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Introduction

The Office of Hearing Services (the Office) is responsible for delivering the Australian Government Hearing Services Program (the program). The goal of the program is to reduce the incidence and consequences of hearing loss and provide access to high quality services and devices for eligible clients.

Hearing services are provided by over 200 Contracted Service Providers (providers) throughout Australia who are contracted by the Australian Government to provide hearing services to eligible clients, through a voucher program.

In return for government funding, providers of hearing services are expected to meet certain requirements relating to the provision of hearing services. The Government’s requirements are set out in:

- the Hearing Services Administration Act 1997 (the Act)
- the Service Provider Contract 1 July 2015 – 30 June 2018 (the Contract)
- the Hearing Services Rules of Conduct 2012 (the Rules)
- a range of Standards:
  - Hearing Rehabilitation Outcomes
  - Schedule of Service Items
  - Schedule of Fees
  - Eligibility criteria for refitting.

For the purposes of this document, these legislated and contractual requirements are collectively described as the ‘mandated requirements’ of the program.

As a funder, the Australian Government has a responsibility to provide assurance to the Australian community that providers are meeting the program’s mandated requirements.

As noted by the Australian National Audit Office (ANAO):

\[ A \text{ systematic, risk-based programme of compliance assessment activities} \]
\[ \text{provides a regulator with a cost-effective approach to monitoring} \]
\[ \text{compliance, enabling it to target available resources at the highest priority} \]
\[ \text{regulatory risks and to respond proactively to changing and emerging} \]
\[ \text{risks}. \]

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1 Copies of the legislation can be found at:

2 Australian National Audit Office – Administering Regulation – Best Practice Guide
**Objective and Purpose**

The objective of the Office’s Audit and Compliance Framework (the Framework) is to ensure that providers are meeting program requirements to safeguard client safety and quality outcomes for clients.

The purpose of this document is to describe the Office’s approach to audit and compliance. There are a number of changes to the way that the Office is monitoring compliance. Some of the key changes are:

- the Office has ceased cyclical auditing of providers and is undertaking a risk-based process for identifying which providers to include on the audit schedule
- the majority of audits will be conducted off-site in the first instance, with on-site visits occurring through random selection, in response to risk indicators or if an off-site audit reveals matters requiring further investigation
- an annual self-assessment process has been introduced, where providers check their own internal systems for ensuring program compliance and undertake self-directed remedial action where necessary
- practitioner and site registration, and the accompanying requirement for documentary evidence at the time of registration, has ceased. Instead, compliance is being checked through audit activities
- there is an increased focus on quality improvement and giving providers the opportunity to improve their systems.

Consistent with this new approach, the Framework aims to provide a realistic and transparent plan for monitoring and encouraging a high level of compliance from providers, in delivering hearing services to clients.

The Framework describes:

- the principles that underpin the Office’s approach to audit and compliance (Chapter 1)
- the way that the Office undertakes risk assessment in order to determine audit and compliance priorities and approaches (Chapters 2 and 3)
- the role that provider self-assessment plays in the overall Framework (Chapter 4)
- the types of audit activity that may be undertaken by the Office (Chapter 5)
- the circumstances in which various types of compliance action may be taken (Chapter 6)
how the Office monitors, reviews and continuously improves its approach to audit and compliance (Chapter 7), including opportunities for providers to give feedback about the Framework.

The development of this Framework has been informed by:

- the feedback provided by stakeholders in relation to an overview of the Framework released in July 2012 and trial audits of providers conducted between October and December 2012.

- During consultation on the Framework, stakeholders emphasised that the Office’s audit and compliance activities should be risk based, transparent and consistently applied. Stakeholders also suggested that the Office’s approach to audit and compliance should be clearly and simply reflected in the Framework.

These, and other suggestions, have informed the development of this Framework. The Office would like to thank all stakeholders for their valuable feedback.

