Quality Assurance and Review Process Procedure

Policy code:	CG1248
Policy owner:	Manager, Policy and Quality Services
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Purpose

This procedure describes the operational aspects of University's Quality Framework. The University is committed to ensuring effective internal governance and quality assurance practices across the University.

Quality assurance processes at the University are continually monitored to determine whether the policies, procedures and operational practice which form the foundation of the Quality Framework are effectively implemented and maintained. These processes also provide opportunities to review practices and identify potential areas for improvement.

Scope

This procedure applies across all areas of the University responsible for ensuring sound quality assurance processes within the School or operational area. This procedure details how internal quality assurance and internal and external governance reviews are conducted.

The University's multiple levels of audits complement each other and are designed to ensure an overarching, consistent and independent audit approach.

Legislative Context

- Federation University Australia Act 2010
- Education Services for Overseas Students Act 2000 (ESOS)
- Financial Management Act 1994 (VIC)
- Tertiary Education Quality and StandardsAgency Act 2011 (TEQSA Act)
- Higher Education Standard Framework (Threshold Standards) 2021

The statutory requirements of the following regulatory bodies are adhered to:

- Australian Skills Quality Authority ASQA
- Victorian Registration Qualifications Authority VRQA
- Tertiary Education Quality and Standards Agency (TEQSA)
- Department of Education; VET Funding Contract

Definitions

Term	Definition
Advisory reviews	Advisory reviews are intended to provide the Audit and Risk Committee with an independent progress assessment of the existing control effectiveness and procedural compliance levels of core operational processes and systems that are being implemented across the university.
Compliance	Compliance can be demonstrated by clear adherence to the required regulatory requirements and University policy and procedure. A compliant result demonstrates general compliance with the specified standard/s policy or procedure as nominated within the audit.
ESOS Act	Education Services for Overseas Students Act (2000)
Internal audit	Independent financial and operational reviews that assess the control effectiveness of the University's business processes, evaluate the adequacy of risk controls and to examine the level of operational compliance with University policies, procedures and key regulatory obligations. Internal audits highlight process gaps and opportunities for improvement through recommendations to senior management to improve the University's internal controls, operational compliance and risk management processes
Non-Compliance	An observation from evidence available that practices do not comply with the requirements of the quality management system.
Non Compliance – Rectification (NCR) **Request**	A request that action is required to determine, the root cause and corrective actions for a non-compliance.
Partial Compliance	Partial Compliance may be recognised when the intent to achieve compliance can be clearly demonstrated through evidence to support

	adherence to the required regulatory requirements and University policy and procedure, achieving most of the major objectives – but not all.
Quality Audit	An independent, systematic, and documented assessment of practice to ensure the control processes established by the University are achieving the ongoing compliance against the Quality Framework. Quality audits also provide an independent review of the operational practice reviews.
University Governance and Management Committees	Relevant committees that support the academic, operational and quality governance of the University's programs and operations. These include, but not limited to: Council and Committees of Council, Academic Board, Curriculum Committee, Learning and Teaching Quality Assurance Committee, International Education Committee and VET Curriculum Quality Committee or their future equivalents.

Actions

A -Internal Quality Audits

Plan, conduct & report on audits

	Activity	Responsibility	Steps
1.	**Plan** Internal Quality audit	Manager, Policy and Quality Services	The Internal Quality Audit schedule is developed and released quarterly, in consultation with relevant stakeholders taking into account: 1. Previous internal audit and external audit results 2. Internal and external risk ratings 3. Preparation required for forthcoming regulatory and contractual compliance audits including Standards for RTO's - ASQA, Higher Education Standards Framework - TEQSA, VET Funding Contract - HESG and Minimum standards and other requirements for schools - VRQA); 4. Operational and procedural changes specifically required by ASQA, TEQSA, VRQAVCAL Standards and the VET Funding Contract

