

For Consultation

Standards for the Accreditation of Immunisation Education Programs

September 2026

Owner:	Health Education and Services Australia
Date of Issue:	October 2026

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HESA Standards for the Accreditation of Immunisation Education Programs

Purpose and context

The Standards for the Accreditation of Immunisation Education Programs were first introduced by Health Education Services Australia (HESA) in 2020 to provide a nationally consistent quality assurance framework for education programs preparing health professionals to undertake immunisation practice. The 2020 Standards were developed to align with the domains and learning objectives in the National Immunisation Education Framework for Health Professionals (The National Framework) and the National Immunisation Strategy for Australia 2019–2024 (Australian Government, Department of Health, Disability and Ageing, 2017; Australian Government, Department of Health, 2019).

HESA is undertaking a review of the 2020 Standards to ensure they remain contemporary, evidence-informed, fit for purpose in supporting the delivery of safe, high-quality immunisation education and, ultimately, protecting public health and safety. The review provides an opportunity to consider developments in immunisation policy and practice, including the National Immunisation Strategy for Australia 2025–2030, as well as developments in health professional immunisation scope of practice, education and assessment, technology, community expectations and quality assurance since the HESA Standards were introduced (Australian Government, Department of Health, Disability and Ageing, 2025).

Aim of the review

The aim of this review is to develop a revised set of Standards that are:

- contemporary, evidence-informed and aligned with best practice
- aligned with the National Framework and national immunisation policy, including the National Immunisation Strategy for Australia 2025–2030
- supportive of education programs that prepare health professionals for safe and effective immunisation practice
- relevant and acceptable to education providers, the immunisation workforce and key stakeholders
- supportive of innovation, flexibility and continuous improvement in immunisation education
- supportive of safe, equitable, and high-quality immunisation services for the Australian public

The HESA Standards do not seek to establish or replace national immunisation policy, clinical guidelines, professional regulation or jurisdictional authorisation arrangements. Rather, the Standards establish the requirements that education providers must meet when designing and delivering a HESA accredited immunisation education program.

How the draft Standards have been developed

Guiding principles

The draft Standards have been developed around three complementary principles:

- National consistency – maintaining alignment with the National Immunisation Education Framework for Health Professionals and the National Immunisation Strategy for Australia 2025–2030, while establishing consistent expectations for the quality of accredited immunisation education.
- Contemporary practice – reflecting current evidence, developments in immunisation practice and education, evolving workforce models and community expectations.
- Contextual responsiveness – recognising differences in jurisdictional, professional, community and service delivery contexts, as well as evolving public health priorities, and providing sufficient flexibility for education programs to prepare graduates to practise safely and effectively within these contexts.

Together, these principles provide a foundation for the revised Standards and will guide consideration of stakeholder feedback during the consultation and finalisation process.

Standards review process

The review of the 2020 Standards is being undertaken through a structured and consultative process comprising five phases: planning, development, targeted consultation, refinement and approval and publication (Figure 1).

The process incorporates an environmental scan, expert review, stakeholder consultation and iterative refinement to ensure the revised Standards remain evidence-informed, relevant and responsive to contemporary immunisation education and practice. The review will culminate in consideration and approval of the revised Standards by the HESA Board, followed by publication of the final Standards and associated accreditation and implementation resources.

Development of the draft Standards

The development of the draft Standards has been informed by activities undertaken during the planning and development phases of the review, including:

- an environmental scan of contemporary immunisation policy and practice, workforce developments, education and accreditation approaches
- establishment of a Standards Review Committee (SRC), comprising expertise across immunisation education, clinical practice, public health, service delivery and relevant professional and regulatory and community contexts
- review of the implementation and accreditation experience of the current Standards, including feedback from education providers and HESA Immunisation Assessors
- consideration of national and international approaches to immunisation education and accreditation, and
- identification of emerging issues and areas where the current Standards may require clarification, revision or strengthening.

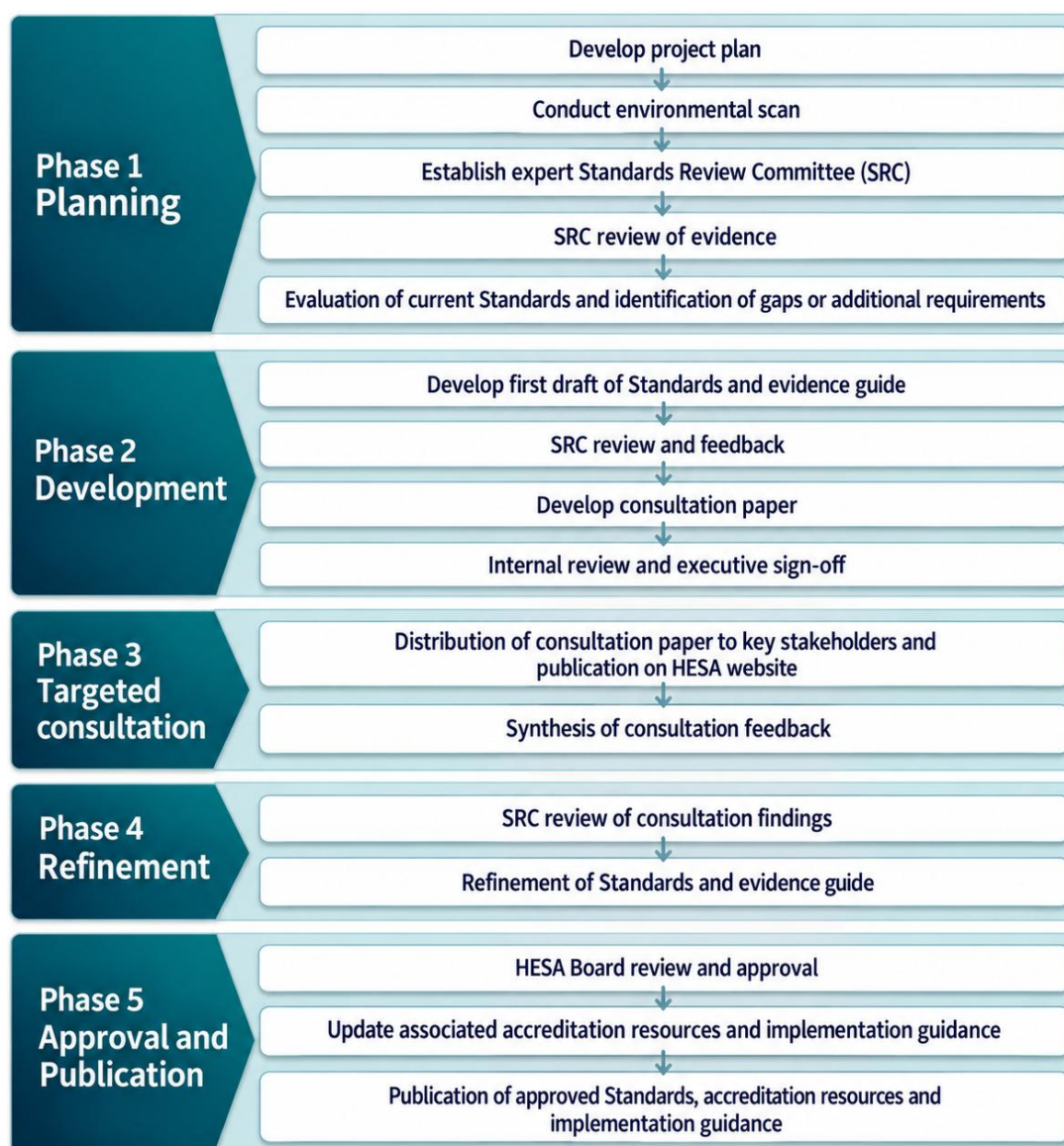


Figure 1. HESA Standards review framework

The environmental scan was informed by the RADAR-ES¹ methodological framework (Nagel, et al., 2026) and drew on peer-reviewed and grey literature, government and regulatory documents, national and international immunisation education guidelines, and feedback from recently accredited education providers and HESA Immunisation Assessors. Evidence was considered across immunisation policy and practice, workforce capability and scope of practice, education and training, digital health and emerging technologies, and consumer and community considerations.

