AUSTRALIAN INSTITUTE
OF HIGHER EDUCATION

Internal Compliance Review Policy and Procedure

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Responsible Officer	Head of Quality Assurance
Approving authority	Board of Directors
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Related Documents	Education Services for Overseas Students Act 2000, Education Services for Overseas Students Regulations 2019 National Code of Practice for Providers of Education and Training to Overseas Students (2018) Higher Education Standards Framework (Threshold Standards) 2021 Tertiary Education Quality and Standards Agency (TEQSA) Quality Assurance Framework ESOS Compliance Framework Institutional Quality and Governance Framework Delegations of Authority Risk Management Plan Policy Framework Internal Review Register Policy and Procedure Register Academic Continuous Improvement Policy Academic Continuous Improvement Procedure Course Design Policy Course Design Procedure External Moderation and Benchmarking Policy External Moderation and Benchmarking Procedure Internal Assessment Moderation Policy and Procedure
HESF (Threshold Standards) 2021	6.1, 6.2

1. Purpose

This Policy and Procedure provides detail regarding how the Institute will internally review departments and their associated processes, and governing bodies of the Institute in a systematic manner. This Policy and Procedure should be read in conjunction with the *ESOS Compliance Framework* and the *Quality Assurance Framework*. The focus of these internal compliance reviews (**Reviews**) will be to determine if the operations and governance are effective, and to measure the level of compliance to:

- Education Services for Overseas Students Act 2000 (**ESOS Act**),
- The National Code of Practice for Providers of Education and Training to Overseas Students (2018) (**National Code**),

- Education Services for Overseas Students Regulations 2019 (Cth) (**ESOS Regulations**),
- Higher Education Standards Framework (Threshold Standards) 2021, (**HESFs**); and
- internal requirements set out in Institute frameworks, policy and procedure, and processes.

The purpose of the Reviews will be to:

- provide assurance to the Board of Directors (**Board**) that compliance is being monitored and maintained,
- enable identification of risks to compliance by governing bodies or departments,
- provide a forum to discuss specific risks with stakeholders and table recommendations to minimise or mitigate these risks to the Board for oversight,
- increase staff awareness and understanding of compliance requirements and the impact of these requirements on Institute processes, and
- develop capacity in management to develop new processes and improve existing policies, procedures, and processes that reduce the risk of non-compliance.

This Policy and Procedure shall set out the principles which apply to the development, review and reporting of internal compliance reviews at the Institute. This Policy and Procedure will provide the principles, scope and context for internal compliance reviews.

2. Principles

The key principle informing this Policy and Procedure is to articulate and support the Institute's commitment to complying with the regulatory framework establishing the minimum requirements for education programs delivered to international students.

Other principles informing this Policy and Procedure are:

Principle	Commitment
Risk-based	Reviews will be proactive and responsive in identifying, assessing and responding to risk. The length of time between Reviews will vary based on risk and arising concerns and be internally published via the *Internal Review Register* (**Register**). *Internal Compliance Review Report* (**Report**) recommendations will prioritise improvements toward items that pose the greatest risk of harm to students, and quality and standing of the Institute.
Proportionate	Report recommendations will be proportionate to the risks that it seeks to address and consider the resources and demands on the area being reviewed.
Necessary	Reviews will not burden departments or governing bodies any more than is reasonably necessary in the circumstances, and will seek opportunities to reduce the administrative burden and avoid duplication where possible.
Collaborative	Reviews will involve relevant ELT members, Department Heads or Chairs (or delegate) and collaborate with staff who hold expert knowledge on the review area.
Evidence-based	Reviews will use agreed-upon evidence supplied by departments to make informed and considered Reports.

Principle	Commitment
Outcomes-focused	Reviews are driven by a desire to maintain compliance, develop best practice approaches and achieve good regulatory outcomes. Progress against outcomes is measured by continuous improvement and progress towards enhancing self-assurance. Individual staff performance is not within the scope of the Reviews or Reports.
Fair	Reviews will undertake compliance monitoring activities in accordance with AIH's policies and processes, including those related to privacy, security, and records management. This is done in a manner that is collegial and ethical.
Transparent	Reviews and Reports will be scheduled and internally published on the Register. Reports will be developed in collaboration with Manager or Chair (or delegate). Finalised Reports will be presented to the Board for approval and at the Audit and Risk Advisory Committee meetings for noting.
Focused on building capability	Review activities will support ELT members, Department Heads or Chairs (or delegates) to meet their obligations and build their capability towards a compliance culture. Reviews and Reports will be constructive and support continuous improvement, and will acknowledge other demands on resources and time.

