Department for Environment Food & Rural Affairs

Government Statistical Service

Statistical Digest of Rural England:

3 - Health and Wellbeing

June 2026

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

Any enquiries regarding this publication should be sent to us at

rural.statistics@defra.gov.uk

www.gov.uk/defra

Cover photos

		Ward 2021	Rural-Urban Classification 2021
TL	Helmsley marketplace	Helmsley	Larger rural: Further from a major town or city
TC	Horton-in-Ribblesdale train station with Penyghent behind	Settle & Penyghent	Smaller rural: Further from a major town or city
TR	St Giles Church, Skelton	Rural West York	Larger rural: Nearer to a major town or city
CL	Fishing Boat, Marske-by-the-Sea with Hunt cliff in the distance	St Germain's; Saltburn	Larger rural: Nearer to a major town or city
CR	Thornton Force Waterfall, Ingleton Waterfalls Trail	Bentham & Ingleton	Smaller rural: Further from a major town or city
BL	Farmer working the fields in Knapton	Rural West York	Smaller rural: Nearer to a major town or city
BC	Remote pub at Ribblehead viaduct	Bentham & Ingleton	Smaller rural: Further from a major town or city
BR	Glamping pod in the North York Moors	Pickering	Larger rural: Further from a major town or city

All cover photos provided by Martin Fowell.

Table of Contents

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.

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

Appendix 1 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 June 2026, the following sections were updated with new data: 'Health outcomes' (previously named 'Life expectancy and Mortality'), 'NHS General Practice', and 'NHS Dentistry' (previously named 'NHS Dentistry Provision').

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	Dec 2023	Sept 2024	Nov 2024	Sept 2025	Jun 2026
Health outcomes	✕	✓	✕	✕	✓
Wellbeing	✕	✓	✕	✕	✕
NHS Dentistry	✕	✕	✓	✕	✓
NHS General Practice	✕	✕	✓	✕	✓
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:

Stephen Hall
Sarah Harriss
Bethany Ricks
Martin Fowell
rural.statistics@defra.gov.uk

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. Table 2 identifies the geography and classification used for each section.

Table 2: Geographies used within subsections of the Health and Wellbeing report
For the specified geography, the 'boundary year' has been presented in brackets. Shorthand has been used in this table: 'LSOA' represents Lower-layer Super Output Areas; 'WPCon' represents Westminster Parliamentary Constituencies; 'LA' represents Local Authorities. 'England' indicates data are from a survey sample, provided to us aggregated to 'rural and 'urban' areas. 'RUC21' represents the 2021 Census-based Rural-Urban Classification, whilst 'RUC11' represents the older 2011 Census-based classification.

Section	Geography	Classification
Health outcomes	LA (2024)	RUC21
Wellbeing	LA (2021)	RUC11
NHS Dentistry	LA (2024)	RUC21
NHS General Practice	LSOA (2021)	RUC21
Childcare provision	WPCon (2019)	RUC11
Loneliness	England	RUC11
Volunteering and charity	England; LA (2023)	RUC11; RUC21

Health and Wellbeing

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

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

A. Health outcomes

In majority rural authorities, life expectancy is higher than in urban authorities, while infant mortality rates are slightly lower. However, preventable mortality rates as well as suicide rates are similar.

Key findings – Health outcomes

Life expectancy is higher in rural areas than urban areas outside London

- In 2022-24, the average life expectancy for males living in majority rural authorities was 80.5 years; this is 2 years higher than for males living in urban authorities outside London (78.5 years). For females, the average life expectancy for those living in majority rural authorities was 84.2 years; this is 1.7 years higher than for males living in urban authorities outside London (82.5 years).
- The average life expectancy has increased over the last twenty years and has been higher in majority rural local authorities than in urban local authorities outside London.

Little difference in preventable deaths in majority rural and urban authorities

- In 2022-24, for males, there were 194 preventable deaths per 100,000 population in majority rural authorities, and 200 preventable deaths per 100,000 population in urban authorities outside London.
- For females there were 107 preventable deaths per 100,000 population in majority rural authorities, and 110 preventable deaths per 100,000 population in urban authorities outside London.