The environmental scan identified significant developments in the immunisation environment since the introduction of the Standards in 2020. These included changes in immunisation policy and clinical guidance; evolving workforce roles and vaccination authorities; increased use of

¹ RADAR-ES refers to the 5-phase methodological approach for environmental scans (ES) in health services delivery research by Nagel et. Al., (2026) which includes: (1) Recognizing the Issue; (2) Assessing Factors for ES; (3) Developing an ES Protocol; (4) Acquiring and Analysing the Data; and (5) Reporting the Results.

digital health systems and data; developments in education and assessment; and greater emphasis on vaccine confidence, communication, equity and culturally safe practice.

Findings from the environmental scan, together with the SRC's review of the existing Standards, informed the development and iterative refinement of the draft Standards and accompanying evidence guide. These documents form the basis of the current targeted consultation.

Standards Review Committee

HESA established a Standards Review Committee (SRC) to provide expert advice throughout the review. The SRC brings together expertise in jurisdictional immunisation service delivery, health professional education, public health, immunisation policy and research, Aboriginal and Torres Strait Islander health and primary health care. See Appendix for the SRC Terms of Reference.

Standards Review Committee membership

- Deidre Brogan — Clinical Nurse Consultant, NSW Immunisation Specialist Service, National Centre for Immunisation Research and Surveillance (NCIRS)
- Kaz Bellamy — Infectious Diseases and Immunisation Nurse Practitioner, Monash Health, Victoria; Voting Member, Australian Technical Advisory Group on Immunisation (ATAGI)
- Katrina Clark — Aboriginal Immunisation Manager, Hunter New England Local Health District, Population Health, Wallsend, New South Wales
- Sally Edwards — Clinical Nurse Consultant, Immunisation, Department of Health, Tasmania
- Sara Drew — General Manager, Education, Australian Primary Health Care Nurses Association (APNA)
- Melissa Fidock — Nursing Director, Immunisation Section, Communicable Disease Control Branch, Department for Health and Wellbeing, South Australia
- Mareeka Hair — Manager, Immunisation, NSW Health, New South Wales
- Palee Holdsworth — Principal Program Officer, Immunisation Program, Communicable Disease Control Directorate, Department of Health, Western Australia
- Alison Kingsbury — Senior Director, Immunisation, Health Protection Service, ACT Health Directorate, Australian Capital Territory
- Ali Maggs — Learning and Development Manager, The Benchmark Group
- Alyce Merritt — Director, First Nations Strategy & Reform, Australian Nursing and Midwifery Accreditation Council
- Michael Morgan — Lead Pharmacist, Immunisation, Department of Health, Tasmania
- Isabel Ngere — Nurse Management Coordinator, Immunisation Unit, Centre for Disease Control, NT Health, Northern Territory
- Jayne Porter — Nurse Management Consultant, Operational Manager Immunisation, Centre for Disease Control, NT Health, Northern Territory
- Roxanne Taylor — Nurse Educator, Queensland Health Immunisation Program, Queensland Health, Queensland
- Kelly Trudgen — National Indigenous Immunisation Lead, NCIRS
- Professor Nicholas Wood — Associate Director, Clinical Research and Services, NCIRS

The SRC has considered the evidence identified through the environmental scan, feedback regarding implementation of the 2020 Standards and emerging issues relevant to immunisation education and practice. Its role is advisory, with the final revised Standards to be considered and endorsed by the HESA Board following stakeholder consultation.

Continuing alignment with the National Framework

A key principle of the review is that the revised Standards will continue to rely on, and align with, the National Immunisation Education Framework for Health Professionals.

Published in 2017, the National Framework establishes nationally consistent educational expectations for health professionals seeking to administer vaccines and provides the educational foundation for HESA-accredited immunisation education programs (Australian Government, Department of Health, Disability and Ageing, 2017). The HESA Standards do not replicate or replace the National Framework; they establish accreditation requirements relating to the governance, design, delivery, resourcing, assessment and quality assurance of education programs that deliver its educational requirements.

Since publication of the National Framework, the immunisation environment has continued to evolve. The environmental scan identified developments in immunisation delivery across the lifespan, workforce scope of practice, vaccine confidence and communication, equity and cultural safety, digital health and data, emerging technologies and public health preparedness. Many of these developments are reflected in the priorities of the National Immunisation Strategy 2025–2030, including equitable access, vaccine confidence, strengthened immunisation data systems, workforce capability and preparedness for emerging diseases (Australian Government, Department of Health, Disability and Ageing, 2025).

Emerging themes considered in the review

Responding to the rapidly evolving immunisation policy and practice

Australia's immunisation policy and practice environment has evolved substantially since the current Standards were introduced in 2020. The Australian Immunisation Handbook (AIH) (Australian Centre for Disease Control, 2026) and National Immunisation Program (NIP) schedule (Australian Government, Department of Health, Disability and Ageing, 2026) continue to respond to emerging evidence, changes in disease epidemiology, new vaccines and vaccine technologies, and revised recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI). The AIH is continually updated as evidence, recommendations and vaccine information change, with practitioners directed to the online resource to ensure they are accessing current clinical guidance.

The COVID-19 pandemic demonstrated the importance of an immunisation workforce and service system capable of responding to emerging public health threats, evolving evidence and changing service requirements. In Australia, immunisation services adapted models of care while maintaining access to routine vaccination, highlighting broader lessons for evidence-informed decision-making and future pandemic preparedness (Basseal, et al., 2023; Giles, O'Bryan, Angliss, Lee, & Krishnaswamy, 2022). These lessons are reflected in the National Immunisation Strategy for Australia 2025–2030, which identifies preparedness for emerging

diseases and changing population needs as a national priority and emphasises a skilled, adaptable and sustainable immunisation workforce, including capability in immunisation practice, surveillance, data and communication (Australian Government, Department of Health, Disability and Ageing, 2025).

Implications for the revised standards

Continual developments in vaccine technology and availability, expansion of funded vaccination programs, evolving recommendations for priority populations and the need to respond to emerging public health threats require immunisation education to extend beyond knowledge of current schedules and recommendations. The draft Standards therefore place greater emphasis on preparing adaptive practitioners who can locate and critically interpret authoritative information, apply evolving evidence and guidance, and use clinical reasoning and professional judgement to respond safely to changes in immunisation policy, practice and public health priorities.

Immunisation workforce and scope of practice

The Australian immunisation workforce has become increasingly diverse, with vaccination services delivered by health professionals across a range of professions, practice settings and jurisdictions (Australian Government Department of Health and Aged Care, 2024; National Centre for Immunisation Research and Surveillance [NCIRS], 2022). Health practitioner registration and professional standards operate nationally through the National Registration and Accreditation Scheme (Australian Health Practitioner Regulation Agency [Ahpra], 2026). However, authority to prescribe, supply and administer vaccines is governed by state and territory legislation, medicines authorities and vaccination arrangements (Australian Technical Advisory Group on Immunisation [ATAGI], 2026; Pharmaceutical Society of Australia, 2025). Consequently, authorised immunisation practice, including requirements for education, authorisation and supervision, varies between jurisdictions.

Since 2020, jurisdictions have continued to expand vaccination authorities in response to workforce, access and service-delivery needs. This includes expanded opportunities for appropriately trained Aboriginal and Torres Strait Islander Health Practitioners to administer vaccines, alongside other reforms to the immunisation workforce (National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners [NATSIHWP], 2024; Queensland Health, 2025; Queensland Health, 2026). While these reforms reflect a broadly consistent direction of travel, their scope and implementation continue to vary across Australia.

Implications for the revised standards

These changes impact education programs that may enrol learners from different professions and jurisdictions, with different pre-registration education, existing capabilities and authorised scopes of practice. The draft Standards therefore strengthen expectations that programs clearly identify their intended learner cohorts, recognise relevant differences in prior learning and professional preparation, and prepare graduates to practise safely within their authorised scope and applicable jurisdictional requirements.

Vaccine confidence and person-centred communication

Maintaining vaccine confidence and supporting informed decision-making are increasingly important aspects of contemporary immunisation practice. The National Immunisation Strategy for Australia 2025–2030 identifies improving vaccine confidence as a national priority, alongside equitable access and a capable immunisation workforce (Australian Government, Department of Health, Disability and Ageing, 2025). This priority is particularly relevant in the context of declining immunisation coverage. Australia has experienced a sustained decline in routine immunisation coverage since 2020, with reductions across childhood milestone ages as well as declining uptake of some adolescent and adult vaccines (Australian Institute of Health and Welfare, 2026). The 2025 Annual Immunisation Coverage Report identified a fifth consecutive year of declining childhood immunisation coverage, with coverage among two-year-olds falling below 90% for the first time in more than a decade (National Centre for Immunisation Research and Surveillance, 2026a).