- the Australian National Audit Office (ANAO) better practice guides. These guides are designed to assist Commonwealth government agencies to improve the quality and consistency of their administration of public service obligations and activities (guides can be located at: http://www.anao.gov.au/Publications/Better-Practice-Guides)


Legislative Authority to Audit

Under Section 16 Conditions of accreditation, of the Hearing Services Administration Act 1997, the Minister is empowered to accredit an entity subject to one or more conditions specified in the instrument of accreditation. Further, this section also empowers the Minister to make a decision to cancel the accreditation of an entity, if the entity contravenes a condition of accreditation. Section 20 Contracted service providers, clause (2) and (3) state:

“\textit{The terms and conditions of engagement are set out in a written agreement between the Minister (on behalf of the Commonwealth) and the contracted service provider. The terms and conditions must be consistent with the accreditation scheme and the rules of conduct.}”

and

“\textit{Each condition of accreditation of the contracted service provider is taken as a condition of engagement.}”

To facilitate this engagement the Office of Hearing Services manages written contracts on behalf of the Minister, which is signed at the point of accreditation. All relevant information provided in Hearing Service Providers Accreditation
Scheme 1997 pack clearly outlines that all Contracted Service Providers must comply with the Hearing Services Act 1997, the Australian Government Hearing Services Program Service Provider Contract (the Contract), the Hearing Services Rules of Conduct 2012, and the Standards as defined in the Contract. Section 15 AUDIT of the Contract provides a list of the audit activities conducted by the Office of Hearing Services and the actions that a Contracted Service Provider must take to support these activities. Section 18.1 (d) stipulates that the Commonwealth may audit any matters it considers relevant to the performance of the Service Providers obligations under the contract.

The Program Management Section audits all contracted service providers throughout the course of their contract, to ensure compliance.
Chapter 1 – Principles underpinning the Office’s approach to audit and compliance

The Office’s approach to audit and compliance is governed by the following principles:

- risk based decision making
- proportionality
- transparency
- accountability
- timeliness
- consistency
- impartiality/fairness.

In dealing with providers, the Office aims to:

- apply a risk based framework to decision-making. This means that the Office: actively identifies, evaluates and monitors risks; prioritises risk based on assessments of likelihood and consequences; and plans and conducts audit and compliance activities to mitigate risk

- adopt a proportionate approach to non-compliance. This means that, in the event that the Office identifies non-compliance through an audit, the Office assesses all of the information available in relation to the non-compliance and responds in a way that is reasonable, and appropriate to the case at hand

- be transparent. Documents such as this Framework are published so that providers can have a clear understanding of the Office’s approach to audit and compliance. In dealing with individual providers, the Office also ensures that its findings and decisions are clearly expressed and transparent. This is done by issuing audit reports, and giving providers an opportunity to respond

- be accountable. The Office acts consistently with legislation, the Contract, guidelines, policies and procedures and ensures that decisions are appropriately and accurately documented

- respond in a timely manner. In all cases the Office aims to undertake audits and compliance activity in a timely way. The time taken varies from case to case
• act consistently. A consistent approach does not mean that all cases are decided in the same way (because no two cases are the same), but it does mean that the Office applies consistent procedures, and reviews cases to confirm that appropriate processes have been applied

• be fair. The Office acts impartially and objectively, ensuring that if any non-compliance is identified, the provider will be given an opportunity to respond.
Chapter 2 - Summary of the Office’s risk based approach to audit and compliance

The Office’s risk based approach to audit and compliance includes:

- risk assessment to inform audit and compliance activity
- provider self-assessments
- audit activities
- compliance activities
- regular monitoring and review of the Office’s approach.

In summary:

- the Office adopts a risk based approach to monitoring compliance. This approach is designed to focus the Office’s resources on the highest priority audit and compliance activities

- a key element of the risk based approach is enabling providers to self-assess against a compliance tool developed by the Office to assist in the identification of any areas of non-compliance with the mandated requirements. An advantage of provider self-assessment is that it provides a timely, structured opportunity for providers to turn their mind to the mandated requirements, critically examine their own systems against the mandated requirements, and take action to address any shortcomings

- using the information from the self-assessments and a wide range of other sources, the Office develops a quarterly schedule of audit activity that is also based on risk. The schedule is implemented flexibly so that unscheduled activities may be undertaken to address new or changed regulatory risks