Preventable deaths are higher for those further from major towns or cities

- The rates of preventable deaths are higher in majority rural authorities where the majority live further from a major town or city in 2022-24, the overall preventable mortality rate for males in such authorities was 219 deaths per 100,000 population - 40 deaths per 100,000 population higher than in majority rural authorities where the majority of residents live nearer to major towns or cities.
- Similarly for females, the preventable mortality rate for females was 125 preventable deaths per 100,000 population - 29 deaths per 100,000 population higher than in authorities where the majority of residents live nearer to major towns or cities.

Infant mortality is lower in majority rural authorities than in urban authorities outside London

- In the three-year period spanning 2022 to 2024, there were 3.4 infant deaths per 1,000 live births in majority rural authorities; this compares to 4.8 infant deaths per 1,000 live births in urban authorities outside London.

Little difference in suicide rates between majority rural and urban authorities

- Suicide rates fluctuate, but historically, the overall suicide rate in majority rural authorities has been slightly higher than in urban authorities outside of London. However, in 2024 there was little difference in the rates, at 11.6 and 11.7 deaths per 100,000 respectively.
- The lowest overall suicide rate seen in majority rural authorities between 2014 and 2024 was 9.9 deaths per 100,000 population in 2017; the highest rate was 12.8 deaths in 2023,before dropping to 11.6 in 2024.
- In urban authorities outside of London, the lowest overall rate seen was in 2017, with 9.5 deaths per 100,000 population. The highest rate was in 2024, with 11.7 deaths.

Summary

Life expectancy is a measure of how long people would live on average based on current death rates. 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.

In 2022-24, the average life expectancy for males living in majority rural authorities was 80.5 years; this is 2 years higher than for males living in urban authorities outside London (78.5 years). For females, the average life expectancy for those living in majority rural authorities was 84.2 years; this is 1.7 years higher than for males living in urban authorities outside London (82.5 years). In 2022-24, the average England life expectancy was 79.4 years for males and was 83.3 years for females.

For both males and females, the rate of preventable mortality was similar across both majority rural authorities and urban authorities outside London. For males there were 194 preventable deaths per 100,000 population in majority rural authorities, and 200 preventable deaths per 100,000 population in urban authorities outside London in 2022-24. This compares to 107 preventable deaths per 100,000 population for females in majority rural authorities, and 110 preventable deaths per 100,000 population in urban authorities outside London. Relative access has greater impact on the rate of preventable mortality. For those living in majority rural authorities, the rate of preventable mortality is generally higher where the majority of the population reside further from major towns or cities, for both males and females.

The infant mortality rate was lower in majority rural authorities than in urban authorities outside London in 2022-24, corresponding to 3.4 deaths per 1,000 live births and 4.8 deaths per 1,000 live births respectively. Between 2013-15 and 2022-24, the infant mortality rate has seen little change in both majority rural authorities and urban authorities outside London, with rates consistently lower in majority rural authorities.

In 2024, there were around 11.6 suicides registered per 100,000 population in majority rural authorities; this is similar to the rate seen in urban authorities outside of London (11.7 suicides per 100,000 population). Overall suicide rates were higher in majority rural authorities than in other types of authority across most years between 2014 and 2024.

Male and Female life expectancy

Life expectancy is a measure of how long people would live on average based on current death rates.

The estimates presented here assume that these death rates stay the same throughout a person's life. This means they are not a prediction of how long someone born today will actually live, because death rates can change over time.

Life expectancy is often shown from birth or from older ages. It is used to compare overall levels of mortality between different areas and over time.

Over the long term, life expectancy in England has generally increased, and females have tended to live longer than males.