			HESG or other standards and contractual obligations as required; 5. The Internal Quality Services Audit Schedule is forwarded to the University Governance and Management Committees for noting and distributed to relevant University management
2.	**Conduct** Audits.	Quality Services	1. Confirm commencement of audit with relevant stakeholder/s, as per the Internal Quality Audit schedule, two weeks prior to commencement of audit. 2. Utilise approved internal checklists/templates for a consistent approach when conducting the audit. 3. Finalise and develop the initial audit report for discussion summarising the findings and any non-compliances on the NCR template. Provide opportunity for discussion of the audit findings with key stakeholders prior to finalising the audit report, identifying non-compliances, partial compliances, compliances and recommendations.
3.	**Report** on Quality Audits	Quality Services/ Auditee	1. Finalise and issue audit report and NCR summary form to nominated stakeholders for applicable audits. Where audit results require a management response, a memo and supporting documentation will be tabled at the appropriate Committee and/or management team for a response/comment and rectification. 2. Log identified NCRs onto the Quality NCR Database (where applicable). 3. Nominated stakeholder to populate the template with proposed actions/rectifications and returned within the

			timeframe requested unless otherwise negotiated. 4. NCR Summary Forms that are not forwarded to Quality Services within the requested timeframe are followed up and if necessary may be escalated to management / University Governance and Management Committees for action.
4.	**Review** non-compliances and proposed rectifications	Quality Services	1. NCRs will be monitored for progress and completion in the proposed timeframe. 2. **Closing NCRs** - When NCR requests have successfully been rectified and evidence of this provided, the NCR will be closed. 3. **Open/incomplete NCRs -** If rectifications are not progressing as outlined in the provided NCR Request after follow up, the audit status may be escalated and reported to the University Governance and Management Committees. 4. Where non-compliance has not been rectified, a follow up audit may be scheduled based on risk level.
5	**Committee and Operational Area Quality Audits**	Operational Areas University Governance and Management Committees	1. Operational Areas are responsible for conducting internal quality audits to monitor compliance with quality assurance practices and processes. 2. University Governance and Management Committees can conduct quality assurance audits to monitor the compliance of the committee and operational areas in achieving quality assurance requirements. Audits are conducted and reported in line with the internal business process of the

			operational area or committee conducting the audit.

B - International and Partnerships - Compliance Audits

Conducting On/Off Shore Education Partner Provider and On Campus Compliance Audits against the ESOS Act 2000 and the Higher Education Standards Framework (HESF)

The purpose of ESOS and HESF audits is to ensure that the University is compliant with the ESOS Act 2000, the National Code 2018 and the Higher Education Standards Framework. On and off shore partners who deliver University programs to international students will be audited for ESOS and/or HESF compliance

	Activity	Responsibility	Steps
1.	**Plan** Partner Provider ESOS and HES Audit (On & Off Shore) and on-campus ESOS audits.	Manager, International and Strategic Compliance	1. At the commencement of each year, mandated auditing and compliance activities for the forthcoming 12 month period are reviewed. An audit schedule is developed in consultation with relevant stakeholders and: a. Using an analysis based on risk, the University decides when, where and who will be involved in each audit. The sources of risk, their consequences and the likelihood that those consequences may occur is taken into consideration. b. The Audit Schedule is developed in consultation with the appropriate stakeholders, which includes the Pro Vice Chancellor (International & Partnerships) and Education Partners where applicable. 2. The Audit Schedule will list the format of the audit to be undertaken. Audits may be a self-assessment/desktop/ onsite audit or a combination of two or more formats. While audits are scheduled as annual audits, high risk areas

			may be audited more frequently than low risk areas. 3. The Audit Schedule is forwarded to the International Education Committee for approval and distributed to relevant University management. 4. Notification requirements and request for the name/s and details of a contact for the audit to be confirmed. 5. If an onsite audit is planned, the day can be negotiated to suit both auditor and partner or school/section. One month's notice should be the minimum advance notice. 6. Confirmation: date and time of audit is to be recorded on the Audit Schedule. 7. Preliminary preparation: request access to relevant documents, databases etc.
2.	**Conduct** Audit	Manager, International and Strategic Compliance	When conducting an ESOS / HES audit, use the relevant audit template for guidance for areas of required compliance to be audited. The audit templates are: 1. ESOS Compliance Self-assessment template (on-campus) 2. Offshore International Partner Provider Annual Audit 3. TAFE Partner Provider Annual Audit Template 4. Onshore International Partner Provider Annual Audit Template Provide the template to the partner and / or Schools / Sections to assist with their preparation. For the desktop audits meet with University staff, review student management systems, review partner websites and request