- individual monitoring activities (including audits) are planned in detail to ensure they are targeted to high priority areas. All providers are notified in advance of audits (including the type, scope and approach of the proposed audit)

- audit findings are reflected in an audit report which is given to the provider. All providers are given the opportunity to respond to the Office’s audit findings. If the audit findings show that the Office is satisfied that the program requirements are met, no further action is required by the provider. However if the Office cannot be satisfied, based on the audit, that the program requirements are being met, the provider is given an opportunity to address the concerns identified in the audit report and to advise the Office what has been done (or will be done) to ensure that the program requirements are being met
• consistent with a risk based approach to non-compliance, not all non-compliance will result in compliance action being taken. In most cases, the approach of the Office will be to raise the issue with the provider (through the audit report) and for the provider to address the concerns, advising the Office how it has done so.

In most cases, no further action will be required. However, in some cases the Office will need to take further action, including: requiring certain remedial actions to be taken; recovering monies; or suspending the Contract. The focus of these actions will be bringing the provider back into compliance and mitigating the risk associated with provider non-compliance.

In some exceptional circumstances, the Contract may be terminated if the Office no longer has confidence that risks to clients, and/or the program, can be managed. Again, if this approach is adopted the provider will be afforded procedural fairness and an opportunity to respond.

• each step in the audit and compliance process is subject to quality assurance processes. Audit reports are developed by the auditor and provided to the Delegate for review before being provided to the provider.

Each of these elements of the Framework is discussed in detail in the following Chapters.
Chapter 3 – Risk assessment and management by the Office

What is risk assessment and management?

The purpose of risk assessment and management is to enable organisations to:

- identify risks
- analyse risks
- evaluate risks
- treat the risks

In order to operate effectively, organisations must adopt a process of risk assessment and management.

In practical terms, a risk assessment is a thorough look at the organisation's practices to identify the activities, situations, processes etc. that may cause an adverse outcome. After identification is made, the organisation evaluates how likely and severe the risk is, and then decides what measures should be in place to effectively prevent or control the adverse outcome.

What is the purpose of risk assessment in the context of the Office's approach to audit and compliance?

In the case of the Office, the adverse outcome is provider non-compliance with mandated requirements which presents risks to clients and the integrity of the program.

Recognising that resources are limited, and providers cannot be monitored at all times, the Office adopts a risk-based approach to monitoring compliance.

This risk-based approach enables the Office to:

- identify the main risks to clients and the program
- identify the type and frequency of monitoring activities, consistent with available resources and an acceptable level of residual risk
- take action to address the greatest risks.
How does the Office conduct risk assessments?

The Office conducts quarterly risk assessments based on three identified program risks:

1. Inappropriate claiming

2. Inappropriate service delivery (for example, client unable to wear a hearing aid because it causes pain)

3. Risks to client safety (clinical) (for example, the non-referral of clients for appropriate medical and further audiological evaluation).

In order to assess the likelihood of any of these risks being realised, as the result of non-compliance, the Office refers to a wide range of data sources including:

1. Claiming Patterns

2. Complaints (clients or health/hearing professionals)

3. Contract management (Contract compliance and practitioner compliance)

4. Previous audits

5. Other information (for example, outcomes from self-assessment process).

Assessment of this data (against the program risks) enables the Office to determine the focus for its monitoring activities.

The information derived from the risk assessment is then used to develop a risk register. The risk register includes risk ratings that assist the Office to schedule audit activities.
Chapter 4 – Provider Self-assessment

What is the purpose of self-assessment?

Each provider is responsible for ensuring that it meets the mandated requirements relating to their participation in the program.

To assist providers to do this, the Office has developed a Self Assessment Tool (SAT) that providers are required to complete and submit (electronically) on an annual basis.

Self-assessment is intended to enable providers to examine their systems and processes, identify any deficiencies or areas for improvement and to take action to ensure continuous improvement.

What is involved with self-assessment?

The self-assessment involves completion of an online questionnaire in which providers are required to identify their practices and processes that contribute to meeting the mandated requirements.

The tool is in a simple checklist format that is designed to assist providers to critically review their processes and procedures, and to identify areas for improvement.

As part of the self-assessment process, details need to be provided relating to any actions taken to address any identified areas of non-compliance.