A Review does not in any way relieve the individual staff members of their individual responsibilities and accountabilities assigned to their role. Nor does it diminish the responsibility of the Board for their responsibilities as outlined in the *Institutional Quality and Governance Framework*.

3. Context

This Policy and Procedure has been developed to support and inform the Institute's internal quality assurance and monitoring processes. The Internal Compliance Review Policy and Procedure expresses the Institute's commitment to a culture of continuous improvement and quality assurance processes that are considered and acted on by its governing boards, documented, and embedded in its operations.

The Institute is categorised as an 'Institute of Higher Education' by TEQSA and is required to apply for registration and accreditation of all courses. In order to successfully apply for limited self-accrediting authority, the Institute will need to demonstrate the maturity and effectiveness of these processes.

4. Scope

This Policy and Procedure applies to all staff and contractors employed or retained by the Institute, and includes members of the decision-making and advisory bodies of the Institute.

This Policy and Procedure relates only to the non-financial compliance requirements of the regulatory body for Higher Education, TEQSA, and the associated requirements that are enforced by the regulator under the Tertiary Education Quality and Standards Agency Act 2011 (**TEQSA Act**), Education Services for Overseas Students Act 2000 (**ESOS Act**) and subordinate legislation.

The documents include:

- National Code
- ESOS Regulations
- HESFs
- Institute Frameworks, Policies, Procedures, and Processes

This Policy and Procedure relates to the compliance of the Institute, and Reviews and Reports on that compliance as actioned by internal staff members, to the relevant legislation and regulations as stated in the Purpose section.

This Policy and Procedure does not relate to the legal or financial compliance requirements of the Institute.

5. Definitions

See the *AIH Glossary of Terms* for definitions.

6. Policy details

6.1 Internal Compliance Reviews of Governing Bodies

Planning and Scheduling Internal Compliance Reviews

a. The *Governance Charter* sets out the governance structure, members' obligations and operations supporting the governing body. Each committee or board will be reviewed every 2 years or as listed in the Framework, whichever is soonest.

b. The Head of Quality Assurance will consider the contextual environment of the Institute, and update the *Internal Review Register* (**Register**) for the proceeding 24-month period.

c. The Register will list the commencing date of the Review, the governing body to be reviewed, the staff involved, the date the Report is to be discussed by the body being reviewed, the date the Report is to be presented to the Board, and, after the conclusion of the Review, the overall compliance rating assigned by the Review.

d. The Register will be presented to the Audit and Risk Advisory Committee and the governing bodies for noting and communication of purpose prior to presentation to the Board for approval.

e. From time to time there may be out-of-cycle Reviews that occur in in response to detection of an emerging risk or weakness. Out-of-cycle Reviews will be scheduled in consultation with impacted staff.

Provision and Consideration of Evidence

f. The Head of Quality Assurance will send out reminders to the relevant Chair and Secretariat (**involved staff**) at intervals of 2 months and 1 month prior to a scheduled Review.

g. The Head of Quality Assurance will access data stored on the Governance drive or requested from body members. This data will be used to report to the Chair and the reviewed governing body on the Terms of Reference set by the Governance Charter on the following items:

- Membership (internal and external members),
- Delegations of Authority,
- reports and information supplied to the body (document packs) to consider if they are sufficient to enable the body to fulfil their role and provide appropriate oversight; and
- appropriate record-keeping of the governance actions (agendas, minutes, action item lists).

Stakeholder Collaboration

h. A draft report will be provided to the Chair and the Secretariat for discussion. Amendments and recommendations from the discussion will be incorporated into the report.

i. An updated report will be then presented to the governing body being reviewed for discussion and comment. The discussion may trigger further changes to the report prior to presentation to the Academic Board and Board.

Report of Findings

j. If a Report has bearing on academic items, it will be presented to the Academic Board for comment and endorsement prior to presentation to the Board.

k. The Report will be presented to the Board for approval, including allocation of funding, as required, to carry out the recommendations.