			materials electronically from the partner. Where necessary due to responses in the self-assessment and / or result of a desktop audit a follow-up onsite audit will be conducted even if not listed in the audit schedule. The lead auditor is responsible for an Onsite Audit – Opening Meeting. Meet with the senior partner and / or School / section staff involved in the audit to ensure that they are clear about the processes and activities to be undertaken by the auditing team. The following should be discussed at the meeting: 1. Introduction of the team members 2. Audit objectives and scope 3. Activities and timetable 4. Confirmation for the working area / office accommodation 5. Confirmation that access to facilities and records within the scope of the audit are available 6. Explanation of the details, timing and purpose of the Feedback Meeting 7. Invite any questions about the audit
3.	**Report** on International and Partnerships Compliance Audits:	Manager, International and Strategic Compliance	Recording Information: 1. Notes must be taken when conducting an audit. 2. Where an area is found to be non-compliant a corrective action will be issued. 3. Improvement opportunities (IO) are recorded where they may lead to non-compliance or partial non-compliance and may also require a corrective action. 4. Evaluation of Audit Findings: after performing the audit, the

			auditor will provide feedback. The auditor should allow time at the end of the meeting to look at the findings and analyse the audit outcomes to draw conclusions and provided as part of the feedback. Initial feedback only needs to be provided orally as a documented summary of the findings will be provided. Oral findings must be consistent with information that will be recorded in the official report. **Audit Report Structure** Upon completion of an audit, a report documenting the findings of the audit must be completed. For partner audits clearly itemise under each area audited and at the end of each report in the section titled “Summary of Audit Findings” including the compliant (C), non-compliant (NC) and improvement opportunities (IO). For on-campus ESOS audits attach a Non-compliance Rectification request (NCR) to the report. • A draft report is sent to the audited party contact so feedback can be provided. If the audited partner and / or School / section advise that they have rectified the non-compliances listed in the report, do not remove from report. The report reflects what was found on the actual day of the audit, but an additional note can be added to advise that the non-compliance no longer exists. Evidence must be provided. 1. The Summary of Audit findings or NCR will indicate the timeframe in which a response on corrective actions is required 2. The status and effectiveness of corrective actions taken to

			remedy non-compliances or in response to improvement opportunities will be monitored. 3. A combined Summary of Audit Findings and their current status will be tabled at meetings of the International & Partnership Committee.
4.	**Review International and Partnerships Compliance Audits:**	Manager, International and Strategic Compliance	1. Follow up audits should be undertaken if there are a number of non-compliances found. The follow-up audit only needs to be performed in those areas that non-compliances were raised. 2. Mechanisms for assistance such as relevant education and support should be provided to stakeholders to assist in achieving compliant results. 3. This audit may be conducted as a desktop audit. 4. The follow-up audit is planned at time mutually agreed to by all participating parties, once evidence has been provided that rectification of the non-compliance has been implemented and education and support have been provided.

C - Internal Audits and reporting to Audit and Risk Management Committee

Internal Audits are an integral part of the University's Governance framework. The function provides the University Council and Audit and Risk Management Committee with independent and objective assurance that internal controls are operating as intended and that they are adequate to minimise risk and assist the University to achieve its strategic goals.

The Internal Audit function also assist the University to achieve sound managerial review over all of its operations to ensure that activities are being carried as effectively and efficiently as possible.