When are self-assessments required to be submitted to the Office?

The SAT is required to be completed by the end of October each year. Once completed, providers are required to submit the SAT online through Citizen Space.

New Contracted Service Providers may also be asked to complete a self-assessment as part of a routine New Provider Audit. This is to be completed six to 12 months after the provider signs their first Contract under the program.

What role does self-assessment play in the Audit and Compliance Framework? What does the Office do with the self-assessments?

The responses provided as part of the self-assessment are used as one of several sources of information in the Office's risk assessment process.
Chapter 5 – Audit activities

What is an audit?

An audit is:

A systematic, independent and documented verification process of objectively obtaining and evaluating audit evidence to determine whether specified criteria are met\(^3\).

An audit enables the Office to check whether the provider has the systems, processes and governance arrangements in place to meet the mandated requirements of the program.

It is important to note that:

- not all audits will examine compliance by the provider with all mandated requirements. Consistent with a risk based approach to auditing, many audits will target areas of risk - this is discussed in more detail below

- the audit does not just assist the Office to measure provider compliance with the program requirements but it also provides an opportunity for providers to look at their own systems and to identify areas for improvement.

How are audits scheduled by the Office?

The audit schedule is identified using risk assessment criteria and data analysis. The schedule for audits (with the exception of random audits) is determined using the outcomes of this analysis.

The schedule will take into consideration the level of resourcing within the Office to ensure that priority is placed on addressing risks of the highest importance.

As the schedule is developed each quarter, there is scope to incorporate planning and implementation of activities based on changes, including new or emerging risks.

Who undertakes the audits?

All audits are undertaken by staff of the Office.

All staff undertaking audits will have completed audit and compliance training to ensure they have the necessary knowledge and skills to conduct audit activities, in accordance with the guidelines outlined in AS/NZS ISO 19011:2003.

In the conduct of audits, staff are expected to comply with the Australian Public Service Code of Conduct.

\(^3\) AS/NZS ISO 19011:2003, Guidelines for quality and environmental management systems auditing
What are the different types of audit?

Audits differ by:

- type
- scope
- method

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<thead>
<tr>
<th>Audit Type</th>
<th>Targeted</th>
<th>Random</th>
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<tr>
<td>Audit Scope</td>
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<tr>
<td>Audit Method</td>
<td>Off-site</td>
<td>On-site</td>
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Each of these concepts is discussed below.

Types of audits

There are two types of audits: targeted audits and random audits

- **Targeted Audits** – the risk assessment discussed in Chapter 3 assists the Office to identify providers which represent a higher potential risk because, for example, there is an unusual claiming pattern, there have been recent relevant complaints, previous audits identified concerns etc.

- **Random Audits** - Sites are chosen randomly for these types of audits through a random number generator. Random audits are conducted off-site, in the first instance. If the outcome of a random audit suggests there are matters that require further investigation, this may proceed to an on-site audit.

The Office anticipates that, from the total number of audits conducted each quarter, a minimum of 10% will be random. This is subject to the number of targeted audits to be conducted and the outcomes of those audits, and will be reviewed as part of the Office’s annual review of this Framework. These random audits will be conducted to assist in monitoring the efficacy of the risk based audit process.
Scope of audits

Targeted or random audits are limited by scope. The scope of the audit may be:

- **General Audit** – This audit seeks to obtain a general picture of the provider’s compliance with the mandated requirements. No particular area of service delivery is targeted for close examination.

- **Limited Audit** – This audit focuses on a particular program requirement or program risk. For example:
  - **Minimum Hearing Loss Threshold (MHLT) Audit** – This audit focuses on determining if MHLT requirements are being met for fitting hearing devices for clients.
  - **Refit Audit** – This audit focuses on determining if the program’s refitting eligibility criteria are being met.
  - **Complex Clients Audit** – This audit focuses on ensuring that services provided to complex clients are in accordance with program requirements. A separate administrative review of complex client notifications to the Office may also be undertaken.
  - **New Provider Audits** – This type of audit only involves new providers. New providers are asked to submit a number of files, six to 12 months after the first Contract under the program is signed.
  - **DVA Audits** – This audit focuses on maintenance claims for Department of Veterans’ Affairs (DVA) clients.

