**APPG on Rural Health and Social Care**

**15 December 2020**

**Parliamentary Inquiry Session 11**

**Emergency Services**

**Present:**

**Anne Marie Morris MP** - Chair

**Witnesses**

**Helen Ray –** Chief Executive, North east Ambulance Service

**Lee Howell** – Chief Fire Officer, Devon and Somerset

**Dr Ed Smith** - Chair: service design and configuration committee, Royal College of Emergency Medicine

**Nikki Cooke** – Chief Executive, LIVES

**Invited Observers**

**Secretariat Team**

**Ivan Annibal -** Director of Operations, National Centre for Rural Health and Care **Dr Jessica Sellick –** Senior Research Fellow, National Centre for Rural Health and Care

**Jonny Haseldine –** Parliamentary Assistant, Office of Anne Marie Morris MP

**Apologies**

**The Right Reverend and Right Honourable Dame Sarah Mullally DBE –** Bishop of London  
**Professor Richard Parish CBE –** Chair National Centre for Rural Health and Care

**Anne Marie Morris** – welcomed delegates and explained that this session would look at emergency services. It is the eleventh in a series of sessions building up to an overall report in early 2021. She introduced the speakers and key themes. Emergency response is always more of a challenge in terms of simple response times in rural settings. She posed a number of scene setting questions: Is enhancing rural services about re-organising how we run emergency services in rural settings? e.g. using GPs and first responders differently. Or do we need to do something more radical – rather than refining what we’ve got to think about a completely different care pathway for rural (this could include a different level of risk weighing in the balance the options around providing some help soon or no help too late).

She went on to introduce the broad spectrum of emergency services police, fire, first responders and a whole range of organisations – making the points that it is the service provided and the rural context is important, not just the organization providing the service. She identified that she was looking forward to a response to a number of key questions including: How can we get the best outcome for the patient? Is there best practice out there that merits further recognition and development? Are there different models we can use? She then went on to introduce Helen Ray, Chief Executive of North East Ambulance Service, who she invited to give her evidence.

Helen Ray – responded to each of the key questions set as a background for witnesses as follows:

In terms of target setting and resource allocation she explained:

Standards are set across the Trust and monitored at the local level. In terms of resources she explained:

* Ambulance Trusts are funded from CCGs.
* CCGs receive an allocation based predominantly on population size. This is adjusted for factors such as health inequalities and demography.
* Within the funding formula there are variables associated with rurality - specifically the ‘remote hospitals adjustment’ (to capture increased costs of running small hospitals) and, most notably for ambulance services, the Emergency Ambulance Cost Adjustment (EACA), which is intended to reflect increased costs of running services in rural areas.
* How CCGs pass this on to Ambulance Trusts is less clear. Unlike the acute sector, the ambulance sector does not have a well-established uniform payment system. Suggested prices are published by NHSE, but these are not mandatory and each ambulance service will have a more ‘bespoke’ approach to funding locally. Some will operate using the suggested tariffs, but others will work on block budgets.
* Ambulance Trusts also span multiple CCGs usually, adding a layer of complexity to local negotiations.

The level of funding for ambulance services is therefore a product of:

* The local system financial position (how well off the ICS is)
* The relative strength and size of other organisations within the system to redirect resources towards themselves
* The ability of the local ambulance provider to ‘make it’s voice heard’ (how noisy is it, how well evidenced it prepares for negotiations, how able it is to influence and place and ICS simultaneously)
* The co-ordination and co-operation of CCGs locally to create a commissioning structure that can operate at ICS level (across multiple CCGs)
* The emphasis the regulator places on ARP when challenging CCGs to comply with performance standards (ARP can be seen as a ‘second class target’)

Ms Ray went on to explain in the context of the North East:

Locally North East Ambulance Service (NEAS) has a block contract, with a conveyance penalty/incentive targeted at reducing conveyance to Emergency Destination. The divert penalty is also in place to support the ambulance handover issues. Both of these have been suspended and will probably be areas of negotiation in the upcoming contract round of financial settlement. The funding basis for the NEAS contract is the ORH review process (ORH is the name of a private business contracted to support and evaluate the operation of emergency services) which set challenging efficiencies for the organization, some of which were unrealistic and would be ‘best in class’ this was not sensible when applied to the lowest funded, lowest cost ambulance service in England. Also, this is not consistent with acute providers who operate on an average cost basis via the national tariff. The current contract also applies national tariff efficiency as well as applying efficiency to fund the investment in the service (i.e. the additional funding provided comes from efficiencies which the service is expected to make Simply put, the tariff efficiency pays for the CCG QIPP, the service efficiencies pay for the service investment required.