	Activity	**Responsibility**	**Steps**

1	**Plan:** Develop 3 - 4 year Strategic Internal Audit Plan and Annual Internal Audit Work Plan	Associate Director, Risk and Integrity/Internal Auditors Audit and Risk Management Committee	1. A high-level risk-based **3 to 4 year rolling Strategic Internal Audit Plan** is created and reviewed at least every 6 months. The plan is developed by the internal auditors in consultation with the Vice-Chancellor's Senior Team and other key stakeholders. 2. The Vice Chancellor's Senior Team considers the internal audit plan and endorses its presentation to the Audit and Risk Management Committee. 3. The Audit and Risk Management Committee approves the Internal Audit Plan. The Audit and Risk Management Committee also approves an annual Internal Audit Work Plan at the commencement of each year that aligns with the internal audit plan.
2	**Conduct:** Determine Internal audit scope and conduct audit	Associate Director, Risk and Integrity/Internal Auditors Audit and Risk Management Committee	1. The internal auditors scope the audit to be conducted in consultation with key stakeholders 2. The Vice Chancellor's Senior Team endorses the scope for presentation to the Audit and Risk Management Committee. 3. The Audit and Risk Management Committee reviews and approves the scope of internal audit work to be performed prior to the commencement of audit work. 4. The internal auditors interview key stakeholder and gather required information to conduct the audit.
3	**Report:** Draft Internal audit reports and submit for approval	Director, Governance and Strategy Audit and Risk Committee	1. The Vice-Chancellor's Senior Team reviews and endorses all internal audit reports and advisory review reports before submission to the Audit and Risk Committee for discussion and approval.

			2. Audit and Risk Committee reviews and approves the internal audit reports and advisory review reports before submission to the University Council. The reviews include discussion on the audit/review findings and recommendations.
4	**Review**: Audit actions and regulatory compliance status briefings	Associate Director, Risk and Integrity and Vice- Chancellor	1. At each Audit and Risk Committee meeting, the Associate Director, Risk and Integrity briefs the Committee on the progress of remedial actions to address audit findings and the status of the open internal audit actions. 2. The Vice-Chancellor is responsible, on behalf of Academic Board and the Vice-Chancellor's Senior Team to update the Audit and Risk Management Committee on the University's internal governance standing in relation to key regulatory obligations (ie. TEQSA, HESG, ASQA, VRQA, ESOS and VAGO). The Director, Governance and Strategy may also be asked to provide additional perspective and commentary from time to time in relation to specific compliance and legal risk matters.

D - Governance Reviews of University Committees

Review Process for Council and Standing Committees

Council is required to review its operation and performance in accordance with the standing Council resolution CM5/05/08, Procedure for Assessment of Council Members Performance and Universities Australia *'Voluntary Code of Best Practice for the Governance of Australian Universities'*.

In accordance with the standing resolution, Council will undertake a formal assessment of the performance of Council and its Standing Committees on an annual basis and a comprehensive external review at least every five years.

1. Standing Committees of Council

	Activity	Responsibility	Steps
1.	Plan to conduct a review of Standing Committees of Council	Executive Officer – Council and Committees of Council	Evaluation form for Assessment of Committee Performance is distributed annually in October to each Standing Committee. A complete listing of the Standing Committees of Council can be found on the Council web site at https://federation.edu.au/staff/governance/feduni-council/council-committees The criteria for the evaluation must align with each Committee's Terms of Reference and responsibilities.
2.	Standing Committee conduct review	Executive Officer – Council and Committees of Council	Once the Standing Committee has conducted its review, responses are collated, de-identified and summarised into a document which is then reviewed by the Committee.
3.	Review tabled at Governance and Strategy Committee and Council for consideration	Executive Officer – Council and Committees of Council	The summarised review document from the Standing Committee is sent to the November meeting of Governance & Strategy Committee and then forwarded as soon as practicable thereafter to Council.
4.	Results from the Standing Committee reviews are considered by the Council	Chancellor	Results from the Standing Committee reviews are considered by the Chair of the Standing Committee and then forwarded to the Governance & Strategy Committee when conducting the annual Terms of Reference review for each standing committee. The Governance & Strategy Committee conducts annual reviews in February of the Terms of Reference of all Council standing committees to ensure currency and relevance.

