


POLICY AND PROCEDURE		
Ref. to Legislative Frameworks: HESF2021: Standard 6.1, 6.2, 6.3 RTO Standards 2025: Outcome Standards National Code 2018: Standard 11	Internal Audit	
Version: 3.0	Owner: Chief Executive Officer	Issued on: 21/04/2026 Review by: 21/04/2028

Revision History

Current Version	Description of Change	Policy Developer(s)	Effective Date
2.0	New	Compliance Manager	06/04/2018
3.0	Combined Policy and Procedure into single document. Updated regulatory references. Updated language to reflect self-assurance framework. Clarified Compliance Manager as the Group role. Removed redundant SRTO 2015 specific standard references. Added risk-based scheduling section. Updated references table.	CEO & Compliance Manager	21/04/2026

PURPOSE

This document documents AAPoly’s internal audit process. The internal audit is the primary mechanism through which AAPoly demonstrates self-assurance — the ongoing, systematic examination of its own operations against regulatory standards and internal policies. The internal audit process underpins AAPoly’s compliance with the Higher Education Standards Framework 2021 (HESF 2021), the 2025 Standards for Registered Training Organisations (RTO Standards 2025), the National Code of Practice for Providers of Education and Training to Overseas Students 2018 (National Code 2018) and the ESOS Act.

POLICY STATEMENT

AAPoly’s systems and practices are internally audited at least once a year. The internal audit is designed aimed to verify compliance with regulatory standards and AAPoly’s own policies and procedures, and to drive corrective actions and continuous improvement.

The internal audit process operates as part of AAPoly’s broader self-assurance framework, consistent with the expectations of the regulatory bodies. Rather than treating internal audit as a discrete compliance exercise, AAPoly embeds audit activity into its governance cycle — using findings to inform planning, resource allocation, and improvement initiatives.

The Group Compliance Manager is responsible for planning and coordinating the internal audit. For obligations specific to AAPoly as a Higher Education provider under HESF 2021, the CEO is ultimately accountable for audit outcomes and corrective actions.

SCOPE

This policy and procedure applies to:

- All systems, practices, and operations of AAPoly subject to regulatory oversight, including HESF 2021, RTO Standards 2025, National Code 2018, and the ESOS Act.
- All regulatory declarations of compliance, including Australian Skills Quality Authority (ASQA) annual compliance declaration, and equivalent requirements under other funding and regulatory arrangements.
- Third-party arrangements where AAPoly retains accountability for compliance outcomes.

DEFINITIONS

Internal Audit	A systematic review against defined criteria, carried out by staff independent of the operations, to determine whether activities and related results comply with planned arrangements and whether these arrangements are implemented effectively and are suitable to achieve compliance with relevant legislative requirements and AAPoly’s policies and procedures.
Self-Assurance	The process by which AAPoly critically examines its own performance against the applicable Standards and training and education outcomes on an ongoing basis, to ensure a focus on quality, continuous improvement, and ongoing compliance. Internal audit is a key mechanism of self-assurance.

Observation	Recommendations or suggestions for system improvement to confirm or enhance system requirements.
Non-Compliance (NC)	Non-fulfilment of specific requirement(s) or elements of relevant regulatory and legislative standards.
Corrective Action	Action taken to eliminate the root cause of a detected non-compliance and to prevent recurrence.
Objective Evidence	Qualitative or quantitative information or statements of fact based on observations, measurements, or tests which can be verified.
Sample	A representative subset of a population selected for review.
Group Compliance Manager (GCP)	The Group-level role within Academies Australasia Group responsible for planning, coordinating, and overseeing internal audits and compliance documentation across all Group colleges, including AAPoly. For HESF 2021-specific audits, the audit is conducted with close coordination with the CEO and/or Academic Dean.
Designated Head (DH)	Head of Department or other relevant senior staff member with operational responsibility for the area being audited.

POLICY GUIDELINES AND PRINCIPLES

- Internal audits are conducted at least annually and are planned to address all applicable regulatory frameworks within each audit cycle.
- Audit scope is risk-based: priority is given to areas of identified risk, previous non-compliances, regulatory change, or upcoming external audits or compliance declarations.
- Regulatory triggers for mandatory internal audit include, but are not limited to:
 - ASQA annual compliance declaration
 - State Funding contract compliance requirements, if relevant.
 - TEQSA registration renewal
 - Course Reaccreditation application
 - CRICOS registration renewal
 - National Code 2018 and ESOS Act obligations
- Internal audit findings, observations, and corrective actions are documented and form part of AAPoly's Continuous Improvement Register.
- Audit reports are produced within two (2) weeks of the conclusion of the internal audit and submitted to the CEO for management review and action.
- Where an internal audit precedes an external audit or regulatory review, the internal audit is used to prepare for and support the external process.
- Policy and procedure documents related to the internal audit are controlled via the Compliance Document Control process. The GCM oversees the issue, communication to students/staff and publication of those documents on the website.

PROCEDURE

1. Audit Planning and Scheduling

- 1.1 The GCM maintains a rolling Internal Audit Schedule that maps all regulatory audit requirements across HESF 2021, RTO Standards 2025, National Code 2018, ESOS Act and any applicable funding body requirements. The schedule is reviewed and updated at the start of each calendar year, or as required when regulatory changes occur.
- 1.2 Audit scheduling is risk-based: the GCM prioritises areas with identified deficiencies, recent regulatory changes, prior non-compliances, or upcoming external audit or compliance declaration deadlines.
- 1.3 The GCM determines the scope, objectives, criteria, and methodology for each scheduled audit, and identifies the stakeholders whose involvement is required.
- 1.4 The GCM informs relevant Designated Heads (DHs) of audit dates, scope, and requirements with sufficient notice to allow preparation.

