfall) were not completed by the end of this fiscal (they were all at a decision drafting stage as of March 31, 2021). Immediate changes will be implemented to ensure timely drafting of panel decisions. The work to set timelines for closing registration matters to be able to benchmark our performance against those was planned for 2020/2021 but due to the pandemic and its effects on the registration department, this work was not complete in 2020/2021 and was moved to 2021/2022. We note that because the benchmarks have not been set yet, we will not be able to assess our performance against this aspect of the Standard in 2021/2022. However, we will be able to present our benchmarks for registration matters in the 2021/2022 report.

## Domain 4: Good Governance

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

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

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Council meetings and briefing materials are available to the public | 1. Council packages<br>2. Council meeting minutes |

| | |
|---|---|
| 2. Council decisions are publicly available<br>3. Committees report to Council on a quarterly and annual basis. | 3. Quarterly and annual committee reports provided to Council |
| Conclusion against this standard: Met x | Partially met ☐ Not met ☐ |

**Review procedure to test compliance with the above standard**

Website audit

**Comments/observations**

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

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

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

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

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

| Evidence of compliance | Data source(s) |
|---|---|
| 1. Eligibility criteria for election to ensure independence of decision-making<br>2. Council member terms on Council are appropriately imposed<br>3. Policies, procedures and criteria for selection and terms of appointment of the governing body are documented and readily available to aid transparency and attract appropriate candidates.<br>4. College by-laws and policies are adhered to and monitored. | 1. By-laws and governance policies<br>2. Election and other information available to midwives to understand the requirements<br>3. Candidate nomination forms including declarations that they met eligibility criteria set out in College by laws<br>4. Council terms document |

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

**Review procedure to test compliance with the above standard**

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

**Comments/observations:**

Criteria to support regulatory integrity

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

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

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

Terms

Under ss. 4-5 of the Code, the term of a Council member who is elected (i.e., professional member) should not exceed three years. In addition, a professional member's term should not exceed nine consecutive years. In general, imposing terms is considered a good governance principle as term limits bring new perspectives to the overall work of Council. The review showed that Council member terms are appropriately monitored and enforced.

Transparency of College governance

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

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

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

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

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

**Review procedure to test compliance with the above standard**

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

**Comments/observations:**

<u>Conflict of interest</u>

The College has a conflict of interest by-law (ss. 8.01-8.15) that governs the conduct of Council and committee members, including a disqualification procedure for members who acted in a conflict of interest. In addition, s. 5.08w of the General by-law states that any candidate that stands for election must complete a conflict of interest form declaring that they do not have a conflict of interest to serve as a

member of Council. The same applies to midwives and members of the public who apply to be appointed to College committees as non-Council committee members. Finally, all Council and committee members are required to complete a conflict-of-interest questionnaire on an annual basis. They also declare any conflicts as they arise in between the meetings and before each Council and committee meeting. All Council and non-Council members must declare a conflict of interest before they can be appointed to a panel to deliberate on/hear a particular case. The review showed that all Council and committee members have a signed conflict of interest form on file for the reporting period. Similarly, in all cases that were randomly selected and reviewed, Council and committee members declared a conflict of interest before they were appointed to a particular panel.

Training:

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

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

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

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

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

**Review procedure to test compliance with the above standard**

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

**Comments/observations:**

Completion of governance education modules prior to nomination

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

Code of conduct – training and acknowledgments

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

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

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

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

| Evidence of compliance | Data source(s) |
|---|---|
| 1. The College has pre-defined competencies for Council and committee members<br>2. Council and committee members self-assess their competency and skill level on an annual basis<br>3. The annual training plan for Council and committees is informed by the needs of Council and its committees and reflect current best practice in governance (including the governance of regulators). | 1. Competency matrix for current Council and committee members<br>2. Schedule of annual trainings developed by the Executive Committee (note in the narrative) |
| Conclusion against this standard: Met x | Partially met ☐ Not met ☐ |

### Review procedure to test compliance with the above standard

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

### Comments/observations:

<u>Meeting pre-determined eligibility criteria</u>

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

committee members prior to the date of nomination. All three candidates who stood for election in 2020 met the eligibility criteria outlined in the by-law.

Orientation before the first meeting

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

A full day training session was held in October 2020 and included an introduction to Council roles and responsibilities, fiduciary duties, the legislative framework that exists in Ontario and the regulatory framework specific to the midwifery profession as well as an introduction to the concepts of professionalism and competence and how the College should ensure those. In addition, two individualized orientation sessions were held on June 17 and September 25 for four new members (two attended each session), in advance of their first Council meeting held in October 2020.

Competency self-assessment and training

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

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

March 2021

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

June 2021
- Personal check in
- Anti-Bias/Anti-Racism training
- Discipline training (this will happen in a separate training in July)
- Chair training

October 2021
- Personal check in
- Re/Orientation to good governance
- Indigenous Cultural Safety and Humility training

December 2021
- Personal check in
- Risk-based regulation
- Future of midwifery
- Government organizational structure and regulation/legislation making

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

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

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

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

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

**Review procedure to test compliance with the above standard**

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

**Comments/observations**

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

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

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

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

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

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

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

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

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