Department for Environment Food & Rural Affairs

Government Statistical Service

Statistical Digest of Rural England:

3 - Health and Wellbeing

November 2024

This publication is available at www.gov.uk/government/publications

Any enquiries regarding this publication should be sent to us at

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Cover photos

		Ward 2011	Rural-Urban Classification
TL	Helmsley marketplace	Helmsley	Rural Village and Dispersed in a sparse setting
TC	Horton-in-Ribblesdale train station with Penyghent behind	Penyghent	Rural Village and Dispersed in a sparse setting
TR	St Giles Church, Skelton	Rural West York	Rural Town and Fringe
CL	Fishing Boat, Marske-by-the-Sea with Hunt cliff in the distance	St Germain's; Saltburn	Rural Town and Fringe
CR	Thornton Force Waterfall, Ingleton Waterfalls Trail	Ingleton and Clapham	Rural Village and Dispersed in a sparse setting
BL	Farmer working the fields in Knapton	Rural West York	Rural Town and Fringe
BC	Remote pub at Ribblehead viaduct	Ingleton and Clapham	Rural Village and Dispersed in a sparse setting
BR	Glamping pod in the North York Moors	Pickering East	Rural Town and Fringe in a sparse setting

All cover photos provided by Martin Fowell.

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About the Statistical Digest of Rural England

The Statistical Digest of Rural England (hereafter the Digest) is a collection of statistics on a range of social and economic topics and provides broad comparisons between Rural and Urban areas by settlement type. For more information on our classifications, including maps and diagrams explaining the classification, see Appendix 2: Defining Rural areas.

The Digest has been restructured into thematic reports and incorporates the previously separate publication the Rural Economic Bulletin.

The Digest consists of the following thematic reports:

1. Population
2. Housing
3. Health and Wellbeing
4. Communities and Households
5. Connectivity and Accessibility
6. Education, Qualifications and Training
7. Rural Economic Bulletin
8. Energy

In March 2024 the content relating to energy that was previously split across the Housing and Communities and Households chapters has been consolidated into a new Energy report. “Appendix 1: The 8 thematic reports that make up the Statistical Digest of Rural England” shows the sub-themes within each of the 8 Digest reports. Thematic reports will be updated individually and not every report with be updated every month.

The most recent updates for this theme are shown in Table 1. In November 2024, the “NHS Dentistry provision” and “NHS General Practices” were overhauled with updated data and new presentation methods; “NHS General Practices” was previously called “General Practices”, but has been renamed to reflect the exclusion of private practices from the data.

Table 1: Update monitor for Health and Wellbeing subsections
where “✔" indicates the topic has been updated, “✘" indicates the topic has not been updated, and “New” indicates a new topic with analysis not previously included within the Digest.

Section	October 2023	December 2023	September 2024	November 2024
Life expectancy and mortality	New	✘	✔	✘
Wellbeing	✘	✘	✔	✘
NHS Dentistry provision	New	✘	✘	✔
NHS General Practices	New	✘	✘	✔
Childcare provision	✘	New	✘	✘
Loneliness	✔	✘	✘	✘
Volunteering and charity	✔	✘	✘	✘

Official Statistics

These statistics have been produced to the high professional standards set out in the Code of Practice for Official Statistics, which sets out eight principles including meeting user needs, impartiality and objectivity, integrity, sound methods and assured quality, frankness and accessibility.

More information on the Official Statistics Code of Practice can be found at: Code of Practice for Statistics.

This publication has been compiled by the Rural Statistics Team within the Rural and Place Team in Defra:

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There is a 2011 Census version of the Digest which looks at the data from the 2011 census and where possible makes comparisons to the 2001 census results.

This can be found at https://www.gov.uk/government/statistics/2011-census-results-for-rural-england

The 2021 Rural-Urban Classification was released on 6 March 2025. Details of the 2021 Rural Urban Classification can be found at: https://www.gov.uk/government/collections/rural-urban-classification. It will take some time for the Digest to be updated throughout using the new classification. Where relevant Statistics drawing on the 2021 Census will be added to Digest thematic reports.

Health and Wellbeing

This part of the Statistical Digest of Rural England focuses on Health and Wellbeing, and covers the following:

- life expectancy and mortality (Section A)
- personal wellbeing (Section B)
- NHS Dentistry provision (Section C)
- NHS General Practices (Section D)
- childcare provision (Section E)
- loneliness (Section F)
- volunteering and charity (Section G)

The key findings from this report are summarised with the following set of headline clouds.

Life expectancy and Mortality – key findings

On average girls born in rural areas have a higher life expectancy than girls born in Urban areas

Of boys born in Rural areas, average life expectancy is highest in Uttlesford (83 years)

Children born in Blackpool have the lowest average life expectancy, at 73 years for boys and 79 years for girls

Of girls born in Rural areas, average life expectancy is highest in Winchester (86 years)

In Rural and Urban areas, more than 2 in every 1,000 male deaths are considered preventable

There was 1 fewer infant deaths in every 1,000 live births in Rural areas compared to Urban areas

Registered suicide rates are slightly higher in Rural areas than Urban areas

Wellbeing – key findings

On average people living in Rural areas rated their satisfaction with life in 2022/23 as 7.6 out of 10

On average people living in Urban areas rated their satisfaction with life in 2022/23 as 7.4 out of 10

On average people living in Rural areas rated their happiness in 2022/23 as 7.5 out of 10

On average people living in Urban areas rated their happiness in 2022/23 as 7.3 out of 10

Between 2021/21 and 2022/23 wellbeing measures showed a slight drop in Rural areas (falling by 0.1 out of 10 on average)

Wellbeing measures showed slightly higher wellbeing in rural areas than in urban areas (by 0.2 out of 10 on average)

NHS Dentistry provision – key findings

There are 4,000 Rural NHS dentists – around 1 in 6 of the NHS dentists in England

3 in 10 adults living in Rural areas had seen an NHS dentist in the last 2 years, as of 2023/24

There were 460 more people living in Rural areas per dentist than in Urban areas in 2023/24

Just under half of children living in Rural areas had seen an NHS dentist in 2023/24

NHS General Practices – key findings

There were 9.6 million patients registered in Rural areas in 2024, and 7,400 NHS GPs (including locums and trainees)

There were 39.9 million patients registered in Urban areas in 2024, with 28,800 NHS GPs (including locums and trainees)

In both Rural and Urban areas, 20% of the GP workforce were in training in 2024

There were proportionally fewer wasted GP appointments in Rural areas (6%) compared to Urban areas (9%)

The median waiting time for a GP appointment was 2 to 7 days in Rural areas, compared to 1 day in Urban areas

8 in 10 GP appointments were face-to-face in Rural areas (including at the practice, and home visits)

Nearly 1 in 4 GP appointments were virtual in Urban areas (including telephone, video and online appointments)

Childcare – key findings

Around 1 in 6 Rural childcare providers were rated outstanding.

Of the 13 thousand Rural childcare providers, 6,100 are childminders and 5,300 are nurseries/pre-schools

Between March 2020 and March 2022, the number of Rural childcare providers fell by 10% but the number of childcare places only fell by 1.5%

There are around 250 thousand childcare spaces in Rural areas

Childcare in London is more than £2 per hour more expensive than in Rural areas (or Urban areas outside of London).

Loneliness – key findings

1 in 5 people living in Rural areas reported never feeling lonely compared 1 in 4 people living in Urban areas

People living in Rural areas were more lonely in 2020/21 than they were in any other year between 2017/18 and 2021/22

More than 7 in every 10 rural people meet with friends or family on a weekly basis

Volunteering and charity – key findings

3 in every 5 people said they had volunteered in the last year in Rural areas; for Urban areas, it is closer to 1 in every 2

2 in every 5 people said they had volunteered in the last month in Rural areas; for Urban areas, it is closer to 1 in every 3

7 in every 10 people said they had recently donated to charity in Rural areas – slightly more than in Urban areas

Fewer people said they had volunteered or donated to charity in 2021/22 than in 2013/14

A. Life expectancy and Mortality

On average, a child born now in a Rural area can expect to live longer than a child born in an Urban area. Preventable mortality rates are similar between settlement types, and the infant mortality rate is lower in Rural areas than in Urban areas. However, the registered suicide rate is higher in Rural areas.

Summary

Life expectancy is the average time that a person is expected to live from their birth. Preventable deaths are those which could be avoided mainly through effective public health and primary prevention interventions. Infant mortality rate denotes infant deaths per 1,000 live births. Registered suicide rates cover deaths by injury or poisoning of undetermined intent, or by intentional self-harm. Understanding the trends for these indicators between Rural and Urban areas provides a useful representation of the overall health of these communities. These outcomes are all affected by a range of factors that differ between Rural and Urban areas, including socio-economic factors; rurality itself will not be necessarily the primary factor.

On average girls born in Predominantly Rural areas in 2020-22 can expect to live for 83.7 years; this is 1.4 years longer than girls born over the same period in Predominantly Urban areas. Boys born in Predominantly Rural areas in 2020-22 can expect to live for 80.1 years; this is 2.0 years longer than boys born over the same period in Predominantly Urban areas. In 2020-22, the average England life expectancy at birth was 82.8 years for girls, and was 78.7 years for boys .

Previous analysis of “Potential Years of Life Lost” within this publication has been replaced with “Mortality from causes considered preventable”. There were more preventable deaths for females than for males, but the rates between broad settlement types were similar in 2020-22. In Predominantly Rural areas, there were 116 preventable deaths per 100,000 population for Females in 2020-22, compared to 213 preventable deaths per 100,000 for Males. In Predominantly Urban areas, there were 116 preventable deaths per 100,000 population for Females, and 216 preventable deaths per 100,000 population for Males.

The infant mortality rate was lower in Predominantly Rural areas than in Predominantly Urban areas in 2020-22, corresponding to 3.2 deaths per 1,000 live births and 4.2 deaths per 1,000 live births respectively. Between 2001-03 and 2020-22, the infant mortality rate decreased by 0.9 deaths per 1,000 live births for Predominantly Rural areas and by 1.6 deaths per 1,000 live births for Predominantly Urban areas.

In 2020-22, the age-standardised mortality rate for suicides was higher in Predominantly Rural areas than in Predominantly Urban areas outside of London (11.7 and 10.9 deaths per 100,000 population, respectively). The suicide rate has been consistently higher in Predominantly Rural areas than in Predominantly Urban areas outside of London since 2015-17; prior to this, the age-standardised mortality rates were similar.

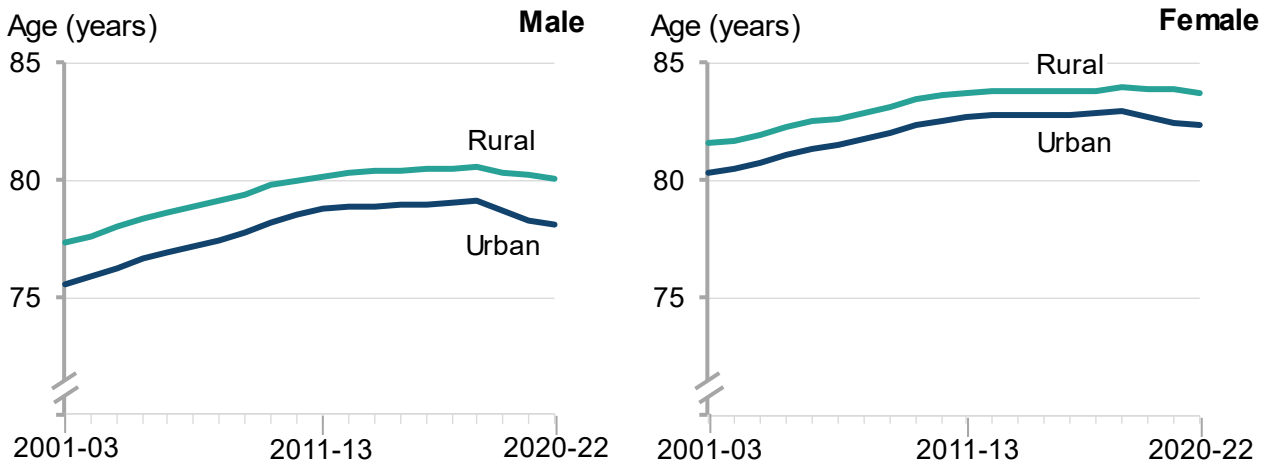
Male and Female life expectancy

Life expectancy is the statistical measure of the average time that a person is expected to live from their birth. Many factors can affect life expectancy. Over the last 40 years life expectancy in England has been increasing and over this period women have had a longer life expectancy than men (Note A-7).

In 2020-22, the average life expectancy for Males in Predominantly Rural areas was 80.1 years; this compares to 83.7 years for Females. In Predominantly Urban areas, the average life expectancy for Males was 78.1 years; this compares to 82.3 years for Females.

The line charts in Figure A-1 show the changes in life expectancy, by sex and broad Local Authority Rural-Urban Classification, between the three-year period spanning '2001 to 2003', to the period spanning '2020 to 2022'. Three-year periods are used instead of single-year figures in order to increase precision and reduce annual fluctuations caused by seasonal events. For more information, please visit: Health state life expectancies, UK Quality and Methodology Information - Office for National Statistics (ons.gov.uk).

Figure A-1: Line charts showing life expectancy at birth, by sex and broad Local Authority Rural-Urban Classification, England, 2001-03 to 2020-22 (Note A-2)
Males are shown on the left-hand chart and Females on the right-hand chart.



The line charts in Figure A-1 can be summarised as follows:

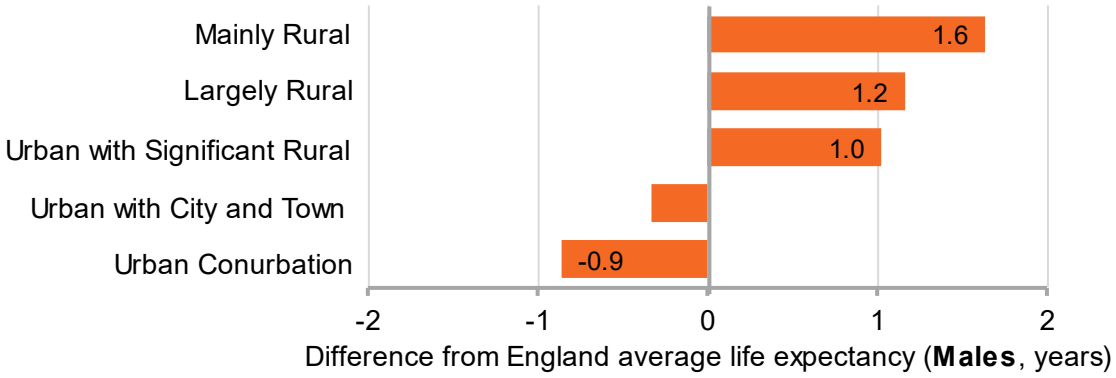
- For both Males and Females, the average life expectancy has consistently been higher for those living in Predominantly Rural areas than in Predominantly Urban areas. It has also consistently been higher for Females than for Males.
- Average life expectancies for both sexes and settlement types increased steadily between 2001-03 and 2011-13; between these periods, the average life expectancy had increased by 2.8 years for Males in Predominantly Rural areas (from 77.4 to 80.2 years), and by 2.1 years for Females in Predominantly Rural areas (from 81.5 to 83.7 years). In Predominantly Urban areas, average life expectancy increased by 3.2 years for Males (from 75.5 to 78.7 years) and 2.4 years for Females (from 80.3 to 82.7 years) between 2001-03 and 2011-13.
- Between 2011-13 and 2017-19, the average life expectancy continued to increase for both sexes and settlement types, but at a much slower rate; for Males, the average life expectancy had only increased by 0.4 years between these periods, and for Females, the life expectancy

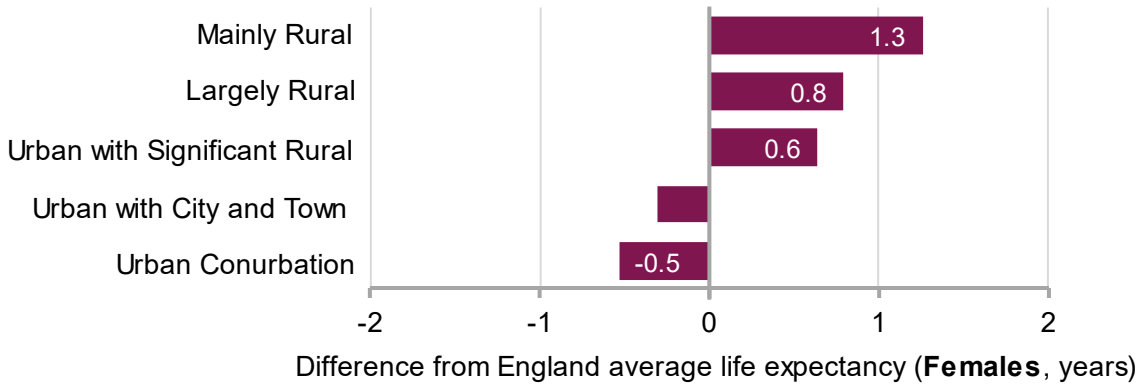
had only increased by 0.3 years. This was the same in both Predominantly Rural and Predominantly Urban areas. The average life expectancies seen in 2017-19 were the highest across the time series.

- From 2018-20 to 2020-22, the average life expectancy began to decrease for both sexes and settlement types; this was largely driven by the COVID-19 pandemic, however it does not mean that a baby born between 2020 and 2022 will go on to live a shorter life.
- The average life expectancy for Males in 2020-22 was still lower than for Females in 2001-03. For example, in Predominantly Rural areas, the average age for Females in 2001-03 was 81.5 years. In 2020-22, the average age for Males in Predominantly Rural areas was 80.1 years.

A range of factors will affect life expectancy that differ between Rural and Urban areas, including socio-economic factors. The bar charts in Figure A-2 show the difference between the life expectancy for each settlement type and the national average, for both sexes, in 2020-22.

Figure A-2: Bar charts showing life expectancy at birth, by sex and detailed Local Authority Rural-Urban Classification, England, 2020-22 (Note A-2, Note A-5)
Males are shown on the top chart and Females on the bottom chart. Only differences of at least 0.5 years have been labelled on the chart.





In the most Rural areas (Mainly Rural), the average life expectancy for Males was 1.6 years higher than the overall England average (80.4 years and 78.7 years, respectively). For Females, the average life expectancy in Mainly Rural areas was 1.3 years higher than the overall England average (84.0 years and 82.8 years, respectively). This was the largest positive difference of all settlement types, for both Males and Females.

In the most Urban areas (Urban Conurbation), the average life expectancy for Males (77.9 years) was 0.9 years lower than the overall England average. For Females, the average life expectancy in Urban Conurbation areas (82.2 years) was 0.5 years lower than the overall England average. This was the largest negative difference of all settlement types, for both Males and Females.

In Urban with City and Town areas, the average life expectancy was 0.3 years lower than the national average for both Males and Females. In Urban with Significant Rural areas, the average Male life expectancy was 1.0 year higher than the national average for Males, and 0.6 years higher for Females. In Largely Rural areas, the average Male life expectancy was 1.2 years higher than the England average for Males, and 0.8 years higher for Females.

The Local Authorities with the lowest and highest average life expectancies for Males are given in Table A-1; for Females, they are given in Table A-2.

Table A-1: Local Authorities with the lowest and highest average life expectancies for Males, by broad Rural-Urban Classification in England, 2020-22

Males	Lowest average life expectancy		Highest average life expectancy	
Rural-Urban Classification	Area	Age (years)	Area	Age (years)
Predominantly Rural	Allerdale	77.1	Uttlesford	82.7
Urban with Significant Rural	Barrow-in-Furness	76.3	Hart	83.7
Predominantly Urban	Blackpool	73.4	Wokingham	82.5

In Predominantly Rural areas, Allerdale had the lowest average life expectancy for Males in 2020-22, at 77.1 years. Uttlesford had the highest average life expectancy for Males, at 82.7 years; this means that there was a difference of 5.6 years between the Predominantly Rural Local Authorities with the highest and lowest average life expectancies for Males.

There was a difference of 7.4 years between the Urban with Significant Rural Local Authorities with the highest and lowest average life expectancies for Males in 2020-22. In Predominantly Urban areas, there was a difference of 9.1 years between the Local Authorities with the highest and lowest average life expectancies for Males.

Blackpool – a Predominantly Urban Local Authority - had the lowest average life expectancy for Males in England in 2020-22, at 73.4 years. In comparison, Hart – an Urban with Significant Rural Local Authority – had the highest average life expectancy for Males in England, at 83.7 years.

Table A-2: Local Authorities with the lowest and highest average life expectancies for Females, by broad Rural-Urban Classification in England, 2020-22

Females	Lowest average life expectancy		Highest average life expectancy	
Rural-Urban Classification	Area	Age (years)	Area	Age (years)
Predominantly Rural	Copeland	80.4	Winchester	85.9
Urban with Significant Rural	Barrow-in-Furness	79.8	Hart	86.1
Predominantly Urban	Blackpool	80.0	Kensington and Chelsea	86.3

In Predominantly Rural areas, Copeland had the lowest average life expectancy for Females in 2020-22, at 80.4 years. Winchester had the highest average life expectancy for Females, at 85.9 years; this means that there was a difference of 5.6 years between the Predominantly Rural Local Authorities with the highest and lowest average life expectancies for Females.

There was a difference of 6.3 years between the Urban with Significant Rural Local Authorities with the highest and lowest average life expectancies for Females in 2020-22. In Predominantly Urban areas, there was a difference of 7.4 years between the Local authorities with the highest and lowest average life expectancies for Females.

As it did for Males, Blackpool had the lowest average life expectancy for Females in England in 2020-22 (80.0 years). In comparison, Kensington and Chelsea – a Predominantly Urban Local Authority – had the highest average life expectancy for Females in England, at 86.3 years.

Mortality rate from causes considered preventable

Deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could be avoided through effective public health and primary prevention interventions.

For more information, please visit Fingertips | Department of Health and Social Care (phe.org.uk).

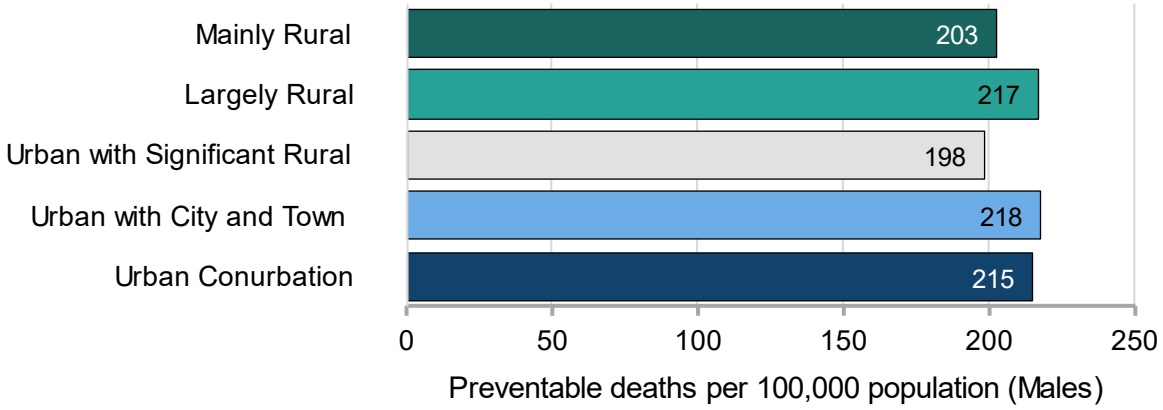
Please note: This analysis replaces statistics on the Potential Years of Life Lost for all causes. The concepts of the data are similar, although mortality rates are often considered to be easier to understand. We now use data from Public Health Outcomes Framework | Fingertips | Department of Health and Social Care (phe.org.uk). As such, the analysis presented in this publication is not comparable to that published in previous years.

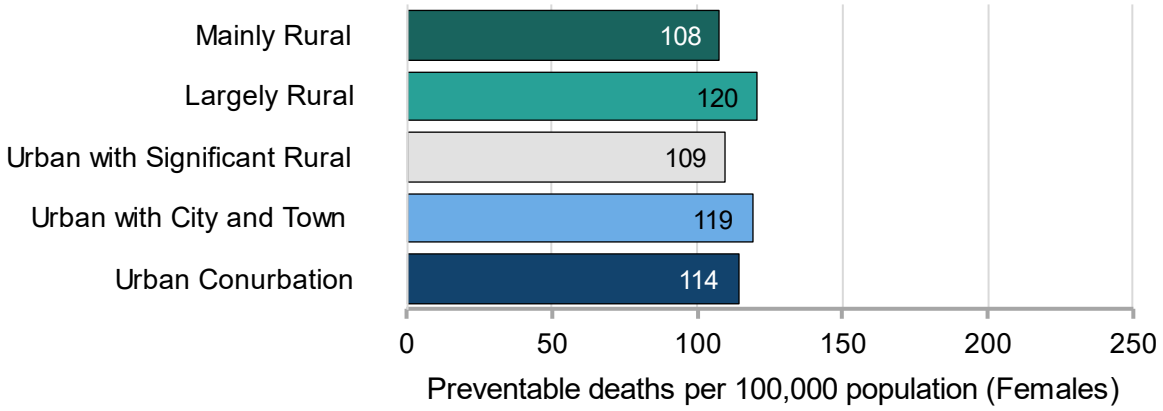
For Females in Predominantly Rural areas, there were 116 preventable deaths per 100,000 population in 2020-22; this is similar to preventable Female deaths per 100,000 population in Predominantly Urban areas. For Males, there were 213 preventable deaths per 100,000 population in Predominantly Rural areas, and 216 preventable deaths per 100,000 population in Predominantly Urban areas. A full time series of mortality rates from causes considered preventable is given in Figure A-4 and in the supplementary data tables.

The two bar charts in Figure A-3 show the number of deaths considered preventable per 100,000 populated aged under 75, by Local Authority Rural-Urban Classification. The top chart represents preventable deaths in Males, whilst the bottom chart represents preventable deaths in Females.

Figure A-3: Bar charts showing the under 75 mortality rate from causes considered preventable, by sex and detailed Local Authority Rural-Urban Classification, in England, 2020-22 (Note A-5, Note A-6, Note A-7)

Males are represented in the top chart and Females are represented in the bottom chart.





Overall, the mortality rate from causes considered preventable was considerably higher for Males than for Females, for all settlement types.

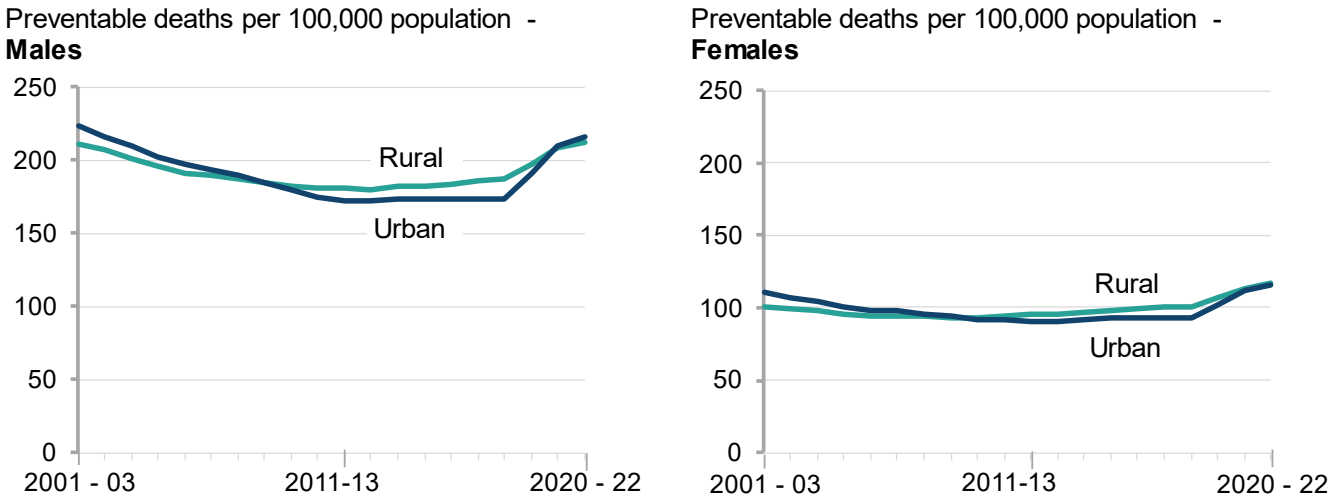
Males: In the most Rural areas (Mainly Rural), there were 203 preventable deaths per 100,000 population in 2020-22. This is less than the 215 preventable deaths per 100,000 population in the most Urban areas (Urban Conurbation). The highest average mortality rate from preventable causes was in Urban with City and Town, where there were 218 deaths per 100,000 population aged under 75. The lowest average mortality rate from preventable causes was in Urban with Significant Rural areas, where there were 198 deaths per 100,000 population.