Ms Ray went on to address the question: Is it possible to meet NHS waiting time targets in all remote and rural areas? She explained that responding in rural areas is much more difficult due to the spread of the population and the road networks. The model of delivery in rural areas has to be different and is coordinated with the other healthcare professionals in the area. NEAS Community Paramedics have good relations with primary care and can access support for patients and hopefully manage them more in the community avoiding long distance travelling to hospitals. She explained that anything is possible with enough funding, but this would require a significant funding increase and would present value for money challenges in a financially constrained system.

Ms Ray then turned to the question: are success rates insufficiently granular to identify areas which cannot be reached in national statistics? She explained that traditionally CCG’s have been reluctant to release granular performance data for rural areas, even though this is available. The performance Gap between Urban and Rural is quite stark.

Responding to the question what solutions have been developed in rural areas to ensure patients receive timely, high quality and safe services? Ms Ray explained that one local example involved in partnership with Northumberland CCG and local General Practices in Berwick upon Tweed committing a resource (Paramedic in Rapid Response Vehicle) that supports the GP’s by providing Home Visiting. However, when a High Acuity incident occurs Category 1 (cardiac arrest) the resource can be quickly deployed whilst a Double Crewed Ambulance is allocated. This has only come about as additional resource has been found by the CCG. The initial pilot was 50% funded by NEAS, with the additional resource being found by the CCG. The pilot was so successful that in the second year the CCG committed 100% of the funding. This has considerably shortened arrival time of first resource to cardiac arrests and other emergencies. NEAS would like to continue to work with the CCG and Practices to make maximum capacity of the resources looking at other lower acuity urgent incidents (Categories 3 and 4) and some Category 2 emergency incidents that the resource could manage or support and provide on scene assessment. However, there is considerable uncertainty as to how this will work once the Primary Care Networks (PCNs) take over the funding and it is not clear if the additional funding into PCNs will allow this flexible working to continue. Similar co-operative work is also underway with the Teams around Patients (TAPS) service in the Durham Dales with Paramedics working with General Practice and Community Nursing teams. The deployment plans are different than in Berwick but similar success have been identified.

Ms Ray next addressed the question; how do ambulance/blue light services respond to calls in rural areas link to urgent and emergency care facilities? She explained that to meet Ambulance response targets (Categories 1 to 4), within existing resource allocations is a real struggle to and explained that NEAS should be able to commit more resources into rural areas. Inevitably resources are pulled towards areas with high density populations to meet performance demands and targets. When an emergency occurs in a rural area, this can result in delays in the nearest resource arriving on the scene and the response times in rural areas are considerably longer than in urban areas. This is compounded in winter months when road conditions deteriorate significantly. To counterbalance this from a safety perspective NEAS do have a single point of contact at hospitals to discuss the needs and care for patients, they are trialing initiatives to improve care.

In response to the question what coordinated action needs to be taken across different services, and at local, regional and national levels (e.g. commissioning, funding)? Ms Ray explained that funding for ambulance services needs to be overhauled – it is a unique service and should be recognised as such. It is her view that currently we are not maximising the community offer that could be provided and the ambulance sector is seen as a transport service when it actually should be seen as a core community service with the ability to transport those who need a different level of care. Funding should allow the meeting of national targets but currently that is not the case. Financial allocations linked to rurality should be wholly transparent and should be fully allocated to the service. Shew went on to explain that NEAS have a number of first responders in rural areas but are all community based and the region also have co-responders in the Fire Service. In her view a blended approach will always work better as the team members bring different skills to delivery of a holistic care package for the person who needs it.

Ms Ray addressed the question: is success in a rural area different to that in an urban area? In her view success is about only transporting patients to hospital who need the care of a hospital and managing patients in the community with the collective skills of the health care professionals wherever possible and in line with the wishes of the individual, their families and carers.