Declining coverage is influenced by multiple and interacting factors, including vaccine confidence, misinformation and disinformation, barriers to accessing vaccination services and changes in health-seeking behaviours following the COVID-19 pandemic (National Centre for Immunisation Research and Surveillance, 2026a). Australian research has also identified increasing parental misperceptions about routine childhood vaccination, reinforcing the importance of evidence-based communication that supports informed decision-making (Kaufman, Hoq, Rhodes, Measey, & Danchin, 2024).

These challenges require immunisation practitioners to do more than provide accurate information. Practitioners need the communication skills and professional behaviours to explore individual concerns, respond appropriately to misinformation, communicate benefits and risks clearly, and support informed decisions about vaccination. Australian resources such as NCIRS's *Sharing Knowledge About Immunisation* (SKAI) provide evidence-based communication strategies and resources to support respectful conversations about vaccination, including with people who have questions or concerns about vaccines (National Centre for Immunisation Research and Surveillance, 2026b).

Implications for the revised standards

The draft Standards therefore place greater emphasis on the development and assessment of communication capabilities and professional behaviours as integral components of safe and effective immunisation practice. Education programs should prepare graduates to communicate evidence and react to uncertainty appropriately, respond constructively to vaccine concerns and misinformation, and support informed decision-making in ways that are person-centred and responsive to individual needs.

Cultural safety and equity for priority populations

Equity is a key principle of contemporary immunisation policy and practice. The National Immunisation Strategy for Australia 2025–2030 identifies equitable access to immunisation as a national priority and recognises a broad range of priority populations who may experience increased risk of vaccine-preventable disease or barriers to vaccination. These populations reflect diverse and intersecting considerations relating to age, health, culture, identity, geographic location and social circumstances (Australian Government, Department of Health,

Disability and Ageing, 2025). Immunisation education needs to prepare graduates to recognise and respond to the diverse and overlapping needs of priority populations identified in the Strategy, and to adapt their practice to address the social, cultural, clinical, geographic and systemic factors that influence vaccination access, participation and equitable outcomes.

Cultural safety is particularly important in addressing health inequities experienced by Aboriginal and Torres Strait Islander peoples. The *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* (Australian Government Department of Health, 2021) identifies culturally safe, responsive and equitable care as fundamental to improving health outcomes. Cultural safety is concerned with how care is provided and experienced and requires practitioners to reflect on their knowledge, attitudes, behaviours and biases, recognise power imbalances and provide care that is responsive to the needs of Aboriginal and Torres Strait Islander peoples (Australian Institute of Health and Welfare, 2023). Australian immunisation research further demonstrates the importance of culturally safe and accessible services, community ownership, local responsiveness and a strong Aboriginal and Torres Strait Islander health workforce in supporting vaccination uptake and timeliness (Ryan, et al., 2026).

Australian research with culturally and linguistically diverse (CALD) communities highlights the importance of culturally responsive approaches to immunisation communication and engagement. Effective approaches recognise diverse health literacy, cultural and contextual needs and emphasise the role of trusted health professionals, community voices, meaningful community engagement, inclusive practices, and respectful, transparent communication about vaccination (Karras, Harrison, Petrakis, Gore, & Seale, 2024; Zachariah, et al., 2022). These findings reinforce the importance of preparing immunisation practitioners to tailor their communication and engagement approaches to the needs and circumstances of the communities they serve, working collaboratively with community leaders to build trust and support informed vaccination decisions.

Barriers to equitable immunisation access and participation vary across populations and contexts. In rural and remote Australia, geographic distance, workforce and service availability, and operational and logistical constraints can affect access to vaccination. Australian research highlights the importance of locally responsive approaches to addressing these barriers, including accessible service models, workforce capacity, adaptability, collaboration and community engagement (Oversby, Hamilton, Ratsch, & Kitchener, 2023; Steffens, et al., 2025).

Other priority populations may experience different or intersecting barriers to immunisation. Older people are at increased risk from a range of vaccine-preventable diseases, yet uptake of recommended vaccines varies considerably. Australian data show that in 2024, zoster vaccination coverage among adults aged 65 years and over was 45.9%, while pneumococcal vaccination coverage among adults turning 71 was 38.6% (Australian Institute of Health and Welfare, 2026). Similar variation has been identified among older people specifically living in Australian residential aged care, which found high uptake of influenza vaccination but substantially lower uptake of pneumococcal and herpes zoster vaccines, highlighting the importance of recognising the differing vaccination needs of older people and ensuring opportunities for recommended vaccination are identified across care settings (Wiblin, Lai, Soulsby, & Hillen, 2025).

Collectively, this evidence demonstrates that equitable immunisation practice requires more than uniform availability of vaccination. Practitioners need to recognise the different and potentially intersecting factors that influence immunisation access and participation and respond appropriately within their practice context. This may require adaptation of communication and engagement approaches, identification of opportunities for catch-up or opportunistic vaccination, and connection with appropriate, accessible and culturally responsive services.

Implications for the revised standards

The draft Standards aim to strengthen expectations for cultural safety and equity across program governance, curriculum and graduate capability. This includes meaningful Aboriginal and Torres Strait Islander representation in program governance and development, consideration of the diverse and overlapping needs and perspectives of priority populations identified in the National Immunisation Strategy for Australia 2025–2030, and preparation of graduates to recognise and respond to factors that contribute to inequitable immunisation access and outcomes.

Contemporary education models and assessment of clinical capability

Online, blended and simulation-based approaches are increasingly used in health professional education and provide greater flexibility in how learning is delivered. Contemporary evidence demonstrates that digital approaches can support the development of clinical skills, with learning outcomes that may be comparable to face-to-face education when appropriately designed and implemented (Eglseder & Littleton, 2021; Lockey, Bland, Stephenson, & Astin, 2022; McGee, et al., 2024). Online clinical skills education can incorporate approaches such as demonstration, repeated practice, observation and feedback, while simulation and virtual learning can provide opportunities for learners to apply knowledge and develop clinical reasoning and decision-making in practice-based scenarios (Eglseder & Littleton, 2021; Sim, et al., 2022).

The development of clinical capability, including effective communication skills, requires more than acquisition of theoretical knowledge. The effectiveness of digital and blended approaches is influenced by the design and integration of learning activities, including supervised opportunities for learners to practise skills, receive feedback and demonstrate performance (Eglseder & Littleton, 2021; McGee, et al., 2024). This is particularly relevant where education is intended to prepare learners to perform practical clinical procedures safely and independently.

For immunisation education, these findings support flexibility in how programs are delivered while maintaining clear expectations for the capabilities graduates are required to demonstrate. Learning and teaching approaches should provide sufficient opportunities for learners to progressively develop, integrate and apply immunisation knowledge, clinical capabilities, communication skills and professional judgement, including the practical skills required for safe vaccine administration across the lifespan.

Implications for the revised standards

The draft Standards therefore do not prescribe a particular mode of delivery but strengthen expectations for the quality and appropriateness of learning, teaching and assessment. Education providers are expected to demonstrate that their educational approaches support

achievement of the program learning outcomes and that assessment provides valid evidence that graduates have achieved the knowledge, clinical capabilities and professional behaviours required for safe immunisation practice.

Assessment integrity and artificial intelligence

The rapid development and accessibility of generative artificial intelligence (AI) present new challenges for assessment integrity and the assurance of learner achievement. While generative AI can support learning, its capacity to produce sophisticated assessment outputs can make it difficult to determine whether submitted work provides valid evidence of a learner's own knowledge and capabilities. Contemporary guidance therefore emphasises assessment design that maintains integrity while recognising the increasing presence of AI in education and practice (Lodge, Howard, & Bearman, 2023; Perkins, Furze, Roe, & MacVaugh, 2024; Tertiary Education Quality and Standards Agency [TEQSA], 2026).

These considerations are particularly important in immunisation education, where assessment must provide assurance that graduates can independently apply immunisation knowledge, undertake clinical reasoning, communicate effectively, exercise professional judgement and safely perform required clinical skills. Assessment strategies therefore need to provide sufficient and appropriate opportunities for learners to demonstrate these capabilities, including through methods that require application of knowledge and observable demonstration of performance where appropriate (Lodge, Howard, & Bearman, 2023).

