

Rural Health Continuing Education Stream Two (RHCE2)

Application Guidelines Round 6: 2015

The Rural Health Continuing Education (RHCE) Program is funded by the Australian Government Department of Health to increase the availability of continuing professional development (CPD) to rural and remote health professionals.¹

These Guidelines outline the objectives of the Rural Health Continuing Education of Stream 2 (RHCE2) Program and the eligibility, selection criteria and priorities for project funding in Round 6 2015. RHCE2 is managed by the National Rural Health Alliance (NRHA) – information about NRHA’s role is available in RHCE2 Operational Guidelines 2015.

This Application Guidelines document should be read in conjunction with the online Round 6 Application Form at <http://rhce.ruralhealth.org.au>.

Overview

The **Aim of the Programme** is to develop and deliver training and support, which may include CPD, Multi-disciplinary Teams (MDT) and orientation programmes for eligible allied health providers, nurses, general practitioners and Aboriginal and Torres Strait Islander Health Workers in rural and remote areas of Australia.

The **primary Objective of the programme** is to provide allied health professionals, nurses, general practitioners and Aboriginal and Torres Strait Islander Health Workers in designated rural and remote areas of Australia with improved access to suitable continuing professional development, multidisciplinary training and orientation activities.

This **Objective** will be met by:

- a. supporting stakeholders to identify, develop and /or deliver relevant CPD, MDT and orientation programmes and activities;
- b. helping to build stakeholder capacity to deliver suitable programmes; and
- c. supporting eligible health professionals and groups of health professionals to access CPD, MDT and orientation programmes.

There is only one funding round in 2015: RHCE2 Round 6.

There are three grant categories:

- up to \$60,000 (or higher amount in exceptional circumstances) for organisations **developing and delivering** CPD for which there is demonstrated need in rural and remote areas;
- up to \$40,000 for organisations **delivering** CPD; and
- up to \$6,000 for individuals or multidisciplinary groups **accessing** CPD.

Round 6 projects must be completed and final reports submitted to the Alliance by 31st October 2015.

¹ RHCE - Stream 1, managed by the Committee of Presidents of Medical Colleges, provides CPD grants for rural medical specialists.

Eligible health professionals

Funding will be available for health professionals working in areas determined using the Australian Standard Geographical Classification- Remoteness Areas (ASGC-RA) system categories 2 to 5 as follows:

- i. RA1: Major city
- ii. RA2: Inner regional
- iii. RA3: Outer regional
- iv. RA4: Remote
- v. RA5: Very remote

All applicants working in ASGC-RA categories 2 to 5 who have current practice qualifications and registration, including compliance with any requirements of states and territories, will be eligible for funding. However, priority will be given to eligible applications for grants providing training and support for health professionals in more remote areas (that is RA3-5). Information on the remoteness classification of any town or community in Australia is accessible through the Department of Health "Map Locator" which is available online via <http://www.doctorconnect.gov.au/internet/otd/Publishing.nsf/Content/Locator> .

From 1 July 2010, applicants in health professions included in the National Registration and Accreditation Scheme (NRAS) will need to comply with the requirements set by the relevant National Board. Further details on the NRAS can be found at www.ahpra.gov.au. Applicants from more remote areas will be given priority.

Overseas trained doctors (OTDs) who have met the requirements of the approved pathway for practice in Australia are eligible.

Allied health professionals and Aboriginal and Torres Strait Islander Health Workers will be eligible for funding through Stream Two. As from 1 July 2012, anyone who wants to use any of the following titles:

- Aboriginal and Torres Strait Islander Health Practitioner; or
- Aboriginal Health Practitioner; or
- Torres Strait Islander Health practitioner; or
- who is required to by their employer

needs to be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia www.atsihealthpracticeboard.gov.au.

Other eligible allied health professions not included in the National Registration and Accreditation Scheme are included in the complete list of eligible allied health professions at **Attachment A**.

All training providers must be nationally accredited, nationally recognised or an accredited/professional private educational provider. Training providers may include but are not confined to universities, registered training organisations (RTOs) or professional bodies such as medical or nursing colleges and their equivalents.

Funding under this programme will not duplicate available programmes but supplement areas not currently serviced by state and territory or other Australian Government programmes.