Females: In the most Rural areas, there were 108 preventable deaths per 100,000 population in 2020-22; this is just over half of the preventable mortality rate for Men in the same areas and is also the lowest of all settlement types. In the most Urban areas, there were 114 preventable deaths per 100,000 population. The highest average mortality rate from preventable causes was in Largely Rural areas, where there were 120 deaths per 100,000 population aged under 75.

The two line charts in Figure A-4 show the change in the mortality rate from causes considered preventable, by broad Local Authority Rural-Urban Classification, between the three-year periods spanning 2001-03 to 2020-22. The left-hand chart is for Males and the right-hand chart is for Females.

Figure A-4: Line charts showing the change in under 75 mortality rates from causes considered preventable, by sex and broad Local Authority Rural-Urban Classification, in England, 2001-03 to 2018-20 (Note A-6, Note A-7)

Males are represented in the left-hand chart and Females are shown in the right-hand chart.



Overall, the mortality rates from causes considered preventable was always higher for Males than for Females between 2001-03 and 2018-20 in both Predominantly Rural and Predominantly Urban areas.

The left-hand line chart in Figure A-4 (representing **Males**) can be described as follows:

- For Males, the highest proportion of preventable deaths occurred in 2020-22 in Predominantly Rural areas (213 deaths per 100,000 population), and in 2001-03 in Predominantly Urban areas (224 deaths per 100,000 population).
- Between 2001-03 and 2011-13, the preventable mortality rate for Males decreased in both Predominantly Rural and Predominantly Urban areas, although at a faster rate in Predominantly Urban than Predominantly Rural. In 2011-13, there were 181 preventable deaths per 100,000 population for Males in Predominantly Rural areas, compared to 174 preventable deaths per 100,000 population for Males in Predominantly Urban areas.
- Between 2012-14 and 2017-19, the preventable mortality rate for Males increased gradually; in Predominantly Rural areas it increased by 7 deaths per 100,000 population, and in Predominantly Urban areas it increased by 1 death per 100,000 population.
- Between 2018-20 and 2020-22, the preventable mortality rate for Males increased by 15 deaths per 100,000 population in Predominantly Rural areas, and by 26 deaths per 100,000 population in Predominantly Urban areas.
- Throughout the period from 2001-3, there has been very little difference in the preventable mortality rates overall between Predominantly Rural and Predominantly Urban areas . Between 2001-03 and 2008-10, there were proportionally slightly fewer preventable deaths for Males in Predominantly Rural areas than in Predominantly Urban areas. Between 2009-11 and 2018-20, this trend changed in that there were proportionally slightly more preventable deaths for Males in Predominantly Rural areas than in Predominantly Urban areas. In 2019-21 and 2020-22, the preventable mortality rate for Males was similar in Predominantly Rural and Predominantly Urban areas.

The right-hand line chart in Figure A-4 (representing **Females**) can be summarised as follows:

- For Females, the highest preventable mortality rates occurred in 2020-22 in both Predominantly Rural areas and in Predominantly Urban areas (116 deaths per 100,000 population for both settlement types).
- Between 2001-03 and 2011-13, the preventable mortality rate for Females decreased in both Predominantly Rural and Predominantly Urban areas, although at a faster rate in Predominantly Urban than Predominantly Rural. The rate of decrease was also smaller for Females than for Males over a similar time period. In 2011-13, there were 95 preventable deaths per 100,000 population in Predominantly Rural areas, compared to 91 preventable deaths per 100,000 population in Predominantly Urban areas.
- Between 2012-14 and 2017-19, the preventable mortality rate for Females increased gradually; in Predominantly Rural areas, it increased by 6 deaths per 100,000 population, and in Predominantly Urban areas, it increased by 2 deaths per 100,000 population.
- Between 2018-20 and 2020-22, the preventable mortality rate for Females increased by 10 deaths per 100,000 population in Predominantly Rural areas, and by 15 deaths per 100,000 population in Predominantly Urban areas.
- Throughout the period from 2001-3, there has been very little difference in the preventable mortality rates overall between Predominantly Rural and Predominantly Urban areas. Between 2001-03 and 2008-10, there were proportionally slightly fewer deaths for Females in Predominantly Rural areas than in Predominantly Urban areas. Between 2009-11 and 2020-22, there were proportionally slightly more deaths for Females in Predominantly Rural areas than in Predominantly Urban areas.

Infant mortality rate (IMR)

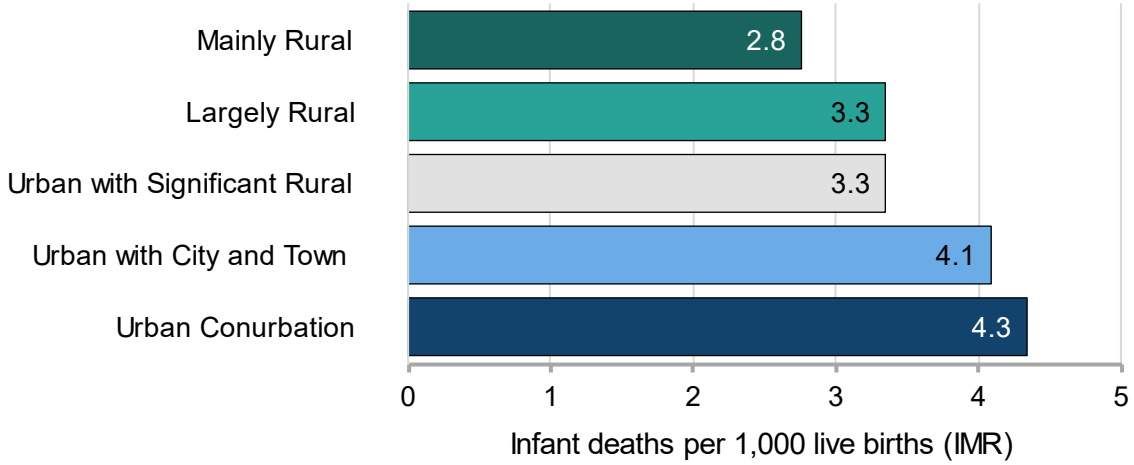
The infant mortality rate (IMR) is the number of infant (under one year old) deaths per 1,000 live births. There are many factors that can influence the IMR, including birth weight, mother's age, and socio-economic status.

Please note: the data source for this analysis has changed. We now use data from Public Health Outcomes Framework | Fingertips | Department of Health and Social Care (phe.org.uk). The analysis presented in this publication is not comparable to that published in previous years.

In the three-year period spanning 2020 to 2022, there were 3.2 infant deaths per 1,000 live births in Predominantly Rural areas; in absolute terms, this is equivalent to 962 infant deaths. In comparison, there were 4.2 infant deaths per 1,000 live births (or 5,215 infant deaths in absolute terms) in Predominantly Urban areas. Statistics regarding infant mortality rates can be found within the Health and Wellbeing supplementary data tables.

The bar chart in Figure A-5 shows the infant mortality rate, by detailed Local Authority Rural-Urban Classification, in 2020-22.

Figure A-5: Bar chart showing the infant mortality rate, by detailed Local Authority Rural-Urban Classification, in England, 2020-22 (Note A-5, Note A-8)

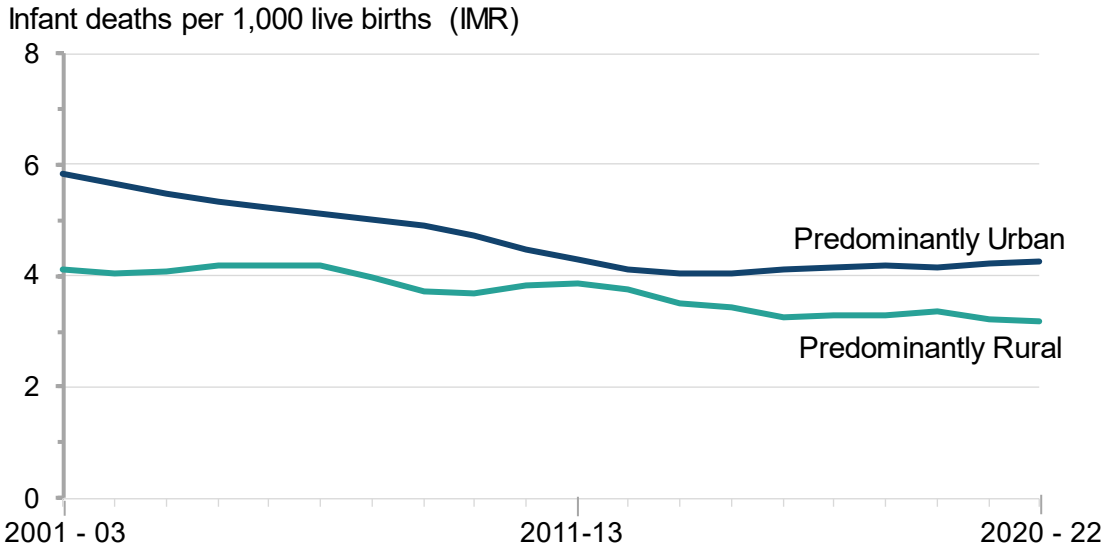


Generally, the more Rural the area, the lower the infant mortality rate. In the most Rural areas (Mainly Rural), there were 2.8 infant deaths per 1,000 live births in 2020-22; this is the lowest of all settlement types. In the most Urban areas (Urban Conurbation), there were 4.3 infant deaths per 1,000 live births; this is the highest of all settlement types. There were 1.6 more deaths per 1,000 births in Urban Conurbation areas than in Mainly Rural areas.

In both Largely Rural and Urban with Significant Rural areas, there were 3.3 infant deaths per 1,000 live births in 2020-22; this was 0.6 deaths per 1,000 births higher than in Mainly Rural areas. In Urban with City and Town areas, there were 4.1 infant deaths per 1,000 live births; this was 1.3 deaths per 1,000 births higher than in Mainly Rural areas, but 0.3 deaths per 1,000 births lower than in Urban Conurbation areas.

The line chart in Figure A-6 shows the change in infant mortality rate between 2001-03 and 2020-22, by broad Local Authority Rural-Urban Classification.

Figure A-6: Line chart showing the change in infant mortality rate, by broad Local Authority Rural-Urban Classification, in England, 2001-03 to 2020-22 (Note A-8)



The line chart can be summarised as follows:

- For each years there have been fewer infant deaths per 1,000 live births in Predominantly Rural areas than in Predominantly Urban areas between 2001-03 and 2020-22.
- Infant mortality rates were highest at the beginning of the time series, in 2001-03. In Predominantly Rural areas, there were 4.1 infant deaths per 1,000 live births; this compares to 5.8 infant deaths per 1,000 births in Predominantly Urban areas.
- Between 2001-03 and 2012-14, the infant mortality rate in Predominantly Urban areas decreased steadily, but has tended to fluctuate more in Predominantly Rural areas. In 2012-14 there were just 0.4 fewer infant deaths per 1,000 births in Predominantly Rural areas than in Predominantly Urban areas.
- Between 2013-15 and 2020-22, the infant mortality rate in Predominantly Rural areas decreased at a steadier rate than previously, but in Predominantly Urban areas began to increase after a short period of little change. In 2020-22, there were 3.2 infant deaths per 1,000 live births in Predominantly Rural areas; this is 1.1 deaths per 1,000 births lower than in Predominantly Urban areas (4.2 infant deaths per 1,000 live births).
- Overall, the infant mortality rate decreased by 0.9 deaths per 1,000 births in Predominantly Rural areas between 2001-03 and 2020-22. In Predominantly Urban areas, the infant mortality rate decreased by 1.6 deaths per 1,000 births overall across the same period.

Suicide rate

In England and Wales, when somebody dies unexpectedly, a Coroner investigates the circumstances to establish the cause of death. After this, the death is officially registered.

For suicides that occurred in England and Wales, the Office for National Statistics then assigns each death with an 'underlying cause', based on the information provided by the Coroner.

Data on suicide concern all deaths that were assigned underlying cause of intentional self-harm (for those aged 10 years and above). Deaths caused by injury or poisoning of undetermined intent (for those aged 15 years and above) are also included, based on the assumption that the majority of these deaths will be suicide. This is referred to as the National Statistics definition of suicide.

For more information, see the Suicides in England and Wales: 2022 registrations statistical bulletin.

If you are struggling to cope, please call Samaritans for free on 116 123 (UK and the Republic of Ireland) or contact other sources of support, such as those listed on the NHS help for suicidal thoughts web page. Support is available 24 hours a day, every day of the year, providing a safe place for you, whoever you are and however you are feeling.

Age-standardised suicide rates

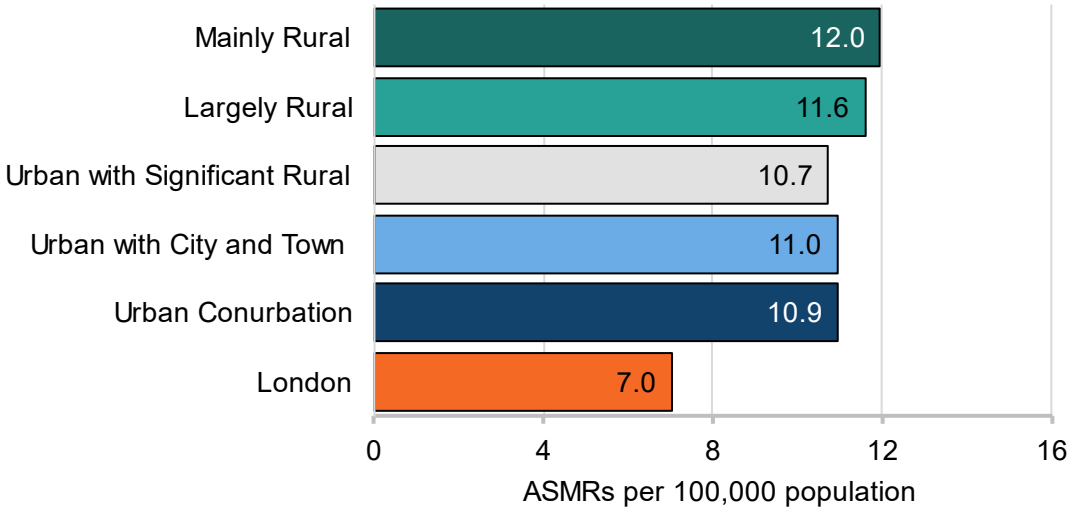
The numbers of deaths per population are influenced by the age distribution of the population. Two populations with the same age-specific mortality rates will have different overall suicide rates if the age distributions of their populations are different.

Age-standardised mortality rates adjust for differences in the age distribution of the population, meaning comparisons can be made between areas/settlement types. Data on registered suicides is based on the victim's usual residence.

In 2020-22, the age-standardised mortality rate for suicides was higher in Predominantly Rural areas than in Predominantly Urban areas outside of London (11.7 and 10.9 deaths per 100,000 population, respectively).

The bar chart in Figure A-7 shows the age-standardised mortality rate (ASMR) for suicides registered between 2020 and 2022, by detailed Local Authority Rural-Urban Classification.

Figure A-7: Bar chart showing the age-standardised mortality rate (ASMR) for suicides, per 100,000 population, by detailed Local Authority Rural-Urban Classification, in England, 2020-22 (Note A-9, Note A-10, Note A-12)



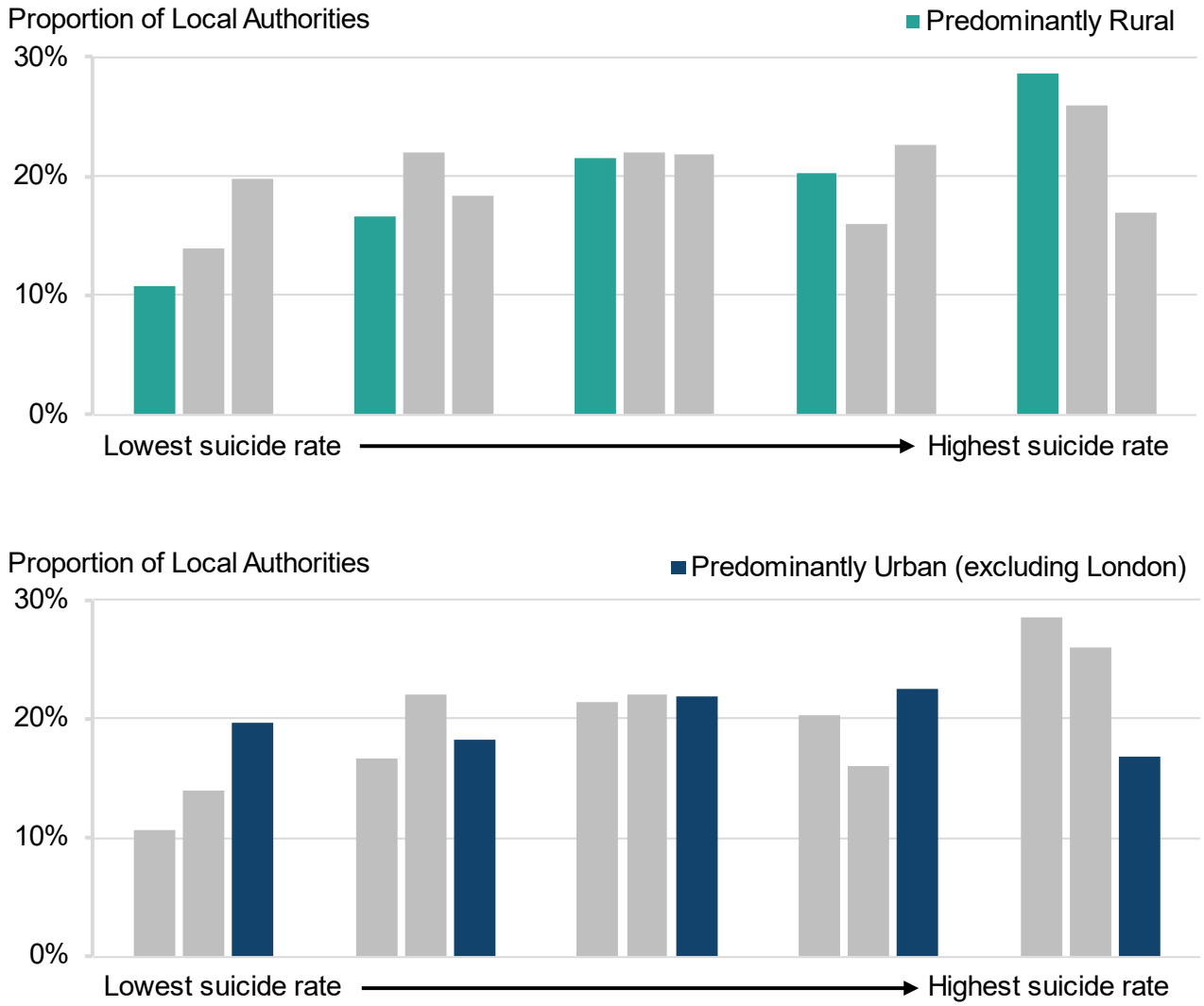
In the most Rural areas (Mainly Rural), there were 12.0 suicides registered per 100,000 population; this was the highest of all settlement types. In comparison, there were 10.9 deaths per 100,000 population in the most Urban areas outside of London (Urban Conurbation). In London, there were 7.0 suicides registered per 100,000 population; this is 5.0 deaths per 100,000 population lower than in Mainly Rural areas, and the lowest of all settlement types.

Suicide rates will vary within settlement types as well as between them. The two bar charts shown in Figure A-8 shows the proportion of Local Authorities within each quintile of ASMR (for suicides) between 2020 and 2022, by broad Rural-Urban Classification; Predominantly Rural areas are highlighted in the top chart, and Predominantly Urban areas are highlighted in the bottom chart.

In Figure A-8, there were more Predominantly Rural Local Authorities in quintiles 4 and 5 (50%) than in quintiles 1 and 2 (28%); this means that half the Rural Local Authorities had some of the highest suicide rates. In comparison, Predominantly Urban Local Authorities outside of London were fairly evenly distributed across quintiles, meaning Urban areas were no more likely to have a low suicide rate than they were to have a high suicide rate.

Figure A-8: Bar charts showing the proportion of Local Authorities within each quintile of age-standardised suicide rate, by broad Rural-Urban Classification, in England, 2020-22 (Note A-9, Note A-10, Note A-12)

The top chart focuses on Predominantly Rural areas (the first bar in each cluster). The bottom chart focuses on Predominantly Urban areas outside of London (the third bar in each cluster). Quintile 1 = lowest suicide rate; quintile 5 = highest suicide rate. The data in the charts excludes London (Note A-11).



Considering some of the quintiles in more detail, Figure A-8 shows:

- In quintile 1 (lowest suicide rates), there were fewer than 8.3 suicides registered per 100,000 population. There were proportionally fewer Predominantly Rural areas within this quintile than Predominantly Urban areas outside of London (11% and 20%, respectively).

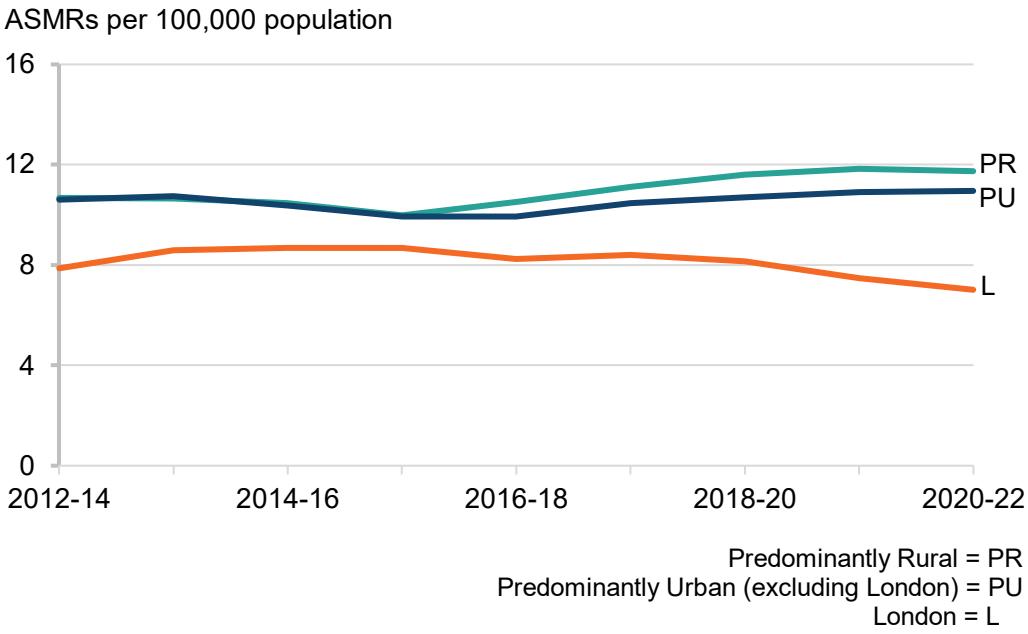
- In quintile 3, there were between 9.7 and 11.3 suicides registered per 100,000 population between 2020 and 2022. For both Predominantly Rural and Predominantly Urban areas outside of London, there were around 21% of Local Authorities within this quintile.

- In quintile 5 (highest suicide rates), there were at least 13.3 suicides registered per 100,000 population. There were proportionally more Predominantly Rural areas within this quintile than Predominantly Urban areas outside of London (29% and 17%, respectively).

Long-term suicide rate trends

As explained in the previous section, age-standardised mortality rates (ASMRs) adjust for differences in the age distribution of the population, meaning comparisons can be made between areas/settlement types. They also allow for comparison over time. Figure A-9 shows the age-standardised mortality rate for suicides registered between 2012-14 and 2020-22, by broad Local Authority Rural-Urban Classification.

Figure A-9: Line chart showing the age-standardised mortality rate (ASMR) for suicides, per 100,000 population, by broad Local Authority Rural-Urban Classification, England, 2012-14 to 2020-22 (Note A-9, Note A-10, Note A-12)



At the beginning of the series (2012-14), the age-standardised suicide rate was similar in Predominantly Rural and Predominantly Urban areas outside of London at around 10.7 deaths registered per 100,000 population.

Rates remained similar until 2016-18, when they started to diverge; the age-standardised suicide rate at that point was higher in Predominantly Rural areas than in Predominantly Urban areas outside of London (10.5 and 9.9 deaths per 100,000 population, respectively).

Suicide rates continued to diverge, reaching their highest level in 2019-21; here, there were 11.8 deaths per 100,000 population in Predominantly Rural areas and 10.9 deaths per 100,000 population in Predominantly Urban areas outside of London. The current series ends with 2020-22, where rates were marginally lower than in 2019-21 in Predominantly Rural areas, but marginally higher in Predominantly Urban areas outside of London.

The age-standardised mortality rate for suicides registered in London has been consistently lower than for any other settlement type; in 2020-22, there were 7.0 deaths registered per 100,000 population. This is the lowest rate across the period, with the highest being in 2014-16 and 2015-17 at 8.7 deaths per 100,000 population.

Life expectancy and Mortality explanatory notes

- **Note A-1**

Tables showing the data presented in this section are available in the Health and Wellbeing data tables.

- **Note A-2**

For the life expectancy analysis, the weighted average is calculated using NOMIS mid-year population estimates by Local Authority and using RUC 2011. 2020-22 population data uses Local Authorities as of April 2021. City of London and Isles of Scilly Local Authorities are excluded from this analysis due to small numbers of deaths and populations.

- **Note A-3**

Restructuring of local governments in England changed the local authority boundaries and areas.

1. Buckinghamshire UA comprises part of the Buckinghamshire county (Aylesbury Vale, Chiltern, South Bucks, Wycombe)
2. North Northamptonshire UA comprises part of the Northamptonshire county (Corby, East Northamptonshire, Kettering, Wellingborough)
3. West Northamptonshire UA comprises part of the Northamptonshire county (Daventry, Northampton, South Northamptonshire

- **Note A-4**

Data source: Office for National Statistics (ONS) Life expectancy tables: Office for National Statistics (ONS) Life expectancy tables

- **Note A-5**

Urban Conurbation" refers to the combination of two categories within the Rural-Urban Classification: "Urban with Minor Conurbation" and "Urban with Major Conurbation".

- **Note A-6**

Where the observed total number of deaths is less than 10, the rates have been suppressed as there are too few deaths to calculate directly standardised rates reliably.

- **Note A-7**

The Isles of Scilly and City of London data have been aggregated with Cornwall and Hackney respectively. This does not affect the higher-level settlement type figures due to the fact that they have been aggregated within the same Rural-Urban Classification categories.

- **Note A-8**

Live births were assigned to geographical areas by Office for National Statistics (ONS) using the postcode of mother's usual residence and the National Statistics Postcode Directory (NSPD). As per ONS guidance, rates were not calculated for Local Authorities where there were fewer than 3 deaths; rates based on such low numbers are susceptible to inaccurate interpretation.

- **Note A-9**

Data on registered suicides is based on the victim's usual residence as provided by the informant upon registration - not where the suicide occurred. Data by Rural-Urban Classification excludes non-residents as is calculated from individual Local Authority data. Years given are based on the date of registration, as opposed to the date the death occurred. Due to the length of time it takes to hold an inquest, it can take months or even years for a suicide to be registered. Statistics are presented over a 3-year period in an attempt to account for these registration delays.

- **Note A-10**

The National Statistics definition of suicide includes intentional self-harm in persons aged 10 years and above, and injury/poisoning of undetermined intent in persons aged 15 years and above.

- **Note A-11**

In Figure A-8, 67% of areas in London would be in quintile 1. 18% of areas would be in quintile 2, and 12% of areas would be in quintile 3. No areas would be in quintile 4. 3% of areas in London would be in quintile 5.

- **Note A-12**

Age-standardised mortality rates refers to a weighted average of the age-specific mortality rates per 100,000 people and standardised to the 2013 European Standard Population.

Age group (years)	European standard population
0	1,000
1-4	4,000
5-9	5,500
10-14	5,500
15-19	5,500
20-24	6,000
25-29	6,000
30-34	6,500
35-39	7,000
40-44	7,000
45-49	7,000
50-54	7,000
55-59	6,500
60-64	6,000
65-69	5,500
70-74	5,000
75-79	4,000
80-84	2,500
85-89	1,500
90+	1,000
Total	**100,000**

B. Wellbeing

Over the last 5 years, Rural residents typically rated their wellbeing higher than the average scores given by people living in Urban Areas; but in both areas, average wellbeing scores are lower than prior to the COVID-19 pandemic.

Summary

Wellbeing as a measurable concept has become more recognised in recent years. This section explores wellbeing via a selection of now well-established measures – scores for life satisfaction, feeling what one does is worthwhile, happiness and anxiety.