Implications for the revised standards

The draft Standards strengthen expectations for assessment integrity across assessment modalities and require education providers to demonstrate that formative and summative assessment provides valid evidence of achievement of program learning outcomes. This includes ensuring that the overall assessment strategy provides assurance that graduates have achieved the knowledge, clinical capabilities and professional behaviours required for safe immunisation practice.

Digital health, immunisation data and emerging technologies

Digital technologies and data systems are increasingly important to contemporary immunisation practice. Immunisation practitioners require the capability to use digital systems effectively, maintain accurate and high-quality health information, and access and apply current evidence and clinical guidance (Australian Digital Health Agency, 2020). This is particularly relevant to the Australian Immunisation Register (AIR) (Australian Centre for Disease Control, 2026b), where mandatory reporting requirements have expanded since 2020.

Immunisation practitioners also increasingly use digital systems and online resources to access vaccination histories, determine vaccine eligibility, support catch-up vaccination and apply current clinical guidance. These developments form part of a broader national shift towards digitally enabled healthcare. The National Digital Health Strategy 2023–2028 identifies a digitally ready and enabled health workforce as an important enabler of contemporary healthcare and emphasises building digital health capability across all health professions, including through education, training and accreditation (Australian Digital Health Agency, 2023). The National Digital Health Capability Action Plan further supports the development of digital health capabilities across the diverse health workforce, recognising that capability

requirements vary according to occupation, role and practice setting (Australian Digital Health Agency, 2025).

The increasing availability of digital clinical resources also changes how practitioners' access and apply immunisation guidance. The Australian Immunisation Handbook is maintained as an online resource and updated as evidence, recommendations and vaccine information change, requiring practitioners to be able to locate, interpret and apply current authoritative information in clinical decision-making (Australian Centre for Disease Control, 2026). Emerging technologies, including artificial intelligence, create further opportunities but also introduce considerations relating to accuracy, evidence, privacy, transparency, bias and appropriate professional judgement (Australian Commission on Safety and Quality in Health Care, 2025).

Implications for the revised standards

The draft Standards respond to these developments by strengthening expectations that programs prepare graduates to engage with evolving digital technologies and contemporary sources of evidence. This includes developing the capability to use authoritative digital resources and relevant immunisation information systems appropriately, maintain data quality, and critically and safely engage with emerging technologies within their professional responsibilities.

Targeted consultation

The draft Standards respond to the emerging themes outlined above while maintaining nationally consistent expectations for safe, high-quality immunisation education. Targeted consultation will seek input from those who develop, deliver, regulate, support and experience immunisation education to determine whether the draft Standards are clear, appropriate, achievable and responsive to contemporary practice. Consultation will seek feedback from a broad range of stakeholders, including Commonwealth, state and territory health departments and immunisation programs, education providers, health services, health professionals involved in immunisation, relevant professional and peak bodies, consumer and advocacy groups, culturally and linguistically diverse (CALD) community representatives, and Aboriginal and Torres Strait Islander health organisations and representatives.

Providing feedback

Consultation will be open for six weeks, commencing Tuesday 20 October 2026 and closing at 5 pm AEDT on Monday 30 November 2026.

Stakeholders are invited to provide written feedback on the draft Standards. Submissions may be provided as a separate document or through comments directly within the draft Standards. Feedback should identify the relevant standard or section and, where possible, include suggested amendments and supporting rationale.

Submissions should be emailed to **consultation@hesa.com.au**, with the subject line *Immunisation Education Standards Consultation*, by the closing date.

Consideration of feedback and finalisation

Following the consultation period, HESA will collate and analyse submissions to identify key themes, areas of agreement, differing perspectives and proposed amendments. Feedback will be considered by the SRC, which will provide expert advice and recommendations to inform revisions to the draft Standards.

The SRC will seek to establish consensus through consideration of stakeholder feedback, available evidence and the objectives of the Standards. Where differing perspectives remain, these will be documented and considered in developing the final recommendations. Further targeted consultation may be undertaken where substantive issues require additional consideration or clarification.

Following consideration of consultation feedback and final recommendations from the SRC, the revised Standards will be submitted to the HESA Board for review and approval. Once approved, the Standards will be published alongside updated accreditation resources and implementation guidance. HESA will communicate relevant implementation arrangements to accredited education providers and other stakeholders.

Application of the Standards

The Standards establish the requirements against which HESA assesses immunisation education programs seeking or maintaining HESA accreditation. Compliance with the Standards is expected for programs seeking HESA accreditation; however, HESA accreditation is not mandatory for all immunisation education programs in Australia.

Education providers must also comply with applicable professional, regulatory and jurisdictional requirements, including any state or territory requirements relating to recognised immunisation education, vaccination authorisation and scope of practice.

Draft Standards

The draft Standards for the Accreditation of Immunisation Education Programs are also organised into five domains: The Education Provider; The Program; Learners; Resources; and Quality and Risk Management. Together, they address program governance, curriculum and assessment, learner participation and support, resources, and ongoing quality improvement and risk management. Following approval of the final standards, relevant materials will be developed to support education providers and assessment teams through the accreditation process.

The current (2020) Standards have been mapped against the draft Standards to show how existing requirements have been retained or revised and where new requirements have been introduced. Table 1 presents the draft Standards in Column 1 alongside the corresponding provisions of the current Standards in Column 2.

Table 1: Draft revised Standards for the Accreditation of Immunisation Education Programs

DOMAIN 1: THE EDUCATION PROVIDER		
DRAFT STANDARD		CURRENT STANDARD
1.1	The education provider is currently registered with the Tertiary Education Quality and Standards Agency (TEQSA) as a higher education provider or the Australian Skills Quality Authority (ASQA) as a Registered Training Organisation (RTO) or delivers the program under a formal affiliation or partnership agreement with a registered education provider.	1.1
1.2	The education provider demonstrates how organisational governance arrangements translate into operational and academic oversight of the immunisation education program, including clearly defined responsibilities, reporting pathways and decision-making authority for the program.	1.2, 1.4
1.3	Responsibility for program development, monitoring, review, evaluation and quality improvement is delegated to the relevant organisational unit or program lead, with clearly defined roles, responsibilities and decision-making authority for personnel involved in these activities.	1.3, 1.4
1.4	For education programs solely targeted to Aboriginal and Torres Strait Islander health professionals, a majority of staff with substantive responsibility for the program governance, design, development and delivery identify as Aboriginal or Torres Strait Islander.	

1.5	A minimum of two Aboriginal and/or Torres Strait Islander representatives hold an ongoing position on a program advisory committee or equivalent governance arrangement which informs program development, monitoring and review and ensures First Nations perspectives are appropriately reflected throughout the curriculum.	1.5
1.6	The education provider has documented advisory arrangements with key immunisation stakeholders and subject matter experts, including those with expertise relating to priority populations, to inform program development, monitoring, review and revision.	1.5
1.7	The education provider retains ultimate responsibility and accountability for the delivery and assessment of the program, including decisions regarding successful completion of the program.	2.8
1.8	Students, supervisors and staff are adequately indemnified for relevant activities undertaken as part of the program requirements.	1.6
DOMAIN 2: THE PROGRAM		
DRAFT STANDARD		CURRENT STANDARD
2.1	The program is designed to accommodate the diverse professional backgrounds and pre-registration education of eligible health professionals and prepares graduates to practise safely within their authorised scope of practice and in accordance with applicable jurisdictional requirements.	2.1, 3.2
2.2	The central focus of the program is immunisation, and the curriculum is directly aligned with the domains and learning outcomes of the National Immunisation Education Framework for Health Professionals. The curriculum is appropriately structured and sequenced to provide the breadth and depth of knowledge, clinical capabilities and professional behaviours required for safe and high-quality immunisation practice.	2.1, 2.2, 2.3, 2.5
2.3	The curriculum develops learners' ability to adapt to contemporary and evolving immunisation practice by critically engaging with emerging evidence, policy, public health priorities and developments in digital technologies.	2.1, 2.2, 2.3, 2.5
2.4	The curriculum advances learners' clinical decision-making and communication capabilities to respond safely and appropriately to individual circumstances and complex immunisation scenarios.	2.1, 2.2, 2.3, 2.5
2.5	The curriculum provides scaffolded learning experiences throughout the program that develop learners' capability to provide equitable, culturally safe and person-centred immunisation services for diverse individuals and communities, including Aboriginal and Torres Strait Islander peoples and communities, culturally and linguistically diverse peoples and communities, and other priority populations.	2.1, 2.5