In Ms Ray’s view it was unrealistic that patients should expect the same level of urgent care in rural areas she believes we should aspire to the same level of service, but service pressures across the whole community and the realities of the economics of service provision mean that delivery (and funding) of equitable performance is unrealistic. She did have the view that the same qualitative care but delivered differently could be provided, recognising that it is unaffordable and not value for money to replicate the same service in a rural area compared to that of an urban area.

In relation to the final question: How might this be explained/accepted by the public? Ms Ray went on to explain rural populations are, in her experience, well versed in assessment of the realities of their location. They have a right to the same high standards of care that urban populations enjoy. It is important to be

open and transparent in terms of the debate about what can be achieved in relation to the “art of the possible” – there are some good examples of that.

**Anne Marie Morris** – thanked Helen Ray for her comments and invited Lee Howell – Chief Fire Officer Devon and Somerset to provide his evidence.

**Lee Howell –** Chief Fire Officer Devon and Somerset explained that there is a changing context for his service. Demand for tradition fire services has reduced by 19% in last 10 years. The portfolio of the service now comprises 28% incidents fire and 42% false alarms and 32% non-fire incidents. There is capacity and willingness to help address the wider emergency service within fire and rescue. There are however some barriers that need to be worked through. There are different crew models in urban and rural areas – urban areas have fire-fighters that work on shifts and undertake training, building audits and risk visits etc.

In terms of incident response times, until 2004 there were national standards, these were: 5 minutes response in urban and 20 minutes in rural settings. This provides the historical context for the location of fire stations and the funding formula still largely reflects this.

In last 15 years there has been a drive to more locally determined models – there are now no national standards for fire service and standards are now set locally. Response standards are a local issue set up local fire authority. There is so much variability that HM Inspectorate has started to ask why services are setting these standards and questioning should they be different in urban and rural areas?

In terms of good practice, a number of fire and rescue services provide a co-responding service. Devon and Somerset fire service has 83 fire stations and can be mobilised by the ambulance service directly not through the fire call centre – they can pick up defibrillation and trauma equipment and work to the ambulance trust and then return to the station once a call is completed.

The service meets the cost of co-responding via a grant from the ambulance trust. The cost of fire fighters undertaking this approach versus non paid for community responder services can be a tension in some areas and this needs to be managed carefully. Rural fire stations have fire-fighters living in communities and this provides a good opportunity to think more insightfully about the opportunities to develop fast emergency responses in rural settings.

Local fire-fighters live in communities and know them, they have a good level of training to deal with medical problems, technical expertise with physical support to move patients safely and understand how to optimise the provision of immediate emergency care in rural locations.

**Anne Marie Morris** – Drew attention to the disparity of targets between ambulance and fire targets for emergency response times based on different ways of setting targets. She identified that we don’t have a consistent basis on which to plan taking account of rural nuances and asked how addressing this balancing the relative merits of local and national target setting might best work?

**Lee Howell -** identified that this is essential – he identified the benefits of the fire service supporting the ambulance service to meet its response targets without too many constraints. Mr Howell drew attention to a national pilot which has stalled around payment issues. He explained that this is not the model deployed in Devon and Somerset where the collaboration is a voluntary arrangement. His view is that co-responding is not new and is not taken up in all areas but may help to level up rural responses to health care needs where it is implemented effectively.

He explained that there were a number of potential refinements required namely- the need to support people from a mental health perspective where they are patients in crisis post Covid that will grow exponentially, and the need to change the time measurement arrangements so that if a community first responder goes to an incident this is recognized as a formal part of the response time.

**Anne Marie Morris –** reflected on the evidence and considered that a review of the Ambulance Response Programme to take account of co-responding and the differential roles of co-responders from the statutory and voluntary services would be highly desirable.

**Anne Marie Morris** – thanked Lee Howell for his comprehensive comments and asked Dr Ed Smith - Chair: service design and configuration committee, Royal College of Emergency Medicine to present his evidence.

**Dr Ed Smith** **Chair: service design and configuration committee, Royal College of Emergency Medicine** - Dr Smith is an Emergency medicine consultant working in Scarborough in North Yorkshire and he lives in the North York Moors national park. He is also involved as a representative of the national body that represents emergency departments nationwide. He described his role as hospital medicine. Dr Smith drew attention to the geographical separation of patients and hospitals in rural areas. He went on to explain that the challenges of being remote from other hospital environments means those delivering these services in rural areas are held to account for the same standards as everywhere else, which are often based on urban mentalities.