In 2022/23 those living in Rural areas on average score themselves marginally better than those living in Urban areas on all 4 of wellbeing measures considered in the Office for National Statistics personal wellbeing estimates. All of the wellbeing estimates show marginally less positive scores in 2022/23 than they did in 2021/22.

Possibly reflecting the effects of the COVID-19 pandemic, average wellbeing scores are less positive in 2022/23 than they were in 2018/19. In both Predominantly Rural and Predominantly urban areas, average scores for levels of anxiety have increased.

Background to the estimates of Wellbeing

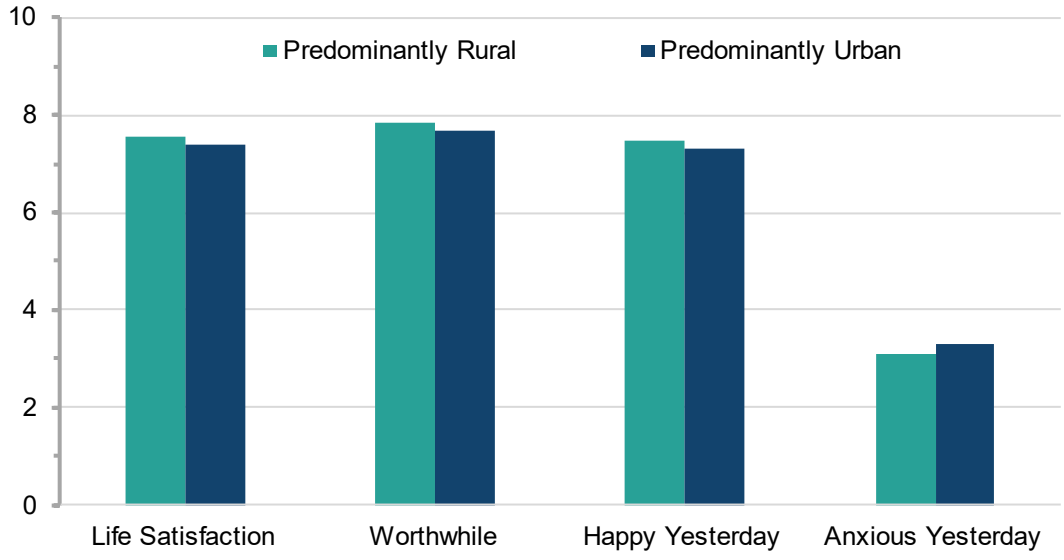
The Office for National Statistics (ONS) produce personal wellbeing estimates on an annual basis (Note B-5). The latest publication is Personal well-being in the UK: April 2022 to March 2023. In this publication the ONS report that: "Average ratings of personal well-being in the UK have declined across all measures in the year ending March 2023". The ONS further note that: (a) "rates of personal well-being have been affected by the coronavirus (COVID-19) pandemic"; and (b) "average ratings of personal well-being still remain below pre-pandemic levels".

The rest of this section will focus on a comparison of person wellbeing in Rural and Urban areas, for readers interested in more details of the national picture including how individual characteristics and circumstances affect personal wellbeing please consult Personal well-being in the UK: April 2022 to March 2023. The ONS state that: "**because of small sample sizes and large confidence intervals, estimates for local authorities should not be ranked against each other. Estimates are intended for local authorities to compare over time and with other local authorities of a similar population size and structure."** Our analysis therefore focuses on just the Rural and Urban averages.

Latest estimates of Wellbeing

Figure B-1 is a bar chart showing that in 2022/23, on average, people living in Predominantly Rural areas rated their wellbeing as slightly better than those in Predominantly Urban areas, although the differences are small. Individuals were asked to rate on a scale from 0 to 10 their life satisfaction, how happy and how anxious they were yesterday (in respect of being anxious, a lower score indicates a more positive response) and how worthwhile the things they do are. On all four metrics the average value for respondents from Predominantly Rural areas was more favourable (a score that was 0.2 out of 10 more favourable) than the average score for respondents from Predominantly Urban areas.

Figure B-1: Bar chart showing the average ratings (out of ten) on four measures of wellbeing, by Local Authority Rural-Urban Classification in England, for the year ending March 2023 (Note B-4, Note B-6, Note B-7, and Note B-8)
In respect of being anxious, a lower score indicates a more positive response. The legend is presented in the same order as the clusters of columns.



Populations in Rural and Urban areas differ across a range of socio-economic measures. Such differences are also likely to affect reported measures of wellbeing. For example, the ONS undertook an analysis of factors affecting life satisfaction (Note B-1) and concluded that "the following individual characteristics and circumstances were shown to have the largest contribution to adults' average ratings of life satisfaction: self-reported health (large contribution); marital status (large contribution); employment status (moderate contribution)". With multiple interacting factors at play, comparisons of the differences between the wellbeing estimates for respondents from Predominantly Rural and Predominantly Urban areas should be made with caution.

Table B-1 summarises the 2022/23 wellbeing results. When wellbeing for those living in Predominantly Rural areas is compared to those living in Predominantly Urban areas, we see the following:

- When asked 'Overall, how satisfied are you with your life nowadays?' on a scale from 0 to 10, where 0 is 'not at all satisfied' and 10 is 'completely satisfied' those living in Predominantly Rural areas gave an average rating of 7.6 compared with an average rating of 7.4 given by those living in Predominantly Urban areas.
- When asked 'Overall, to what extent do you feel the things you do in your life are worthwhile?' on a scale from 0 to 10, where 0 is 'not at all worthwhile' and 10 is 'completely worthwhile' those living in Predominantly Rural areas gave an average rating of 7.8 compared with an average rating of 7.7 given by those living in Predominantly Urban areas.
- When asked 'Overall, how happy did you feel yesterday?' on a scale from 0 to 10, where 0 is 'not at all happy' and 10 is 'completely happy' those living in Predominantly Rural areas gave an average rating of 7.5 compared with an average rating of 7.3 given by those living in Predominantly Urban areas.
- When asked 'Overall, how anxious did you feel yesterday?' on a scale from 0 to 10, where 0 is 'not at all anxious' and 10 is 'completely anxious' those living in Predominantly Rural areas gave an average rating of 3.1 compared with an average rating of 3.3 given by those living in Predominantly Urban areas (a lower score indicates a more positive response).

Table B-1: Average ratings (out of ten) on four measures of wellbeing, by Local Authority Rural-Urban Classification in England, for the year ending March 2023 (Note B-4, Note B-6, Note B-7, and Note B-8)

In respect of being anxious, a lower score indicates a more positive response.

	Overall, how satisfied are you with your life nowadays?	Overall, to what extent do you feel the things you do in your life are worthwhile?	Overall, how happy did you feel yesterday?	Overall, how anxious did you feel yesterday?
Predominantly Rural	7.6	7.8	7.5	3.1
Urban with Significant Rural	7.6	7.8	7.5	3.1
Predominantly Urban	7.4	7.7	7.3	3.3
England	**7.4**	**7.7**	**7.4**	**3.2**

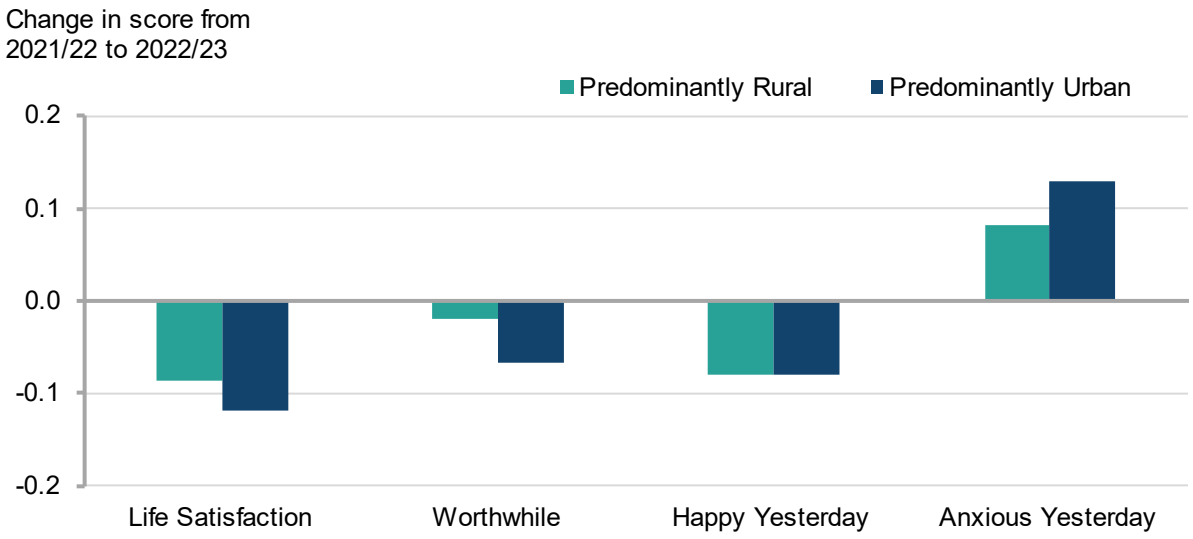
Figure B-2 is a bar chart showing the decline in wellbeing in both Predominantly Rural and Predominantly Urban areas between the year ending March 2022 and the year ending March

2023. The change in the value of each of the four wellbeing metrics between 2021/22 and 2022/23 shown in Figure B-2 can be summarised with the following bullets.

- In both Predominantly Rural and Predominantly Urban areas the average scores for life satisfaction and happiness reduced between 2021/22 and 2022/23, but for life satisfaction the change was marginally greater in Predominantly Urban areas.
- In Predominantly Rural areas there was little change in the average scores for feeling their life is worthwhile between 2021/22 and 2022/23, but in Predominantly Urban areas the average score for this metric decreased.
- In both Predominantly Rural and Predominantly Urban areas the average scores for anxiety were higher in 2022/23 than they were in 2021/22 and the change in the Predominantly Urban average was greater than for the Predominantly Rural average.
- In Predominantly Rural areas the change for all 4 metrics was smaller than 0.1 out of 10 whereas from Predominantly Urban areas the metric changed by more than this for life satisfaction and anxiety.

Figure B-2: Bar chart showing the change in the score of 4 measures of wellbeing between 2021/22 and 2022/23 by Local Authority Rural-Urban Classification in England (Note B-4, Note B-5, Note B-6, Note B-7, and Note B-8)

The legend is presented in the same order as the clusters of columns. Unlike the other 3 categories, an increase in the score for anxiety is an indicator of a deterioration in wellbeing.



Notes

- In Table B-1 and Figure B-1, for the anxiousness question a lower score represents a more favourable outcome. For the other 3 questions a higher score represents the more favourable outcome.
- Data are for the years April 2022 to March 2023 and April 2021 to March 2023.

Wellbeing over the last 5 years

The differences in wellbeing ratings between Predominantly Rural and Predominantly Urban areas are small over the period 2018/19 to 2022/23 (Table B-2, Table B-3, Table B-4 and Table B-5).

However average wellbeing scores in Predominantly Rural areas have been 0.1 or 0.2 out of 10 higher than the average in Predominantly Urban areas across all four measures.

Comparing the wellbeing estimates for 2018/19 (prior to the initial COVID-19 outbreak) with 2020/21 (after the initial COVID-19 outbreak but whilst the world was still dealing with its consequences for society) shows that average scores for anxiety went up while those for life satisfaction, sense of things being worthwhile, and happiness went down. This was the case in both Predominantly Rural and Predominantly Urban areas.

Table B-2: Average ratings (out of ten) on the question "Overall, how satisfied are you with your life nowadays?", by Local Authority Rural-Urban Classification in England, 2018/19 to 2022/23 (Note B-5)

Satisfaction	2018/19	2019/20	2020/21	2021/22	2022/23
Predominantly Rural	7.8	7.8	7.5	7.7	7.6
Predominantly Urban	7.6	7.6	7.3	7.5	7.4
England	**7.7**	**7.7**	**7.4**	**7.5**	**7.4**

Table B-3: Average ratings (out of ten) on the question "Overall, to what extent do you feel the things you do in your life are worthwhile?", by Local Authority Rural-Urban Classification in England, 2018/19 to 2022/23 (Note B-5)

Worthwhile	2018/19	2019/20	2020/21	2021/22	2022/23
Predominantly Rural	8.0	8.0	7.8	7.9	7.8
Predominantly Urban	7.8	7.8	7.7	7.7	7.7
England	**7.9**	**7.9**	**7.7**	**7.8**	**7.7**

Table B-4: Average ratings (out of ten) on the question "Overall, how happy did you feel yesterday?", by Local Authority Rural-Urban Classification in England, 2018/19 to 2022/23 (Note B-5)

Happiness	2018/19	2019/20	2020/21	2021/22	2022/23
Predominantly Rural	7.7	7.6	7.5	7.6	7.5
Predominantly Urban	7.5	7.4	7.3	7.4	7.3
England	**7.6**	**7.5**	**7.3**	**7.5**	**7.4**

Table B-5: Average ratings (out of ten) on the question "Overall, how anxious did you feel yesterday?", by Local Authority Rural-Urban Classification in England, 2018/19 to 2022/23 (Note B-4, Note B-5)

In respect of being anxious, a lower score indicates a more positive response.

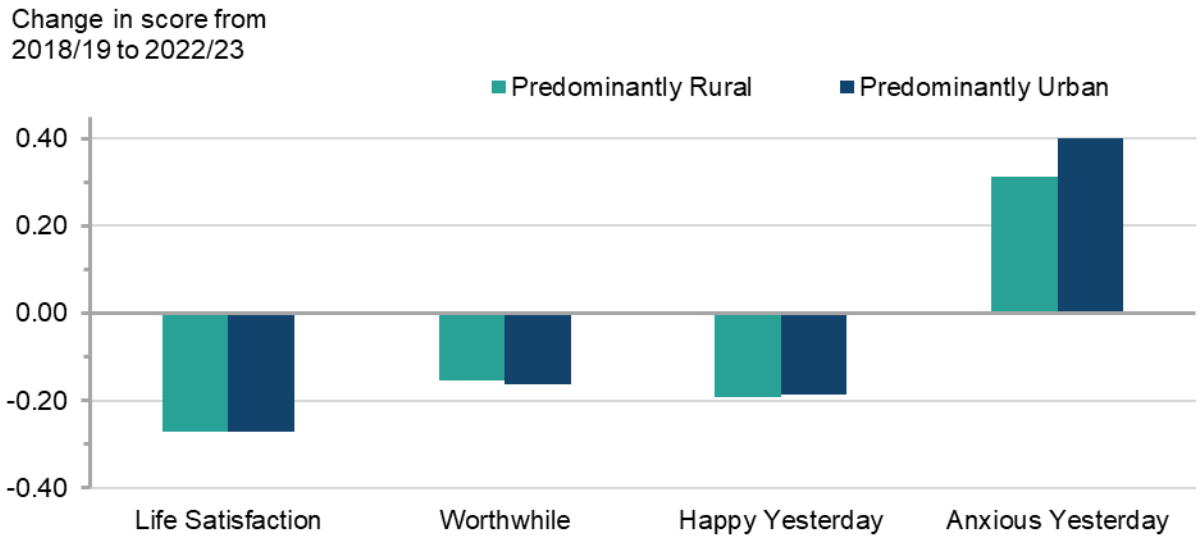
Anxiety	2018/19	2019/20	2020/21	2021/22	2022/23
Predominantly Rural	2.8	3.0	3.2	3.0	3.1
Predominantly Urban	2.9	3.1	3.4	3.2	3.3
England	**2.9**	**3.0**	**3.3**	**3.1**	**3.2**

In 2022/23 all 4 wellbeing metrics indicated lower average scores than they did immediately prior to the COVID-19 pandemic (2018/19). Figure B-3 is a bar chart showing the change in each

wellbeing metric between 2018/19 (pre COVID-19 pandemic) and 2022/23. In both Predominantly Rural and Predominantly Urban areas, anxiety is the metric that changed the most over this 5 -year period. Anxiety changed by 0.3 out of 10 in Predominantly Rural areas and 0.4 out of 10 in Predominantly Urban areas. For the other 3 metrics the average score changed a similar amount in both Predominantly Rural and Predominantly Urban areas over this 5-year period. The second biggest change in the average metric score was for life satisfaction which decreased by 0.3 out of 10 over this 5-year period.

Figure B-3: Bar chart showing the change in the score of 4 measures of wellbeing between 2018/19 and 2022/23 by Local Authority Rural-Urban Classification in England (Note B-4, Note B-5, Note B-6, Note B-7, and Note B-8)

The legend is presented in the same order as the clusters of columns. Unlike the other 3 categories, an increase in the score for anxiety is an indicator of a deterioration in wellbeing.



Notes

- In Table B-2, Table B-3, Table B-4 and Table B-5 and Figure B-3, for the anxiousness question a lower score represents a more favourable outcome. For the other 3 questions a higher score represents the more favourable outcome.
- Data are for the period 1 April to 31 March in each of the relevant years.

Wellbeing explanatory notes

- **Note B-1**

Current data source: Personal well-being in the UK: April 2022 to March 2023

- **Note B-2**

The personal well-being statistics are produced from the Annual Population Survey (APS). The APS is a household survey of people in the UK. It covers those living at private addresses, but does not include most communal establishments. On the APS, the well-being questions are only asked of persons aged 16 years and over who gave a personal interview, as proxy answers are not accepted.
These statistics were designated as National Statistics from the April 2013 to March 2014 dataset onwards (April 2014); before this, they were designated as experimental.

- **Note B-3**

Tables showing the 2022/23 wellbeing estimates by Local Authority and by detailed Local Authority Rural-Urban Classification are available in the Health and Wellbeing data tables.

- **Note B-4**

For the question "Overall, how anxious did you feel yesterday?" lower score indicate a more positive outcome in Table B-1, Table B-5 and Figure B-1. Similarly on Figure B-2 and Figure B-3 an increase in the score for anxiety is an indicator of a deterioration in wellbeing.

In Personal well-being in the UK: April 2022 to March 2023 the ONS use the following thresholds to aid the description of the score.

For the life satisfaction, feeling that the things done in life are worthwhile and happiness there is a common grouping.

Score	Descriptor
0 to 4	low
5 to 6	medium
7 to 8	high
9 to 10	very high

For the anxiety question, ratings are grouped differently to reflect the fact that higher anxiety is associated with lower personal well-being.

Score	Descriptor
0 to 1	very low
2 to 3	low
4 to 5	medium
6 to 10	high

- **Note B-5**

The ONS produce personal wellbeing estimates on an annual basis according to 1 April to 31 March financial years.

- **Note B-6**

In the ONS personal wellbeing publication changes have been made to way that the data points of lower accuracy are handled. Previously, published estimates were suppressed based on their co-efficient of variation values being over 20. For the year ending March 2023 publication the ONS switched their approach such that for all Local Authorities with a sample size of 50 or fewer respondents, the estimates were suppressed with "[u]" due to their low reliability. This change results in more missing data points in the 2022/23 personal wellbeing dataset than in previous years as detailed in Note B-7.

- **Note B-7**

The Scilly Isles are not included within the ONS personal wellbeing estimates dataset. For the data representative of 1 April 2022 to 31 March 2023, the data was suppressed (Note B-6) for the following 3 Predominantly Rural Local Authorities: (1) Maldon, (2) Richmondshire and (3) West Devon. It was also supressed for the following 5 Predominantly Urban Authorities: (1) Burnley, (2) City of London, (3) Epsom and Ewell, (4) Harlow, and (5) Runnymede. These 8 Local Authorities account for over 0.5 million people.

In the dataset for 1 April 2021 to 31 March 2022 there was just 3 suppressed Local Authorities and all of them were Urban: (1) City of London, (2) Gravesham and (3) Oadby and Wigston.

- **Note B-8**

When we calculate the average wellbeing estimates for Rural and Urban areas we weight the average according to population. Retaining those Local Authorities with missing data in the calculations has the potential to apply a small negative bias to the wellbeing estimates. Further, since the overall population is smaller for Predominantly Rural areas than for Predominantly Urban areas, missing data has the potential to bias the Predominantly Rural estimate by a larger amount than for the Predominantly Urban estimate.

When undertaking the analysis of the April 2021 to March 2022 dataset we checked for this effect and concluded that the difference was so small that it would disappear when rounding the estimates to one decimal place for publication. The effect was therefore not accounted for.

When undertaking the analysis of the April 2022 to March 2023 dataset it became clear that the additional missing data meant that the effect of the missing data was not lost in the rounding to one decimal place. The methodology was then adapted to remove those missing Local Authorities from the analysis. The analysis for several years was redone using this revised approach to provide a consistent 5-year time series in order to permit more robust comparisons years within the series.

- **Note B-9**

The Data collection methods changed in March 2020 to accommodate for the COVID-19 pandemic, meaning all data was collected over the telephone as opposed to mixed modes of face-to-face and telephone. Where possible, adjustments have been made to make the data collected following the modal change comparable to data collected prior to the modal change. Further information can be found in the technical paper: Data collection changes due to the pandemic and their impact on estimating personal well-being.

- **Note B-10**

The Local Authority population estimates used in the weight process (Note B-8) were taken from NOMIS in July 2024. These data incorporate the rebasing of population estimates done in autumn 2023. The dataset contains the population estimates for each country and local authority of the UK rebased to the results of the 2021/2022 censuses across the UK. These estimates replace previously published estimates for 2011 to 2022. Full details of the revision are within NOMIS.

C. NHS Dentistry provision

On average populations relative to NHS dentist numbers are higher in Predominantly Rural areas compared with Predominantly Urban areas and the proportion of people recently visiting a dentist is lower in Predominantly Rural areas than in Predominantly Urban areas.

Summary

Dentists can be either private practitioners, NHS practitioners or a mixture of the two. The number of NHS dentists per population can allow some rural and urban comparisons on the provision of NHS dentistry.

In 2023/24, there were around 24,300 dentists in England. There were 45 dentists per 100,000 population in Predominantly Rural areas compared with 56 dentists per 100,000 population in Predominantly Urban areas. This equates to one NHS dentist for every 2,200 people in Predominantly Rural areas, and one dentist for every 1,800 people in Predominantly Urban areas.

Generally, the more Rural the area, the lower the proportion of people who have visited an NHS dentist recently. In the most rural areas (Mainly Rural), 30% of adults had been seen by an NHS dentist within the last 2 years; this compares with 43% of adults in the most Urban areas (Urban Conurbation). In the most Rural areas, 44% of children had been seen by an NHS dentist within the last 12 months; this compares with 56% in the most Urban areas.

People may visit a dentist where they live, while others may visit a dentist near their place of work or elsewhere. The availability of dentists relative to population should be therefore considered with caution

Prior to November 2024, this section included analysis of NHS Dentists leaving or joining roles between 2021/22 and 2022/23. However, with dentists regularly moving to and from NHS roles, this did not provide a good indication of dental service provision. We have decided to remove these statistics and replace them with a more detailed analysis of dental visits; this includes the addition of geospatial information.

Availability of dental care

National Health Service (NHS) dental activity in England is usually commissioned through Integrated Care Boards (ICBs), who make contracts with providers of dental services. Dental statistics are published annually, and as of 2023/24 they are published by the NHS Business Services Authority (NHSBSA); prior to this, it was published by NHS England. All time-series data has been revised using the NHSBSA source, and therefore the statistics presented within this publication should be used instead of those published previously. The data within this section exclude NHS dental activity in hospitals, cosmetic treatments, and private dental treatments.

In 2023/24, there were around 24,300 dentists in England (Note C-1). Dentists can, and indeed do, operate in more than one geographical area so the number of dentists in Predominantly Rural (4,000) and Predominantly Urban (19,600) areas sums to more than the overall total in England. Table C-1 shows the total number of NHS dentists in England by Rural-Urban Classification from 2019/20 to 2023/24. There were 180 fewer dentists working in Predominantly Rural areas in 2023/24 than in 2019/20. In comparison, there were 350 more dentists working in Predominantly Urban areas in 2023/24 than in 2019/20.

Table C-1: Total number of NHS dentists, by broad Rural-Urban Classification for sub-Integrated Care Boards, in England, year ending March 2020 to year ending March 2024 (Note C-1, Note C-2)
Figures are rounded to the nearest 10 dentists.

Rural-Urban Classification	2019/20	2020/21	2021/22	2022/23	2023/24
Predominantly Rural	4,220	4,140	3,990	4,260	4,030
Urban with Significant Rural	19,260	17,620	16,970	19,450	19,610
Predominantly Urban	5,990	5,770	5,610	6,110	6,040
England	**24,710**	**24,620**	**23,760**	**24,230**	**24,340**

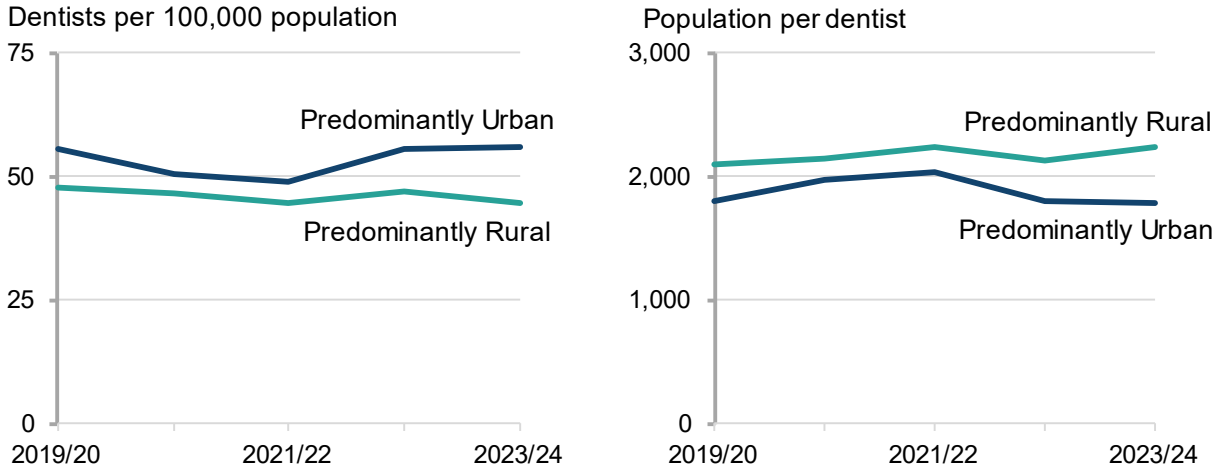
Apportioning the total number of dentists to the population provides some indication of provision across settlement types. The line charts in Figure C-1 show the number of dentists per 100,000 population (left-hand chart), as well as the population per dentist (right-hand chart), for Predominantly Rural and Predominantly Urban areas between 2019/20 and 2023/24.

There were consistently fewer dentists per population in Predominantly Rural areas compared to Predominantly Urban areas between 2019/20 and 2023/24. In 2023/24, there were 45 dentists per 100,000 population in Predominantly Rural areas compared with 56 dentists per 100,000 population in Predominantly Urban areas (Figure C-1 – left-hand chart). For Predominantly Rural areas, this is the lowest rate seen across the period spanning 2019/20 to 2023/24; for Predominantly Urban areas, the lowest rate was instead seen in 2021/22 (49 dentists per 100,000 population). The highest rate in Predominantly Rural areas was in 2019/20, where there were 48 dentists per 100,000 population; in Predominantly Urban areas, the highest rate was the one seen in 2023/24.

The right-hand chart of Figure C-1 shows that there were consistently more people per dentist in Predominantly Rural areas compared to Predominantly Urban areas; this indicates a lower availability of NHS dentists in Predominantly Rural areas. There were 2,240 people living in Predominantly Rural areas per dentist in 2023/24, compared with 1,780 in Predominantly Urban areas. The lowest rate in Predominantly Rural areas was in 2019/20 (2,100 people per dentist),

whereas the highest rate was in 2023/24. In Predominantly Urban areas, the lowest rate was in 2023/24, whereas the highest rate was in 2021/22 (2,040 people per dentist).

Figure C-1: Line charts comparing the number of NHS dentists to population estimates, by broad Rural-Urban Classification for sub-Integrated Care Boards, in England, year ending March 2020 to year ending March 2024 (Note C-1, Note C-2)
The left-hand chart shows the number of dentists per 100,000 resident population and the right-hand chart shows the population per dentist.



These estimates are based on the number of people living in the area and the number dentists offering NHS treatment, but of course for some it will be more convenient to attend a dentist where they work or study and these people might not live and work/study within areas holding the same Rural-Urban Classification category.

Table C-2 shows the sub-Integrated Care Boards with the **highest** number of NHS dentists per 100,000 population within each settlement type of the broad Rural-Urban Classification, as of 2023/24.

Areas with a particularly high dentist-to-population ratio are more likely to experience shorter waiting times and greater availability of NHS appointments when compared to the rest of England. Many people choose to visit a private dentist as they are less likely to have to go on a waiting list, but these are not factored into the analysis presented in this publication.