2.6	Programs delivered across multiple teaching sites, jurisdictions or delivery modes are designed and implemented to provide equivalent learning opportunities and assessment approaches, ensuring all learners have equitable opportunities to achieve the program learning outcomes.	2.4, 2.6, 3.4
2.7	Learning and teaching strategies are constructively aligned with the program learning outcomes and assessment, and provide learners with opportunities to progressively develop, integrate and apply immunisation knowledge, clinical capabilities, professional behaviours and sound clinical judgement.	2.2, 2.5
2.8	Assessment provides valid formative and summative opportunities for learners to demonstrate achievement of the program learning outcomes across knowledge, clinical capabilities and professional behaviours required for safe and high-quality immunisation practice.	2.7, 2.11
2.9	Assessment is fair, valid, reliable and transparent, with processes in place to ensure its integrity and authenticity across all delivery modes.	2.6, 2.9, 2.10
DOMAIN 3: THE LEARNER		
DRAFT STANDARD		CURRENT STANDARD
3.1	Prospective students are provided with clear, accurate and accessible information before enrolment to enable informed decisions about participation in the program, including the modes of delivery and any relevant jurisdictional or eligibility requirements.	3.1
3.2	Admission processes are transparent, equitable and based on published criteria that align with the requirements of the program, the intended learner cohort and relevant jurisdictional regulatory requirements.	3.2
3.3	The education provider encourages Aboriginal and Torres Strait Islander peoples to apply and provides culturally safe and appropriate support to enable their participation, progression and successful completion of the program.	3.5
3.4	The education provider has processes to identify and support students experiencing academic difficulties and academic or professional conduct concerns.	3.3
3.5	Students have equitable access to learning resources, assessment opportunities and academic support, including reasonable adjustments where appropriate, to enable participation, achievement of the program learning outcomes and successful program completion.	3.4

DOMAIN 4: RESOURCES		
DRAFT STANDARD		CURRENT STANDARD
4.1	The education provider maintains sufficient teaching and administrative staff to support the delivery, assessment, governance, continuous improvement and student support requirements of the program.	4.1
4.2	Staff involved in teaching, assessing and supporting the program have the relevant qualifications, contemporary clinical expertise, advanced immunisation knowledge and educational capability appropriate to their roles. The teaching team includes practicing immunisers who maintain the authorisation and continuing professional development requirements applicable in the jurisdiction(s) in which they practise.	4.2
4.3	The education provider ensures that facilities, equipment and digital learning resources are sufficient in quality, quantity and accessibility to support the current and planned student enrolment and achievement of the program learning outcomes.	4.3
DOMAIN 5: QUALITY AND RISK MANAGEMENT		
DRAFT STANDARD		CURRENT STANDARD
5.1	The education provider implements quality improvement mechanisms that support ongoing program evaluation, enhancement and monitoring, including: a) evaluation of curriculum content to ensure alignment with contemporary and emerging immunisation practice, policy, evidence and health care priorities b) evaluation of student learning environments, learning experiences and student outcomes c) consideration of feedback from students, academic, clinical and professional support team members, program advisory stakeholders and relevant subject matter experts d) identification, implementation and review of actions arising from program evaluation to improve the program and student learning experience, and e) monitoring of the effectiveness of implemented changes to inform ongoing quality improvement.	5.1, 5.2
5.2	The education provider regularly evaluates the effectiveness and capability of staff involved in teaching, assessment and student support and provides opportunities for ongoing professional development.	5.3
5.3	The education provider identifies, manages and monitors risks associated with program delivery.	5.4

Draft Evidence Guide

The Evidence Guide has been developed with input from immunisation academics and clinicians and provides recommendations for applying the Standards and examples of evidence that may be submitted for accreditation. The examples should be considered in the context of the education provider, program design and delivery model. They are illustrative rather than prescriptive, and education providers may provide other forms of evidence which demonstrate that the intent and requirements of the relevant Standard have been achieved.

Once endorsed, the Standards will remain unchanged between formal review cycles. However, the Evidence Guide may be updated to reflect changes in the Australian immunisation landscape, including changes to policy, public health priorities, clinical practice, and emerging immunisation evidence. Updates to the Evidence Guide will not change the inherent requirements of the endorsed Standards.

Table 2: Draft Evidence Guide for the Standards for the Accreditation of Immunisation Education Programs

1: THE EDUCATION PROVIDER		
STANDARD		EVIDENCE
1.1	The education provider is currently registered with the Tertiary Education Quality and Standards Agency (TEQSA) as a higher education provider or the Australian Skills Quality Authority (ASQA) as a Registered Training Organisation (RTO) or delivers the program under a formal affiliation or partnership agreement with a registered education provider.	• Certificate of registration or hyperlink to the relevant national register • Documents demonstrating the formal agreement with a registered education provider, including evidence of defined responsibilities for program governance and quality assurance.
1.2	The education provider demonstrates how organisational governance arrangements translate into operational and academic oversight of the immunisation education program, including clearly defined responsibilities, reporting pathways and decision-making authority for the program.	Evidence should demonstrate that governance arrangements are functional and appropriate to the education provider's organisational context. Education providers may use different governance structures and titles; however, responsibilities, reporting pathways and decision-making authority should be clear and demonstrate effective academic and operational oversight of the program. Evidence should demonstrate how governance arrangements operate in practice, rather than simply describe the organisational structure. Examples of evidence may include: • Organisational governance structure identifying where responsibility for the program sits • Terms of reference or equivalent documentation demonstrating academic and operational oversight • Position descriptions or role statements defining responsibilities and decision-making authority

1: THE EDUCATION PROVIDER		
STANDARD		EVIDENCE
		- Documented reporting and escalation pathways between program leadership and relevant governance structures - Evidence of decisions or actions arising from program monitoring, evaluation, risks, stakeholder feedback or changes in immunisation practice.
1.3	Responsibility for program development, monitoring, review, evaluation and quality improvement is delegated to the relevant organisational unit or program lead, with clearly defined roles, responsibilities and decision-making authority for personnel involved in these activities.	Evidence should demonstrate that responsibility for the program lifecycle is formally assigned and understood by relevant personnel. Education providers may use different organisational structures, roles and processes; however, there should be clear accountability for program development, monitoring, review, evaluation and quality improvement, including appropriate authority to make or recommend decisions and implement improvements. Evidence should demonstrate how these responsibilities operate in practice. Examples of evidence may include: - Program delegations and governance or responsibility matrices - Position descriptions, role statements or delegations identifying responsibility and decision-making authority for program development, monitoring, review, evaluation and quality improvement - Terms of reference or equivalent documentation defining the roles and responsibilities of personnel involved in these activities - Curriculum development and/or review procedures.
1.4	For education programs solely targeted to Aboriginal and Torres Strait Islander health professionals, a majority of staff with substantive responsibility for the program governance, design, development and delivery identify as Aboriginal or Torres Strait Islander.	Evidence should demonstrate that Aboriginal and Torres Strait Islander staff hold substantive responsibility for the governance, design, development and delivery of the program. Education providers may use different staffing structures and role titles; however, the evidence should demonstrate that a majority of staff with substantive responsibility for the program identify as Aboriginal or Torres Strait Islander and have meaningful involvement in decision-making and program delivery. Examples of evidence may include: - An organisational or program structure identifying the roles, and position descriptions of Aboriginal and Torres Strait Islander staff involved in the program - Committee or working group membership records demonstrating Aboriginal and Torres Strait Islander representation in program governance - Evidence of Aboriginal and Torres Strait Islander staff involvement in curriculum design, program development and delivery.
1.5	A minimum of two Aboriginal and/or Torres Strait Islander representatives hold an ongoing position on a program advisory committee or equivalent governance	Evidence should demonstrate that Aboriginal and Torres Strait Islander representatives have an ongoing and meaningful role in program governance and contribute to program development, monitoring and review. Education providers may use different advisory or governance structures; however, at least two representatives should be formally appointed and supported to contribute to decision-making and ensure Aboriginal and Torres Strait Islander