Implementation of Recommendations

l. Once approved, the Secretariat or named role, will enact the approved recommendations. The Secretariat will collect appropriate data to assess the efficacy of any improvements or recommendations enacted.

m. The Report will be tabled at the Audit and Risk Advisory Committee meeting by the Secretariat to communicate the report findings and recommendations to internal staff.

n. The Secretariat will include the recommendations on the governance body action item list and provide updates where relevant. Recommendations may be discontinued or altered with the approval of the Board.

6.2 Internal Compliance Reviews of Departments

Planning and Scheduling Internal Compliance Reviews

a. Department Heads will consider the roles and responsibilities of their department and how to ensure compliance with the requirements of the HESFs, the ESOS Act, and the National Code.

b. Department Heads will complete the *Quality Assurance and Data Planning* template and plan to ensure that sufficient and relevant data demonstrating compliance are collected to enable review of their department.

c. The Head of Quality Assurance and each Department Head will meet to discuss the data collection process and frequency to ensure it is fit-for-purpose. Additional advice and guidance can be provided by the Head of Quality Assurance as required.

d. The Head of Quality Assurance will consider the contextual environment of the Institute, and update the Register for the proceeding 24-month period.

e. The Register will list the commencing date of the Review, the department to be reviewed, the external requirements for compliance, the staff and documents involved, the date the Report is to be presented to the Board and, after the conclusion of the Review, the overall compliance rating assigned by the Review.

f. The Register will be presented to the Audit and Risk Advisory Committee for noting prior to presentation to the Board for approval.

g. From time to time there may be out-of-cycle Reviews that occur in in response to detection of an emerging risk or weakness. Out-of-cycle Reviews will be scheduled in consultation with impacted staff.

Provision and Consideration of Evidence

h. The Head of Quality Assurance will send out reminders to the relevant Department Head and other identified stakeholders and experts (**involved staff**) at intervals of 2 months and 1 month prior to a scheduled Review.

i. The Department Head and their staff will set up an online folder with all agreed evidence as per the Data Planning and Quality Assurance document.

j. The Head of Quality Assurance will request access to the folder on the day of the Review.

k. The Head of Quality Assurance and involved staff will review all material within the folder and consider this with respect to requirements and key processes.

Stakeholder Collaboration

l. The involved staff will meet with the Head of Quality Assurance and discuss the following:

- the evidence provided and the level of compliance demonstrated,
- contextual and operational details,
- regulatory assessments or changes that may affect compliance requirements; and
- the previous Review and Report, what recommendations were approved, and whether these strategies were effective in improving compliance.

m. A series of recommendations and commendations will be proposed by staff during the meeting.

Report of Findings

n. The Head of Quality Assurance will complete the Report as a draft document with the input of the Department Head.

o. The Department Head will have 20 working days to review and request amendments to the Report prior to presentation to any governing body.

p. If the Report has bearing on academic items, it will be presented to the Academic Board for endorsement prior to presentation to the Board.

q. The Report will be presented at the Board of Directors for approval, and as required, allocation of funding to carry out recommendations.

r. The approved Report will be tabled at the Audit and Risk Advisory Committee meeting to communicate the report findings and recommendations to internal staff.

Implementation of Recommendations

s. The Department Head will be responsible for communicating the outcomes of the Report to impacted staff and implementing any recommendations that were approved by the Board of Directors.

t. The Department Head will be responsible for providing updates to the Board and the Audit and Risk Advisory Committee regarding the implementation of the recommendations. Recommendations may be discontinued or altered with the approval of the Board.

u. The Department Head will update the *Data Planning and Quality Assurance* plan to collect evidence to enable evaluation of the effectiveness of the recommendations at the next internal compliance Review point.

7. Legislation

This Policy complies with the following legislation:

- Education Services for Overseas Students Act 2000 (**ESOS Act**),
- The National Code of Practice for Providers of Education and Training to Overseas Students (2018) (**National Code**),
- Education Services for Overseas Students Regulations 2019 (Cth) (**ESOS Regulations**),
- Higher Education Standards Framework (Threshold Standards) 2021, (**HESFs**).