Activities covered

Eligible professionals may apply for support of any activity deemed to be CPD. However, given the balance between grant funds available and demand under the program, and in pursuit of equity, certain priorities will apply.

Preference will be given to CPD for which standard provisions within a single profession do not already apply. For example, because GPs, nurses and midwives and pharmacists have more developed CPD systems in place than Aboriginal and Torres Strait Islander practitioners and some allied health professionals, preference will be given to those latter two groups. However it will always be possible for applicants - including GPs, nurses, midwives and pharmacists - to provide evidence about a CPD gap that exists in their profession or locality.

Priority will be given to:

- applications for CPD activity undertaken in, or for professionals working in, RA3-5.
- CPD undertaken in multidisciplinary teams, especially when it can be demonstrated that the individuals in those learning groups will gain skills and knowledge not available to them in their own single profession's CPD activities.
- CPD in which there is an emphasis on Inter-Professional Learning (IPL).
- projects that will work with Medicare Locals/Primary Health Networks to assist them to assume responsibility for CPD for their staff and other relevant parties.

Not Eligible:

- RHCE2 funding is **not** available to cover the administration costs for universities or for academic salaries.
- RHCE2 funding is **not** available to cover locum support ('backfill') for those undertaking CPD.
- General Practitioners and nurses eligible for separate funding arrangements for CPD will be excluded from funding for CPD under Stream Two funding, but eligible for funding for all other activities.
- Education and training activities that are deemed parts of the normal responsibility of an employer to their staff (particularly in respect to ensuring staff are safe and meet the requirements of their position) are not eligible for RHCE2 funding.

The funded programs will:

- provide CPD to health professionals working in rural and remote areas in Australia;
- be those for which there is evidence of need;
- be those able to demonstrate a positive effect on their participants;
- be properly evaluated in order to test for practice change, knowledge transfer and, where possible, long term community benefit;
- enable their participants to improve clinical care and/or health promotion work in the local rural or remote area;
- be delivered as far as practicable in the participants' local areas and working environments;

- facilitate innovative approaches to workforce training, education pathways and professional support eg coaching, mentoring, clinical supervision, simulated learning environments;
- wherever possible, incorporate follow-up elements to provide ongoing support for Primary Health Networks and sustainability of outcomes once the RHCE2 funding is finished;
- be likely to help support the recruitment and retention of health professionals to rural or remote areas; and
- potentially result in ongoing learning materials being produced and maintained.

CPD programs must be accredited or endorsed by the relevant professional body or bodies, be directly relevant to the current employment of intended program participants in a rural or remote area, be based on evidence of effectiveness and quality, and be delivered in Australia.

Eligible orientation programs may include cultural awareness and safety, and orientation to rural and remote environments.

Delivery of CPD and MDT projects

In recognition of the importance of professional networks in rural and remote areas activities should, wherever possible, incorporate follow-up elements ensuring that the training provider and the participants have opportunities for ongoing interaction to improve support for health professionals in the field.

Training should, wherever possible, be delivered in the participants' own working environments and local areas. There may, for example, be limited use in attending CPD in a metropolitan area and being trained in the use of equipment and systems that are not available in or relevant to the participants' usual place of work.

Funding is **not** available to support infrastructure costs such as purchasing clinical equipment or computer hardware, or software (without the permission of the Department).

Delivery of CPD

Projects funded for the delivery of CPD activities should reduce professional isolation through facilitation of learning opportunities that meet the needs of allied health providers, nurses, general practitioners and Aboriginal and Torres Strait Islander Health Workers living and working in rural and remote areas of Australia and improve the skill and competence of these health professionals.

CPD events must be approved by the Fund Manager, directly relevant to the applicant's current employment in a rural or remote area and is to be accomplished in Australia. Courses and /or training activities nominated must be accredited by the relevant professional body.

CPD events must:

- meet a specific learning need;
- have specific and explicit learning objectives;
- contain specific learning activities planned according to the educational objectives;
- have a clear process for monitoring the achievement of learning objectives; and
- clearly document the outcomes of learning and implications for practice.

Delivery of MDT

Projects funded for the delivery of MDT must include a focus on the delivery of additional skills to health professionals that are likely to result in improved team based care arrangements.

MDT projects must also include enduring materials and skills transfer components (such as train-the-trainer elements), be based on evidence of effectiveness, and/or be accredited by the relevant college/professional associations for the purposes of CPD.