Table C-2: Sub-Integrated Care Boards (sub-ICBs) with the highest number of NHS dentists per 100,000 population in each category of the broad Rural-Urban Classification in England, year ending March 2024 (Note C-2, Note C-3)
"Rate" represents the number of NHS dentists per 100,000 population.

Rural-Urban Classification	Sub-ICB name	Rate
Predominantly Rural	Buckinghamshire, Oxfordshire and Berkshire West (10Q)	63
Urban with Significant Rural	Buckinghamshire, Oxfordshire and Berkshire West (14Y)	62
Predominantly Urban	Greater Manchester (02A)	115
England	**Greater Manchester (02A)**	**115**

The Predominantly Rural area with the highest dentist-to-population ratio was within the "Buckinghamshire, Oxfordshire and Berkshire West" Integrated Care Board (sub-ICB: 10Q); here, there were 63 NHS dentists per 100,000 population in year ending March 2024.

The Predominantly Urban area with the highest dentist-to-population ratio was within the “Greater Manchester” Integrated Care Board (sub-ICB: 02A); here, there were 115 NHS dentists per 100,000 population. This means that per population, there were almost double the number of dentists in the Predominantly Urban area with the highest dentist-to-population ratio compared to the equivalent Predominantly Rural area in 2023/24. The “Greater Manchester (02A)” sub-ICB also had the highest number of NHS dentists per population in England.

Table C-3 shows the sub-Integrated Care Boards with the **lowest** number of NHS dentists per 100,000 population within each settlement type of the Rural-Urban Classification, as of 2023/24.

Areas with a particularly low dentist-to-population ratio are more likely to experience longer waiting times and lower availability of NHS appointments when compared to the rest of England.

Table C-3: Sub-Integrated Care Boards (sub-ICBs) with the lowest number of NHS dentists per 100,000 population in each category of the broad Rural-Urban Classification in England, year ending March 2024 (Note C-2, Note C-3)
“Rate” represents the number of NHS dentists per 100,000 population.

Rural-Urban Classification	Sub-ICB name	Rate
Predominantly Rural	Humber and North Yorkshire (02Y)	30
Urban with Significant Rural	Northamptonshire (78H)	37
Predominantly Urban	Mid and South Essex (07G)	38
England	**Humber and North Yorkshire (02Y)**	**30**

The Predominantly Rural area with the lowest dentist-to-population ratio was within the “Humber and North Yorkshire” Integrated Care Board (sub-ICB: 02Y); here, there were 30 NHS dentists per 100,000 population in year ending March 2024. Overall, this was the lowest rate in England. Of the 19 Predominantly Rural sub-ICBs, there were 7 with fewer than 40 NHS dentists per 100,000 population in year ending March 2024.

The Predominantly Urban area with the lowest dentist-to-population ratio was within the “Mid and South Essex” Integrated Care Board (sub-ICB: 07G); here, there were 38 NHS dentists per 100,000 population.

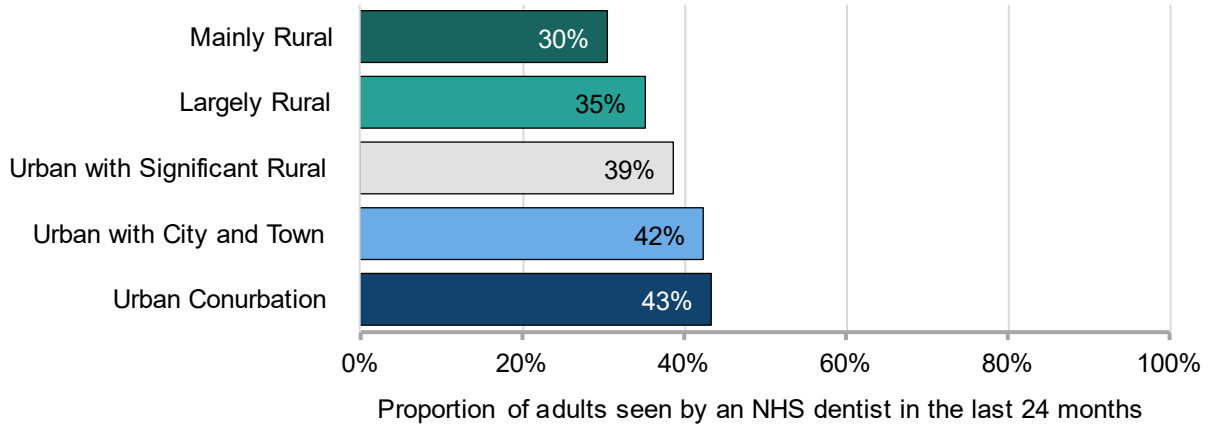
Visiting an NHS Dentist

Dental check-ups allow dentists to see if a patient has any dental problems; leaving problems untreated could make them more difficult to treat in the future, so regular check-ups can help to prevent these issues.

The analysis presented in this section is based on people attending a dentist (Note C-6) and the resident population. For some people, it will be more convenient to attend a dentist where they work or go to school in the case of children, therefore this is not a true proportion of the resident population having treatment (Note C-4).

The bar chart in Figure C-2 shows the proportion of adults who have been seen by an NHS dentist within the last 2 years, by detailed Local Authority Rural-Urban Classification, as of 2023/24.

Figure C-2: Bar chart showing the proportion of adults who had seen an NHS dentist in the last 24 months, by detailed 2023 Local Authority Rural-Urban Classification, in England, 2023/24 (Note C-4, Note C-6)

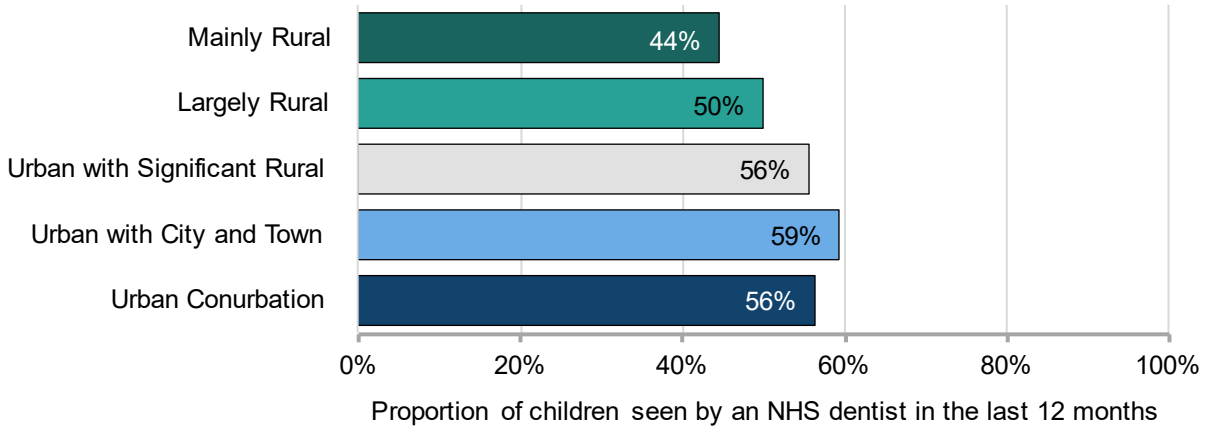


The more Rural the area, the lower the proportion of adults who have visited an NHS dentist recently. In the most Rural areas (Mainly Rural), 30% of adults had been seen by an NHS dentist within the previous 24 months. This compares with 43% of adults in the most Urban areas (Urban Conurbation), meaning the proportion of adults having seen an NHS dentist recently was 13 percentage points lower in Mainly Rural areas compared to Urban Conurbation areas in 2023/24.

Please note that the proportion of people having seen any dentist is likely to be higher, as this analysis does not include private dental care. It should be reiterated that this analysis is only relating dentist visits to the resident population.

With children, it can be more important for them to visit the dentist to ensure that their adult teeth grow in correctly. The bar chart in Figure C-3 shows the proportion of children who had seen an NHS dentist in the last year, by detailed Local Authority Rural-Urban Classification, as of 2023/24.

Figure C-3: Bar chart showing the proportion of children who had seen an NHS dentist in the last 12 months, by detailed 2023 Local Authority Rural-Urban Classification, in England, 2023/24 (Note C-4, Note C-6)



In the most Rural areas (Mainly Rural), 44% of children had been seen by an NHS dentist within the previous 12 months. This compares with 56% in the most Urban areas (Urban Conurbation). The largest proportion of children who had visited an NHS dentist recently was in Urban with City and Town areas, at 59%. This means the proportion of children having seen an NHS dentist recently was 15 percentage points lower in Mainly Rural areas compared to Urban with City and Town areas in 2023/24. Again, this analysis is only relating dental visits to resident populations.

In Predominantly Rural Local Authorities overall, 34% of adults had seen an NHS dentist in the last two years, as of 2023/24; this compares to 43% of children in Predominantly Urban Local Authorities. Some Local Authorities have particularly high or low relative proportions of people who had visited the dentist recently. The map shown in Figure C-4 highlights these areas for adults who had been seen by an NHS dentist within the last 24 months; the lightest colour represents areas where less than 20% of adults had visited an NHS dentist recently, whereas the darkest colour represents areas where at least 40% of adults had visited an NHS dentist within the last 24 months.

The map in Figure C-4, showing adult dentist visits in **Predominantly Rural** Local Authorities as of 2023/24, can be summarised as follows:

- There were 7 Predominantly Rural Local Authorities (9% of all Predominantly Rural areas) in which less than 20% of adults had been seen by an NHS dentist within the last 2 years.
- There were 51 Predominantly Rural Local Authorities (68% of all Predominantly Rural areas) in which between 20% and 40% of adults had visited an NHS dentist within the last 2 years.
- There were 16 Predominantly Rural Local Authorities (21% of all Predominantly Rural areas) in which at least 40% of adults had been seen by an NHS dentist within the last 2 years.
- There was 1 Predominantly Rural Local Authority (Isles of Scilly) where dentistry estimates were not collected, as related dental data are instead often included within mainland contracts.
- “North Kesteven” had the lowest proportion of adults visiting an NHS dentist recently in Predominantly Rural areas, at 11%; in comparison, “Derbyshire Dales” had the highest proportion, at 49%.

The map shown in Figure C-5 highlights the areas with particularly low or high relative proportions of adults who had been seen by an NHS dentist within the last 24 months in Predominantly Urban or Urban with Significant Rural Local Authorities. The lightest colour represents areas where fewer than 25% of adults had visited an NHS dentist recently, whereas the darkest colour represents areas where at least 50% of adults had visited an NHS dentist within the last 2 years.

The map in Figure C-5, showing adult dentist visits in **Predominantly Urban or Urban with Significant Rural** Local Authorities as of 2023/24, can be summarised as follows:

- There were 7 Predominantly Urban or Urban with Significant Rural Local Authorities (3% of all non-Rural areas) in which less than 25% of adults had been seen by an NHS dentist within the last 2 years.
- There were 175 Predominantly Urban or Urban with Significant Rural Local Authorities (79% of all non-Rural areas) in which between 25% and 50% of adults had been seen by an NHS dentist within the last 2 years.
- There were 39 Predominantly Urban or Urban with Significant Rural Local Authorities (18% of all non-Rural areas) in which at least 50% of adults had been seen by an NHS dentist within the last 2 years.
- “City of London” had the lowest proportion of adults visiting an NHS dentist in Predominantly Urban or Urban with Significant Rural areas (15%), whilst “Lincoln” had the highest (79%).

Figure C-4: Map showing the proportion of adults who had seen an NHS dentist in the last 24 months, for 2023 Predominantly Rural Local Authorities within the Rural-Urban Classification in England, 2023/24 (Note C-4, Note C-7)

The Predominantly Rural Local Authorities with the highest and lowest proportions of adults who had visited an NHS dentist recently are labelled on the map. White areas on the map represent Predominantly Urban or Urban with Significant Rural areas; the colour grading of these areas is instead given on Figure C-5. Data excludes Isles of Scilly.

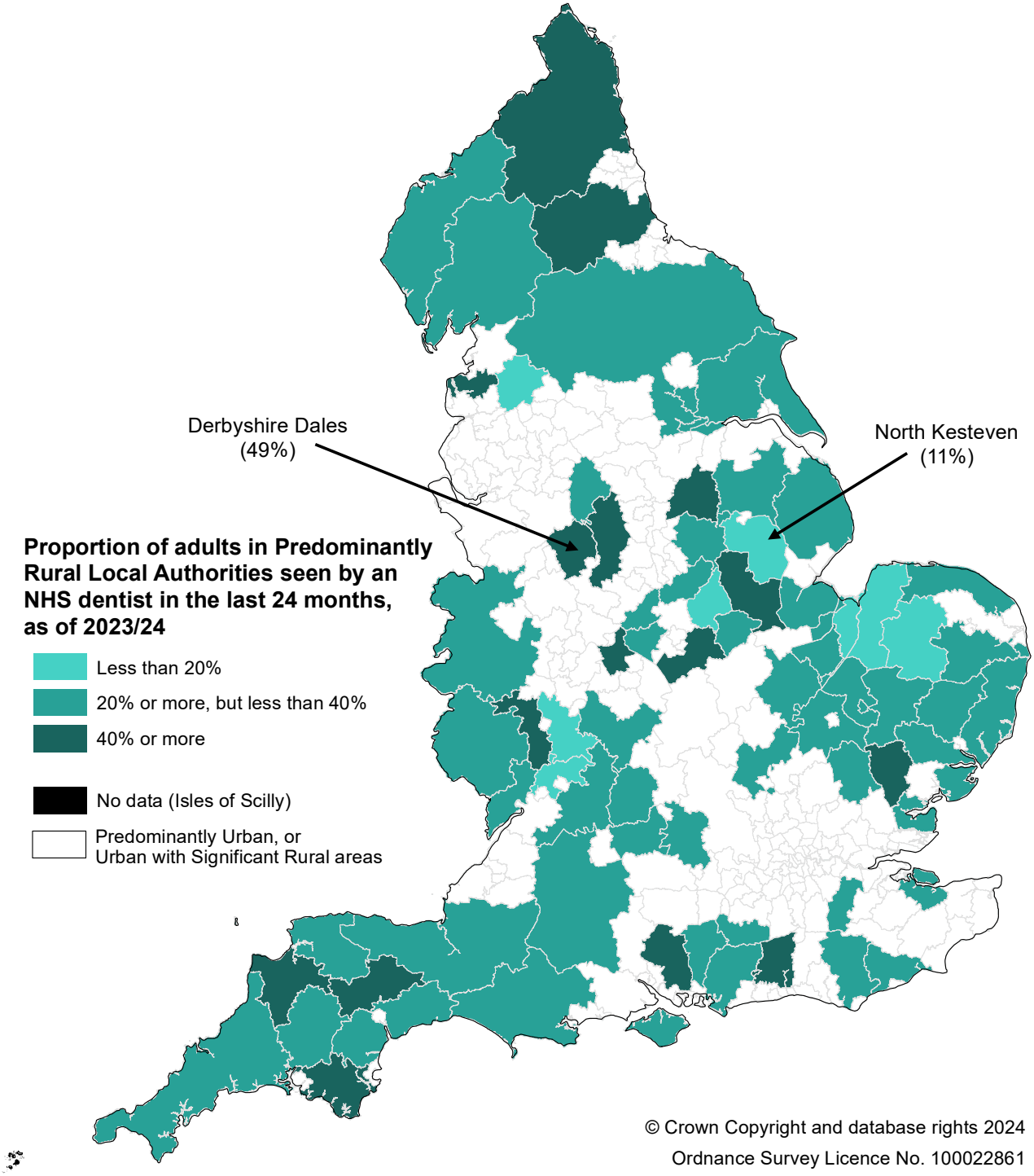
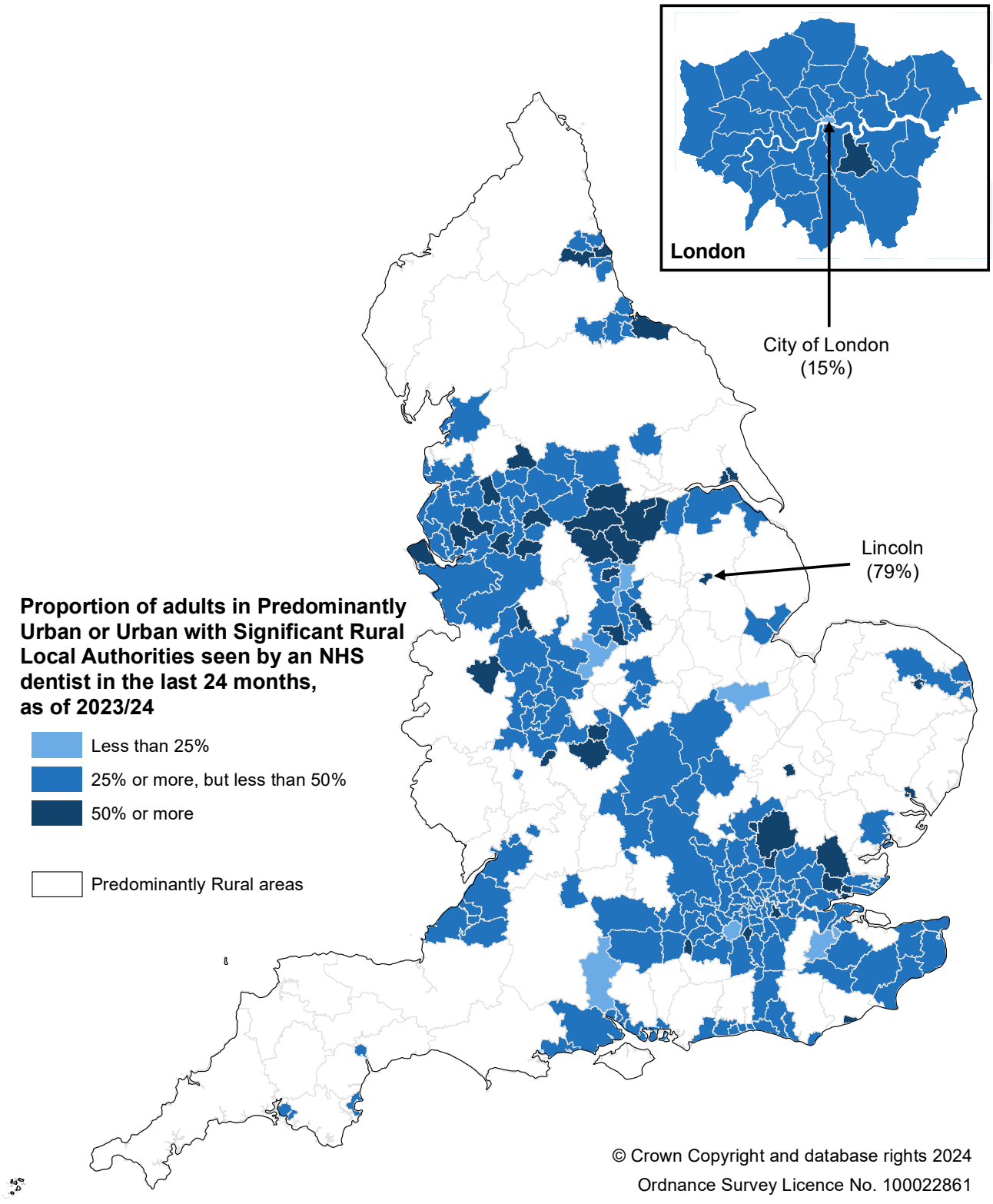


Figure C-5: Map showing the proportion of adults who had seen an NHS dentist in the last 24 months, for 2023 Predominantly Urban or Urban with Significant Rural Local Authorities within the Rural-Urban Classification in England, 2023/24 (Note C-4, Note C-7)

The Predominantly Urban or Urban with Significant Rural Local Authorities with the highest and lowest proportions of adults who had visited an NHS dentist recently are labelled on the map. There is an inset map in the top right of the figure showing the Local Authorities within London for easier identification of the labelled Authority. White areas on the map represent Predominantly Rural areas; the colour grading of these areas is instead given on Figure C-4.



Across England, children tend to visit an NHS dentist more frequently than adults.

In Predominantly Rural Local Authorities overall, 48% of children had been seen by an NHS dentist within the last 12 months, as of 2023/24; this compares to 57% of children in Predominantly Urban Local Authorities. The map shown in Figure C-6 highlights areas with particularly high or low proportions of children who had visited an NHS dentist within the last year. The lightest colour on the maps represents areas where less than 30% of children had visited an NHS dentist recently, whereas the darkest colour represents areas where at least 60% of children had visited an NHS dentist within the last year.

The map in Figure C-6, showing children's dentist visits in **Predominantly Rural** Local Authorities as of 2023/24, can be summarised as follows:

- There were 4 Predominantly Rural Local Authorities (5% of all Predominantly Rural areas) in which less than 30% of children had been seen by an NHS dentist within the last 12 months.
- There were 63 Predominantly Rural Local Authorities (84% of all Predominantly Rural areas) in which between 30% and 60% of children had been seen by an NHS dentist within the last 12 months.
- There were 7 Predominantly Rural Local Authorities (9% of all Predominantly Rural areas) in which at least 60% of children had been seen by an NHS dentist within the last 12 months.
- "Breckland" had the lowest proportion of children visiting an NHS dentist recently in Predominantly Rural areas, at 15%. In comparison, "Torridge" had the highest proportion, at 66%.

The map shown in Figure C-7 highlights the areas with particularly low or high relative proportions of children who had been seen by an NHS dentist within the last 12 months in Predominantly Urban or Urban with Significant Rural Local Authorities. The lightest colour represents areas where less than 45% of adults had visited an NHS dentist recently, whereas the darkest colour represents areas where at least 60% of adults had visited an NHS dentist within the last year.

The map in Figure C-7, showing children's dentist visits in **Predominantly Urban or Urban with Significant Rural** Local Authorities as of 2023/24, can be summarised as follows:

- There were 20 Predominantly Urban or Urban with Significant Rural Local Authorities (9% of all non-Rural areas) in which less than 45% of children had been seen by an NHS dentist within the last 12 months.
- There were 114 Predominantly Urban or Urban with Significant Rural Local Authorities (52% of all non-Rural areas) in which between 45% and 60% of children had been seen by an NHS dentist within the last 12 months.
- There were 87 Predominantly Urban or Urban with Significant Rural Local Authorities (39% of all non-Rural areas) in which at least 60% of children had been seen by an NHS dentist within the last 12 months.
- "Rochford" had the lowest proportion of children visiting an NHS dentist recently in Predominantly Urban or Urban with Significant Rural areas, at 31%. In comparison, "Lincoln" had the highest proportion, at 110%; this number is indicative of children who live elsewhere visiting NHS dentists in Lincoln.

Figure C-6: Map showing the proportion of children who had seen an NHS dentist in the last 12 months, for 2023 Predominantly Rural Local Authorities within the Rural-Urban Classification in England, 2023/24 (Note C-4, Note C-7)

The Predominantly Rural Local Authorities with the highest and lowest proportions of children who had visited an NHS dentist recently are labelled on the map. White areas on the map represent Predominantly Urban or Urban with Significant Rural areas; the colour grading of these areas is instead given on Figure C-7. Data excludes Isles of Scilly.

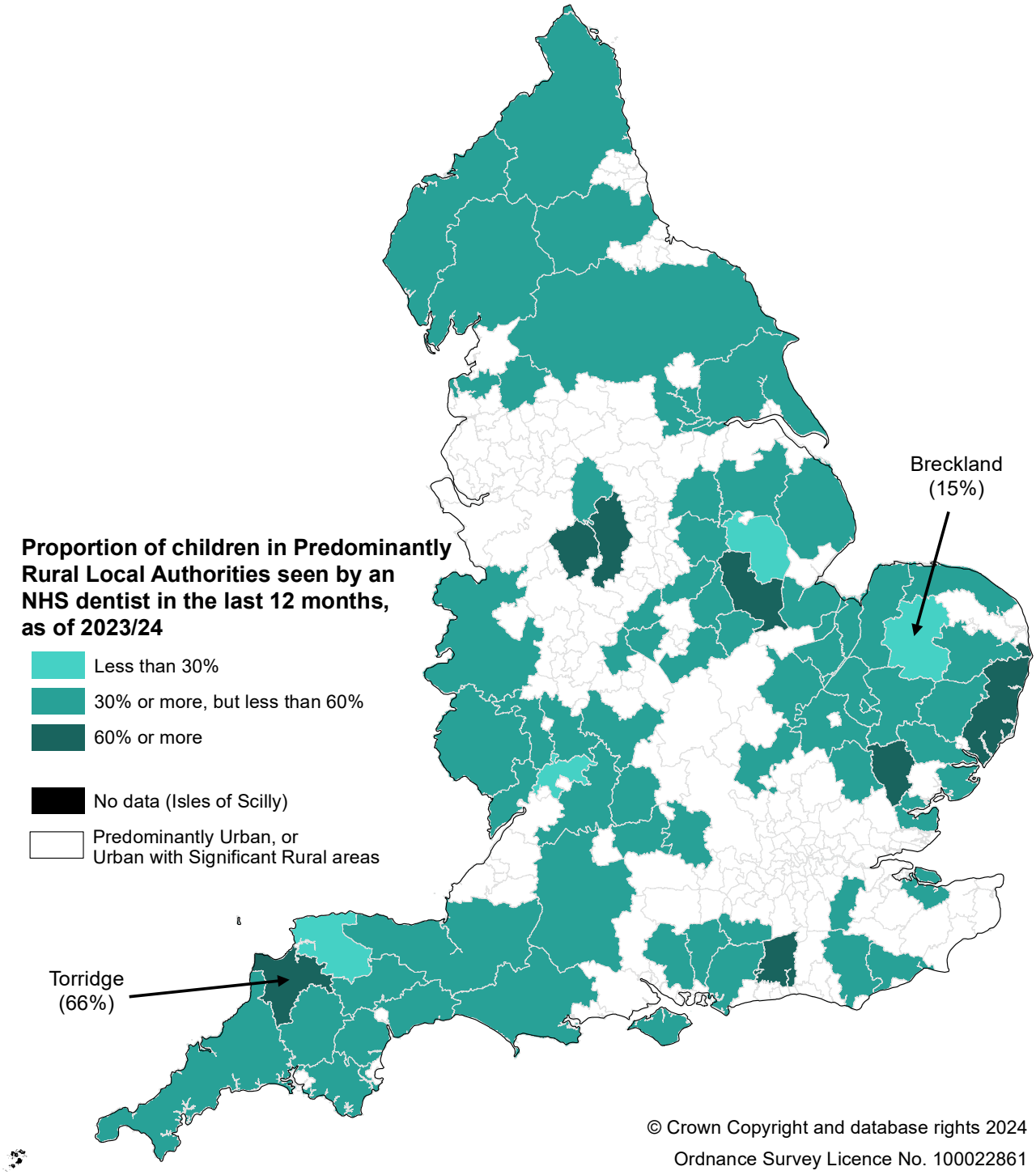
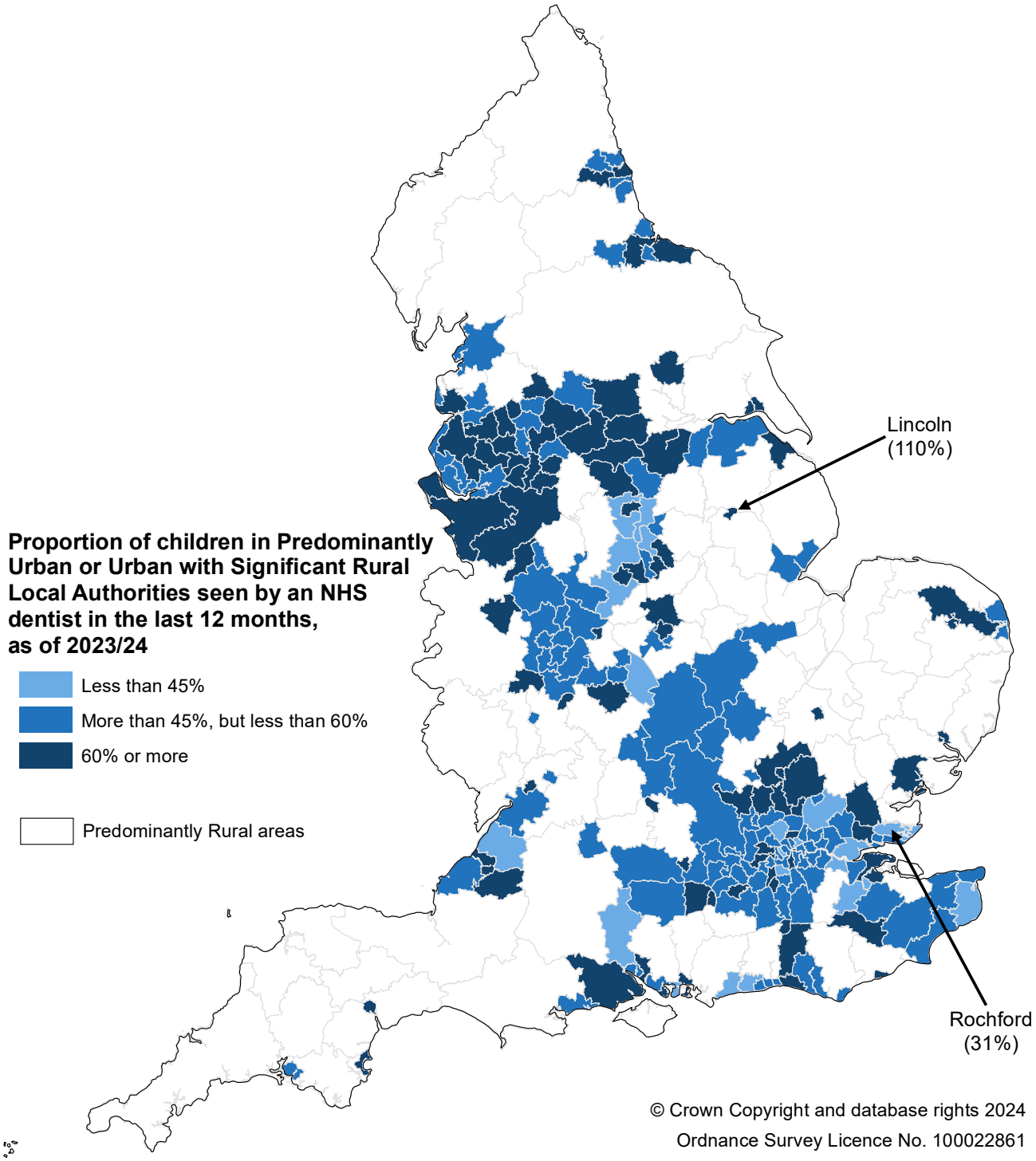