2. Council - Annual Review

	Activity	Responsibility	Steps
1.	Self-evaluation process is issued and completed to assess the committee's performance.	Executive Officer – Council and Committees of Council Governance & Strategy Committee	An annual on-line self-evaluation form is made available around the end of November, to all members of Council for the assessment of the committee's performance. The Governance and Strategy Committee reviews the content of the survey each September, and forwards to Council at its October meeting for approval prior to the survey going 'live' around November.
2.	Development of a report detailing the results of the surveys	Council Secretary	Once all members of Council have completed the evaluation, a comprehensive report detailing the results of the individual surveys will be developed. This confidential report is provided only to the Chancellor for consideration.
3.	Chancellor reviews and discusses feedback.	Chancellor	The Chancellor will meet with each Council member individually to discuss their feedback.
4.	Responses are collated and tabled at Council for review and discussion	Executive Officer – Council and Committees of Council	The collated and de-identified responses are summarised into a document which is then provided to Council at its first meeting of the following year, for review and discussion.
5.	Development of an Action Plan to address findings.	Chancellor	An Action Plan addressing the issues identified is developed and monitored by Council to ensure the implementation of relevant modifications.

3. External Review of Council

	Activity	Responsibility	Steps
1.	A tender is issued to conduct a review of the University's Council.	Deputy Vice-Chancellor - Global & Engagement/Director, Governance and Strategy	In the early part of the year in which an external review is to be conducted, a tender is to be issued inviting submissions from external consultants to conduct a review of the University's Council.

			Council is required to review its operation and performance in accordance with the standing Council resolution CM5/05/8, the HESF, Procedure for Assessment of Council Members Performance and Universities Australia *'Voluntary Code of Best Practice for the Governance of Australian Universities'*.
2.	A consultant is appointed to conduct the review	Director, Governance & Strategy	A consultant should be appointed by the end of February.
3.	In consultation, an appropriate evaluation will be developed to cater for the needs and circumstance of Council.	Chancellor	A finalised format for the evaluation should be available as soon as practicable so that the review can commence in May. The evaluation will be designed to meet the current and future requirements for the governance of the University. This includes identifying any needed skills and expertise which would contribute to effective governing.
4.	Development of a report detailing the results of the surveys	Chancellor	Once all members of Council have completed the evaluation, a comprehensive report detailing the results of the individual surveys will be developed. As the full evaluation may take place over several weeks Council will be provided with regular updates on the status of the review.
5.	Report is provided for consideration at Council	Chancellor	A final report including an Executive Summary and Recommendations to be provided for the consideration of the Governance & Strategy Committee at its July meeting. This will be forwarded to the September meeting of Council for review and discussion.
6.	An Action Plan is to be developed, implemented and monitored by Council	Chancellor	An Action Plan addressing the issues identified is developed, implemented and monitored by

			Council to ensure the achievement of the recommendations. This Plan should include timelines for the completion of all actions. The Action Plan should be approved at the final meeting of Council for the year. Actions should be incorporated into the Council Schedule of Business to ensure relevant actions are implemented.

E - Review Process for Academic Board and Standing Committees

Academic Board is required to review its operation and performance in accordance with the standing Council resolution CM7/08/8, the HESF, Procedure for Assessment of Council Members Performance and Universities Australia *'Voluntary Code of Best Practice for the Governance of Australian Universities'*.

In accordance with the standing resolution, Academic Board adopted a systemic and regular reviewing of its own and that of its Standing Committees performance. Academic Board will undertake self- assessments on an annual basis and a formal review with external and internal representation every three years.