Dr Smith identified from this point of view that the challenge from a clinical perspective is about selling the different ways of doing things without this being seen as “dumbing down” the service. There is a danger that in setting alternative targets and standards for rural places it looks to the outside observer that you are unable to manage the national standards and that causes anxiety amongst clinicians.

In some cases due to the distances involved you may need to do things slightly slower the key thing however is to measure outcomes not process (with the aim of having the same or better outcomes for rural patients, sometimes delivered differently).

The service delivered is regulated by the Care Quality Commission – which sets standards for remote hospitals based on their location in urban environments (e.g. Weston-Super-Mare, Scarborough) but without recognizing that they are surrounded by a rural population with health needs. This can create a vicious circle where hospitals with rural hinterlands are consistently below the standards set and can’t recruit because they are marked down which has an impact on their status (reputational, morale, recruitment).

In response to this challenge the Royal College is developing a set of measures which will help make the case that this is not dumbing down but recognizing the different nature of the challenge.

In terms of primary care Dr Smith went on to explain that the level of service provision does not have the depth of response linked to critical mass that is available in urban settings. This leads to ambulance service first responders making decisions as to whether to leave the patient at home or transport to hospital with often modest support . This should be replaced by a model of care where the local hospital is involved in that conversation as that is often where the patient ends up. Dr Smith explained that this is one good example of how we have to be insightful about how we link up our pockets of expertise in rural areas.

Dr Smith moved on to offer his view about how we should define “rural”. He explained that within the Royal College there have debates for decades about the terms rural and remote. From his point of view there are so many different contexts it is difficult to draw a boundary.

Dr Smith went on to explain that he would support the rural generalist as a concept acknowledging the challenges of training and supporting such individuals in remote settings. From his point of view the challenge is about understanding how we select, support and incentivise rural independent thinking skills to manage rural patients. This process should involve links with hospitals to support decision making around when people enter acute care. It involves working across the patient care pathway and bringing people together in a decision making dialogue.

**Anne Marie Morris -**  went on to explain that from her perspective we need to rethink the centralised model to think about what’s appropriate in rural areas. She asked is there an argument for not closing community hospitals and the concept of different types of hospital – district generals, community hospitals? Should we recreate different classifications of hospitals – providing out of hours support and what services should we be looking at them providing?

**Dr Smith** explained that from his point of view we have moved beyond community hospitals and it is difficult to bring this model of care back because of staffing in rural areas and training and generalisation and in some senses clinicians don’t have the skills anymore. Nurse practitioners supported by GPs in community hospitals have been withdrawn and in many cases the approach is now based on signposting and is highly risk averse – this reflects the changing context and governance in which people are working. Another factor militating against small district hospitals is the recognition that social care should happen close to where the patient lives and long convalescence isn’t needed anymore.

Notwithstanding these comments Dr Smith is an advocate for community health care hubs –he feels it is desirable for ambulance and fire and police to be able to have a common base, there are strong arguments that the estate could be functioning in new way, however in terms of difficult choices that might be required to make this work he acknowledged that communities are often very wedded to their hospital and closure is a political challenge.

**Anne Marie Morris** - went on to explore the concept of the GP with a can-do and trained approach to risk and has fundamentally changed in 30+ years, she asked should GPs be trained to deal with emergency response?

**Dr Smith –** Responded by saying that a conversation was needed across all the Royal Colleges to look at skills sets not job titles – he thought it was important to consider how do we define the skills sets required for community response in rural areas? His view is that enhanced dialogue and communication across specialisms maximizing the opportunities linked to new technology was at the heart of this agenda. His view is that change needs to be better managed to ensure rural considerations inform the natural opportunities new approaches bring to service delivery. He gave the example of the difference between travel times which affect emergency responses but are not adequately reflected in the process for judging the effectiveness of emergency services. He explained that distance from services and different attitudes to illness mean that often rural patients present late and have more acute support needs. There is an increasing trend of people being admitted to acute care through a primary care visit. This means that GPs and their staff often need emergency response skills they are not trained or equipped to exercise. He drew attention to models such as direct links between remote and emergency settings in Australia which enable a blending of acute and primary care in first response situations which could be translated to the UK.