Figure C-7: Map showing the proportion of children who had seen an NHS dentist in the last 12 months, for 2023 Predominantly Urban or Urban with Significant Rural Local Authorities within the Rural-Urban Classification in England, 2023/24 (Note C-4, Note C-7)

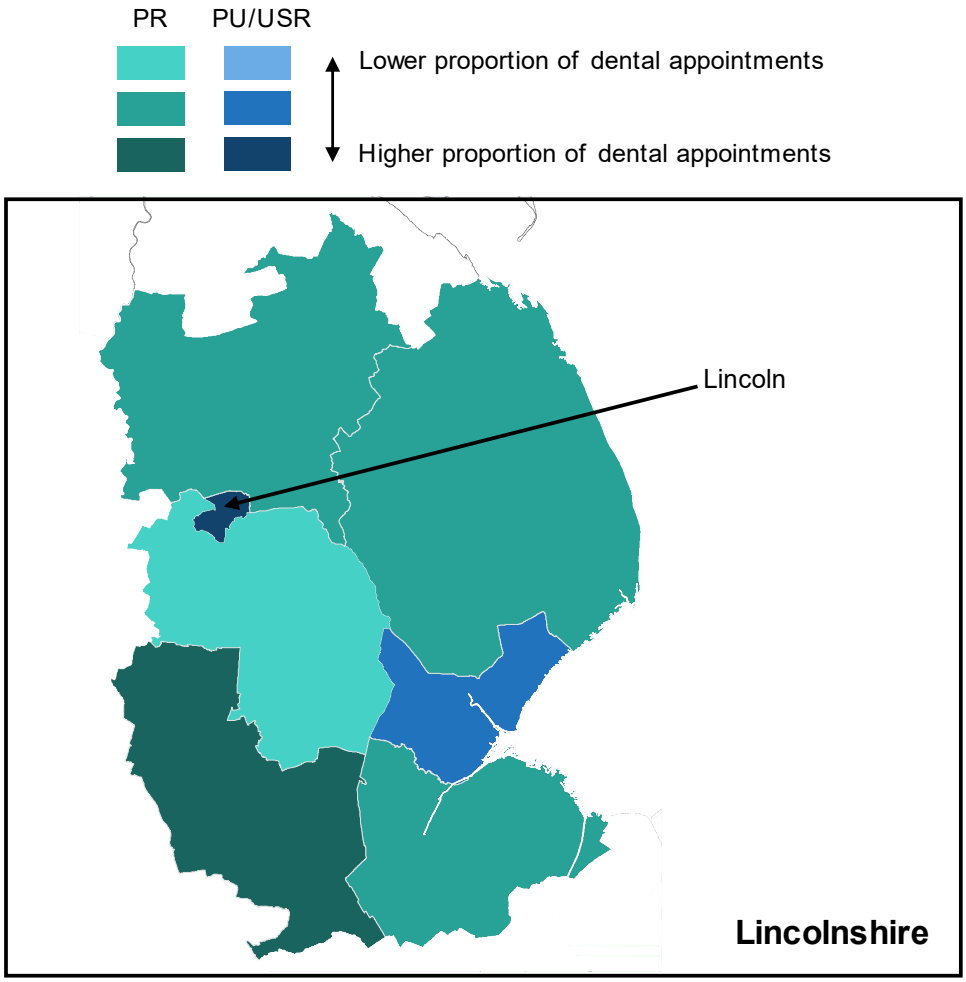
The Predominantly Urban or Urban with Significant Rural Local Authorities with the highest and lowest proportions of adults who had visited an NHS dentist recently are labelled on the map. White areas on the map represent Predominantly Rural areas; the colour grading of these areas is instead given on Figure C-6.



People may not attend an NHS dental practice local to where they live. This could be for several reasons, for example convenience from school/work, or availability of practices with NHS contracts within their local area.

In “Lincoln”, the ratio of dental visits to population is 110%. This is likely to be as a result of children travelling from the surrounding authorities to attend dental appointments in Lincoln. The map in Figure C-8 shows proportion of people who had an NHS dentist recently in Lincolnshire, as of 2023/24; the map uses data for children seeing a dentist within the last 12 months, but the trend is the same for adults seeing a dentist within the last 24 months.

Figure C-8: Map showing the proportion of people who had seen an NHS dentist recently in Lincolnshire, by Local Authority Rural-Urban Classification in England, 2023/24 (Note C-4)
Only the Local Authorities within Lincolnshire are coloured. Lincoln is labelled on the map as it is being used as an example of where NHS dental patients may travel for an appointment.



PR = Predominantly Rural

PU/USR = Predominantly Urban or Urban with Significant Rural

Lincoln – the Predominantly Urban Local Authority with the highest proportion of children (110%) and adults (79%) having seen an NHS dentist recently – is surrounded by Predominantly Rural Local Authorities. These surrounding areas have generally lower proportions of their populations having seen an NHS dentist attendance; for example, in North Kesteven, there were just 11% of adults and 23% of children who had visited an NHS dentist recently.

This suggests that, for both adults and children, there may be incidences where people living in the surrounding Local Authorities are travelling into Lincoln to visit an NHS dentist.

According to the Health Scrutiny Committee for Lincolnshire, many of the dental practices with NHS contracts were concentrated in and around Lincoln; as of April 2024, 11 of the 51 NHS dental practices in Lincolnshire were in Lincoln. This supports the idea that people may be less able to see an NHS dentist where they live in Lincolnshire, and instead have to travel.

NHS Dentistry provision explanatory notes

- **Note C-1**
  Within this publication, dentists are defined as performers with NHS activity recorded in the given period. Dentists can, and indeed do, operate in more than one geographical area. The England total excludes dentists counted more once. Hence the population per dentist is higher and the dentists per population lower for England overall compared with the sub-national figures.
- **Note C-2**
  Sub-Integrated Care Boards are transitional and correspond with the former Clinical Commissioning Group (CCG). There are 106 in England, and these have been classified using the Rural-Urban Classification methodology for higher geographies. The names refer to the ICB whereas the numbers refer to the sub-ICB.
- **Note C-3**
  Only one of the 10 sub-Integrated Care Boards with the lowest numbers of dentists per population were found in Predominantly Urban areas; the rest were in Predominantly Rural and Urban with Significant Rural areas.
- **Note C-4**
  Geographical data are for Local Authorities to which the Rural-Urban Classification has been applied. Patients might not attend a dentist in the area in which they live. Data does not include the Isles of Scilly Local Authority, as related dental data is often included in mainland contracts instead.

  Urban Conurbation" refers to the combination of two categories within the Rural-Urban Classification: "Urban with Minor Conurbation" and "Urban with Major Conurbation".
- **Note C-5**
  Source: Defra analysis of Dental statistics – England 2023/24 | NHSBSA
- **Note C-6**
  Patients seen also includes orthodontist visits; it is not possible to separately determine which patients were seen for orthodontic visits. Whilst the scales are the same on Figure C-2 and Figure C-3, they are not directly comparable as adults are represented when having visited an NHS dentist within the last 24 months, whereas children, it is the last 12 months.
- **Note C-7**
  Scales differ between the maps within this section; caution is advised when comparing between maps.

D. NHS General Practices

There were more General Practitioner working hours per patient in Predominantly Rural areas than in Predominantly Urban areas, however the average wait times for patient appointments were longer.

Summary

The network of NHS General Practices provides an essential first point of access to health care for Rural communities. These statistics do not include General Practitioners working for private practices.

In March 2024, there were 7,420 General Practitioners (GPs) in Predominantly Rural areas – 5,860 of which were permanent and fully-qualified. In Predominantly Urban areas, there were 28,760 GPs in March 2024 – 22,100 of which were permanent and fully-qualified. There was the equivalent workforce of around 6.1 full-time GPs per 10,000 patients in Predominantly Rural areas in March 2024, based on the distribution of Full Time Equivalent to patients. In Predominantly Urban areas, this was slightly lower at around 5.6 equivalent full-time GPs per 10,000 patients.

In March 2024, 47% of patients in Predominantly Rural areas were seen the same day or the day after they made an appointment; this was lower than in Predominantly Urban areas, where 50% of patients were seen the same or next day. 26% of patients in Predominantly Rural areas had to wait more than one week for an appointment at their General Practice, compared to 21% of patients in Predominantly Urban areas.

Prior to November 2024, this section included analysis of permanent General Practitioners leaving or joining roles between 2019/20 and 2022/23 using individual-level data. Due to difficulties in matching records across years, our analysis overestimated the role changes each year. We have decided to remove this analysis and replace it with information about GP appointments (mode, status, and waiting times).

Number of NHS General Practitioners

As one of the first points of access to health care, the network of General Practices provides an essential service for Rural communities. Please note: this analysis only focuses on those publicly available NHS practices, and therefore does not include private practices.

Table D-1 shows the total number of General Practitioners (GPs) in Predominantly Rural and Predominantly Urban areas, as at 31st March 2024. For the purposes of this analysis, "Permanent" GPs includes Salaried GPs, GP Partners, and GP Retainers, whereas "Non-permanent" GPs includes Locum GPs and GPs in Training (Note D-4, Note D-5); this includes both full-time and part-time practitioners.

Table D-1: Total number of General Practitioners (GPs) in roles, by detailed staff role and broad Rural-Urban Classification, as at 31st March 2024 (Note D-1, Note D-2, Note D-3)
Number of roles may not sum to totals due to some individuals having multiple roles.

Staff role group	Staff role	Predominantly Rural	Predominantly Urban
Permanent	GP Partners	3,090	11,290
	GP Retainers	110	310
	Salaried GPs	2,700	10,630
	Permanent GP role total	**5,860**	**22,100**
Non-permanent	GP Regular Locums	110	1,200
	GPs in Training Grades	1,470	5,750
	Non-permanent GP role total	**1,580**	**6,940**
Total	**All GP roles**	**7,420**	**28,760**

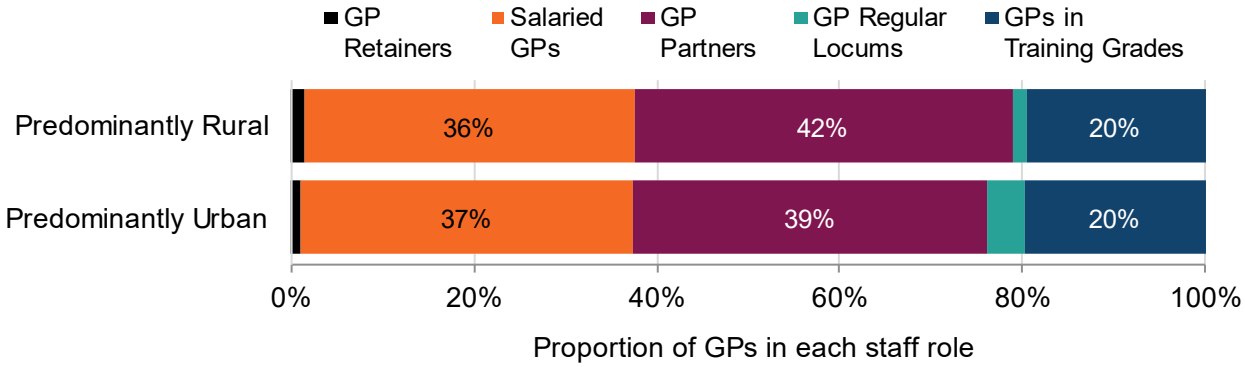
In Predominantly Rural areas, there were 7,420 GPs in roles in March 2024; this consisted of 5,860 permanent GPs and 1,580 non-permanent GPs. In comparison, there were 28,760 GPs in roles in Predominantly Urban areas, consisting of 22,100 permanent GPs and 6,940 non-permanent GPs. Absolute values are not directly comparable between settlement types due to population differences, and are therefore provided purely as contextual information.

Figure D-1 shows the distribution of GPs in roles, by Rural-Urban Classification, as at 31st March 2024. Analysis of detailed staff roles can be summarised as follows:

- 42% of all roles in Predominantly Rural areas were permanent, fully qualified GP Partners. In Predominantly Urban areas, this was slightly lower, at 39%.
- 36% of all Predominantly Rural roles were Salaried GPs; this was similar to Predominantly Urban areas (37%).
- In both Predominantly Rural and Predominantly Urban areas, 20% of all roles were GPs in Training Grades.
- There were similar proportions of GP Retainers in Predominantly Rural and Predominantly Urban areas, at 2% and 1% of all roles within each settlement type, respectively.
- 1% of all roles in Predominantly Rural areas were GP Regular Locums, compared to 4% in Predominantly Urban areas.

Figure D-1: Bar chart showing the proportion of General Practitioners (GPs) in roles, by detailed staff role and broad Rural-Urban Classification, in England, as at 31st March 2024 (Note D-1, Note D-2, Note D-3)

The legend is presented in the same order and orientation as the stacked bars. Values less than 5% have not been labelled on the chart.



The size of the GP workforce has steadily increased since March 2019, as shown in Table D-2; across the period March 2019 – March 2024, the GP workforce was at its largest in 2024.

In Predominantly Rural areas, the total GP workforce was 10% larger in March 2024 than in March 2019, increasing from 6,740 GPs to 7,420 GPs. In Predominantly Urban areas, the number of GPs also increased by 10%, from 26,070 GPs to 28,760 GPs.

The number of permanent GPs in Predominantly Rural areas increased by 5% (264 roles) between 2019 and 2024, compared to an increase of 4% (887 roles) in Predominantly Urban areas.

The number of non-permanent GPs in Predominantly Rural areas increased by 36% (417 roles) between 2019 and 2024. In Predominantly Urban areas, the non-permanent workforce increased by 34% (2,659 roles) over the same period.

Table D-2: Total number of General Practitioners (GPs) in roles, by staff role permanency group and broad Rural-Urban Classification in England, as at 31st March of each year, 2019 to 2024 (Note D-1, Note D-2, Note D-3)

Number of roles may not sum to totals due to some individuals having multiple roles.

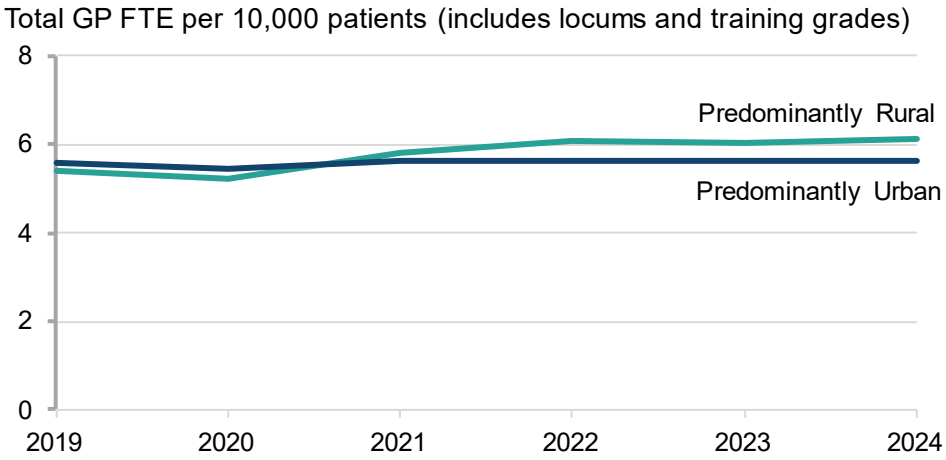
Rural-Urban Classification	Staff role group	2019	2020	2021	2022	2023	2024
Predominantly Rural	Permanent	5,600	5,540	5,720	5,810	5,770	5,860
	Non-permanent	1,160	1,140	1,260	1,360	1,450	1,580
	Total	**6,740**	**6,670**	**6,960**	**7,150**	**7,200**	**7,420**
Predominantly Urban	Permanent	21,220	21,270	21,810	21,750	21,500	22,100
	Non-permanent	5,150	5,380	5,940	6,130	6,610	6,940
	Total	**26,070**	**26,400**	**27,500**	**27,570**	**27,820**	**28,760**

Total Full-Time Equivalent (FTE) for NHS General Practitioners

In some cases, the role of a GP may be shared by multiple part-time people. In order to provide a more accurate depiction of the availability of GPs, it is possible to calculate the total full-time equivalent for GPs in Predominantly Rural and Predominantly Urban areas (Figure D-2). For the purposes of NHS workforce statistics, full-time is classed as working 37.5 hours per week. Comparison between settlement types is possible by weighting the data using the number of registered patients.

Figure D-2: Line chart showing total Full-Time Equivalent (FTE) for all General Practitioners (GPs) per 10,000 patients, by broad Rural-Urban Classification in England, as at 31st March of each year, 2019 to 2024 (Note D-2, Note D-3)

Total GP FTE is derived from total GP hours, and is indicative of availability to patients.



Over the period 2019 to 2022, the total GP FTE increased marginally in Predominantly Rural areas but stayed constant in Predominantly Urban areas. The time series can be described as follows:

- In 2019, there was the equivalent of 5.4 full-time GPs per 10,000 patients in Predominantly Rural areas. This was slightly lower than in Predominantly Urban areas, where there were 5.6 equivalent full-time GPs per 10,000 patients.
- In Predominantly Rural areas, the total GP FTE to patient rate increased over the period 2020 to 2022 to 6.1 equivalent full-time GPs per 10,000 patients. Following this, rates were similar in both 2023 and 2024 in Predominantly Rural areas.
- In Predominantly Urban areas, the rate of total GP FTE to patients was consistent at 5.6 equivalent full-time GPs per 10,000 patients between 2019 and 2024, except for in 2020, where there were 5.4 equivalent full-time GPs per 10,000 patients.
- Between 2021 and 2024, the total GP FTE per 10,000 patients was slightly higher in Predominantly Rural areas than in Predominantly Urban areas.

Sub-Integrated Care Board (sub-ICB) locations - previously known as CCGs - are NHS organisations that organise the delivery of NHS services in England. They are clinically led groups that include all of the GP groups in their geographical area. As of March 2024, there are 106 sub-ICBs in England.

When evaluating specific sub-ICBs, a particularly low GP FTE per 10,000 patients might indicate higher pressure on the practices (i.e., making it more difficult to get an appointment to be seen by a GP), whereas a particularly high GP FTE per 10,000 patients could indicate less pressure.

Table D-3 highlights the areas with the lowest GP FTE per 10,000 patients by Rural-Urban Classification, as at March 2024.

Table D-3: Sub-Integrated Care Boards (sub-ICBs) with the lowest General Practitioner (GP) Full-time Equivalent (FTE) per 10,000 patients in each category of the broad Rural-Urban Classification in England, 31st March 2024 (Note D-2, Note D-3)
"Rate" represents the total GP FTE per 10,000 patients within each area.

Rural-Urban Classification	Sub-ICB name	Rate
Predominantly Rural	Staffordshire and Stoke-on-Trent (05V)	5.2
Urban with Significant Rural	Kent and Medway (91Q)	4.6
Predominantly Urban	Mid and South Essex (07G)	4.2

The Predominantly Rural area with the lowest GP FTE-to-patient ratio was within the "Staffordshire and Stoke-on-Trent" Integrated Care Board (sub-ICB: 05V); here, there was the equivalent of 5.2 full-time GPs per 10,000 patients in March 2024. The Predominantly Urban area with the lowest GP FTE-to-patient ratio was within the "Mid and South Essex" Integrated Care Board (sub-ICB: 07G); here, there was the equivalent of 4.2 full-time GPs per 10,000 patients.

Table D-4 highlights the areas with the highest GP FTE per 10,000 patients by Rural-Urban Classification, as at March 2024.

Table D-4: Sub-Integrated Care Boards (sub-ICBs) with the highest General Practitioner (GP) Full-time Equivalent (FTE) per 10,000 patients in each category of the broad Rural-Urban Classification in England, 31st March 2024 (Note D-2, Note D-3)
"Rate" represents the total GP FTE per 10,000 patients within each area.

Rural-Urban Classification	Sub-ICB name	Rate
Predominantly Rural	Humber and North Yorkshire (42D)	7.3
Urban with Significant Rural	Staffordshire and Stoke-on-Trent (05G)	7.2
Predominantly Urban	Cheshire and Merseyside (12F)	8.2

The Predominantly Rural area with the highest GP FTE-to-patient ratio was within the "Humber and North Yorkshire" Integrated Care Board (sub-ICB: 42D); here, there was the equivalent of 7.2 full-time GPs per 10,000 patients. The Predominantly Urban area with the highest GP FTE-to-patient ratio was within the "Cheshire and Merseyside" Integrated Care Board (sub-ICB: 12F); here, there was the equivalent of 8.2 full-time GPs per 10,000 patients.

The sub-ICBs with the highest and lowest GP FTE rates in England overall were both found in Predominantly Urban areas.

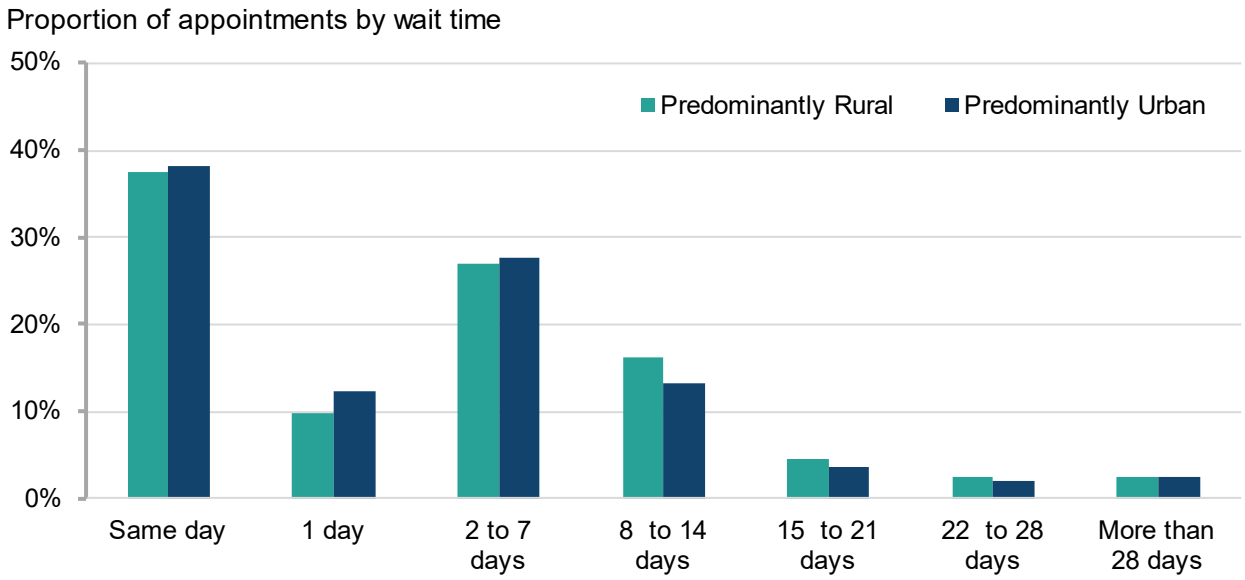
NHS General Practice appointments

Appointment waiting times

Wait times for an appointment to see a General Practitioner can vary for many reasons, including patient demand and staff shortages. The bar chart in Figure D-3 shows the proportion of NHS General Practice appointments within each wait time band in Predominantly Rural and Predominantly Urban sub-Integrated Care Boards in March 2024.

Patients were most likely to get a same-day appointment than any other wait time. Failing this, they were likely to have to wait 2 to 7 days for an appointment in March 2024. Having to wait more than three weeks for an appointment was uncommon in March 2024.

Figure D-3: Bar chart showing the proportion of NHS General Practice appointments within each band of waiting times, by broad sub-Integrated Care Board Rural-Urban Classification in England, March 2024 (Note D-2, Note D-6, Note D-7)
The legend is presented in the same order and orientation as the clusters of bars.



The bar chart in Figure D-3 can be described as follows:

- 37% of people requesting an appointment in Predominantly Rural areas were seen the **same day**; this is slightly lower than in Predominantly Urban areas (38%). These were the highest percentages seen for any wait-time band.
- 10% of people requesting an appointment in Predominantly Rural areas were seen within **1 day**; this is lower than in Predominantly Urban areas (12%).
- 27% of people requesting an appointment in Predominantly Rural areas were seen within **2 to 7 days**; this is slightly lower than in Predominantly Urban areas (28%).
- 16% of people requesting an appointment in Predominantly Rural areas were seen within **8 to 14 days**; this is higher than in Predominantly Urban areas (13%).
- In both Predominantly Rural and Predominantly Urban areas, 4% of people requesting an appointment were seen within **15 to 21 days**.

- In both Predominantly Rural and Predominantly Urban areas, 2% of people requesting an appointment were seen within **22 to 28 days**.
- 3% of people wanting an appointment in Predominantly Rural areas were seen **more than 28 days** after their initial request; this is similar to Predominantly Urban areas.

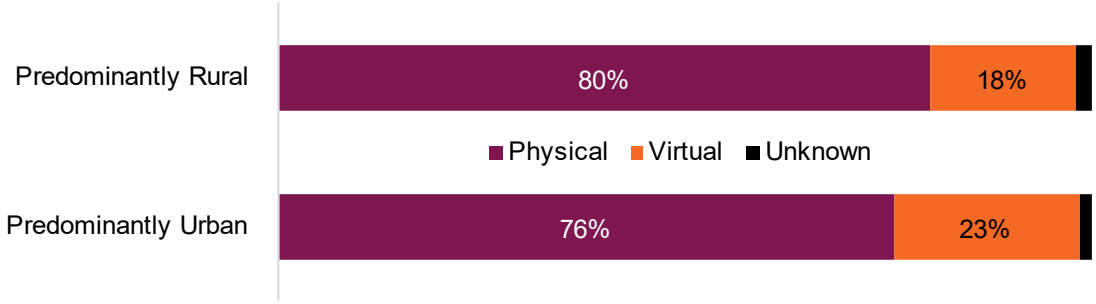
The median wait time to be seen in March 2024 was 2 to 7 days in Predominantly Rural areas, and 1 day in Predominantly Urban areas. This means that people in Predominantly Rural areas might wait slightly longer to be seen by a GP compared to those in Predominantly Urban areas; however, in all settlement types, people are still likely to be seen the same day.

Mode and status of appointments

In an attempt to reduce the waiting times for an appointment, General Practices offer both physical and virtual appointments. “Physical” includes face-to-face appointments at the practice, and home visits. “Virtual” includes telephone and video conference/online appointments.

The bars in Figure D-4 show that a larger proportion of appointments were physical in Predominantly Rural areas compared to Predominantly Urban areas (80% and 76%, respectively); the majority of physical appointments were face-to-face in the GP surgery, corresponding to 74% of all appointments in both Predominantly Rural and Predominantly Urban areas. A smaller proportion of appointments were virtual in Predominantly Rural areas than in Predominantly Urban areas (18% and 23%, respectively). 2% of appointments did not have a recorded mode in both settlement types.