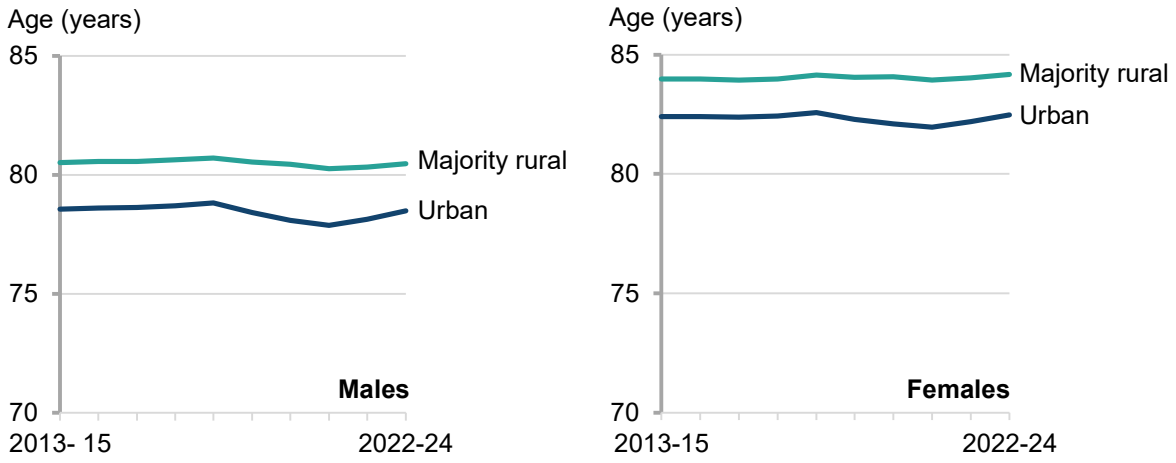
In 2022-24, the average life expectancy for males living in majority rural authorities was 80.5 years; this is 2 years higher than for males living in urban authorities outside London (78.5 years).

For females, the average life expectancy for those living in majority rural authorities was 84.2 years; this is 1.7 years higher than for females living in urban authorities outside London (82.5 years).

The line charts in Figure A-1 show the changes in life expectancy, by sex and 2021 rural-urban classification of local authorities, between the three-year period spanning 2013 to 2015, to the period spanning 2022 to 2024. Three-year periods are used instead of single-year figures in order to increase reliability 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 2021 rural-urban classification of local authorities in England, 2013-15 to 2022-24 (Note A-1, Note A-2, Note A-3, Note A-4)

Males are shown on the left-hand chart and females on the right-hand chart.
Urban excludes London. Vertical axis does not start at 0. Intermediate rural, intermediate urban and London are not shown on the chart but are included in the supplementary data tables.



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 majority rural authorities than in urban authorities outside London. Life

expectancy has also consistently been higher for females than for males across types of authority.

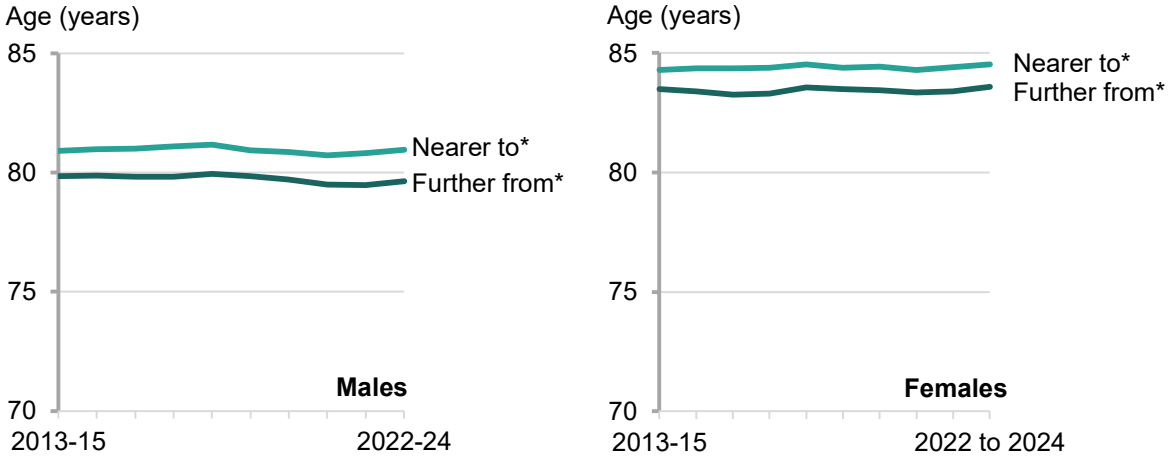
- For males living in majority rural authorities, average life expectancies saw little change between 2013-15 and 2022-24, ranging between 80.3 and 80.7 years. Males living in urban authorities outside London saw a slightly bigger change over the period, with average life expectancies ranging from 77.9 to 78.8 years. Both types of authority saw small downward trends in life expectancy due to the COVID-19 pandemic, but average life expectancies are returning to pre-pandemic levels.
- For females living in majority rural authorities, average life expectancies saw little change between 2013-15 and 2022-24, ranging between 83.9 and 84.2 years. Females living in urban authorities outside London saw a slightly bigger change over the period, with average life expectancies ranging from 82.0 to 82.6 years. Both types of authority saw small downward trends in life expectancy due to the COVID-19 pandemic, but average life expectancies are returning to pre-pandemic levels