Multi-disciplinary teams should be encouraged to identify their own learning needs and priorities. Relevant training can then be delivered at the team's usual premises or working environment, using their own equipment.

Topics may include but not necessarily be limited to:

- maternity/obstetrics;
- emergency medicine;
- aged care;
- chronic diseases, particularly cardiovascular care;
- cultural safety;
- orientation to rural and remote environments (particularly location specific);
- Indigenous health;
- mental health;
- preventative health;
- injury prevention; and
- practical as well as clinical training, such as in communications skills and team management.

Where possible, MDT activities will be looked upon favourably.

Grant priorities

Priority will be given to eligible applications from groups of individuals and organisations that are proposing projects that will be:

- providing training and support for health professionals in more remote areas (RA 3-5). Applications for projects in RA2 areas and national projects will also be considered;
- addressing gaps in existing arrangements and supporting initiatives that are demonstrated by evidence-based research as needing urgent intervention;
- working with Medicare Locals/Primary Health Networks to assist them to assume responsibility for CPD for their staff and other relevant parties in providing inter-professional learning or multi-disciplinary teams activities, especially projects jointly proposed by two or more professional organisations or groups of individuals;
- delivered as far as practicable in the participants' local areas and working environments in Australia;
- facilitating innovative approaches to workforce training, education pathways and professional support eg. coaching, mentoring, clinical supervision, simulated learning environments;
- wherever possible, incorporating follow-up elements to improve the ongoing support for Primary Health Networks and sustainability of outcomes once the RHCE2 funding is finished.

Multiple applications will be accepted but, given the strongly competitive nature of the grants, no single entity will be given more than one grant within Round 6.

Application process

All applications for RHCE2 Round 6 must be submitted on the online RHCE2 Round 6 Grant Application Form available at <http://rhce.ruralhealth.org.au/>.

Applications must be submitted by 5.00 pm Eastern Time on 3rd March 2015. Late applications cannot be accepted.

Multiple applications will be accepted but, given the strong competitive nature of the grants, no single entity/organisation will receive more than one grant.

All Round 6 projects must be finalised and final reports submitted to the NRHA by 31st October 2015.

Needs assessment requirements

Applications for Round 6 project grants must be based upon a needs assessment including evidence based research or outcomes/recommendations from previous RHCE2 projects.

A *needs assessment* must identify the intended target group(s), their localities, and the need for the proposed training and provide evidence of the target audience's intent to participate. Clinical or academic evidence alone is not sufficient for this application. Applicants may consider using previous information collected about the professional training needs of the intended audience.

Ethics application processes should be identified for projects that include research and evaluation activities, especially when involving Indigenous Australians, and considered in the timeline.

Evaluation requirements

Successful applicants receiving grants will be required to develop a comprehensive evaluation plan for the project to determine whether or not the objectives of the project have been met and to provide the evaluation results within an agreed timeframe for the project.

Draft evaluation plans will be required as part of the application. (See [Attachment B](#) for further guidance).

Information and data from the project evaluations and the stakeholder survey will be gathered and analysed for the final report to the Department in November-December 2015.

Budget guidelines

The online application form provides a template for budget breakdown and calculations.

Grant categories

Category 1: If successful with their application, accredited organisations:

- developing and delivering CPD for which there is a demonstrated need in rural and remote areas; and
- developing relationships and strategies with Primary Health Networks to assist them to assume responsibility for CPD and provide opportunities for formal knowledge translation/knowledge transfer from RHCE2 projects funded to date,

will be eligible for grants up to \$60,000.² .

² In special circumstance, and subject to prior discussion with the Project Manager, certain collaborative national programs with the desired characteristics may be eligible for amounts above this.

Category 2: Organisations whose project involves:

- the delivery of proven CPD; and
- the establishment of relationships and delivery strategies with Primary Health Networks to assist them to assume responsibility for CPD for health professionals employed in rural/remote areas from 1 July 2015,

will be eligible for grants up to \$40,000.

Category 3: Individuals or, preferably, multidisciplinary groups who want:

- to access effective CPD; and
- for health professionals employed in rural/remote areas to develop strategies and partnerships with Primary Health Networks to access relevant CPD,

will be eligible for grants of up to \$6,000.