Figure D-4: Bar chart showing the proportion of NHS General Practice appointments, by mode of appointment and broad sub-Integrated Care Board Rural-Urban Classification in England, March 2024 (Note D-2, Note D-6, Note D-7)
The legend is presented in the same order and orientation as the bars. Proportions smaller than 5% have not been labelled.

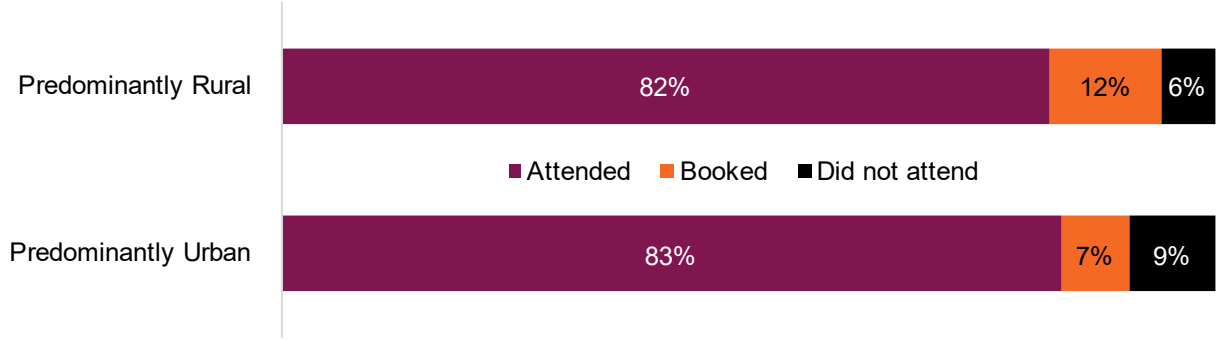


Wasted appointments (i.e., when a patient does not attend their scheduled appointment) can affect waiting times as it means patients who are willing to attend will have to wait longer to be seen.

The bars in Figure D-5 show that a smaller proportion of patients wasted their appointments by not attending in Predominantly Rural areas compared to Predominantly Urban areas (6% and 9%, respectively). A similar proportion had attended appointments in Predominantly Rural (82%) and Predominantly Urban (83%) areas in March 2024.

Figure D-5: Bar chart showing the proportion of NHS General Practice appointments, by appointment status and broad sub-Integrated Care Board Rural-Urban Classification in England, March 2024 (Note D-2)

The legend is presented in the same order and orientation as the bars. “Booked” represents appointments which have not yet been attended.



Same or next day appointments

When evaluating specific sub-Integrated Care Boards, a particularly low proportion of appointments being the same day or the day after they were booked may indicate where practices are struggling to meet patient demand. Table D-5 highlights the areas with the lowest proportion of same or next-day appointments, by Rural-Urban Classification, in March 2024.

Table D-5: Sub-Integrated Care Boards (sub-ICBs) with the lowest proportion of appointments being the same day or the day after they were booked in each category of the broad Rural-Urban Classification in England, March 2024 (Note D-2, Note D-6, Note D-7)

Rural-Urban Classification	Sub-ICB name	Rate
Predominantly Rural	Cornwall and the Isles of Scilly (11N)	10%
Urban with Significant Rural	Devon (15N)	15%
Predominantly Urban	Cheshire and Merseyside (01V)	0%

Of the sub-ICBs with recorded appointment wait time data, the Predominantly Rural area with the lowest proportion of same/next day appointments in March 2024 was within the “Cornwall and the Isles of Scilly” Integrated Care Board (sub-ICB: 11N); here, 10% of patients were seen the same day or the day after they made an appointment.

The Predominantly Urban area with the lowest proportion of same/next day appointments in March 2024 was within the “Cheshire and Merseyside” Integrated Care Board (sub-ICB: 01V); here, there were no patients who were seen the same day or the day after they made an appointment. However, this is likely caused by the small number of appointments made within this sub-ICB in March 2024.

Table D-6 highlights the areas with the highest proportion of same or next-day appointments, by Rural-Urban Classification, in March 2024.

Table D-6: Sub-Integrated Care Boards (sub-ICBs) with the highest proportion of appointments being the same day or the day after they were booked in each category of the broad Rural-Urban Classification in England, March 2024 (Note D-2, Note D-6, Note D-7)

Rural-Urban Classification	Sub-ICB name	Rate
Predominantly Rural	Norfolk and Waveney (26A)	66%
Urban with Significant Rural	Sussex (97R)	81%
Predominantly Urban	Hertfordshire and West Essex (06N)	77%

The Predominantly Rural area with the highest proportion of same/next day appointments in March 2024 was within the "Norfolk and Waveney" Integrated Care Board (sub-ICB: 26A); here, 66% of patients were seen the same day or the day after they made an appointment.

The Predominantly Urban area with the highest proportion of same/next day appointments in March 2024 was within the "Hertfordshire and West Essex" Integrated Care Board (sub-ICB: 06N); here, 77% of patients were seen the same day or the day after they made an appointment.

NHS General Practices explanatory notes

- **Note D-1**

Data has been rounded to the nearest 10 GPs. Unrounded data is available in the Health and Wellbeing supplementary data tables.

- **Note D-2**

In this section, a Rural-Urban Classification has been applied using the sub-Integrated Care Board (or Clinical Commissioning Group) of each General Practitioner.

- **Note D-3**

Source: General Practice Workforce - NHS Digital. Data has been taken from 31st March of each year.

- **Note D-4**

According to NHS definitions General Practitioners (GPs) can be a salaried GP, a GP Retainer, or a GP partner. A salaried GP is employed by a GP practice, Local Authority, Integrated Care Board (ICB), or sub-ICB location. GP retainers are fully qualified GPs who deliver a maximum of four sessions in general practice per week to retain skills and progress their careers potentially with a view to increasing their working commitment in the future. GP partners are self-employed GPs who are responsible for running their own practice. In either case they can work full-time or part time. Full time is considered to be 37.5 hours per week and part-time is anything less than that. Where available, actual FTE values were used for individuals. Where data were not available, estimates of FTE were used based on contractual hours.

- **Note D-5**

Not all General Practitioners (GPs) will hold a permanent position at one or more practices. According to NHS definitions they can also be: (i) Locum GPs; or (ii) GPs in training.

Locum GPs are GPs who provide service sessions in general practice on a temporary basis. They may work in the practices for relatively long periods but may also provide cover on a short-term or ad hoc basis. This group includes Locums covering vacancies, sickness, and maternity/paternity absence. GPs in training are fully registered physicians who are being trained for general practice under an arrangement approved by the Secretary of State. This category of GPs includes Foundation Training (FT) 1/2 and Speciality Training (ST).

- **Note D-6**

Data includes scheduled surgery appointments and scheduled telephone consultations. Data also includes the following activities, if they are recorded as individual appointments and booked to a patient: telephone triage; online consultations; home visits; immunisations; enhanced access appointments. Appointments outside of core hours with a valid attendance status are also included. Some sub-ICBs have not been included in the waiting times analysis; they are represented in the supplementary tables with a “missing data” symbol. Source data are experimental statistics.

For more information, visit: Appointments in general practice: supporting information - NHS England Digital.

- **Note D-7**

Source: Appointments in General Practice, March 2024 - NHS England Digital

E. Childcare provision

Childcare is changing in both Rural and Urban areas; in the last 7 years the number of providers has reduced alongside a move away from childminders and towards childcare on non-domestic premises; and the overall quality of childcare has improved.

Summary

Childcare provision in both Rural and Urban areas is an important service that some parents need in order to take up employment.

In 2022 childminders were the most common form of childcare provider in both Predominantly Rural and Predominantly Urban areas and accounted for 47% and 46% of providers respectively. The distribution of childcare providers is changing; comparing 2015 to 2022 shows that there has been a shift away from childminders towards childcare on non-domestic premises. This shift was bigger in Predominantly Urban areas than in Predominantly Rural areas.

In March 2022 there were 13,000 childcare providers in Predominantly Rural areas and 47,300 in Predominantly Urban areas. The number of active childcare providers in Predominantly Rural areas decreased by 28% between 2015 and 2022. A large loss of childcare providers does not necessarily mean an equivalent loss of childcare places; in 2015 there were 270,000 childcare places on the Early Years Register (EYR) in Predominantly Rural areas and by 2022 the number of places had fallen by 5.1% to 255,000.

In 2022, 7,900 providers (97%) in Predominantly Rural areas received a Good or Outstanding rating at their most recent inspection and only 100 were rated Inadequate. The overall quality of childcare providers has improved in both Predominantly Rural and Predominantly Urban areas since 2015. The proportion of providers judged to be Good or Outstanding has increased by 10% in Predominantly Rural areas and by 13% in Predominantly Urban areas.

For 3- or 4-year-old children, in 2022, the median hourly fee was £4.79 in Predominantly Rural areas and £4.93 in Predominantly Urban (excluding London) and both were less than the overall median fee for England (£5.38) which was pushed up by expensive childcare in London (£7.04 per hour). A parent can expect to pay more for childcare for a 2-year-old than a 3- or 4-year-old. For 2-year-old children the median hourly fee was £4.95 in Predominantly Rural areas and £4.99 in Predominantly Urban (excluding London) areas.

Childcare provider types

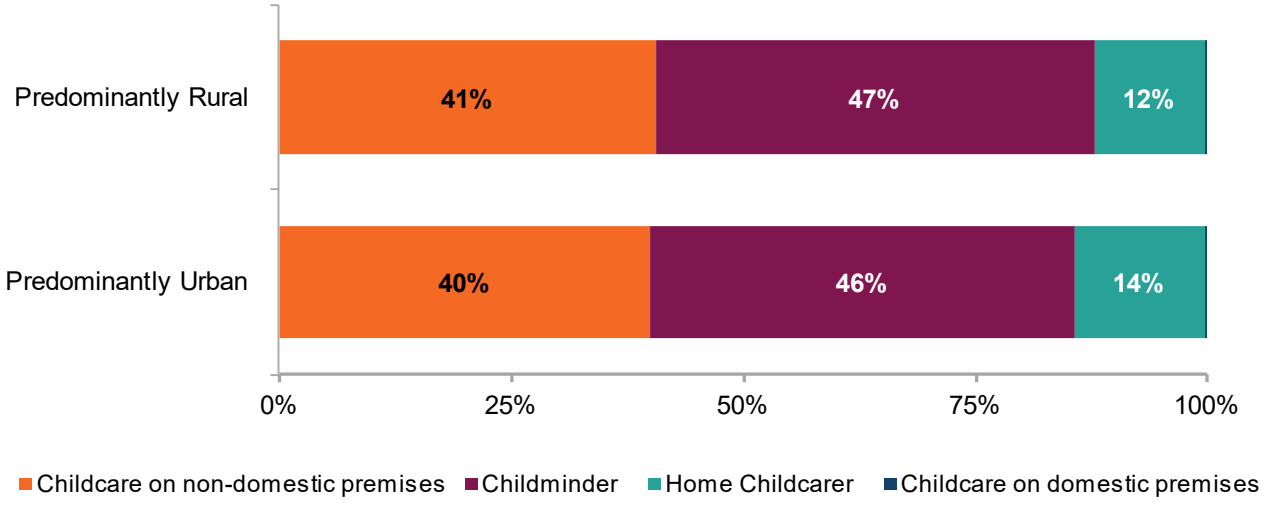
In England it has become common for both parents, or the single parent, to be in employment rather than the child having a full time stay at home parent. Formal childcare then becomes an important service to allow parents to balance parenting and earning. Many parents need to use formal childcare such as those described in Table E-1. Sometimes this will be instead of or in conjunction with informal arrangements such as the additional support provided by grandparents.

Table E-1: Definitions for formal childcare categories

Type of Provider	Description
Childcare on non-domestic premises	Nurseries, pre-schools, holiday clubs and other group-based settings, usually registered on the Early Years Register (EYR) because they look after children aged 0 to 5 years.
Childminders	People who look after one or more children they are not related to for payment or reward. The care takes place in a home that is not the child's own. The majority register on the EYR because they look after children aged 0 to 5 years, but those who look after 5 to 7-year olds need to register on the Childcare Register (CR).
Home childcarers (nannies)	Individuals who care for children aged 0 to 18 years wholly or mainly in the child's own home. They are not required to register with Ofsted. Though they may choose to do so on the Voluntary Childcare Register (VCR).
Childcare on domestic premises	Where four or more people look after children together in a home that is not the child's. The majority are registered on the EYR and some are registered on the CR, depending on the age of the children they look after.

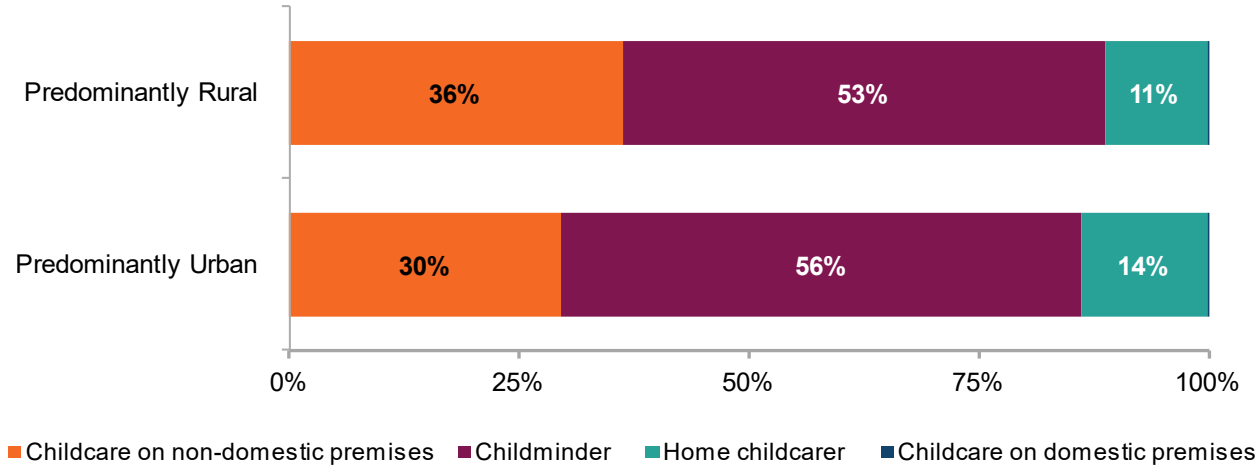
Figure E-1 is a stacked bar chart which shows that in 2022 childminders were the most common form of childcare provider in both Predominantly Rural and Predominantly Urban areas and accounted for 47% and 46% of providers respectively. The second most common provider type was childcare on non-domestic premises (nurseries) which was 41% of providers in Predominantly Rural areas and 40% of providers in Predominantly Urban areas. Home childcare (nannies) is marginally more prevalent in Predominantly Urban areas than Predominantly Rural areas.

Figure E-1: A stacked bar chart showing the proportion of childcare providers, by type of provider (Table E-1) and by Rural-Urban Classification, March 2022, England
The legend is presented in the same order and orientation as the stacks in the bars.



The distribution of childcare providers is changing. Figure E-2 is a stacked bar chart which shows the proportion of childcare providers by provider type in 2015. In 2015 childminders were still the most popular provider type in both Predominantly Rural and Predominantly Urban areas followed by childcare on non-domestic premises. Over the period 2015 to 2022 there has been a shift in the distribution away from childminders and towards childcare on non-domestic premises and this shift was bigger in Predominantly Urban areas than in Predominantly Rural areas. This shift might in part have been driven by the fact that it is easier to meet certain regulations and expected standards in a purpose-built setting generating income from more children than a single childminder can cater for.

Figure E-2: A Stacked bar chart showing the proportion of childcare providers, by type of provider (Table E-1) and by Rural-Urban Classification, March 2015, England
The legend is presented in the same order and orientation as the stacks in the bars.



Number of childcare providers

In March 2022 there were 68,000 childcare providers in England, of which 13,000 were in Predominantly Rural areas and 47,300 were in Predominantly Urban areas (Table E-2). In Predominantly Rural areas there were 6,100 childminders and 5,300 providers offering a childcare service on non-domestic premises.

Table E-2: Number of Childcare Providers, by type of provider and by Parliamentary Constituency Rural-Urban Classification, March 2022, England

	Childcare on non-domestic premises	Childminders	Home childcare (nannies)	Childcare on domestic premises	Total providers
Predominantly Rural	5,280	6,140	1,560	40	13,010
Urban with Significant Rural	3,070	3,660	930	30	7,690
Predominantly Urban	18,940	21,580	6,630	180	47,320
England	27,290	31,370	9,120	240	68,030

The number of childcare providers in England is in decline. Figure E-3 Is a line chart showing that the total number of active childcare providers has declined every year since 2015 in both Predominantly Rural and Predominantly Urban areas. Table E-3 shows that the number of active childcare providers in Predominantly Rural areas has decreased by 28% since 2015, while in Predominantly Urban areas there has been a 21% fall.

In March 2020 there was 14,500 childcare providers in Predominantly Rural areas and by March 2022 the number had fallen to 13,000 (Table EA1, Health and Wellbeing data tables). This is a loss of 10% of the childcare providers in Predominantly Rural areas in the first 2 years after the Covid-19 pandemic first hit the UK in early 2020. Predominantly Urban areas lost 9% of childcare providers over the same 2 year period.

Figure E-3: A line chart showing the Index of total number of childcare providers (2015 = 100), by Parliamentary Constituency Rural-Urban Classification, March 2015 to March 2022, England

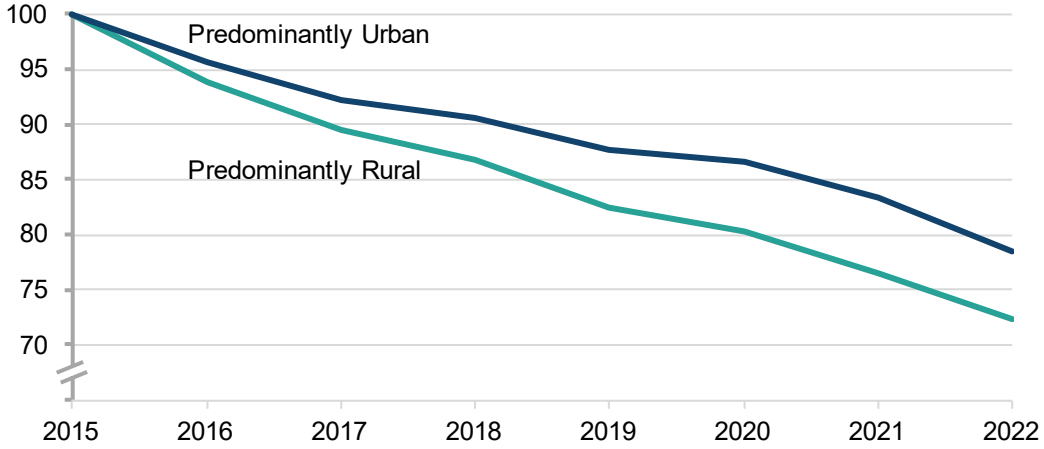


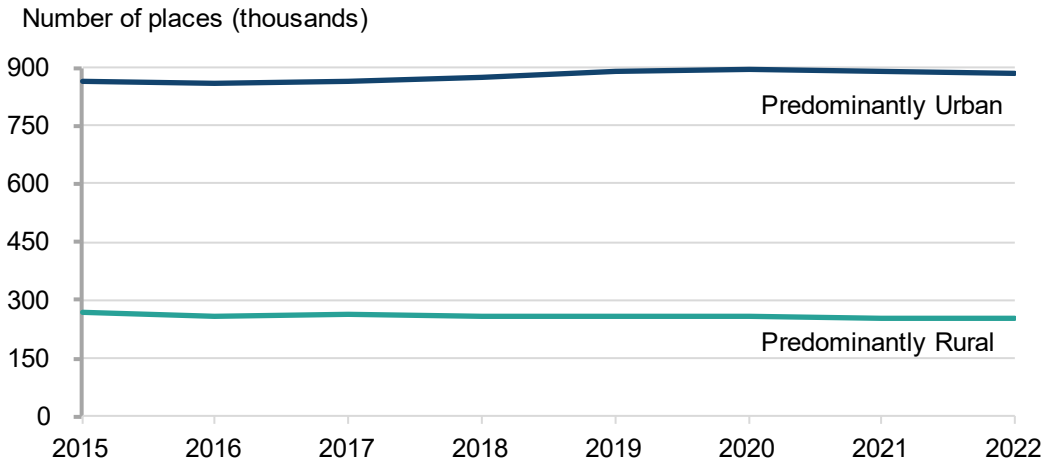
Table E-3: Index of change in Childcare Providers (2015 = 100), by Rural-Urban Classification, March 2015 to March 2022, England (Note E-3)

	2015	2016	2017	2018	2019	2020	2021	2022
Predominantly Rural areas	100	93.8	89.6	86.8	82.4	80.3	76.4	72.3
Urban with Significant Rural	100	94.7	90.9	88.1	83.1	80.0	76.4	73.0
Predominantly Urban	100	95.6	92.2	90.6	87.6	86.6	83.3	78.5
England	**100**	**95.3**	**91.3**	**89.5**	**86.0**	**84.2**	**80.8**	**76.3**

A loss of childcare providers does not necessarily mean a loss of childcare places; expansion of, or the creation of new, larger providers can cover for the loss of smaller providers. Registered places are collected for all providers on the Early Years Register (EYR) – which includes all providers of pre-school childcare. Registered places are the capacity for the provider (Note E-4). It is an estimate of the number of children that can attend the provision at any one time not the number of places occupied, or the number of children benefiting from a place at the establishment.

In England there was 1.3 million childcare places on the on the EYR in March 2015 and in March 2022 there was still 1.3 million childcare places on the EYR. But as Figure E-4 shows, there has been a small change in the distribution of these 1.3 million places across Predominantly Rural and Predominantly Urban areas. In 2015 there was 270,000 childcare places on the EYR in Predominantly Rural areas and by 2022 the number of places had fallen by 5.1% to 255,000. By contrast in Predominantly Urban areas the number of places on the EYR increased from 860,000 in 2015 to 885,000 in 2022. This was an increase of 2.7%. In both Predominantly Rural and Predominantly Urban areas more childcare places were available in March 2019 prior to the Covid-19 pandemic than were available in March 2022. In Predominantly Rural areas there was 3,900 (1.5%) fewer childcare spaces in 2022 than in 2019, whilst for Predominantly Urban areas there was 4,600 (0.5%) fewer spaces.

Figure E-4: A line chart of the number of registered places at providers on the Early Years Register (EYR) by Parliamentary Constituency Rural-Urban Classification, March 2015 to March 2022, England (Note E-4, Note E-5)



Notes

- The childcare provider data in Table E-2 has been rounded to the nearest 10 therefore the totals might not equal the sum of the component parts.

Quality of childcare providers

Being part of the Early Years Register (EYR) is compulsory for providers who care for children up to the age of 5 years. Active EYR providers are inspected on a 4-year cycle and are given an Overall Effectiveness grade, in line with Ofsted's Common Inspection Framework (CIF), which measures the overall quality of childcare provision. A complementary analysis focused on the quality of schools is contained with our education report (Note E-10).

Figure E-5 shows that between 2015 and 2022 the percentage of EYR childcare providers judged to be Good or Outstanding in Predominantly Rural areas increased from 87% to 97% of the inspected EYR providers. In Predominantly Urban areas the proportion judged to be Good or Outstanding increased from 83% to 96%. Whilst the proportion of providers judged to be Good or Outstanding was higher in Predominantly Rural areas than in Predominantly Urban areas in 2015, in 2022 this proportion was similar.

Table E-4 shows the number of childcare providers receiving each of the inspection outcome categories at their most recent assessment in both Predominantly Rural and Predominantly Urban areas in 2015 and 2022. In absolute terms, in 2022, 7,900 providers in Predominantly Rural areas received a Good or Outstanding rating at their most recent inspection and only 100 were rated Inadequate.

It should be noted that in 2022 the inspection status was unknown for 22% of providers in Predominantly Rural areas; while in Predominantly Urban areas the inspection status was unknown for 26% of providers. A higher proportion of providers had an unknown inspection status in 2022 than in 2015 when the proportions were 12% for Predominantly Rural areas and 15% for Predominantly Urban areas. The disruption to the inspection process caused by the Covid-19 pandemic will have had an impact on the proportion of providers with an unknown inspection status, but the proportion of providers with an unknown inspection status is lower in 2022 than it was in 2021 indicating that progress in being made to catch up.

Figure E-5: Early Year Registered (EYR) child carer inspection outcomes as percentage of total EYR childcare providers, by Parliamentary Constituency Rural-Urban Classification, March 2022 (top chart) and March 2015 (bottom chart), England

Only bars representing more than 5% are labelled and the legend is presented in the same order and orientation as the stacks in the bars.

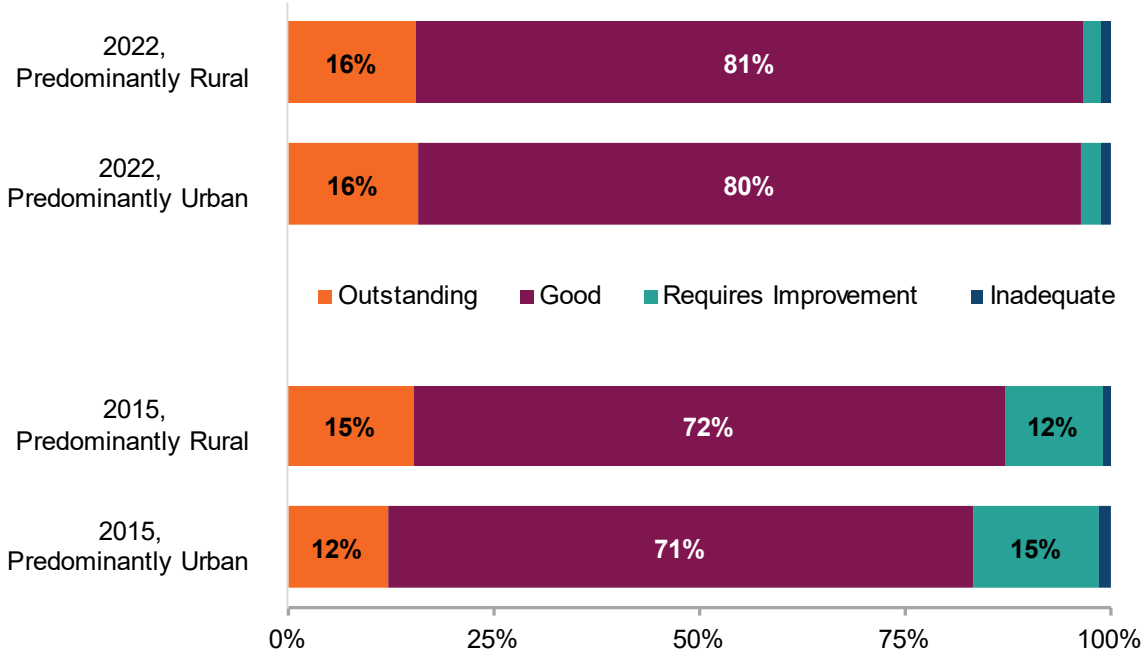


Table E-4: Number of Early Year Registered child carers most recent inspection outcome, by Rural-Urban Classification, 2015 and 2022, England

	2015, Predominantly Rural	2022, Predominantly Rural	2015, Predominantly Urban	2022, Predominantly Urban
Inspections with known outcome	**13,510**	**8,170**	**41,550**	**27,030**
Outstanding	2,060	1,280	5,050	4,300
Good	9,720	6,620	29,590	21,760
Requires improvement	1,590	170	6,340	670
Inadequate	150	100	570	310
Inspections with unknown outcome	1,860	2,270	7,360	9,530

Notes

- The inspection data presented in Table E-4 & Figure E-5 are as of March in the reference year specified. The data in Table E-4 has been rounded to the nearest 10 therefore the totals might not equal the sum of the component parts.
- The percentages presented in Figure E-5 are calculated on the basis of the total number of providers with a known inspection outcome. More providers had an unknown inspection outcome in 2022 than in 2015.

Cost of childcare

When parents use formal childcare to allow them to balance parenting and earning there is obviously a cost of doing so.

The Department for Education collect information on the cost of childcare as part of the Childcare and early years provider survey (SCEYP). SCEYP covers childcare provided by group-based providers, school-based providers and childminders. Note E-6 provides more information on these provider types.