One or more of these audit scopes may be conducted during a single audit. For example, if a provider is selected for a general audit, they may also be selected for a refit audit at the same time.

Audit method

The Office may conduct audits either off-site (i.e. a desk-based review) or on-site (i.e. at the site at which the hearing services are provided).

The audit scope and method chosen is appropriate to the risk(s) identified during the risk assessment process. However, it is anticipated that the majority of audits identified through the risk assessment will be conducted off-site. On-site audits will mostly occur through random selection, in response to risk indicators or where an off-site audit reveals any issues that require further investigation.

During an off-site audit, the provider submits a number of files (usually between 10 and 20 although more may be requested by the Office) and other information, for review off-site by the Office. The Office aims to hold files for no more than 10 days.
If the audit is conducted on-site, Office auditors attend the provider's premises and meet with staff to review the services against the mandated requirements, and in accordance with the scope of the audit.

**Are providers advised in advance of an audit?**

Yes. The provider is notified of the audit scope and method (off-site and on-site) in advance of the audit commencing.

Notice is given in writing, to the primary address or head office of the provider.

The period of advance notice given depends on the audit scope and the reasons why the provider has been selected for audit. In most cases, providers are given a minimum of 10 working days notice of an audit. Short notice audits may be conducted, if the identified program risks suggest that this is appropriate. In these cases, the Office generally provides a minimum notice period of 24 hours.

The proposed date and time of the audit is outlined in the notification letter (along with the scope of the audit, the method of the audit and any information that may be needed from the provider).

**What can providers expect from an audit?**

**Off-site audit**

After receiving the files from the provider, an auditor will review all files against the audit scope (be it general or limited). If necessary, the auditor may:

- contact the provider for additional information
- seek clarification in relation to any issues identified
- request that more files be provided to the Office. Consistent with the Contract, the Office expects files to be provided within seven working days of the request.
- the auditors will request the provider’s representatives to participate in a closing meeting via telephone. The purpose of the closing meeting will be to identify any concerns noted by the auditors and give the provider an opportunity to provide additional information or explanation. It is important to note that at the closing meeting auditors will not pre-empt the final outcome of the audit. Rather, the closing meeting provides an opportunity to discuss preliminary matters prior to the issue of the audit report (when the provider has a further opportunity for comment).
On-site audit

As part of the conduct of an on-site audit, providers can expect that:

- there will be an opening meeting where the auditors will explain the scope and conduct of the audit and give the provider’s representatives an opportunity to ask any questions

- the auditors will spend most of the day reviewing files but may also ask to speak with staff. The auditors will expect the provider’s staff to assist them to obtain the necessary information

- the auditors will request the provider’s representatives to participate in a closing meeting. The purpose of the closing meeting will be to identify any concerns noted by the auditors and give the provider an opportunity to provide additional information or explanation. It is important to note that at the closing meeting auditors will not pre-empt the final outcome of the audit. Rather, the closing meeting provides an opportunity to discuss preliminary matters prior to the issue of the audit report (when the provider has a further opportunity for comment).

In exceptional circumstances, auditors may contact program clients directly to seek information that may assist the auditor to determine whether the provider is meeting program requirements. This may occur in the case of either an on-site or off-site audit.

**What does the Office expect of providers during an audit?**

The Contract requires that the provider must participate promptly and cooperatively in any audit activities. In particular, the provider must:

- provide, and ensure that each of its personnel provide, all reasonable assistance to the Office (and arrange for provider personnel to be interviewed)

- ensure the attendance of a qualified practitioner who is able to assist the auditor with any inquiries.

The Office does, however, appreciate that audit activities can be disruptive to business flow and will aim to minimise any disruption.
How are the audit outcomes communicated to providers and what opportunity does the provider have to respond to an audit report?

The audit outcomes are reflected in an audit report.

In summary, the audit report will detail:

- the method and scope of the audit

- the audit findings. If the Office cannot be satisfied that the program requirements are being met, the Office will seek advice from the provider about the actions that the provider has, or will, take to ensure that the program requirements are met

- proposed recoveries. During the course of an audit, the Office may identify circumstances in which the Act, contract or standards have not been met. The Office may propose to recover payments for these services.