Relevant excerpts from the HESFs follow:

6.1 Corporate Governance

1. There is a formally constituted governing body, which includes independent members, that exercises competent governance oversight of and is accountable for all of the higher education provider's operations in or from Australia, including accountability for the award of higher education qualifications, for continuing to meet the requirements of the Higher Education Standards Framework and for the provider's representation of itself.

2. Members of the governing body:

    a. are fit and proper persons, and

    b. meet the Australian residency requirements, if any, of the instrument under which the provider is established or incorporated, or otherwise there are at least two members of the governing body who are ordinarily resident in Australia.

3. The governing body attends to governance functions and processes diligently and effectively, including:

    a. obtaining and using such information and advice, including independent advice and academic advice, as is necessary for informed and competent decision making and direction setting

    b. defining roles and delegating authority as is necessary for effective governance, policy development and management; and monitoring the implementation of those delegations

    c. confirming that the provision of higher education and research training and the conduct of research, whether by the provider or through an arrangement with another party, are governed by the registered provider's institutional policies, and the operations of the provider and any associated party(ies) are consistent with those policies

    d. undertaking periodic (at least every seven years) independent reviews of the effectiveness of the governing body and academic governance processes and ensuring that the findings of such reviews are considered by a competent body or officer(s) and that agreed actions are implemented, and

    e. maintaining a true record of the business of the governing body.

4. The governing body takes steps to develop and maintain an institutional environment in which freedom of speech and academic freedom are upheld and protected, students and staff are treated equitably, the wellbeing of students and staff is fostered, informed decision making by students is supported and students have opportunities to participate in the deliberative and decision making processes of the higher education provider.

6.2 Corporate Monitoring and Accountability

1. The provider is able to demonstrate, and the corporate governing body assures itself, that the provider is operating effectively and sustainably, including:

    a. the governing body and the entity comply with the requirements of the legislation under which the provider is established, recognised or incorporated, any other legislative requirements and the entity's constitution or equivalent

    b. the provider's future directions in higher education have been determined, realistic performance targets have been established, progress against targets is monitored and action is taken to correct underperformance

    c. the provider is financially viable and applies, and has the capacity to continue to apply, sufficient financial and other resources to maintain the viability of the entity and its business model, to meet and continue to meet the requirements of the Higher Education Standards Framework, to achieve the provider's higher education objectives and performance targets and to sustain the quality of higher education that is offered

    d. the financial position, financial performance and cash flows of the entity are monitored regularly and understood, financial reporting is materially accurate, financial management meets Australian accounting standards, effective financial safeguards and controls are operating and financial statements are audited independently by a qualified auditor against Australian accounting and auditing standards

    e. risks to higher education operations have been identified and material risks are being managed and mitigated effectively

    f. mechanisms for competent academic governance and leadership of higher education provision and other academic activities have been implemented and these are operating according to an institutional academic governance policy framework and are effective in maintaining the quality of higher education offered

    g. educational policies and practices support participation by Aboriginal and Torres Strait Islander people and are sensitive to Aboriginal and Torres Strait Islander knowledge and cultures

    h. qualifications are awarded legitimately

    i. there are credible business continuity plans and adequately resourced financial and tuition safeguards to mitigate disadvantage to students who are unable to progress in a course of study due to unexpected changes to the higher education provider's operations, including if the provider is unable to provide a course of study, ceases to operate as a provider, loses professional accreditation for a course of study or is otherwise not able to offer a course of study

j. the occurrence and nature of formal complaints, allegations of misconduct, breaches of academic or research integrity and critical incidents are monitored and action is taken to address underlying causes, and

k. lapses in compliance with the Higher Education Standards Framework are identified and monitored, and prompt corrective action is taken.

8. Version Control

This Policy and Procedure has been endorsed by the Australian Institute of Higher Education Board of Directors as at July 2024 and is reviewed every 3 years. The Policy and Procedure is published and available on the Australian Institute of Higher Education website http://www.aih.nsw.edu.au/ under 'Policies and Procedures'.

Change and Version Control				
Version	**Authored by**	**Brief Description of the changes**	**Date Approved:**	**Effective Date:**
2023.1	Compliance and Executive Officer	New Policy	19 April 2023	27 April 2023
2024.1	Head of Quality Assurance	Minor updates; title changes, document title updates	23 July 2024	24 July 2024