**Anne Marie Morris –** Asked if we need a new breed of rural doctors that have generalist skills but also skills in emergency medicine? She identified the potential value of a new pathway – that manages the transition from primary care to acute settings supported at appropriate stages along the way. She also reflected that the CQC might have to regulate in a different way if this was to work successfully.

**Dr Smith –** Explained that there is a tension between providing the perfect care arrangements for everyone versus having care locally which may or may not hit all the expectations people have for it. His view is that we need to look at outcomes as the key driver of change.

**Anne Marie Morris -** Asked Dr Smith about the knock on effect of social care not working properly.

**Dr Smith** - explained that on occasions the quantity of social care need in rural communities is not deliverable in people’s homes and then you have the mental health and isolation issues which are also important in this context to accommodate. Right now community hospitals could not be properly staffed to provide an out-reach service so this definitely puts pressure on acute settings.

**Anne Marie Morris** – thanked Dr Smith for his contributions and asked Nikki Cooke – Chief Executive of LIVES (first responder service based in Lincolnshire) to present her evidence.

**Nikki Cooke –** Explained that LIVES is an emergency response charity which has been running for 50 years. Its purpose is to deliver a timely and skilled response to medical emergencies.

LIVES has 600 volunteers it is the largest voluntary sector first responder scheme in country. The organization has a tradition of working in partnership with the fire service to deliver a co-responding service lining with the ambulance service.

LIVES operates under its own clinical governance. The organization also provides community education to teach a full spectrum of disciplines from first aid to life-saving procedures at the roadside.

The organization motto is: “It takes a team to save a life.”

Last year LIVES responded to15,000 calls – 40 responses a day. In terms of a “high end job” which requires more than one responder and 83% of first responders arrive before the ambulance. LIVES has the capacity to complement ambulance crew expertise with specialist clinical skills.

It is useful to split LIVES perspectives on the issues into two core themes:

1) The Community response model. The Charity achieved first responder recognition for its work in 1989 as response to cardiac arrest and the role has evolved since then supported by its own governance and CQC registration. LIVES responders work at different levels. A significant number of LIVES volunteers go onto careers in the health service. GPs are represented amongst our responders. Nurses, paramedics and hospital doctors also volunteer. Volunteers undertake additional training in their own time and at their own expense and they do it because they care.

There are 26 first responder schemes across the country not all ambulance services support them. Lives is biggest in country – it has 57 clinicians and 17 work at critical care levels.

The biggest issues facing LIVES and the sector more widely are: sustainability, funding, scalability and profile.

There is a constant treadmill linked to the organisations which have to fundraise for equipment, training and do it alongside their day job. Responders have equipment work £30,000 in the boot of their car. A new innovation (the equivalent of a mobile GP practice) - Doctor cars; carry £100,000 worth of equipment.

None of the first responder schemes have benefitted from statutory funders and do not meet lottery grant criteria. In terms of a snapshot in relation to impact on care in 2020 the critical team with 17 members has out 980 responses so far on 130 occasions they have used surgical or anaesthesia skills. LIVES response costs £200 per incident versus cost of air ambulance – it can be likened to a land based version of the air ambulance. It has no desire to compete or challenge the value of the air ambulance. It provides a complementary service.

Notwithstanding this comparison First Responder schemes fly under the radar and have immense potential a small investment in them could yield huge benefits.

2) Emerging models of care – doctor cars and “community emergency medicine”: There is currently an emergency response vortex where patients get taken to hospital and sucked into the system new responses being piloted by LIVES provide scope to overcome this. Doctor Cars comprise a multidisciplinary team involving 2 people in 3 crews responding to category 2 and 3 calls – this approach was piloted in 2019 and has been fully operational since April 2020.

NHS commissioners were quite visionary in supporting this innovation and could see the value of using skills differently, 56% of patients avoid hospital and other health interventions, 15% avoid emergency department but access other health services elsewhere. This approach works as it delivers services differently based on the fact that the team has been set up to bridge the gap between primary care and hospital care and are used to making decisions in the communities they work in. The service is very well regarded in the emergency response community. 71% of people in service have travelled from outside of Lincolnshire to join the team; the teams carry diagnostic equipment beyond that found on ambulances.

The real achievements around this approach are based on ensuring patients can get on to the right care pathway – it has led to some new community pathways to meet gaps; including an extension in the treatment options that are available in terms of the availability of drugs through changes to prescribing protocols, wider primary care record access, a new focus on skills around wound closure, end of life care planning for patients; and a broader community focused ethos concentrating on how to keep people in community not just to keep them out of A&E.