1: THE EDUCATION PROVIDER		
STANDARD		EVIDENCE
	arrangement which informs program development, monitoring and review and ensures First Nations perspectives are appropriately reflected throughout the curriculum.	perspectives are appropriately reflected throughout the curriculum. Examples of evidence may include: • Committee or governance terms of reference identifying the roles and ongoing membership of Aboriginal and Torres Strait Islander representatives • Meeting agendas and minutes demonstrating meaningful participation in program development, monitoring and review • Evidence of Aboriginal and Torres Strait Islander input into curriculum design, content and review • Documentation demonstrating how advice or recommendations from representatives have informed program decisions or improvements .
1.6	The education provider has documented advisory arrangements with key immunisation stakeholders and subject matter experts, including those with expertise relating to priority populations, to inform program development, monitoring, review and revision.	Evidence should demonstrate that the education provider has established appropriate advisory relationships to inform the development, monitoring, review and revision of the program. The nature and composition of advisory arrangements may vary according to the provider and program. Advisory arrangements should include relevant immunisation stakeholders and subject matter experts, including expertise relating to priority populations and the scope of practice of eligible learners that may not be represented within the program's current staff expertise. This may include, for example, pharmacist representation where pharmacists are eligible to enrol, or paediatric immunisation expertise where this is not represented within the program's existing staff expertise. Examples of evidence may include: • Terms of reference, membership records or other documentation describing advisory arrangements • Records identifying immunisation stakeholders and subject matter experts engaged by the provider • Evidence of expertise relating to priority populations represented within advisory arrangements • Meeting agendas, minutes or consultation records demonstrating input into program development, monitoring, review or revision • Examples of program changes or improvements informed by stakeholder or subject matter expert advice.
1.7	The education provider retains ultimate responsibility and accountability for the delivery and assessment of the program, including decisions regarding successful completion of the program.	Evidence should demonstrate that the education provider retains clear and ultimate responsibility for program delivery and assessment, regardless of whether aspects of delivery or assessment are delegated or undertaken by external personnel or organisations. Decision-making authority for student progression and successful completion should remain clearly defined and accountable to the education provider. Examples of evidence may include: • Governance documents that clearly identify the education provider as responsible for the delivery, assessment and determining successful completion of the program • Where teaching, assessment or workplace learning is supported by external organisations or individuals, documented agreements that clearly define the roles and responsibilities of each party and confirm that

1: THE EDUCATION PROVIDER		
STANDARD		EVIDENCE
		responsibility for assessment and successful completion remains with the education provider - Assessment policies confirming that final assessment decisions are made by the education provider - Policies that define responsibility and delegations for decisions regarding successful completion.
1.8	Students, supervisors and staff are adequately indemnified for relevant activities undertaken as part of the program requirements.	Evidence should demonstrate that appropriate indemnity arrangements are in place for students, supervisors and staff undertaking activities required as part of the program. Coverage should be appropriate to the nature and setting of the activities and remain current for the duration of participation in the program. Examples of evidence may include: - Documented indemnity arrangements for students, supervisors and staff undertaking activities required as part of the program - Information provided to students, supervisors and staff regarding indemnity arrangements and responsibilities as required

2: THE PROGRAM		
STANDARD		EVIDENCE
2.1	The program is designed to accommodate the diverse professional backgrounds and pre-registration education of eligible health professionals and prepares graduates to practise safely within their authorised scope of practice and in accordance with applicable jurisdictional requirements.	Evidence should demonstrate that the curriculum is appropriate for the intended learner cohort and takes account of differences in professional background, prior education, knowledge, skills and scope of practice. Requirements for prior knowledge, skills, registration or professional scope should be clearly established and appropriate to the program. Where the curriculum assumes prior knowledge or clinical skills relevant to immunisation, assumptions are explicitly identified and supported through relevant eligibility criteria and professional standards. Examples of evidence may include: • Documentation demonstrating how admission requirements align with the intended learner cohort and any relevant jurisdictional regulatory requirements • Processes for monitoring and updating the program in response to changes in jurisdictional requirements or scope of practice • Curriculum mapping identifying and supporting assumed prior learning according to professional registration standards, scope of practice requirements or jurisdictional authorisation requirements, where applicable • Curriculum content that supports learners to understand their scope of practice and the jurisdictional requirements in which they practise.
2.2	The central focus of the program is immunisation, and the curriculum is directly aligned with the domains and learning outcomes of the National Immunisation Education Framework for Health Professionals. The curriculum is appropriately structured and sequenced to provide the breadth and depth of knowledge, clinical capabilities and professional behaviours required for safe and high-quality immunisation practice.	Evidence should demonstrate constructive alignment between the National Immunisation Education Framework for Health Professionals, the program learning outcomes and curriculum content. The curriculum structure is clear and coherent, with content appropriately mapped across the program and sequenced to support progressive learning. The curriculum should provide sufficient coverage of the knowledge, capabilities and professional behaviours needed for immunisation practice, with appropriate depth for the level and purpose of the program. Examples of evidence may include: • A complete curriculum mapping document demonstrating alignment between: - Program learning outcomes - Curriculum content/topics/modules aligned to the four domains and minimum learning outcomes described in the National Immunisation Education Framework for Health Professionals (2017) - Associated learning and teaching activities - Associated assessment tasks and assessment criteria • Module/topic outlines and demonstrating sequencing and scaffolding of content.
2.3	The curriculum develops learners' ability to	Evidence should demonstrate that learners are supported to critically engage with changes in immunisation

2: THE PROGRAM		
STANDARD		EVIDENCE
	adapt to contemporary and evolving immunisation practice by critically engaging with emerging evidence, policy, public health priorities and developments in digital technologies.	evidence, policy, public health priorities and digital technologies. Learning experiences should develop learners' ability to evaluate and apply contemporary information and adapt their practice in response to changes in the immunisation environment. Examples of evidence may include: - Processes for monitoring developments in evidence, policy and technology and incorporating relevant changes into the curriculum - Curriculum content, learning and assessment activities requiring learners to critically evaluate and apply contemporary evidence or guidance, for example: - Locating and evaluating updates to immunisation policy and public health priorities - Locating and evaluating emerging scientific evidence and vaccine technologies - Alternative administration techniques or the vaccination of at-risk groups in response to vaccine shortage - Examples of curriculum content, learning or assessment activities addressing the use, benefits, limitations or implications of digital technologies relevant to immunisation practice.
2.4	The curriculum advances learners' clinical decision-making and communication capabilities to respond safely and appropriately to individual circumstances and complex immunisation scenarios.	Evidence should demonstrate that the curriculum provides learners with opportunities to develop and apply clinical decision-making and communication capabilities in a range of immunisation contexts. Learning experiences should prepare learners to assess individual circumstances, respond to complexity and communicate effectively support safe, informed and person-centred care. Examples of evidence may include: - Simulation and case-based learning or other activities involving complex or individualised immunisation decisions requiring learners to apply clinical judgement, recognise limits of scope and escalation and referral practices - Simulation and case-based learning or other activities addressing communication including: - Communication of relevant information and informed consent - Responding to questions, concerns, and supporting vaccine confidence - Providing post-vaccination advice - Communicating with interpreters or support persons - Communicating with vaccine hesitant individuals and appropriately addressing misinformation - Inclusion of relevant learning resources to support the ongoing development of clinical decision-making and communication capabilities.
2.5	The curriculum provides scaffolded learning experiences throughout the program that develop learners' capability to provide	Evidence should demonstrate that equitable, culturally safe and person-centred immunisation practice is progressively developed throughout the program rather than addressed as isolated content. Learning experiences should support learners to understand and respond appropriately to the needs, circumstances and priorities of