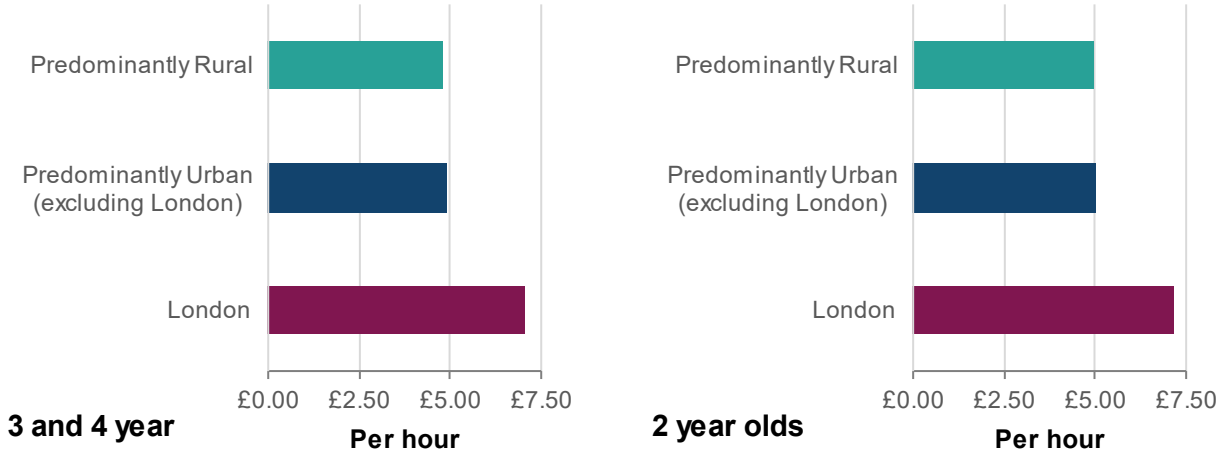
The 2022 survey collected the average hourly fee at (Upper Tier) Local Authority level (Note E-7) for both 2-year-old children and 3- or 4-year-old children. Both the mean and the median hourly cost was collected. For most Local Authorities the mean cost was higher than the median cost and for more than 20 Local Authorities the mean cost was more than 50p per hour more than the median cost (Note E-8). This implies that the distribution of hourly rates for childcare is skewed such that there are some much more expensive providers raising the overall mean childcare cost. These outliers coupled with relatively small sample sizes for some Local Authorities caused the precision of the mean for at least a third of the Local Authorities to be quite low (Note E-9); therefore, in our analysis we have used the median estimates.

The cost of childcare in London is a lot more expensive that it is elsewhere in the country, so we have separated London from the other Urban areas into its own category. This allows for a better comparison of the costs between Predominantly Rural and Predominantly Urban areas.

For 3- or 4-year-old children, in 2022, the median hourly fee was £4.79 in Predominantly Rural areas and £4.93 in Predominantly Urban (excluding London) areas (Figure E-6 – left-hand bar chart). The difference between these values was quite small and both were less than the overall median fee for England (£5.38) and over £2 per hour less than the median childcare fee for 3- or 4-year-olds in London (which was £7.04). In a hypothetical scenario where a parent has a full-time job of 37 hours per week and needs childcare for 42 hours per week (to allow 30 mins to get to and from work after drop-off and before pick-up), using the median fee the parent would spend £5.83 per week less for this childcare in Predominantly Rural than in Predominantly Urban (excluding London) areas.

Figure E-6: Bar chart showing the median the hourly fee for childcare by Local Authority Rural-Urban Classification, 2022, England

The left-hand chart is for 3- and 4-year-old children and the right-hand chart is for 2-year-old children. The RUC has been applied at Upper Tier Local Authority level (Note E-7) and London has been separated out from other Urban areas.



For 2-year-old children the median hourly fee was £4.95 in Predominantly Rural areas and £4.99 in Predominantly Urban (excluding London) areas (Figure E-6 – right-hand bar chart). These values

are very similar, and both were less than the overall median fee for England (£5.46) and over £2 per hour less than the median childcare fee for 2-year-olds in London (which was £7.17). Using the same hypothetical scenario of the working parent from the previous paragraph, if their child was a 2-year-old then the parent would only spend £1.72 per week less for this childcare in Predominantly Rural than in Predominantly Urban (excluding London) areas.

Childcare provision explanatory notes

- **Note E-1**

An unrounded version of Table E-2 is available in the Health and Wellbeing data tableshttps://www.gov.uk/government/statistics/statistical-digest-of-rural-england.

- **Note E-2**

In this section, a Rural-Urban Classification has been applied using the Parliamentary Constituency of each childcare provider, since this was the lowest level of geography published that covered all providers. As of the 2019 General Election there are 533 parliamentary constituencies in England.

- **Note E-3**

The total childcare provider data, used for the index, is drawn together from three Ofsted registers: Early Years Register (EYR), Compulsory Childcare Register (CCR) and Voluntary Childcare Register (VCR). The individual register data is found in the Ofsted providers level data (Note E-5).

A decline in childcare providers does not necessary imply a decline in the number of childcare places available.

For more information see the Main findings and methodology report on the Childcare providers and inspections as at 31 March 2020 Official Statistics homepage.

- **Note E-4**

Registered places are the number of children that may attend the provision at any one time. Registered places are not the number of places occupied, nor the number of children who may benefit from receiving places through providers offering sessions at different times of the day. Place numbers are only collected for providers on the Early Years Register (EYR). But being part of the EYR is compulsory for providers who care for children up to the age of 5 years Provider type averages are used to estimate the number of places for a very small number of providers whose place numbers are not available at the time of the analysis.

- **Note E-5**

Source data for this section: Ofsted Childcare providers level data as at 31 March 2022

- **Note E-6**

Group-based providers (identified from the Ofsted register): providers registered with Ofsted and operating on non-domestic premises. Eligible group-based provision includes full day and sessional care for children below school age. The two main types of group-based providers covered are:

1. Private group-based providers: These are private companies and include employer-run childcare for employees.
2. Voluntary group-based providers: These are voluntary organisations, including community groups, charities, churches, or religious groups.

School-based providers (identified from the School Census). The two types of school-based providers are:

1. Maintained nursery schools: These are purpose-built maintained schools specifically for children in their early years and with a qualified teacher present.
2. School-based providers offering nursery: These are other maintained schools, and non-maintained schools, offering nursery provision.

Childminders (identified from the Ofsted register): Ofsted-registered childminders providing early years care and operating on domestic settings (childminders registered with a childminder agency are not included in the survey).

- **Note E-7**

The Department for Education (DfE)'s Survey of Childcare and Early Years Providers (SCEYP) data uses Upper Tier Local Authorities (UTLAs) of which there are only 152 in England. 21 of these UTLAs are Predominantly Rural, 109 are Predominantly Urban and the remaining 22 are Urban with Significant Rural. The SCEYP data used for this analysis contained only 150 UTLAs, it did not cover the Isles of Scilly or City of London. Data for 2-year-olds was not available for Barking and Dagenham.
Figures quoted in the cost of childcare text are rounded to the nearest penny, but any calculations were done using unrounded figures.

- **Note E-8**

For 2-years-olds the mean hourly fee is higher than the median hourly fee in 132 of 149 UTLAs; and for 23 of these UTLAs the mean is at least 50p per hour more than the median. For 3- and 4-year-olds the mean hourly fee is higher than the median hourly fee in 131 of 150 UTLAs; and for 25 of these UTLAs the mean is at least 50p per hour more than the median.

- **Note E-9**

For 2-years-olds the confidence interval associated with the mean hourly childcare fee is more than +/- 50p per hour in 55 UTLAs. For 3- and 4-years-olds the confidence interval associated with the mean hourly childcare fee is more than +/- 50p per hour in 64 UTLAs.

- **Note E-10**

School inspection results are covered in "Statistical Digest of Rural England: 6 - Education, Qualifications and Training"

F. Loneliness

People in Rural areas are marginally less likely to report loneliness than in Urban areas and Rural people are more likely to meet friends and family in person than Urban people.

Summary

Loneliness is a subjective, unwelcome feeling of lack or loss of companionship and it occurs when there is mismatch between the quantity and quality of social relationships that we have, and those that we want. There is variation in how people understand the term “loneliness” and some people or groups of people within society might be reluctant to admit to loneliness, so we assess levels of loneliness with a direct and an indirect measure.

The reported rates of loneliness using the direct measure were slightly lower in Rural areas than in Urban areas in 2021/22. Just under 6% of people living in Rural areas reported feeling lonely often or always, compared with just over 6% of people living in Urban areas. Changes in reported levels of loneliness over the period 2017/18 to 2021/22 were marginal.

People in Rural areas reported a slightly lower occurrence of loneliness in 2021/22 when the assessment is made with an indirect estimate. This means that 7% of people in Rural areas often feel at least two of the following three things: (i) “they lack companionship”; or (ii) “left out”; or (iii) “isolated from others”. In both Rural and Urban areas when using the indirect measure of loneliness people were less lonely in 2021/22 than they were in 2020/21.

In 2021/22 there was little difference in the proportion of people who meet up with friends and family at least once a week in Rural and Urban areas. The most common way of keeping in touch with friends and family in both Rural and Urban areas was by text and instant messages. 84% of people living in Rural areas used text or instant messages compared to 80% calling friends and family on an audio or video call.

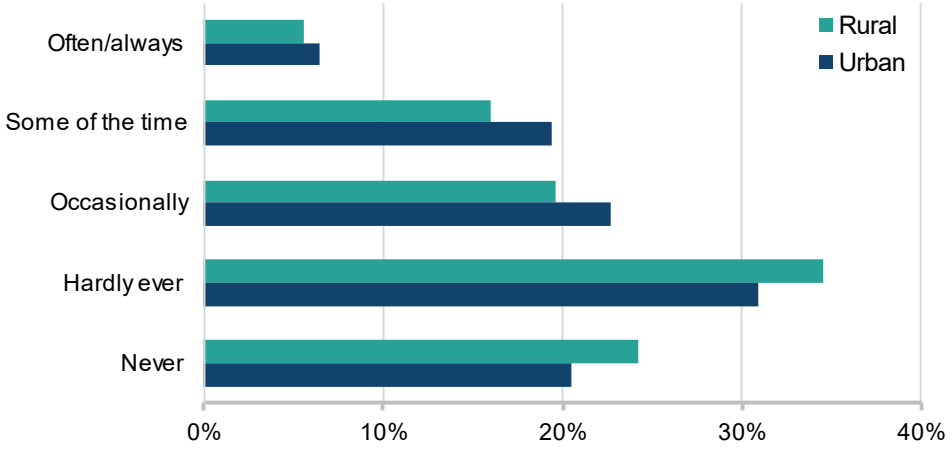
Frequency of loneliness

As explained in the Loneliness Strategy, loneliness is "a subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want." Loneliness is therefore different to social isolation.

The Department for Culture, Media and Sport (DCMS) Community Life Survey includes questions on loneliness (Note F-4). One of the questions asks: "How often do you feel lonely?". Using this question Figure F-1 shows reported rates of loneliness were slightly lower in Rural areas than in Urban areas in 2021/22. Just under 6% of people living in Rural areas reported feeling lonely often or always, compared with just over 6% of people living in Urban areas. 35% of people living in Rural areas reported feeling lonely hardly ever compared with 31% of people living in Urban areas. 1 in every 5 people living in Rural areas (20%) reported never feeling lonely compared with 24% of people living in Urban areas (roughly 1 in 4 people).

Changes in reported levels of loneliness were examined over the period 2017/18 to 2021/22. The changes were marginal and within the confidence levels for the estimates in both Rural and Urban areas. For those wishing to see the proportions please go to Table FA3 and Table FA4 in the Health and Wellbeing data tables.

Figure F-1: Responses to the question "How often do you feel lonely?", by Rural-Urban Classification, England, 2021/22 (Note F-1, Note F-4)
The legend is presented in the same order and orientation as the clusters of bars.



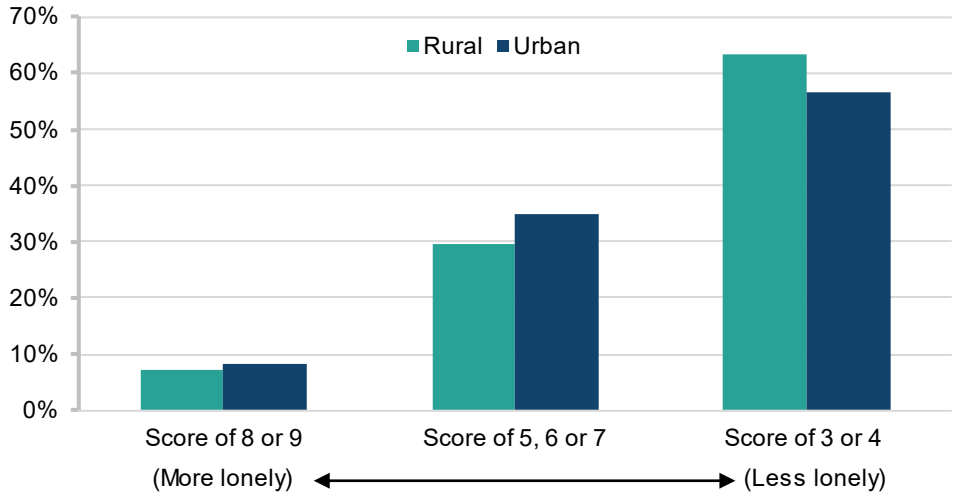
Indirectly estimating loneliness

There is variation in how people understand the term "loneliness" and some people or groups of people within society might be reluctant to admit to loneliness. A multi-item measure that does not mention loneliness directly can be helpful to address these two issues. The University of California developed a three-item loneliness score, that takes responses from three questions and combines them into a composite loneliness score, based on feeling: (i) "they lack companionship"; or (ii) "left out"; or (iii) "isolated from others". On this scoring system, higher scores indicate a higher level of loneliness (Note F-2).

Similar to the direct loneliness estimate (Figure F-1), people in Rural areas reported a slightly lower occurrence of loneliness in 2021/22 when the assessment is made with this indirect estimate

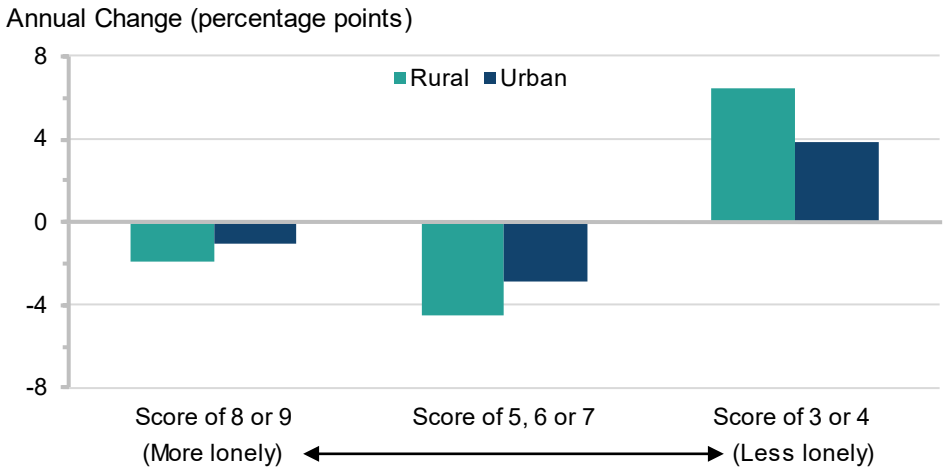
(Figure F-2). 7% of people living in Rural areas and 8% of people living in Urban areas scored an 8 or 9. This means that 7% of people in Rural areas often feel at least two of the following three things: (i) “they lack companionship”; or (ii) “left out”; or (iii) “isolated from others”. However, 63% of people in Rural areas scored a 3 or 4 on the loneliness scale (are least lonely) compared with 57% in Urban areas.

Figure F-2: Composite scores for loneliness in Rural and Urban areas based on the University of California’s three-item loneliness scale, England, 2021/22 (Note F-2, Note F-4)
The legend is presented in the same order and orientation as the clusters of columns.



Using this composite score, people living in both Rural and Urban areas were less lonely in 2021/22 than they were in 2020/21 (Figure F-3). In Rural areas the proportion scoring a 3 or 4 was 6 percentage points higher in 2021/22 and the proportion scoring an 8 or a 9 was 2 percentage points lower. Whilst the trend was the same for Urban areas, the magnitude of the changes was smaller. This reduction in loneliness was an expected result given that the 2020/21 data covered a series of COVID-19 related restrictions that meant that contact with friends and family was limited beyond households.

Figure F-3: Change in the composite scores for loneliness (2021/22 compared to 2020/21) in Rural and Urban areas based on the University of California’s three-item loneliness scale, England, 2021/22 (Note F-2, Note F-4)
The legend is presented in the same order as the clusters of columns.



Friends, family and support networks

Taking time to meet and communicate with friends and family is an important way of combatting loneliness. As Table F-1 shows, in 2021/22 there was little difference in the proportion of people who meet up with friends and family at least once a week in Rural and Urban areas. These estimates were higher than those seen in 2020/21 for people living in Rural and Urban areas (67% and 66% respectively) reflecting the restrictions on face-to-face contact during the COVID-19 pandemic. This resulted in an increase in audio and video calls between family and friends. Prior to the COVID-19 pandemic, it is likely that many people had never made video calls over the internet using programs like Zoom or Skype; and if they had it was in a work, rather than a personal context (Note F-6). The result is that in 2020/21, 86% of people in Rural areas were speaking to family or friends at least once a week via audio or video calls. This is an increase from 79% in 2018/19 (Figure F-4). In 2021/22, the data showed that the proportion of people in Rural areas were speaking with friends and family on a weekly basis had fallen back to 80%. With the exception of 2020/21, there was a marginally smaller proportion of people making weekly calls to friends and family in Rural areas than in Urban areas over the period 2018/19 to 2021/22.

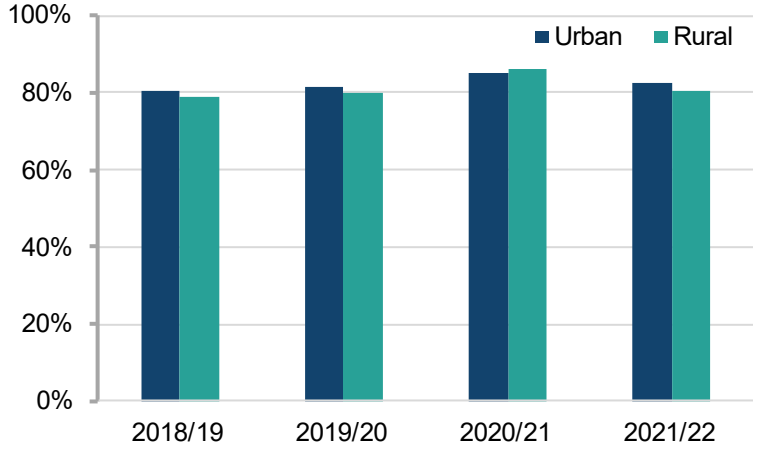
Table F-1: The proportion of people meeting or communicating at least once a week with friends and family through a variety of means in Rural and Urban areas of England (2021-22)

	Meet up in person with friends or family (%)	Speak to on the phone or have a video call with friends or family (%)	Email or write to friends or family (%)	Exchange texts or instant messages with friends or family (%)
Rural	73	80	34	84
Urban	70	83	33	87

The most common way of keeping in touch with friends and family in both Rural and Urban areas was by text and instant messages (Table F-1). It is a quick and easy way to stay in touch and was used on a weekly basis by 84% in Rural areas and 87% in Urban areas. This estimate remained unchanged from 2020/21. In 2021/22, only a third of people chose to email or write to friends and family on a weekly basis. This estimate has fallen from 41% in Rural areas and 36% in Urban areas in 2020/21.

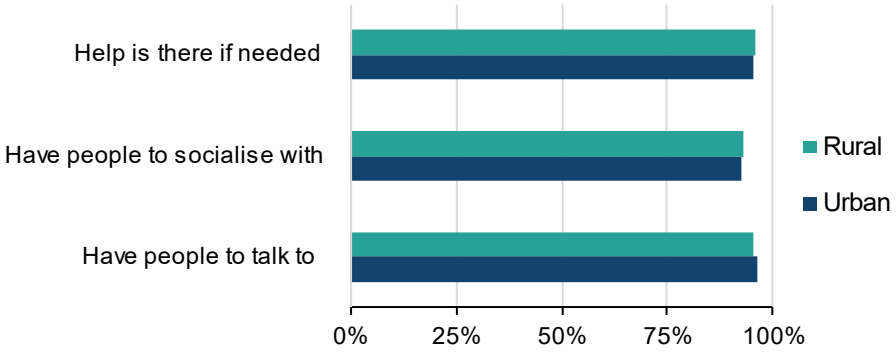
Figure F-4: The proportion of people who speak to on the phone or have a video call with friends or family at least once a week by Rural-Urban Classification, England, 2018/19 to 2021/22 (Note F-4)

The legend is presented in the same order as the clusters of bars.



Most people felt that they had access to support networks when needed (Figure F-5). Whether somebody lived in a Rural or Urban area made little difference to their responses to these 3 questions (Note F-5). In Rural areas, for each of these questions 4% or 5% of respondents were unable to agree that they had access to the support mechanism mentioned in the question.

Figure F-5: The proportion of people agreeing with statements about their access to support networks by Rural-Urban Classification, England, 2021/22 (Note F-4)
The legend is presented in the same order as the clusters of bars. The statements have been summarised for the categorical axis. The full statements are available in Note F-5.



Loneliness explanatory notes

- **Note F-1**

"How often do you feel lonely?" is one of 4 GSS harmonised questions on different aspects of loneliness.

- **Note F-2**

The other 3 GSS harmonised questions come from University of California, Los Angeles (UCLA) three-item loneliness scale and are used to generate an indirect estimate of loneliness. These questions are: "How often do you feel that you lack companionship?"; "How often do you feel left out?"; and "How often do you feel isolated from others?".

Each of these questions has the possible responses: "Hardly ever or never", "Some of the time" and "Often". These responses score 3, 2 and 1 point respectively, leading to an overall score that has a range between 3 and 9. Higher scores indicate a greater degree of loneliness.

- **Note F-3**

A table showing the data presented in Figure F-1 and Figure F-2 is available in the Health and Wellbeing data tables.

- **Note F-4**

The Department for Culture, Media & Sport took on responsibility for publishing results from the Community Life Survey (CLS) for 2016-17 onwards. The survey collects data for financial years from April to March the following year. Most of the data used in this section cover the period April 2021 to March 2022. The annual comparison compares this to the period April 2020 to March 2021. Figure F-4 uses data for the following 4 financial years: 2018/19, 2019/20, 2020/21 and 2021/22. More information on the survey is available at: https://www.gov.uk/government/collections/community-life-survey--2

- **Note F-5**

On Figure F-5 an abridged form of the survey questions has been used. These are the full survey questions.

Help is there if needed: 'Definitely or tend to agree that If I needed help there are people who would be there for me'.

Have people to socialise with: ‘Definitely or tend to agree that If I wanted company or to socialise, there are people I can call on’.

Have people to talk to: ‘Agree that there is one person or more you can really count on to listen to you when you need to talk’.

- **Note F-6**

From the data provided in the Community Life survey (CLS) publication it is not possible to separate out the video and telephone calls.

G. Volunteering and charity

In 2021/22, 62% of people in Rural areas said they had volunteered within the last year, compared to 53% in Urban areas. Similarly, 71% of people in Rural areas said they had given to charity in the past four weeks, compared to 65% in Urban areas.

Summary

The Community Life Survey is a household self-completion survey including questions on formal and informal volunteering, as well as charitable giving.

A greater proportion of people said they volunteered in Rural areas over the period 2013/14 to 2021/22 than did so in Urban areas; however, the proportion of people saying they volunteered has fallen in both Rural and Urban areas over this period, by 13 percentage points and 16 percentage points respectively. Volunteering is likely to reflect socio-economic factors, which differ between Rural and Urban areas.

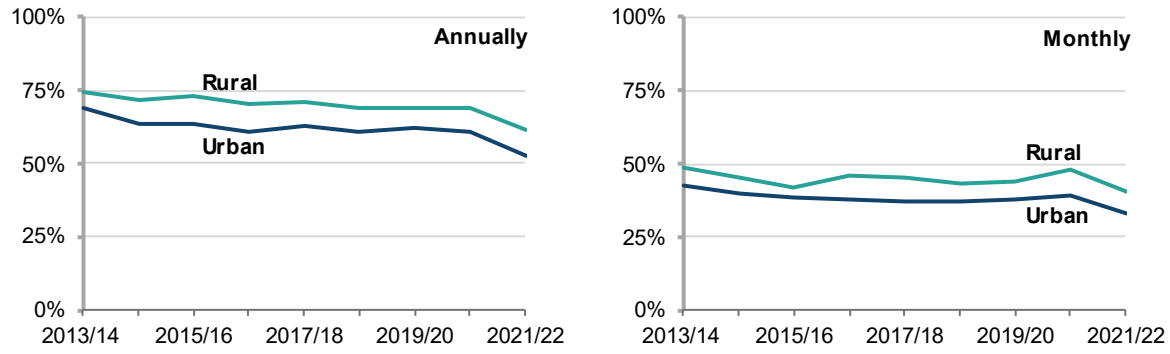
A greater proportion of people in Rural areas said they gave money to charity over the period 2013/14 to 2020/21 than did so in Urban areas. Between 2020/21 and 2021/22 the proportion reporting that they recently gave to charity rose by 6 percentage points in Rural areas and 3 percentage points in Urban areas, but this proportion is lower than the historical levels.

Volunteering

Many activities within local communities in both Rural and Urban areas could not happen without the help of volunteers. Some activities are regular, like running the local Scouts group, whilst others are one-off tasks like helping to organise a fete. As well as formal volunteering associated with groups people may give up their time on an informal basis to help others, for example delivering food to those isolating or sheltering during the height of the COVID-19 pandemic (Note G-1). The Department for Culture, Media and Sport (DCMS) includes questions on volunteering on the Community Life Survey (Note G-5).

Figure G-1 shows that a greater proportion of people say they volunteered in Rural areas over the period 2013/14 to 2021/22 than did so in Urban areas. A greater proportion of people say they volunteered at least once in the 12 months prior to their survey response (Figure G-1 left-hand chart) than did so in the month prior to their survey response (Figure G-1 right-hand chart).

Figure G-1: Percentage of people in Rural and Urban areas of England reporting that they volunteered either formally or informally within the year prior to completing the survey (left-hand chart) and within the month prior to competing the survey (right-hand chart), 2013/14 to 2021/22 (Note G-5)



In 2013/14, 74% of people in Rural areas reported volunteering (either formally or informally) within the last year, compared to 69% of people living in Urban areas. By 2020/21 this had fallen to 69% of people in Rural areas reporting volunteering (either formally or informally) within the last year, and to 61% of people living in Urban areas. This is a drop in participation in voluntary activity of 5 percentage points in Rural areas and 8 percentage points in Urban areas between 2013/14 and 2020/21.

Between 2020/21 and 2021/22 the proportion volunteering fell a further 7 percentage points in Rural areas and a further 8 percentage points in Urban areas. In 2021/22 only 62% of people in Rural areas reported volunteering (either formally or informally) within the last year, compared to only 53% of people living in Urban areas.

So, the overall drop in volunteering over the period 2013/14 to 2021/22 is 13 percentage points in Rural areas and 16 percentage points in Urban areas with more than half of the drop occurring during the most recent year.

In 2021/22, 40% of people living in Rural areas reported volunteering (either formally or informally) within the month prior to completing the survey, compared with 33% of people living in Urban areas. Between 2020/21 and 2021/22 the proportion who volunteered in the month prior to completing the survey fell by 8 percentage points in Rural areas and 6 percentage points in Urban

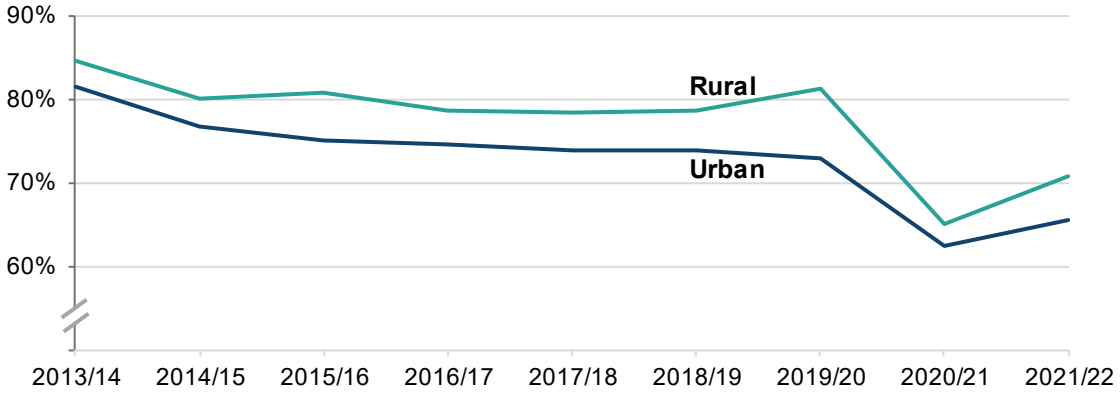
areas. For context, this decline in participation in both Rural and Urban areas is bigger than the overall fall in participation between 2013/14 and 2020/21 in Rural and Urban areas respectively.