Ms Cooke also drew attention to the falls team which has been established and sits alongside this work. At the heart of the impact of the first responder model is the opportunity to ameliorate the long term impact of long waits for an ambulance which can significantly affect people’s health outcomes.

At the heart of the achievement of LIVES is its ability to tap into the resourcefulness and community spirit in rural communities. She reflected that at the heart of the logic behind the service was the premise that just because you live rurally does not mean you should have less good health outcomes than if you lived next door to a hospital.

**Anne Marie Morris –** asked a number of follow up questions: How do you attract volunteers? Where do they find the time?

Ms Cooke resonded - we’ve created a culture of innovation, support, developing skills and confidence in our people, which means they are valued by our clinicians. Our way of working and model won’t attract everyone but we support career development. We offer a portfolio career – flexible, part time and person centred. There is a really strong relationship between our volunteers and the local health system where many of them work.

**Anne Marie Morris** asked - Where does the funding come from to provide this infrastructure?

Ms Cooke responded – the Doctor Car is NHS funded – fundraising and grants fill the balance – the organization has a dedicated fundraising team and runs promotions linked to projects such as its cook-book. She identified that there are some limits to how much fund-raising on its own could address some key themes such as raising funds for activities such as clinician training/CPD.

**Anne Marie Morris** asked - How did you develop your clinical governance model?

Ms Cooke explained that LIVES has been CQC registered since 2013. In 2020 the registration has expanded into diagnostic treatment registration with CQC. LIVES

employ a medical director and clinical governance manager – they abide by the same requirements that ambulance or hospital trust would. It gives the organisation flexibility and scope to deliver to the needs of communities and patients. The registration also provides assurance to ambulance trust. The ability to build these accreditations and relationships is based on 50 years of building relationships and working together on the frontline – it would be difficult to start from scratch today on this journey because of how governance is understood.

**Anne Marie Morris** reflected in terms of the drive to find a new model of care, and the establishment of a new rural pathway that the approach taken by LIVES has made some considerable progress. She asked how do you think we take where we are and suggestions today so we get something that is joined up? How do we mainstream good practice and scale it up?

Ms Cooke indicated that getting the right mindset in place with commissioners was important. She expressed a view that everybody has a part to play – encompassing ambulance, fire, police, co-responding, pathways in and out of hospital and wider refinements to the approach to primary care. She said it was really important not to discount the volunteer. We need to positively challenge the way standards work for example in terms of LIVES clinicians arriving on the scene being formally acknowledged as part of the response in relation to response times– targets drive behaviour – thinking about deployment and joining up in the rural communities could make a significant impact. She expressed the view that there may not be an ambulance on every corner but there can be a skilled person. In Lincolnshire all communities are no more than half a mile from a person who can deliver life-saving skills. She is keen to further develop the principle of initial and immediate responders to develop a system so people can arrive within 2-3 minutes using technology, until advanced practitioners can reach those in need. LIVES has shown how being embedding in the whole system can run through into the establishment of the ICS. LIVES is a respected organisation and seen as 4th emergency service in the county of Lincolnshire.

**Anne Marie Morris –** thanked Nikki Cooke for an inspirational presentation. She expressed a strong view that the achievements of this service should act as a wider beacon for the value and potential provided by well organized first responder services. She then asked Ivan Annibal to offer some concluding comments and reflections.

**Ivan Annibal –** offered the following overarching thoughts arising from the session including:

* The need for significant redesign to deliver responses not a blanket approach.
* The importance of understanding and managing how things are arranged – where the key points of treatment are and how you get to people – the value of a holistic understanding of how the system works.
* Flows and pathways are really important in this context and are best delivered by locality planning.
* The duality of urban determined standards/response in ambulance versus local determination in fire and neither approach hitting the mark.
* Attitudinal challenges – change is not about lower quality of service. There is a willingness within system to change but fear around risk, criticism.
* The session has identified significant scope for innovation and some inspirational models and approaches that work in rural areas.
* The merits of a whole population approach to emergency services agenda. With key opportunities and learning associated with providing first/emergency responses by training people in rural areas?
* All of this calls for commissioners to better understand what is rural and the value of a nuanced approach in how services are designed and delivered.