2: THE PROGRAM		
STANDARD		EVIDENCE
	equitable, culturally safe and person-centred immunisation services for diverse individuals and communities, including Aboriginal and Torres Strait Islander peoples and communities, culturally and linguistically diverse peoples and communities, and other priority populations.	diverse individuals and communities with particular focus on: - Aboriginal and Torres Strait Islander peoples and communities - Culturally and linguistically diverse peoples and communities - Priority populations as defined in the National Immunisation Strategy Examples of evidence may include: • Curriculum and assessment mapping demonstrating the progressive integration and scaffolding of equity, cultural safety, person-centred care and responsiveness to diverse and priority populations • Learning activities, case studies, scenarios or simulations addressing diverse immunisation contexts, including Aboriginal and Torres Strait Islander peoples and communities, culturally and linguistically diverse peoples and communities, and other priority populations • Learning activities that support the development of culturally safe communication skills that establish trust and partnership with diverse individuals, families and communities • Relevant learning resources, including resources developed with or by Aboriginal and Torres Strait Islander peoples, communities or organisations and other priority populations where appropriate.
2.6	Programs delivered across multiple teaching sites, jurisdictions or delivery modes are designed and implemented to provide equivalent learning opportunities and assessment approaches, ensuring all learners have equitable opportunities to achieve the program learning outcomes.	For education programs that are delivered across multiple teaching sites, jurisdictions or delivery modes, evidence should demonstrate that all learners have equitable opportunities to achieve the program learning outcomes. Education providers may use different delivery approaches; however, the learning opportunities, assessment requirements and expected outcomes should be equivalent and consistently implemented. Examples of evidence may include: • Curriculum and assessment documentation demonstrating consistent program learning outcomes and assessment requirements across delivery sites or modes • Processes for ensuring consistency in teaching and assessment across sites, jurisdictions or delivery modes • Moderation or quality assurance processes for teaching and assessment • Orientation, guidance or resources provided to staff delivering the program across different contexts • Monitoring or evaluation data demonstrating equitable learner experiences and outcomes.
2.7	Learning and teaching strategies are constructively aligned with the program learning outcomes and assessment, and provide learners with opportunities to progressively develop, integrate and apply immunisation knowledge, clinical capabilities, professional behaviours and	Evidence should demonstrate constructive alignment between program learning outcomes, learning and teaching strategies and assessment. Learning experiences should provide progressively challenging opportunities for learners to develop, integrate and apply immunisation knowledge, clinical capabilities, professional behaviours and sound clinical judgement. Examples of evidence may include: • Curriculum mapping demonstrating alignment between program learning outcomes, learning and teaching

2: THE PROGRAM		
STANDARD		EVIDENCE
	sound clinical judgement.	activities, and assessment • Examples of scaffolded and experiential learning activities that progressively develop and integrate immunisation knowledge, clinical capabilities, clinical judgement and professional behaviours • Learning activities that require learners to apply, integrate and critically evaluate immunisation knowledge and make evidence-informed decisions including: - Case-based learning - Scenario-based clinical reasoning - Application of national immunisation resources - Use of real-world immunisation decision-making scenarios
2.8	Assessment provides valid formative and summative opportunities for learners to demonstrate achievement of the program learning outcomes across knowledge, clinical capabilities and professional behaviours required for safe and high-quality immunisation practice.	Evidence should demonstrate that assessment provides sufficient and appropriate formative and summative opportunities for learners to demonstrate achievement of the program learning outcomes. Assessment should evaluate the range of knowledge, clinical capabilities and professional behaviours required for safe and high-quality immunisation practice, including communication and clinical reasoning capabilities. Examples of evidence may include: • Assessment mapping that demonstrates alignment between assessments and program learning outcomes • Assessments addressing knowledge, clinical capabilities and professional behaviours, including communication and clinical reasoning • A range of assessment methods that are appropriate to the learning outcomes and reflect authentic immunisation practice such as, but not limited to: - Objective Structured Clinical Examination (OSCE) - Simulation-based assessments - Workplace-based assessment - Video-recorded performance assessments • Assessment criteria, marking guides or rubrics demonstrating how achievement of knowledge, clinical capabilities, professional behaviours, communication and clinical reasoning is evaluated. • Examples of feedback processes that support learners to develop and refine these capabilities. • Processes for reviewing the validity, reliability and effectiveness of assessment in measuring learner achievement.
2.9	Assessment is fair, valid, reliable and transparent, with processes in place to ensure its integrity and authenticity across all delivery modes.	Evidence should demonstrate that assessment is designed and implemented using fair, valid, reliable and transparent processes. Appropriate measures should be in place to support assessment integrity and provide confidence that submitted work represents the learner's own achievement, regardless of delivery mode.

2: THE PROGRAM		
STANDARD		EVIDENCE
		Examples of evidence may include: • Assessment policies and procedures addressing fairness, validity, reliability, transparency, integrity and authenticity • Documentation demonstrating that assessment and course completion decisions are made by appropriately qualified educators or assessors authorised by the education provider • Examples of assessment instructions, criteria and marking guides provided to learners • Moderation, calibration or other quality assurance processes for assessment and marking • Processes for identifying and managing academic integrity concerns, including the appropriate use of digital and emerging technologies • Assessment security and identity verification procedures • Measures designed to support assessment authenticity across online, face-to-face and other delivery modes.

3: THE LEARNER		
STANDARD		EVIDENCE
3.1	Prospective students are provided with clear, accurate and accessible information before enrolment to enable informed decisions about participation in the program, including the modes of delivery and any relevant jurisdictional or eligibility requirements.	Evidence should demonstrate that prospective students have access clear and accurate information before enrolment. Information should enable prospective learners to understand the requirements of the program and make informed decisions about their eligibility, participation and capacity to meet program requirements. Examples of evidence may include: - Publicly available program information, including program structure, duration, and modes of delivery. - Information outlining eligibility and relevant jurisdictional requirements. - Information about assessment, participation or other program requirements. - Processes for reviewing and maintaining the accuracy and currency of prospective student information. - Accessible formats or processes to support prospective students to obtain and understand program information.
3.2	Admission processes are transparent, equitable and based on published criteria that align with the requirements of the program, the intended learner cohort and relevant jurisdictional regulatory requirements.	Evidence should demonstrate that admission processes are transparent, equitable and consistently applied. Published admission criteria should align with the requirements of the program, the intended learner cohort and relevant jurisdictional or regulatory requirements. Examples of evidence may include: - Admission policies or procedures describing the application, assessment and enrolment process including procedures for managing admission appeals, complaints or requests for review - Documentation demonstrating how admission requirements align with the intended learner cohort and any relevant jurisdictional regulatory requirements - Examples of application or enrolment documentation used to verify applicant eligibility - Processes for reviewing admission requirements in response to changes in program or regulatory requirements - Documentation demonstrating how equity is considered within the admission process, such as alternative application pathways, processes for requesting reasonable adjustments during enrolment, or documented procedures that ensure admission decisions are applied consistently, fairly and without discrimination.
3.3	The education provider encourages Aboriginal and Torres Strait Islander peoples to apply and provides culturally safe and appropriate support to enable their participation, progression and successful completion of the program.	Evidence should demonstrate that the education provider actively supports the participation and progression of Aboriginal and Torres Strait Islander students. Support arrangements should be culturally safe, appropriate to student needs and informed by Aboriginal and Torres Strait Islander expertise. Examples of evidence may include: - Strategies or initiatives encouraging Aboriginal and Torres Strait Islander peoples to apply for the program - Policies, procedures or support services available to Aboriginal and Torres Strait Islander students - Evidence of relationships with Aboriginal and Torres Strait Islander support services, staff or organisations

3: THE LEARNER		
STANDARD		EVIDENCE
		- Processes for obtaining feedback from Aboriginal and Torres Strait Islander students about their learning and support needs - Examples of actions or improvements implemented in response to identified needs or feedback.
3.4	The education provider has processes to identify and support students experiencing academic difficulties and academic or professional conduct concerns.	Evidence should demonstrate that the education provider has timely and appropriate processes to identify, manage and support students experiencing academic difficulties or academic and professional conduct concerns. Processes should support early intervention while ensuring that concerns are appropriately documented, managed and escalated where required. Examples of evidence may include: - Policies or procedures addressing and academic progress, student support and academic or professional conduct concerns - Processes for identifying students requiring additional academic or other support - Documented intervention, support or remediation processes - Clear processes for managing, documenting and escalating academic or professional conduct concerns - Information provided to students about available support and relevant processes.
3.5	Students have equitable access to learning resources, assessment opportunities and academic support, including reasonable adjustments where appropriate, to enable participation, achievement of the program learning outcomes and successful program completion.	Evidence should demonstrate that students have equitable opportunities to participate in learning, assessment and academic support and to achieve the program learning outcomes. Reasonable adjustments and other support arrangements should be implemented where appropriate without compromising the requirements necessary for safe and competent immunisation practice. Examples of evidence may include: - Policies and procedures addressing accessibility, inclusion and reasonable adjustments - Processes for identifying, considering and implementing reasonable adjustments - Evidence that learning resources and assessment opportunities are accessible across delivery modes - Information provided to all students regarding academic support services or available resources - Processes for monitoring the effectiveness and equity of student access and support arrangements.