There are also circumstances where the Office is required under legislation to recover payments. These include where a provider has:

- failed to meet requirements under MHLT;
- provided services prior to the date of voucher issue;
- allowed services to be provided by a provisional practitioner, or a practitioner not listed with the Office, without appropriate supervision; or
- claimed for services where there is no evidence a service has been provided.

- other observations. For example, observations made during the audit, of issues not within the scope of the original audit. These observations may relate to areas of performance, or processes that could be improved by the provider.

The Office aims to give the audit report to the provider:

- in the case of an off-site audit, within 20 working days of receiving the provider’s audit files
- in the case of an on-site audit, within 10 working days of the on-site audit.

These timeframes may however change based on the complexity of the audit.

If the audit indicates that program requirements are being met, the provider will receive a letter advising that no response is required. Providers may respond to the audit report within 10 working days if they wish. However, if no response is received the audit is closed after 10 working days.
If the Office is not satisfied that program requirements are met through the audit, the provider will be required to respond to the Office (in writing within 10 working days), describing how the areas of concern will be addressed. Following receipt of the provider’s response, the Office will consider whether any further action is required. If the Office is satisfied with the response, the audit is closed and no further action is required by the provider. If the Office is not satisfied with the response, compliance action may be taken (as discussed in the following Chapter).

**Does the Office publish the outcomes of audits?**

Audit reports will only be given to the provider. However, a summary of audit outcomes (across the industry) and learnings for providers and the Office will be published periodically. This information will be de-identified.
Chapter 6 – Compliance activity

How does compliance activity differ to audit activities?

As detailed in the previous chapter, the purpose of an audit is to identify whether providers are meeting program requirements.

By contrast, compliance action is the way that the Office responds to identified non-compliance with the mandated program requirements. It describes the actions that the Office may take in order to return the provider to compliance or, in cases where this is not possible or desirable, to suspend or terminate the provision of services by the provider. In some cases recovery of money paid to the provider may also be appropriate.

In dealing with non-compliance, the Office aims to ensure that:

- procedural fairness is given to the provider. In most cases, this means giving the provider an opportunity to respond to concerns identified by the Office and to propose an acceptable course of action to remedy the non-compliance
- its actions are timely (in order to minimise any ongoing risks to clients or the program)
- it acts in the public interest. For example, as a funder of hearing services the Office has a responsibility for ensuring that public monies are expended appropriately. This also means that the Office must take action to recover such monies where this is not the case.

The following diagram demonstrates the difference between audit and compliance activities.
What is the Office’s approach to compliance activity?

The Office achieves its compliance objectives by employing three integrated strategies:

- encouraging compliance by educating and informing
- administrative resolution of non-compliance
- enforcing the law and contractual obligations, where necessary.

Encouraging compliance by educating and informing

In some cases, non-compliance results from providers being unaware of a particular requirement, or being uncertain as to how to meet a requirement. This can give rise to unintended non-compliance with the legislation, or with the terms of the Contract.

The Office’s approach to compliance therefore includes:

- feedback as part of the audit process
- identifying trends or common areas of challenge for providers and releasing information on these topics. The Office does this through ad hoc forums, presentations to provider groups and information on the Office website
- provision of education and advice to individual providers.

Administrative resolution of non-compliance

After identifying potential non-compliance through an audit, the first response of the Office is to give the provider an opportunity to address the concerns raised. This is often the most effective and efficient way to address the non-compliance, and it enables the provider to take responsibility for looking into the non-compliance and proposing a solution.

Where the provider demonstrates willingness to act, and an understanding of the problem, this approach can deliver positive results and no further compliance action is required.

Enforcing the law and contractual obligations, where necessary

In some circumstances, the Office’s compliance objectives cannot be met through education, or assisting providers to comply. For example, there can be circumstances where:

- a provider has contravened a condition of its accreditation
- there has been a history of non-compliance and a provider has continuously failed to address identified problems
• public monies have been expended for services that were not provided, were inappropriately provided or did not meet legislative requirements, and the Office must recover these monies

• a provider is acting in a fraudulent way

• a provider has failed to respond (or failed to respond appropriately) to attempts by the Office to assist the provider to return to compliance

• the provider is unable to address the non-compliance and may no longer be suitable to provide hearing services.