Donating to charity

There are numerous charities in England in both Rural and Urban areas. The Community Life Survey has questions on giving to charity. In 2021/22, 71% of people living in Rural areas reported giving to charity in the past four weeks, compared with 65% of those in Urban areas. As shown in Figure G-2, in every year between 2013/14 and 2020/21 a greater proportion of people in Rural areas reported giving money to charity than in Urban areas. Socio-economic factors differ between Rural and Urban areas, which may affect differences in charitable giving.

People reporting having given to charity in the last four weeks fell by 16 percentage points in Rural areas and 10 percentage points in Urban areas between 2019/20 and 2020/21. The pandemic will have reduced both the opportunity and the ability to give. Between 2020/21 and 2021/22 the proportion reporting that they recently gave to charity rose by 6 percentage points in Rural areas and 3 percentage points in Urban areas, but the proportions are still lower than the historical levels. Overall, there has been a long-term decline in giving. People reporting having given to charity in the last four weeks fell by 14 percentage points in Rural areas and 16 percentage points in Urban areas between 2013/14 and 2021/22 (Figure G-2).

Figure G-2: Percentage of people in Rural and Urban areas of England reporting that they have given to charity in the past four weeks, 2013/14 to 2020/21 (Note G-5)



Volunteering and charity explanatory notes

- **Note G-1**

Formal volunteering refers to giving unpaid help through clubs or organisations and informal volunteering refers to giving unpaid help to individuals who are not a relative.

- **Note G-2**

Tables detailing rates of both formal and informal volunteering broken down by broad Rural-Urban Classification covering 2013/14 to 2020/22 are available in the Health and Wellbeing data tables.

- **Note G-3**

Figures for charitable giving between 2013/14 and 2017/18 include a very small number of respondents who had only indicated they had given to charitable causes by donating goods or prizes. 2018-19 onwards only

includes those who gave money to charitable causes. This will have a minimal effect on the overall estimates.

- **Note G-4**

A table detailing rates of charitable giving in the past four weeks, broken down by broad Rural-Urban Classification covering 2013/14 to 2020/22 is available in the Health and Wellbeing data tables

- **Note G-5**

The Department for Culture, Media & Sport (DCMS) took on responsibility for publishing results from the Community Life survey (CLS) for 2016-17 onwards. The survey collects data for financial years from April to March the following year. More information on the survey is available at: https://www.gov.uk/government/collections/community-life-survey--2.

Appendix 1: The 8 thematic reports that make up the Statistical Digest of Rural England (and the topics included within them)

1. Population

A. Population level and change
B. Population age profile
C. Ethnicity
D. Internal migration
E. Local Authority population data

2. Housing

A. Housing stock: age and type
B. Housing stock: additions
C. Housing costs: purchases and rentals
D. House purchase affordability
E. Second and empty homes
F. Homelessness
G. Land use change for housing
H. Housing quality

3. Health and Wellbeing

A. Life expectancy and Mortality
B. Wellbeing
C. NHS Dentistry provision
D. NHS General Practices
E. Childcare provision
F. Loneliness
G. Volunteering and charity

4. Communities and Households

A. Deprivation
B. Poverty due to low income
C. Household expenditure
D. Police recorded crime and outcomes
E. Crime surveys: local police and businesses
F. Feelings about the local neighbourhood

5. Connectivity and Accessibility

A. Broadband and mobile
B. Travel behaviours
C. Access to personal transport
D. Access to services
E. Home working

6. Education, Qualifications and Training

A. Schools and their workforce
B. Class sizes
C. Secondary education attainment
D. School inspections
E. Free school meals - eligibility
F. Alternative and specialist education provision
G. Progression to higher education
H. Apprenticeships and on-the-job training
I. Workforce education level

7. Rural Economic Bulletin

A. Employment
B. Earnings
C. Redundancies
D. Claimant count - Jobseeker's Allowance
E. Output and productivity measured by Gross Value Added (GVA)
F. Business demographics
G. Businesses by industry
H. Business survival and growth
I. Innovation and investment

8. Energy

A. Fuel poverty
B. Energy Performance Certificates: average Energy Efficiency Score
C. Energy Performance Certificates: achieving energy efficiency category C
D. Energy Costs
E. Energy Consumption
F. CO_2 emissions

Each of the 8 themes also has their own set of supplementary data tables that include the larger source data that could not be included in the presented document. The chapter headings above are hyperlinked to the home page for that specific digest theme. The supplementary tables can be accessed from these home pages.

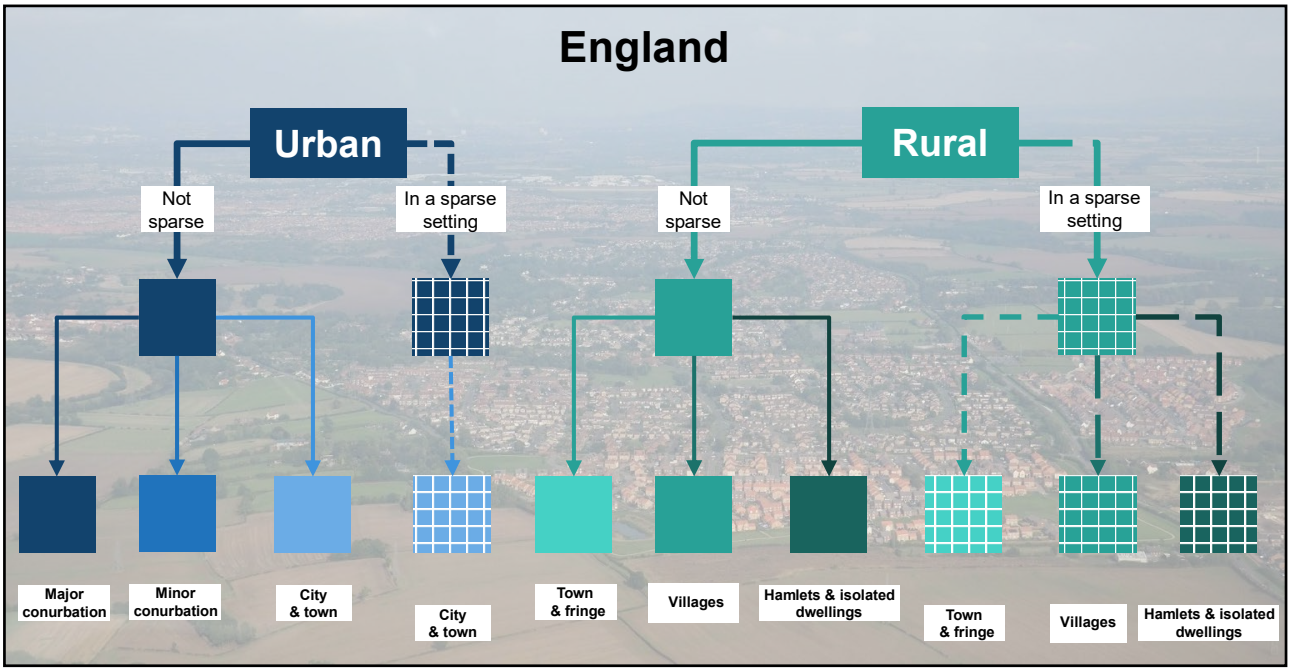
There is a further document including the individual Local Authority data tables, which have been separated for ease of use.

Appendix 2: Defining Rural areas

Wherever possible, the Rural-Urban Classification is used to distinguish Rural and Urban areas. The Classification defines areas as Rural if they fall outside of settlements with more than 10,000 resident population.

Census Output Areas are the smallest areas for which data are available from Censuses. These Census Output Areas are assigned to one of four Urban or six Rural categories (Figure X-1) based on dwelling densities. Those described as "in a sparse setting" reflect where the wider area is sparsely populated (again based on dwelling densities). From Census Output Areas, other small area geographies can be classified based on how they map to Census Output Areas (such as Lower Super Output Areas (LSOAs), Wards, and postcodes – Note 1).

Figure X-1: Classifying Rural and Urban areas for small geographical areas



A map showing the distribution of the Rural and Urban Census Output Areas is shown in Figure X-2.

When data are not available at a small geographical scale, it may be possible to apply the Rural-Urban Local Authority Classification or a similar classification for other larger geographies. This classification categorises districts and unitary authorities on a six-point scale from Rural to Urban. It is underpinned by Rural and Urban populations as defined by the Census Output Area Classification. A map of the geographical distribution of the Rural and Urban Local Authorities is shown in Figure X-3.

However, the Local Authority Classification also considers some Urban areas as Hub Towns (with populations of between 10,000 and 30,000). These Hub Towns have met statistical criteria (based on dwelling and business premise densities) to be considered hubs for services and businesses for a wider rural hinterland and their populations are therefore classified as effectively Rural for the purposes of determining the classification of the authority.

Figure X-2: Map of the 2011 Rural-Urban Classification for Census Output Areas in England

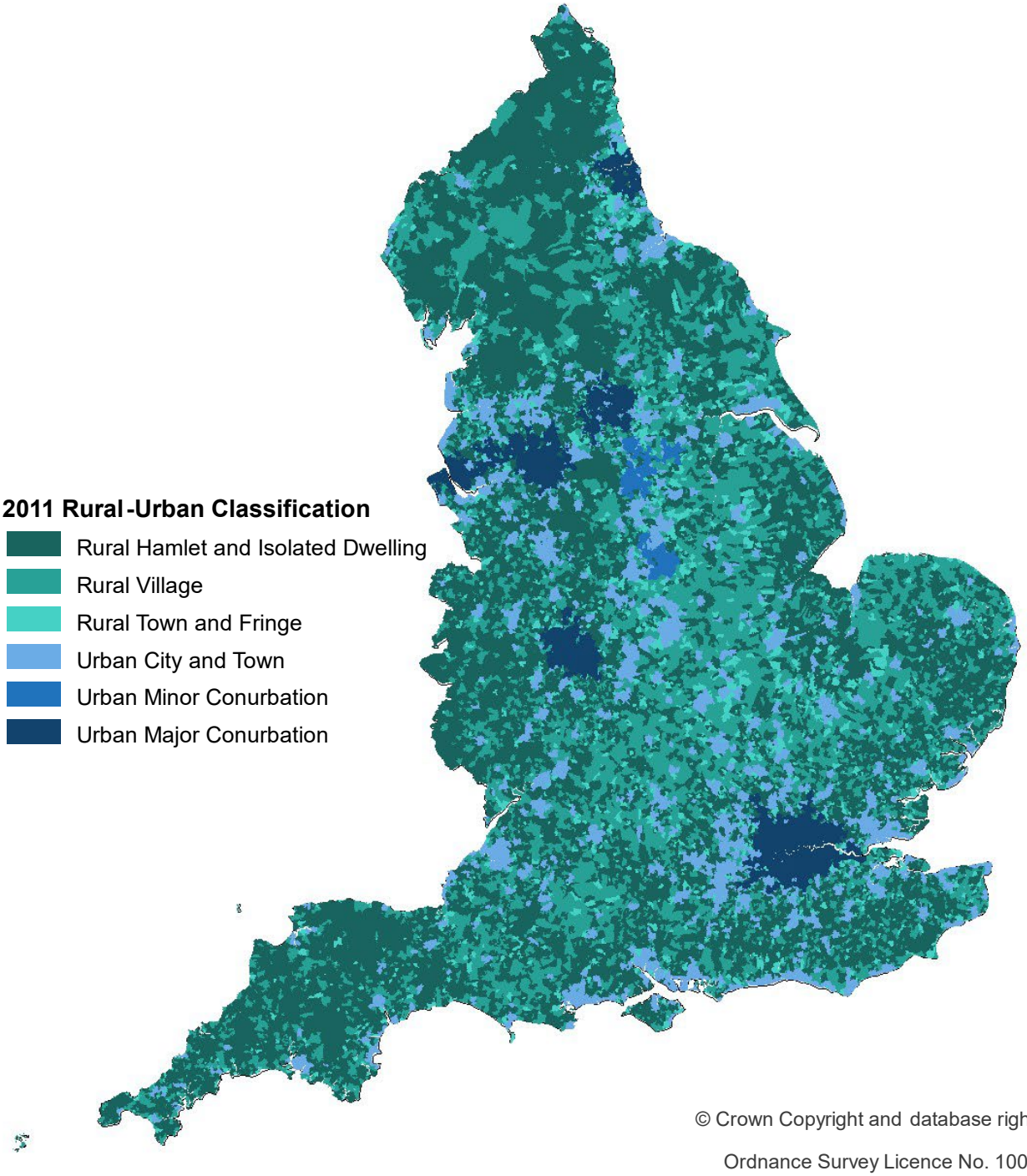
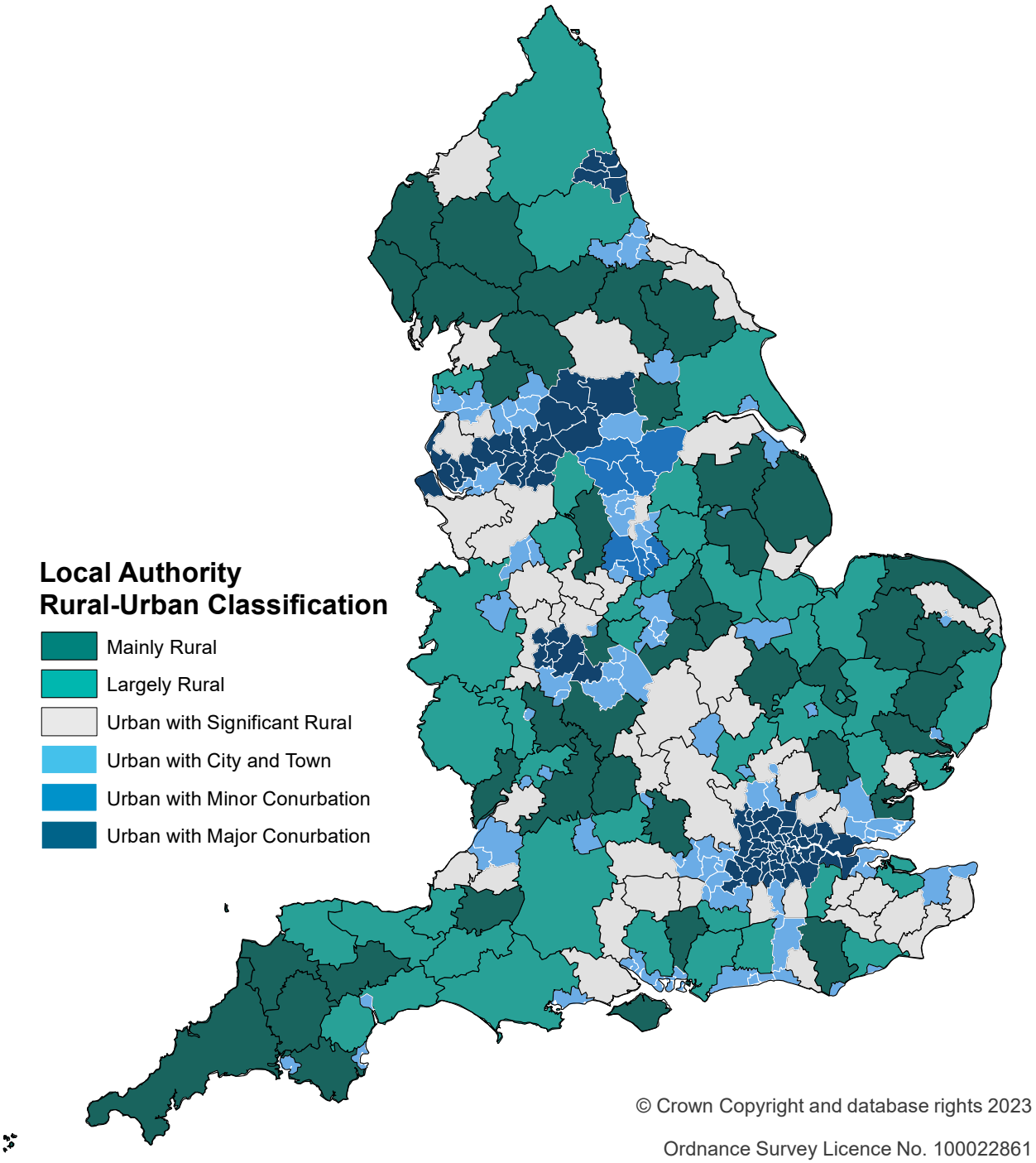
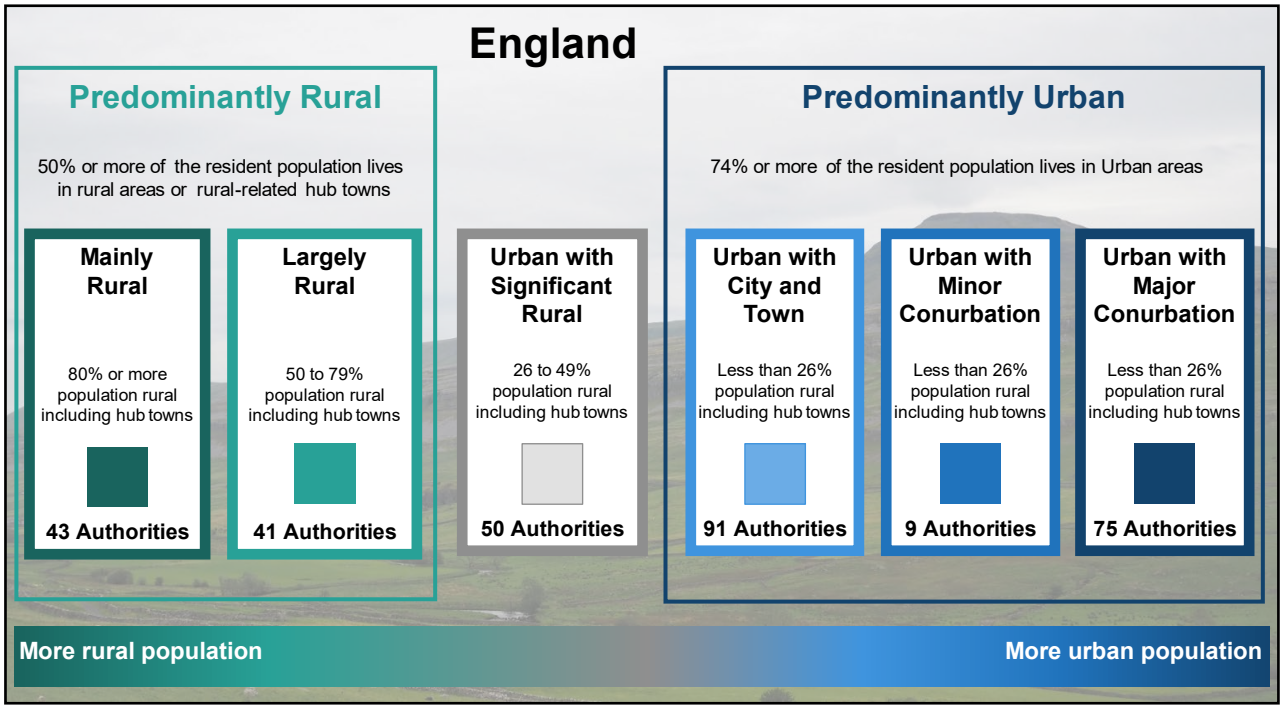


Figure X-3: Map of the 2011 Rural-Urban Classification for Local Authority Districts and Unitary Authorities in England



Under the classification, which is shown in Figure X-4, each Local Authority is assigned to one of six categories on the basis of the percentage of the total resident population accounted for by the combined Rural and Hub Town components of its population and its 'conurbation context'. The Local Authority Classification categories are frequently aggregated to ‘Predominantly Rural’, ‘Urban with Significant Rural’ and ‘Predominantly Urban’ as shown on Figure X-4.

Figure X-4: 2011 Rural-Urban Classification for Local Authorities in England



The Local Authority Rural-Urban Classification is based on populations and settlement patterns, not on how much countryside there is. Authorities classified as Urban may have wide areas of countryside and may have sizeable Rural populations. The classification has been made according to the proportions of the population residing in Urban settlements and outside Urban settlements. More information on the classifications can be found at: The Rural-Urban Definition.

A similar approach to that for Local Authorities was used to create a classification for Westminster Parliamentary Constituencies. Under this classification, which is shown in Figure X-5, each Parliamentary Constituency is assigned to one of six categories on the basis of the percentage of the total resident population accounted for by the combined Rural and Hub Town components of its population and its 'conurbation context'. A map of the geographical distribution of the Rural and Urban Westminster Parliamentary Constituencies is shown in Figure X-5. This map depicts a classification for the new rebalanced Parliamentary Constituencies that were introduced for 2024 General Election. The Parliamentary Constituency Classification categories are frequently aggregated to ‘Predominantly Rural’, ‘Urban with Significant Rural’ and ‘Predominantly Urban’ as shown on Figure X-6.

Figure X-5: Map of the 2011 Rural-Urban Classification for Westminster Parliamentary Constituencies in England

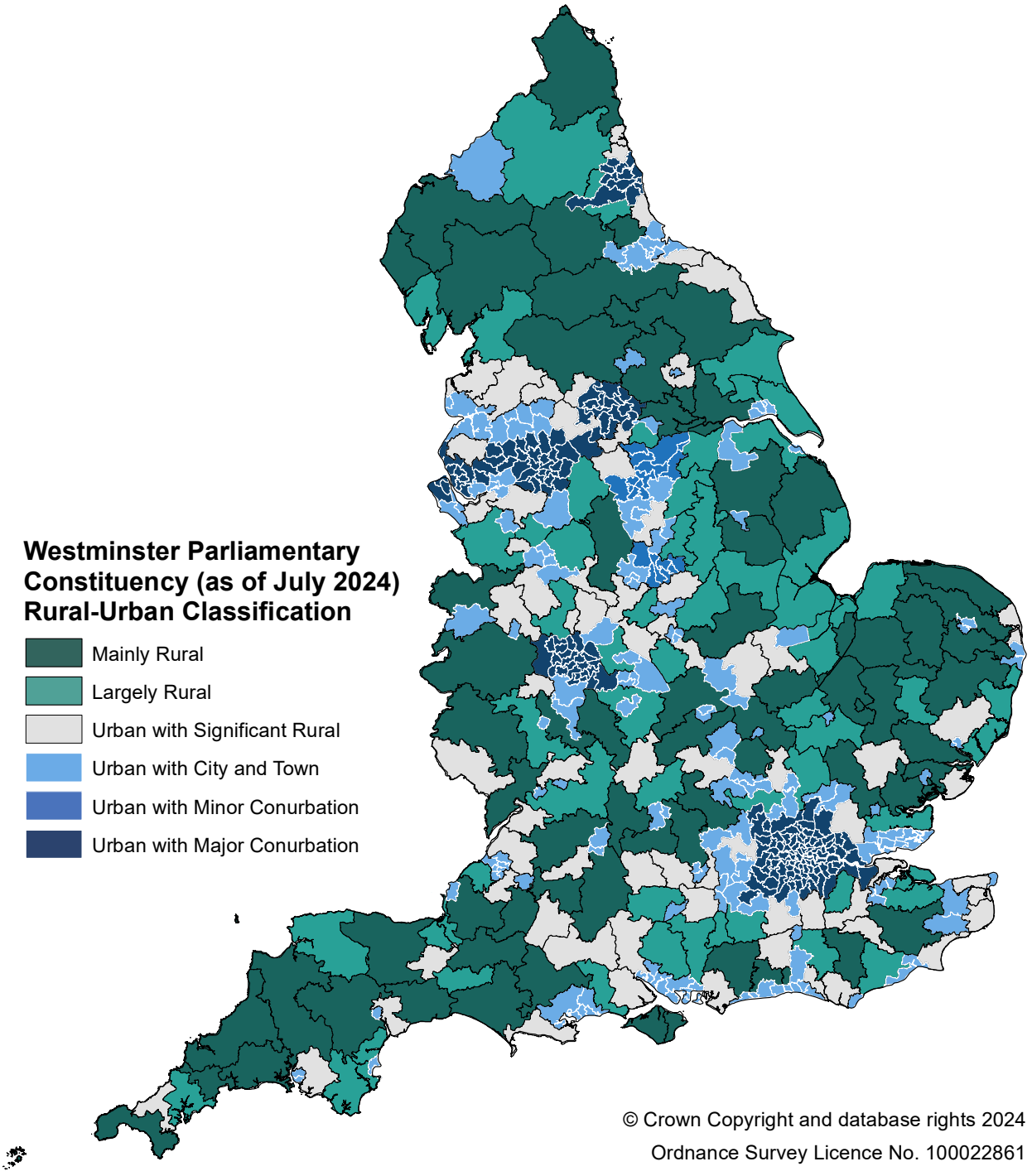
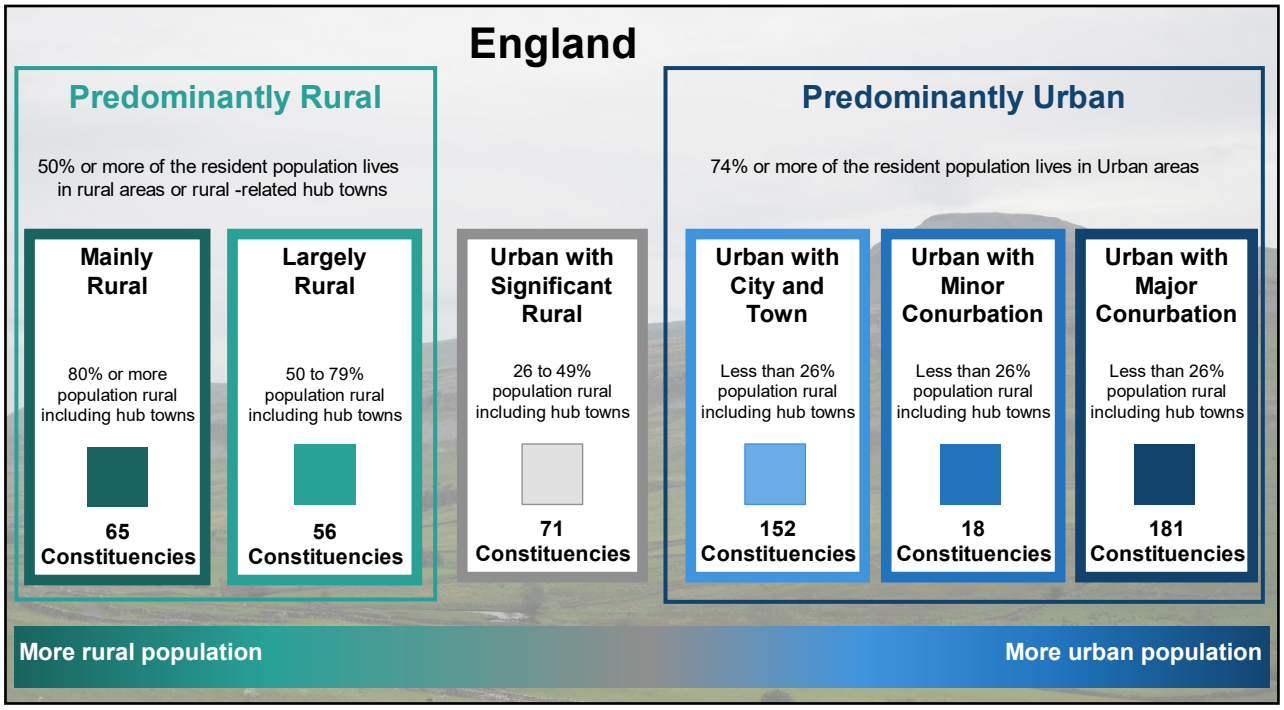


Figure X-6: 2011 Rural-Urban Classification for Westminster Parliamentary Constituencies in England



Defining Rural areas explanatory notes

- **Note 1:** Defining Super Output Areas and Wards

Census Output Areas (OAs) were created for publication of the results of the recent Censuses. They cover around 125 households. In practice few datasets are produced at OA level. However, other larger geographies can be built up from OAs. These include *Lower Layer Super Output Areas* (LSOAs) which typically contain 5 OAs, so contain approximately 625 households or a population of approximately 1,500 and a minimum 1,000. Their Rural-Urban Classification is based on the majority category of OAs they contain. Some other geographies, for example postcodes are classified based on the location of their central point and the classification of respective OA.

- **Note 2:** Accessibility of Figure X-2

We accept that this map might not be accessible for all users, but it is difficult to develop a map containing six colours that will provide enough contrast between all colours to enable every user to see them, especially when the shaded areas are small. Separate maps (showing only three levels of shading) for Rural and Urban areas are available on request from: rural.statistics@defra.gov.uk