It is possible to explore whether proximity to larger urban centres affects like expectancy. Relative access indicates proximity to a major town or city for the majority of the resident population (Note A-5). The line charts in Figure A-2 show the changes in life expectancy, by sex and relative access in majority rural authorities, between the three-year periods spanning 2013-to-2015 to 2022-to-2024.

Average life expectancy is generally higher in majority rural authorities where the majority of the population reside nearer to major towns or cities, for both males and females.

In 2022-to-2024, male life expectancy in majority rural authorities where the majority of the population live nearer to a major town or city was 81.0 years: 1.3 years higher than in authorities where the majority of residents live further from major towns or cities. Female life expectancy was 84.5 years: 1.0 year higher than in authorities where the majority of residents live further from major towns or cities.

Figure A-2: Line charts showing life expectancy at birth, by sex and relative access in majority rural authorities as defined within the 2021 rural-urban classification, England, 2013-15 to 2022-24 (Note A-1, Note A-2, Note A-3, Note A-4, Note A-5)
Males are shown on the left-hand chart and females on the right-hand chart.
Vertical axis does not start at 0.



* a major town or city (for the majority of the population)

Trends over time follow a similar pattern to those shown in Figure A-1.

Life expectancy is influenced by variables that differ between rural and urban areas, including socio-economic factors. The bar charts in Figure A-3 show the difference between the life expectancy for each type of authority and the national average, for both sexes, in 2022-24.

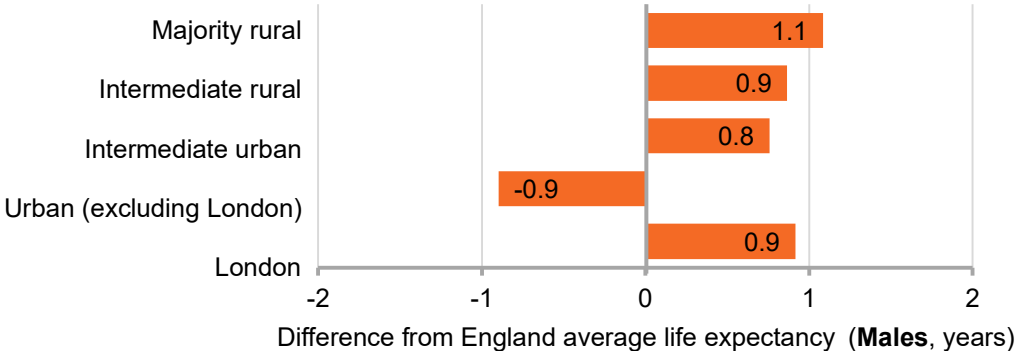
In majority rural authorities the average life expectancy for both males and females was higher than the national average for England. For males, the average life expectancy in majority rural authorities was 1.1 years higher than the national average (80.5 years and 79.4 years, respectively). For females, the average life expectancy in majority rural authorities was 0.9 years higher than the national average (84.2 years and 83.3 years, respectively). For males, majority rural authorities had the largest difference above the England average compared with other types of authority.