4: RESOURCES		
STANDARD		EVIDENCE
4.1	The education provider maintains sufficient teaching and administrative staff to support the delivery, assessment, governance, continuous improvement and student support requirements of the program.	Evidence should demonstrate that the education provider maintains sufficient and appropriately resourced staffing to support all aspects of program delivery including teaching, assessment, governance, continuous improvement and student support requirements for current and planned student enrolments. Examples of evidence may include: - Completed Staff Matrix which includes each staff member involved in the program, delivery including leadership, teaching, assessment, clinical, technical and administrative staff - Evidence that staffing levels are appropriate for the current and projected student cohort - Position descriptions or role statements outlining staff responsibilities for program delivery - Evidence of succession planning or contingency arrangements for key teaching roles (where applicable)
4.2	Staff involved in teaching, assessing and supporting the program have the relevant qualifications, contemporary clinical expertise, advanced immunisation knowledge and educational capability appropriate to their roles. The teaching team includes practicing immunisers who maintain the authorisation and continuing professional development requirements applicable in the jurisdiction(s) in which they practise.	Evidence should demonstrate that staff have qualifications, contemporary expertise and educational capability appropriate to their roles. The teaching team should collectively provide the breadth of immunisation expertise required for the program and include practising immunisers who maintain relevant authorisation and continuing professional development requirements. Examples of evidence may include: - Completed matrix demonstrating each staff* members: - Current role within the program - Professional registration (where applicable) with no conditions or undertakings on their registration relating to performance or conduct - Academic qualifications - Teaching qualifications and/or educational expertise - Evidence of ongoing professional development relevant to immunisation, education and contemporary clinical practice - Evidence that staff who are authorised immunisers maintain the continuing professional development or authorisation requirements applicable in the jurisdiction(s) in which they practise - Evidence that staff responsible for assessment possess appropriate expertise in the content they assess.
4.3	The education provider ensures that facilities, equipment and digital learning resources are sufficient in quality, quantity and accessibility to support the current and planned student enrolment and achievement of the program learning outcomes.	Evidence should demonstrate that the resources required to deliver the program are sufficient, accessible and appropriate for current and planned student enrolments. Resources should support effective learning, teaching and assessment and enable all learners to achieve the program learning outcomes. Examples of evidence may include: Current and planned maximum student enrolment numbers

4: RESOURCES		
STANDARD		EVIDENCE
		• Description of facilities, equipment and digital learning environments available to students • Evidence that online learning platforms, digital resources and technical support are sufficient for student learning • Evidence that resources are reviewed and adjusted in response to changes in student numbers or delivery mode.

4: QUALITY AND RISK MANAGEMENT		
STANDARD	EVIDENCE	
5.1	The education provider implements quality improvement mechanisms that support ongoing program evaluation, enhancement and monitoring, including: a) evaluation of curriculum content to ensure alignment with contemporary and emerging immunisation practice, policy, evidence and health care priorities b) evaluation of student learning environments, learning experiences and student outcomes c) consideration of feedback from students, academic, clinical and professional support team members, program advisory stakeholders and relevant subject matter experts d) identification, implementation and review of actions arising from program evaluation to improve the program and student learning experience, and e) monitoring of the effectiveness of implemented changes to inform ongoing quality improvement.	Evidence should demonstrate that the education provider uses systematic and ongoing quality improvement processes to evaluate, monitor and enhance the program. Evaluation should draw on relevant evidence, stakeholder and student feedback and student outcomes, and result in identified actions that are implemented, monitored and reviewed for effectiveness. Examples of evidence may include: • A documented quality improvement, program evaluation or review framework • Curriculum review processes demonstrating consideration of contemporary and emerging immunisation practice, policy, evidence and health care priorities • Student, staff, advisory stakeholder and subject matter expert feedback and evaluation data • Program evaluation reports, action plans or quality improvement registers demonstrating identified actions and responsibilities • Evidence demonstrating that implemented changes are monitored and evaluated to determine their effectiveness.
5.2	The education provider regularly evaluates the effectiveness and capability of staff involved in teaching, assessment and student support and provides opportunities for ongoing professional development.	Evidence should demonstrate that the education provider regularly evaluates staff capability and performance in relation to their program responsibilities. Evaluation should inform appropriate professional development and support staff to maintain and enhance their clinical, immunisation, educational and student support capabilities. Examples of evidence may include: • Procedures for evaluating the effectiveness and capability of staff involved in program delivery • Student feedback mechanisms used to evaluate teaching effectiveness, assessment practices and student support

5: QUALITY AND RISK MANAGEMENT		
STANDARD		EVIDENCE
		• Peer review, moderation, supervisor feedback processes used to evaluate staff performance and identify opportunities for improvement • Processes to address areas where staff capability or performance may require enhancement • Evidence of professional development opportunities provided to staff
5.3	The education provider identifies, manages and monitors risks associated with program delivery.	Evidence should demonstrate that the education provider has systematic processes to identify, assess, manage and monitor risks associated with program delivery. Risk management processes should support timely action, appropriate escalation and ongoing review of the effectiveness of implemented controls. Examples of evidence may include: • Organisational and program risk management policies and procedures • A program risk register or equivalent documentation identifying relevant risks and controls • Evidence of regular review and monitoring of identified risks • Records demonstrating the escalation and management of significant risks or incidents • Documentation demonstrating review of the effectiveness of risk controls and actions.

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Appendix

Standards Review Committee Terms of Reference

The Standards Review Committee (SRC) was established to provide expert advice and oversight throughout the review of the Immunisation Education Program Accreditation Standards.

The approved Terms of Reference are provided to support transparency regarding the Committee's purpose, composition, responsibilities and role in the review process. The Terms of Reference are an approved governance document and do not form part of the draft Standards subject to consultation.

Standards Review Committee

Terms of Reference

Standards for the Accreditation of
Immunisation Education Programs

Owner:	Health Education and Services Australia
Date of Issue:	June 2026

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Purpose

The HESA Standards for the Accreditation of Immunisation Education Programs – Standards Review Committee will provide expert advice and clinical insight to support the review of the Standards. The Committee will ensure the Standards remain evidence-informed and aligned with contemporary immunisation policy, practice, and education.

Working collaboratively, the Committee will review the existing Standards and make recommendations to ensure curriculum content, practice requirements, and assessment and evaluation methods continue to support high-quality immunisation education and safe, effective immunisation practice.

Structure and Composition

Membership

The committee may consist of members from the following categories:

- Relevant professional associations
- Clinical leaders and subject matter experts
- Education providers
- Workforce, policy, or regulatory bodies
- Relevant community representation

A member's participation may be ended based on one of the following:

- Resignation of a member
- Regular non-attendance at meetings
- Failure to comply with the code of conduct and confidentiality requirement

Confidentiality

Members are required to comply with the HESA confidentiality policy and code of conduct.

Co-opting

The committee may co-opt members from time to time for a specific period and purpose.

Chair

The HESA Program Director will be the appointed chair. Where the Chair is absent a committee member will be asked to Chair the meeting.

The role of the Chair is to preside over all meetings of the committee, ensuring meetings are run effectively, discussions are productive, and decisions are made efficiently.

Quorum

A quorum will consist of the majority.

Operation of the Committee

Meetings

- Monthly meetings will be held for the duration of the standards review process
- Meetings will be held virtually via Microsoft Teams
- Meeting dates will be scheduled in the first meeting
- One week from each meeting an agenda will be circulated, including supporting papers
- Meeting minutes will be shared for endorsement within one week of each meeting
- The endorsed meeting minutes will be included in the papers for subsequent HESA Board meetings.

Reporting

This committee reports to the HESA Executive Lead.

Conflict of Interest

Where a committee member determines that they have an actual or potential conflict of interest between their duties and responsibilities as a committee member and existing private interests they must declare it to the Chair as soon as they become aware of it.

Members of the Committee must not participate in discussions and must not vote on any issues in respect of which there is an actual or perceived conflict of interest. The Committee will determine the appropriate way to manage the conflict and record their decision in the minutes of the meeting.

The secretariat will maintain a register of all actual, potential or perceived conflicts of interest as notified.

Secretariat support

Secretariat support will be provided by HESA, and will include:

- Preparing and distributing agendas, papers, and minutes
- Recording actions and decisions
- Tracking action items and reporting progress to the committee
- Maintaining committee records.