Expenses not related to the direct costs of implementing the project (e.g. overheads), must be justified and broken down in the budget section of the online Application Form. Project administration costs should be no more than 10% of the project budget and the evaluation and audit up to 7% of the total budget.

Project grants will not support budget items relating to previously developed content, unless it is being refined/redesigned to improved useability and accessibility; to the costs of purchasing surgical, clinical or computer hardware or software.

The RHCE2 program encourages the inclusion of funds from additional sources. Such additional funding must be identified in the project application form. Any funds received from other sources will not affect the amount of RHCE 2 funding allocated to the project.

Assessment process and selection criteria

The Program Management team of the National Rural Health Alliance will establish an independent Assessment Panel to assess shortlist and rank project proposals.

Proposals will be assessed according to the following criteria:

- consistency with RHCE2 program aims and objectives, including relevance for rural and remote practice, cost-effectiveness and support for recruitment and retention of health professionals;
- consistency with eligibility and budget criteria;
- consistency with program Round 6 priorities;
- change management or knowledge transfer projects to showcase the lessons learnt from the RHCE2 program and to assist Primary Health Networks (PHNs) to take on the role of supporting Continuing Professional Development (CPD) in the future.
- demonstrated efficacy of proposed development activity and/or demonstrated capacity of training provider to deliver quality outcomes for similar, competing types of programs; and
- value for money.

The project selection process will be transparent. Members of the Assessment Panel will abstain from voting on any proposals in which they have a vested interest.

All Panel Members will complete a 'Conflict of Interest' *pro forma* prior to their assessment of applications for each funding round.

The decisions of the Assessment Panel will be final.

Where appropriate, the Assessment Panel has the right to ask the applicant to revise the proposal in accordance with its suggestions for improvement.

The Program Management Team and the Assessment Panel have the right to request project applicants to modify their budget as appropriate.

Contractual arrangements

Successful applicants will be required to enter into a funding agreement with the National Rural Health Alliance. The application submitted may form part of the funding agreement. Further details are in [Attachment C](#).

In the instance where two or more stakeholders have jointly applied for project funding, one stakeholder must nominate to be the Principal Participant and hence the fund holder and be named on the funding agreement.

Payment of funds

Grant categories 1 and 2:

Three payments will be made to successful applicants (groups or organisations):

- 60 per cent of budget will be paid within 14 days of the signing of the contract;
- 30 per cent of budget will be paid within 14 days of the receipt of an acceptable progress report; and
- 10 per cent of budget will be paid within 14 days of the receipt of an acceptable final report and audited financial report.

Grant category 3:

Two payments will be made to successful applicants (individuals, groups or organisations) in the grant category:

- 80 per cent of the grant will be paid within 14 days of signing of the contract;
- 20 per cent of the grant will be paid within 14 days of the receipt of the post-training assessment report and audited financial statement.

RHCE2 Program Manager

For additional information please contact:

Wendy Downs, Program Manager (RHCE2) on (02) 6162 3374 or Freecall 1800 987 440 or email RHCE@ruralhealth.org.au.

ELIGIBLE ALLIED HEALTH PROFESSIONS

- Aboriginal Health Practitioner/Worker
- Audiology
- Ambulance Officers/Paramedic
- Chiropractic
- Credentialed Diabetic Educators
- Dental & Oral Health
- Dietetics & nutrition
- Exercise Physiology
- Genetic Counselling
- Health Promotion Practitioners
- Medical Radiation Science (including Medical Imaging, Nuclear Medicine Technology, Radiation Therapy)
- Occupational Therapy
- Optometry
- Orthoptics
- Osteopathy
- Pharmacists – Hospital & Community
- Physiotherapy
- Podiatry
- Prosthetics and Orthotics
- Psychology
- Social Work (including Drug & Alcohol, Welfare & Community Development Workers)
- Sonography
- Speech pathology

Attachment B

Evaluation Principles

Evaluation is an integral component of each RHCE2 project. The draft evaluation plan (submitted as part of the application for funding) and the actual project evaluations conducted by successful applicants, will be assessed by the Project Management team at the National Rural Health Alliance against the evaluation principles outlined below.

Part One: Guiding principles

A number of guiding principles should be used to guide the evaluation process.