2. Audit Preparation

- 2.1 The GCM contacts relevant stakeholders prior to the audit to confirm staff availability and audit logistics, and to provide an evidence request list.
- 2.2 The GCM prepares audit tools including checklists, sampling frameworks, and document review criteria aligned to the applicable regulatory standards.
- 2.3 Where the audit relates to HESF 2021 obligations, the GCM coordinates with the AAPoly CEO and the Academic Dean, to confirm scope and approach.

3. Conducting the Audit

- 3.1 Compliance staff conducting the audit (Auditors) hold an opening meeting (optional but recommended) with relevant stakeholders to confirm scope, objectives, and the audit process.
- 3.2 The GCM and any co-auditors conduct the internal audit using defined tools and techniques to gather objective evidence. Auditors assess compliance, identify observations, and document findings progressively throughout the audit.
- 3.3 Auditors are encouraged to identify process concerns and opportunities for improvement as well as areas of good practice throughout the audit.
- 3.4 Audit findings are verified for accuracy and, where practicable, acknowledged by the relevant stakeholders before the audit closes.
- 3.5 An audit closure meeting (optional) may be held to discuss preliminary findings and observations before the formal report is prepared.

4. Reporting

- 4.1 The GCM prepares the internal audit report within two (2) weeks of completing the audit. The report includes audit scope and objectives; criteria used; findings (compliant, observations, non-compliances); objective evidence; and recommended corrective actions.
- 4.2 The audit report is circulated to the CEO and relevant Designated Heads. For HESF 2021 matters, a summary is also provided to the Academic Board and, where significant, the Board of Directors.

4.3 The CEO and relevant DHs review the report and determine appropriate corrective actions and timeframes.

5. Corrective Actions and Close-Out

5.1 DHs and relevant stakeholders are responsible for implementing agreed corrective actions within the timeframes specified in the audit report.

5.2 The GCM monitors the progress of corrective actions and escalates unresolved issues to the CEO or Board as required.

5.3 Once corrective actions have been adequately addressed and verified, the GCM formally closes the audit report and records the outcome in the Compliance Document Control system and Continuous Improvement Register.

5.4 The GCM reports the status of closed audits and outstanding corrective actions to the CEO regularly, and to the Board of Directors at least annually.

6. Preparation for External Audits

6.1 Where an external audit is scheduled to follow an internal audit, the GCM oversees preparation to ensure all stakeholders are ready and that the required evidence is complete and accessible.

6.2 Internal audit findings and corrective action records are made available to external auditors as evidence of AAPoly’s self-assurance activity.

RESPONSIBILITIES

Role	Responsibilities
CEO	<ul style="list-style-type: none"> • Overall responsibility for the development, maintenance, and oversight of this policy and procedure. • Receiving and reviewing internal audit reports. • Ensuring corrective actions are escalated and resolved at the appropriate governance level. • Signing the annual ASQA compliance declaration and any equivalent declarations required by regulatory authorities. • Primary accountability for HESF 2021 audit scope and findings (as AAPoly-specific obligations).
GCM	<ul style="list-style-type: none"> • Planning and maintaining the Internal Audit schedule across all relevant regulatory frameworks (ASQA, TEQSA/HESF, National Code, funding bodies). • Determining audit scope based on regulatory requirements, risk profile, identified deficiencies, and results of previous audits. • Informing relevant Designated Heads of scheduled audit dates and requirements. • Conducting or coordinating the internal audit, gathering objective evidence. • Preparing and circulating audit reports to the CEO, Designated Heads, and other relevant stakeholders within two (2) weeks of audit completion.

	<ul style="list-style-type: none"> • Overseeing preparation for external audits where these follow internal audits. • Closing audit reports once corrective actions have been adequately addressed and reporting status to the CEO.
Designated Heads (DH) / Relevant Stakeholders	<ul style="list-style-type: none"> • Cooperating with the GCM and audit team and providing requested evidence of compliance. • Determining and implementing corrective actions for identified non-compliances within agreed timeframes. • Escalating issues that require further action or cannot be resolved within their area of responsibility. • Ensuring relevant staff in their area are aware of and prepared for scheduled audits.
Academic Board	<ul style="list-style-type: none"> • Receiving and considering internal audit findings relevant to Higher Education academic governance (HESF 2021). • Directing corrective actions and improvements within the academic governance domain.
Board of Directors	<ul style="list-style-type: none"> • Receiving summary reports of internal audit outcomes and corrective actions. • Providing governance oversight and direction where systemic or significant non-compliances are identified.

FEEDBACK

Queries or feedback about this policy should be directed to the CEO through suggestionstotheceo@aapoly.edu.au. The CEO will respond in writing to the feedback or enquiries within two (2) weeks unless an extenuating circumstance requires an immediate response or action. Any material changes to this policy because of the feedback will be documented in the version control register and utilised as part of continuous improvement and quality assurance of AAPoly.

REFERENCES

Source	Document Title
Internal	Compliance Policy
	Benchmarking and Continuous Improvement Policy and Procedure
	AAPoly Academic Board Charter
	Academic Quality Assurance Preamble
	Risk Management Policy and Procedure
External	Higher Education Standards Framework (Threshold Standards) 2021
	2025 Standards for Registered Training Organisations (Outcome Standards and Compliance Standards)
	National Code of Practice for Providers of Education and Training to Overseas Students 2018
	ASQA Annual Compliance Declaration requirements
	TEQSA Guidance Notes: Governance and Accountability