In these circumstances, the Office draws on its contractual and legislative rights and responsibilities to take action.

Some of the actions available to the Office include:

• remedial actions

• recoveries

• suspension

• termination.

The type of compliance action taken depends on the nature of the provider’s non-compliance and could include one, or a combination, of the above compliance activities.

What are remedial actions?

The Contract requires providers to promptly take corrective action to rectify any error, non-compliance or inaccuracy identified in any audit.

In most cases, before enforcing its right to require the provider to undertake remedial action, the Office will give the provider an opportunity to address the problem, within a timeframe acceptable to the Office.

However, the appropriate course of action in each case will depend on the facts and circumstances. In some cases, this may mean that the Office requires the provider to take immediate remedial action.

Remedial actions involve the Office requiring a provider to remedy its non-compliance in a particular way.

Remedial actions may include (but not be limited to) requiring the provider to remove specified service provider personnel (in respect of provision of services to program clients), recalling clients and rectifying any site or equipment deficiencies, such as calibration of equipment or testing ambient noise levels.
What are recoveries?

If a provider has made a claim for a service that is in contravention of the mandated requirements, the Office may seek to recover the money that has been paid by government, to the provider, for the service.

What is suspension?

The Contract enables the Office to direct the provider to stop providing all, or a specified part of, the services to clients if it is satisfied that there has been a breach of the Contract.

If an audit activity has revealed breaches or practices that place the program and/or its clients at risk, the Office may issue a Suspension Notice directing a provider to stop providing all or part of their services to program clients.

Prior to suspending a Contract, the Office will write to the provider giving the provider an opportunity to explain why the Contract should not be suspended. Providers are given 28 days to respond, but this time period may be shortened if the risk to clients, or the program, demands a quicker response. This is within the discretion of the Office.

The Office will consider the provider’s response and decide whether or not to suspend the Contract.

What is termination?

Termination of the Contract may occur if an audit activity has, for example:

- revealed practices that place the program and/or its clients at significant risk
- identified non-compliance that the provider has been unable or unwilling to address, despite being given the opportunity to do so
- identified possible fraud.

Termination of the Contract can also follow:

- persistent non-compliance by the provider, with the mandated requirements
- a period of suspension of services.

Prior to terminating a Contract, the Office will write to the provider giving the provider an opportunity to explain why the Contract should not be terminated. The provider will generally be given 28 days to respond but this time period may be shortened if the risk to clients (or the program) warrants a quicker response.

The Office considers the provider’s response and decides whether or not to terminate the Contract. If the Contract is terminated, the provider will no longer be able to provide services under the program. The provider’s accreditation is revoked if the Contract is terminated.
Chapter 7 - Monitoring, reviewing and improving this Framework

The Office is committed to continuously improving the effectiveness of its Audit and Compliance Framework.

In addition to making ongoing adjustments to the Framework, in response to any changed or emerging risks, the Office will review the Framework annually and make any necessary adjustments. Providers are invited to contribute to this process by completing a feedback survey following their audit experience. The link to this instrument is supplied in the audit closure letter, received once the audit process has been completed.

Providers may wish to contribute further to the feedback process by making any suggestions or comments about the Framework to:

Audit Coordinator  
Office of Hearing Services  
Department of Health  
MDP 113, GPO Box 9848  
Canberra City ACT 2601

Or via email to Hearing@Health.gov.au

Alternatively, providers may:

- contact the Office Customer Service Centre from 9.00am to 5.00pm (EST and ESDST) Monday to Friday on:
  - Telephone: 1800 500 726  
  - TTY: 1800 500 496

- provide feedback through one of the stakeholder consultation bodies constituted by the Office (such as the Service Provider Consultative Group).

Feedback is welcome at any time.

The Framework will also be comprehensively evaluated at the end of each Contract cycle, as part of the development of the next Audit and Compliance Framework for the commencement of the next Contract.