OZFORD
Institute of Higher Education

COMPLIANCE PROCEDURE

Approving authority	Executive Management Team
Purpose	This Procedure sets out how the Institute meets its compliance obligations.
Responsible Officer	President and CEO
Next scheduled review	August 2026
Document Location	R:\Managers\OIHE\Policies
Associated documents	Academic Staff Professional Development Policy and Procedure Changes to Registered Provider Ownership or Management Policy Delegations Schedule Governance Framework Human Resources Policy and Procedure (Manual) Policy Development and Review Policy Privacy Policy and Procedure Procedure Development and Review Policy Professional Staff Professional Development Policy and Procedure Quality Management Framework Registering Courses on CRICOS Policy and Procedure Risk Management Framework Staff Code of Conduct Policy and Procedure Strategic Internal Audit plan Compliance Policy

1. PRINCIPLES

Ozford Institute of Higher Education (hereafter referred to as 'the Institute') is committed to the highest level of compliance with relevant legislation, regulations, standards and codes. The Institute fulfils its compliance obligations through strong governance and leadership, a culture of compliance and a robust set of policies and values.

The Institute is acutely aware that it will not be able to meet, provide or pursue any form of financial, cultural or environmentally sustainable future unless it is well managed and pursues a sustainable regulatory future. To this end the Institute has developed a strong governance framework and a responsible approach to its operations to ensure compliance with necessary and relevant legislation and regulation.

The Institute has established an Audit and Risk Committee (ARC) with appropriate delegations from the Governing Board to provide advice on financial reporting, risk management, risk mitigation and regulatory and legislative compliance, including improving management performance and internal controls, to oversee compliance and risk functions, and to oversee the integrity of the Institute's operations.

The Institute has developed this policy to promote its culture of good corporate governance and compliance practices, and gain assurance through its governance arrangements that the Institute has systems a, processes and practices that enable it to comply with its compliance obligations.

2. SCOPE

This procedure applies to all staff and contractors involved in the Institute's operations.

3. DEFINITIONS

Compliance
Meeting the requirements of laws, regulations, national standards and codes, principles of good governance, and accepted community and ethical standards.

Compliance culture
The values, ethics, beliefs and behaviours that exist across the Institute that lead to and ensure positive compliance outcomes.

Compliance approach
A series of activities that when combined are intended to achieve compliance.

Compliance Obligation
A requirement specified by laws, regulations, codes or organisational standards.

Material Non-compliance
A material non-compliance will depend upon the individual circumstances of the breach. A number of factors may contribute to a material non-compliance - the number or frequency of similar non-compliance, the impact of the non-compliance or likely non-compliance and an application of a lesson is learnt leading to quality improvement and training.

Non-Compliance
An act or an omission whereby the Institute does not meet its compliance obligations. It could be an occurrence of non-compliance with applicable legislation, regulations, standards and codes. An unintentional or deliberate act or omission, which leads to the Institute and/or staff member(s) failing to meet their compliance obligations.

Responsible officer
The Position assigned responsibility for developing, reviewing and maintaining Institute policies or procedures to ensure consistency and quality within a common standard that is relevant and easily understood.

Risk mitigation
A positive action or actions take to divert or address an identified risk.

4. PROCEDURE

4.1 All staff are made aware of the behaviours that create and support compliance and behaviours that compromise compliance and are not tolerated through provision of the ***Staff Code of Conduct Policy and Procedure***:

4.2 All staff are expected to engage with the Institute's staff training and development to understand their role in managing compliance obligations as set out in the **A*cademic Staff Professional Development Policy and Procedure*** and the ***Professional Staff Professional Development Policy and Procedure.*** Compliance training will be provided to all staff during their induction process and staff will be required to complete refresher and/or additional compliance training in accordance with their role and responsibilities.

4.3 The Responsible Officer has responsibility for developing policies and procedures to meet compliance obligations as set out in the ***Policy Development and Review Policy*** and the ***Procedure Development and Review Policy.***

4.4 The Responsible Officer has responsibility for ensuring that compliance obligations are managed proactively and proportionately according to current risk exposure and effectiveness of existing controls. This includes monitoring compliance with the policy or procedure to ensure the compliance obligations are met.

4.5 The Responsible Officer has responsibility for reviewing and amending the policy or procedure to ensure that it is efficient, effective and continues to meet all compliance obligations.

4.6 The Responsible Officer has responsibility for seeking approval from the Approving Authority for any new or changed policy or procedure.

Strategic Internal Audit plan

4.7 The Executive Management team has responsibility for developing the ***Strategic Internal audit plan*** that cyclically reviews the Institute's business processes and compliance obligations. The Strategic Internal audit plan identifies internal audits that are conducted each year.

4.8 The ***Strategic Internal audit plan*** once developed is submitted to the Audit and Risk Committee for endorsement. The ***Strategic Internal audit plan*** is also reported to the Governing Board.

4.9 The Executive Management team have responsibility for resourcing the internal audits. The internal audits will be undertaken in consultation with the Responsible Officer and the staff in the area subject to review. A report will be prepared setting out the findings from the internal audit, proposed recommendations and the actions taken in response to the findings.

4.10 The Executive Management team will report to the Audit and Risk Committee on the progress implementing internal audit report recommendations until all agreed actions have been completed.

Identification of Non- Compliance

4.11 Non-Compliance with the compliance obligations can be identified by a number of mechanisms including but not limited to:

- A staff member due to professional development or in the course of their work realises and reports that an Institute policy or procedure or activity is not compliant or not effective.
- An error, omission or lapse in compliance identified as part of business operational oversight processes, ie. a staff member or supervisor identifies the non-compliance or lack of effectiveness.
- Non-compliance or lack of effectiveness is identified as a result of an internal audit conducted as part of the Strategic Internal Audit plan.
- An external review identifies non-compliance or lack of effectiveness.
- In the process of managing a complaint or appeal it is realised that an Institute policy or procedure or activity is not compliant or not effective.