The evaluation process should encourage honest feedback

As far as possible, the evaluation should be designed to provide the opportunity for informants to provide frank and honest feedback without fear of consequences. Factors which will assist in this process include:

- clearly verbalised messages to focus on evaluation as part of continuous quality improvement;
- use of confidential surveys which do not require applicants to identify themselves (may require different approaches in smaller groups); and
- use of independent facilitators to conduct focus groups or interviews at the conclusion of the project.

Evaluation measures should be as objective as possible

While much of the information gathered for the evaluation will necessarily be qualitative and subjective, objective measures will contribute to a stronger evaluation process.

Elements which may assist in making the process more objective include:

- skills or knowledge questions which measure knowledge before and after the program;
- baseline and post-training data (for example, on billing of certain MBS items, capacity to provide a particular service, client satisfaction data, client health data); and
- use of survey and interview questions which encourage identification of change in practice as a result of training.

Information should be collected within timeframes that support accurate recall

As outlined below, different aspects of the data collection may occur either before, during or after the training. Still other aspects will be evaluated after the participants have had the opportunity to apply their knowledge skills and experience.

As the ability to recall events will decline over time, data should be collected as soon as it is reasonably possible to assess some aspect of the program. For example, an evaluation of the training event should be conducted at the end of the training session, whereas an evaluation of the implementation of the learning should occur within a time agreed with training participants as to when they would be able to apply new knowledge or skills.

Part Two: Principles of Educational Evaluation

The following principles, including those based on the Kirkpatrick model of educational evaluation³, should be reflected in the evaluation of the program

The Kirkpatrick Model

The Kirkpatrick model contains four key elements that should be considered throughout the evaluation. Different elements are examined at individual project stages to develop a comprehensive understanding of the ways in which the program was able to meet its objectives.

1. Reaction	•How did the participants react to the program?
2. Learning	•To what extent did participants improve their knowledge, skills and attitudes as a result of the training?
3. Behaviour	•To what extent did participants change their behaviour on their return to the workplace as a result of the training?
4. Results	•How did the program achieve its objectives in achieving a demonstrated benefit for the community and/or organisation?

The different elements require very different types of information and are not all of equal importance. In fact the importance and relevance increases from level 1 to 4.

Consequently, the key focus for the evaluation should be on Element 4 which focuses on results and outcomes of the project.

³ The most well-known and used model for measuring the effectiveness of training programs was developed by Donald Kirkpatrick in the late 1950s. It has since been adapted and modified by a number of writers; however, the basic structure has well stood the test of time.

Examples of Evaluation Questions for each element

Evaluation Element	Questions to investigate
Reaction	<ul style="list-style-type: none"> • Was the information presented in a manner that made learning easy? • What level of effort was required to participate in the training? • What level of participation was encouraged? • To what extent do you perceive that the training can be applied in your clinical work? • Do you feel it was a worthwhile investment of your time?
Learning	<ul style="list-style-type: none"> • What measurable change is there in the knowledge, skills and attitudes of the participant as a result of the training? • Did the participant learn what was intended to be taught? • What additional (if any) learning occurred that was not explicitly included in the learning objectives? • How has this training contributed to the overall professional development program for the individual/group? • What specific skills did participants develop and which components of this learning could be easily applied in the work environment?
Behaviour	<ul style="list-style-type: none"> • To what extent have the participants applied the new knowledge, skills or behaviour in their workplace? • What examples can be provided of things that the participant now does or says differently when compared with previous professional behaviour? • How have behaviour changes impacted on team-based care arrangements? • What evidence is there that the training has resulted in changed behaviours in relation to other professionals including those from other disciplines? • To what extent were the changes in behaviour maintained over time? • Were there opportunities for the participant to share the new knowledge, skills or attitudes with colleagues or community members? • Is there evidence that clients or patients noted changes in the approach of the participant?

Evaluation Element

Questions to investigate

Results

Retrospective analysis

- What evidence is there that the project goals have been achieved?)
- What evidence can be provided that the capacity of the organisation/individual to serve some of the priority health needs of their rural and remote communities has been increased?
- How has the program enabled the individual/organisation to improve their ability to deliver team based care arrangements? Are there stand-out examples of community needs that can be more appropriately met/addressed as a result of the program?
- What evidence is there for the sustainability of the program and that the resources developed for the program were/will be used over time?
- What opportunities have been identified to use this program or the materials to provide support for professionals in more remote areas?
- Is there evidence of plans or strategies to use the materials or learning from the program to support skills transfer to other professionals in the future?
- How has the program contributed to the retention of the health professionals who were able to participate?
- To what extent has the project provided a good return on investment and how can this be appropriately measured?
- What evidence is there that program elements have included ‘enduring materials’ that have been used in other settings or contexts? Alternatively, what evidence is there that this might occur in the near future?