1. Academic Board - Annual Internal Review

	Activity	**Responsibility**	**Steps**
1.	Development of a self-evaluation which is distributed all members of Academic Board and its Standing Committees	Academic Board Executive Executive Officer – Academic Secretariat	A brief concise self-evaluation is developed by Academic Board Executive each year to be distributed electronically / hard copy to all members of Academic Board and its Standing Committees. This self-evaluation is distributed following the second last meeting for Academic Board and each of its Standing Committees annually. Academic Secretariat will send reminders to Board and Committee members to ensure that all self-assessments are returned. A complete listing of the Standing Committees of Academic Board can be found on the Academic Board web site http:// federation.edu.au/staff/

			governance/academic-board/standing-committees.
2.	Members complete self-evaluation	Executive Officer – Academic Secretariat	Once all members of Academic Board and its Standing Committees have completed the self-evaluation, a brief report detailing the results of the assessment will be developed.
3.	Academic Board Annual Report is developed	Executive Officer – Academic Secretariat	The collated and de-identified responses are summarised into a document which becomes part of the Academic Board Annual Report. The results are also provided to Council at its first meeting of the following year for consideration.
4.	Action Plan is developed and monitored by Academic Board	Executive Officer – Academic Secretariat	An Action Plan addressing any issues identified is developed and monitored by Academic Board to ensure the implementation of relevant modifications.

2. Academic Board - Periodic External Review

	Activity	**Responsibility**	**Steps**
1.	Academic Board Executive to develop Terms of Reference for the conducting of the formal review of Academic Board.	Academic Board Executive	These Terms of Reference must be submitted to Council for approval at the June Meeting so that the external review can commence in July. Academic Board is required to review its operation and performance in accordance with the standing Council resolution CM7/08/8, Procedure for Assessment of Council Members Performance and Universities Australia *'Voluntary Code of Best Practice for the Governance of Australian Universities'*.
2.	The selection of the Review Panel will take place by Academic Board Executive,	Academic Board Executive	Refer to the approved Terms of Reference for the Review Panel membership.

			One member is appointed as Chair to ensure the smooth running of the Panel.
3.	Panel will conduct a comprehensive review of Academic Board and its Standing Committees.	Review Panel	In accordance with the Terms of Reference, the Panel will conduct a comprehensive review of Academic Board and its Standing Committees. This Review will include the interviewing of members of the Board and its Standing Committees, a range of University members including the Chancellor, senior executives, academic and teaching staff and students. The Review will be conducted during July to enable the Review Report to be submitted to Council for endorsement at the August meeting.
4.	Review Report is been endorsed by Council.	Executive Officer – Academic Secretariat	Once the Review Report has been endorsed by Council it will be forwarded to Academic Board for consideration.
5.	Review and implementation of any recommendations from the Review Report and development an Action Plan.	Consultation Group	A consultation process to be initiated with the Chancellor, the Chair of Academic Board and Deputy Vice-Chancellors to plan the implementation of any recommendations from the Review Report and develop an Action Plan. The Action Plan is to be endorsed at the December Academic Board meeting. This Plan should include timelines for the completion of all actions.
6.	The Action Plan addressing any issues identified is forwarded to Council for consideration.	Chancellor	The implementation of the Action Plan is to be managed by Academic Board and monitored by Council to ensure to ensure the achievement of the recommendations.

			The Action Plan will be endorsed at a meeting of Council in the following year.

Supporting Documents

- VET Learning and Teaching StaffInduction and Compliance Manual
- Higher Education Staff Induction and Compliance Manual

Responsibility

- The Chief Operating Officer is responsible for monitoring the implementation, outcomes and scheduled review of this procedure.
- The Manager, Policy and Quality Services as the Document Owner is responsible for maintaining the content of this procedure.

Promulgation

The Quality Assurance and Review Procedure will be implemented throughout the University via:

1. an Announcement Notice under 'FedNews' on the ‘the University Homepage’ website and through the University Policy - ‘Recently Approved Documents’ webpage to alert the University-wide community of the approved Procedure; and
2. inclusion on the University Policy Central website

Implementation

The Quality Assurance and Review Procedure will be implemented throughout the University via:

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Records Management

Title	Location	Responsible Officer	Minimum Retention Period
Quality Audit Reports	Academic Portfolio	Quality Services	Destroy 7 years after action completed
NCR database	Academic Portfolio	Quality Services	Destroy 2 years after action completed
Partner Audit Reports	Academic Portfolio	Manager, International and Strategic Compliance	Destroy 7 years after action completed