4.12 Any staff member who becomes aware of non-compliance must:

- coordinate immediate action to contain the instance of non-compliance;
- ensure evidence that may be valuable for an investigation is maintained and not compromised; and
- immediately report the non-compliances to the Responsible Officer, who must assess the report and escalate it as necessary to the Executive Management team.

4.13 All staff, who may access confidential and personal information in the course of managing non-compliance must comply with the requirements of the ***Privacy Policy and Procedure***.

Addressing Non- Compliance

4.14 The Responsible Officer will in response to a non-compliance investigate/review the circumstances and develop an action plan that may include:

- Consulting with staff and where necessary seeking external support to address the non-compliance
- Reviewing the Policy or Procedure and make necessary changes to ensure compliance.
- Reviewing any supporting process or system and make necessary changes to ensure compliance.
- Rectifying errors or omissions in electronic or physical records.
- Provide staff training and professional development to staff involved in the process.

4.15 Where this is not possible to rectify the non-compliance due to system or other constraints (such as PRISMS, the Responsible Officer will prepare records that set out the actions taken in response to the non-compliance or lack of effectiveness.

4.16 The Responsible Officer will consider the roles of staff who are involved in or aware of a material non-compliance and if the staff did not report the non-compliance, the staff may be subject to disciplinary action in accordance with the ***Human Resources Policy and Procedure (Manual)***.

4.17 The Responsible Officer will report on the rectification to the Executive Management Team. Internal audit and external reviews will be reported to the Executive Management Team, Audit and Risk Committee and/or Academic Board and/or Education Committee and/or Governing Board.

4.18 In all cases the Institute will ensure it has records to demonstrate through documentation and practice how it has addressed the non-compliance and so demonstrate its compliance with legislation and regulation.

5. QUALITY ASSURANCE

To ensure that this procedure is fit for purpose and meet the requirements of the HESF (Threshold Standards), and other relevant legislation and guidelines, the procedure will be:

5.1 internally approved by the Executive Management Team on development or review

5.2 externally reviewed as part of any independent review of the HESF Threshold Standards approved by the Governing Board;

5.3 internally reviewed by the Responsible Officer every three years from the date of approval (if not earlier).

5.4 referenced to the applicable HES threshold Standard and/or other legislation/regulation.

6. FEEDBACK

Feedback or comments on this procedure is welcomed by the listed Responsible officer of the Institute.

7. ACKNOWLEDGEMENT

This procedure was developed with reference to the following:

- CQU Compliance Management Policy and Procedure (2021) (https://delivery-cqucontenthub.stylelabs.cloud/api/public/content/compliance-management-policy-and-procedure.pdf)
- Deakin University, Compliance management Policy (2022) (Compliance Management policy / Document / Deakin Policy Library)
- James Cook University, Compliance Framework and Compliance Policy (2021) (https://www.jcu.edu.au/policy/corporate-governance/compliance-policy)

8. VERSION CONTROL

Version	Date approved	Description	Approved by
1.0	March 2015	Initial	EMT
2.0	August 2018	Internal review to better meet HESF standards	EMT
2.1	November 2021	Change of procedure title to align with policy	EMT
3.0	August 2023	Internal Review	EMT
Related legislation/ regulation/standard	Tertiary Education Quality and Standards Act 2011 (Cth) Higher Education Standards Framework (Threshold Standards) 2021 (Cth) Education Services for Overseas Students Act (ESOS) 2000 (Cth) Education Services for Overseas Students Regulations 2019 (Cth) The National Code of Practice for Providers of Education and Training to Overseas Students 2018 (Cth) Higher Education Support Act 2003 (Cth) FEE-HELP Guidelines 2017 (Cth) Higher Education Provider Guidelines 2012 (Cth) Higher Education Support (HELP Tuition Protection Levy) Act 2020 (Cth) Higher Education (Up-front Payments Tuition Protection Levy) Act 2020 (Cth) Fair Work Act 2009 (Cth) Fair Work Regulations 2009 (Cth) Privacy Act 1988 (Cth) Privacy and Data Protection Act 2014 (Vic), Health Records Act 2001 (Vic), Public Records Act 1973 (Vic) Australian Consumer Law (Cth) Competition and Consumer Act 2010 (Vic) Victorian Child Safe Standards Child Wellbeing and Safety Act 2005 (Vic) Children, Youth and Families Act 2005 (Vic) Occupational Health and Safety Act 2004 (Vic) Occupational Health and Safety Regulations 2017 (Vic) Dangerous Goods Act 1985 (Vic) Workplace Injury Rehabilitation and Compensation Act 2013 (Vic)		

	Crimes Act 1914 (Cth) Crimes Act 1958 (Vic) Sexual offence Crimes Act 1958 (Cth) Racial Discrimination Act 1975 (Cth) Sex Discrimination Act 1984 (Cth) Disability Discrimination Act 1992 (Cth) Disability Standards for Education 2005 (Cth) Australian Human Rights Commission Act 1986 (Cth) Workplace Gender Equality Act 2012 (Cth) Age Discrimination Act 2004 (Cth) Fair Work Act 2009 (Cth) Equal Opportunity Act 2010 Racial and Religious Tolerance Act 2001 (Vic) Spent Convictions Act 2021 SPAM Act 2003 (Cth) Copyright Act 1968 (Cth)

Note:

EMT = Executive Management Team