Future applications

- What improvements or modifications to the program have been identified that would likely result in better achievement of the project goals?
- What changes or modifications would be required to extend the applicability of the program to other professional groups or to different communities?
- If the opportunity for program extension arose in the future, how might you apply the training to improve outcomes or increase cost-effectiveness?

Attachment C

Contractual Requirements

In the instance where two or more organisations have jointly applied for project funding, one must nominate to be the Principal Participant and hence the fund holder and be named in the Funding Agreement.

Intellectual Property in all Contract Material - Clause 14 of the Funding Agreement: Any Intellectual Property rights and title to, or in relation to, the Project Material will vest, upon creation, in the Participant/Principle.

The Participant/Principle grants to the Commonwealth (Head Principal) a perpetual, irrevocable, royalty-free and licence fee-free, world-wide, non-exclusive licence (including a right of sub-licence) to use, reproduce, modify, adapt, publish, perform, broadcast, communicate, commercialise and exploit the Intellectual Property in the Project Material.

This clause does not affect the ownership of any Intellectual Property in any Existing Material. However, the Participant grants, or undertakes to arrange for a third party to grant to the Commonwealth, a perpetual, irrevocable, royalty-free and licence fee-free, world-wide, non-exclusive licence (including a right of sub-licence) to use, reproduce, modify, adapt, publish, perform, broadcast, communicate, commercialise and exploit the Intellectual Property in the Existing Material but only in conjunction with the other Project Material.

The Participant warrants that anything done by the Participant in the course of the Project, including in developing the Reports, will not infringe the Intellectual Property rights of any person.

Insurance: The contract states that the Participant shall, for so long as any obligations remain in connection with this Contract, effect and maintain insurance (noting the interests of the Principal) as follows: public liability insurance in the sum of \$10 million; professional indemnity insurance in the sum of \$10 million; and Workers' Compensation for an amount determined by the relevant State legislation.

Acknowledgement: Any correspondence, public announcement, advertising material, research reports or other material produced by or on behalf of the Participant shall:

- acknowledge the support of the Rural Health Continuing Education Stream Two program, an initiative of the Department of Health; and
- note that the Participant is solely responsible for the content of, and views expressed in, any report and/or related materials produced.

Conflict of Interest: Any conflict of interest relating to an external subcontracted agency, speaker, project participant or other individual or organisation involved in the Project, must be declared in the Project Application process.

Reporting Requirements: During the contract period, the Participant shall submit Project Progress Reports and a Final Project Report as specified in the Funding Agreement, which includes an independent financial audit.

Payment of Funds:

Grant categories 1 and 2:

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Grant category 3:

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Subcontracting Projects: The RHCE2 project grants aim to support accredited/registered training providers to deliver continuing professional development. Any training provider that subcontracts work to other organisations needs to consider issues including intellectual property and must demonstrate how the accredited/registered training provider is involved in the Project's content development and implementation.

As the intellectual property remains with the Participant/Head Principal, (see **Intellectual Property in all Contract Material - Clause 14 of the Funding Agreement**), training providers subcontracting external agencies need to ensure this is stated in any agreement.

The following are examples of the terminology that could be used in subcontracts to cover the issues of Intellectual Property. However, legal advice should be sought prior to subcontracting.

- Ownership of and Intellectual Property in all Contract Material shall vest in the Principal upon creation.
- The Contractor grants to the Principal and the Head Principal a perpetual, irrevocable, royalty-free and licence-free, worldwide, non-exclusive licence (including a right of sub-licence) to use, copy, modify and exploit the Contract Material.
- At the end of the Contract Period or on the earlier termination of this Agreement, the Contractor must deliver a complete copy of the Contract Material to the Principal.
- The Contractor warrants that anything done by the Contractor in the course of the Contract Services will not infringe the Intellectual Property rights of any person.
- Organisations involved in subcontracting will be asked to provide information regarding content development and use of content outside the RHCE2 project.