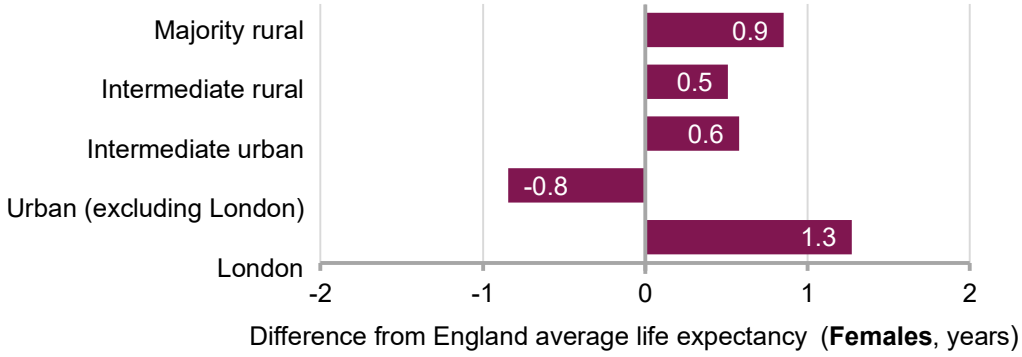
In urban authorities outside London the average life expectancy for both males and females was lower than the national average for England. For males, the average life expectancy of 78.5 years was 0.9 years lower than the national average. For females, the average life expectancy in urban authorities outside London (82.5 years) was 0.8 years lower than the national average.

In London authorities the average life expectancy for both males and females was higher than the national average for England. For males, the average life expectancy in London authorities was 0.9 years higher than the national average (80.3 years and 79.4 years, respectively). For females, the average life expectancy in London authorities was 1.3 years higher than the national average (84.6 years and 83.3 years, respectively). For females, this was the largest positive difference of all settlement types.

Intermediate rural and intermediate urban authorities had average life expectancies higher than the national average for England for both males and females.

Figure A-3: Bar charts showing life expectancy at birth, by sex and 2021 rural-urban classification of local authorities, England, 2022-24 (Note A-1, Note A-2, Note A-3, Note A-4)
Males are shown on the top chart and females on the bottom chart.





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).

The first part of this section looks at the total mortality rate grouping together all deaths from causes that were considered preventable. The second part of the section goes into more detail, presenting analysis for four specific causes of death that are considered preventable: cancer, cardiovascular disease, liver disease and respiratory disease.

Three-year periods are used instead of single-year figures in order to increase precision and reduce annual fluctuations caused by seasonal events. Deaths are expressed as the number of deaths per 100,000 population aged under 75. Populations used to create the number of deaths per 100,000 population are sex specific, the male death rate uses the total male population as the denominator and the female death rate uses the total female population.

Mortality rate from all causes considered preventable

In 2022-24, for males, overall, there were 194 preventable deaths per 100,000 population in majority rural authorities, and 200 preventable deaths per 100,000 population in urban authorities outside London. For females, overall, there were 107 preventable deaths per 100,000 population in majority rural authorities, and 110 preventable deaths per 100,000 population in urban authorities outside London. 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-4 show the total number of deaths considered preventable per 100,000 population aged under 75, by 2021 rural-urban classification of local authorities in England. The top chart represents all preventable deaths in males, whilst the bottom chart represents all preventable deaths in females.

Overall, the mortality rate from all causes considered preventable was considerably higher for males than for females, for all types of authority. For both males and females, overall mortality rates were lower in majority rural authorities than in urban authorities outside of London, which had the highest overall mortality rates of all types of authority. In contrast, London had the lowest overall mortality rates for both males and females.

Males: In majority rural authorities, overall, there were 194 preventable deaths per 100,000 population aged under 75 in 2022-24. This is less than the 200 preventable deaths per 100,000 population overall in urban authorities outside London. The lowest average overall mortality rate from preventable causes was in London, where there were 132 deaths per 100,000 population.

Females: In majority rural authorities, overall, there were 107 preventable deaths per 100,000 population aged under 75 in 2022-24; this is just over half of the preventable mortality rate for males in the same type of authority. In urban authorities outside London, overall, there were 110 preventable deaths per 100,000 population. The lowest overall mortality rate from preventable causes was in London, where there were 62 deaths per 100,000 population aged under 75.

Figure A-4: Bar charts showing the under 75 mortality rate from all causes considered preventable, by sex and 2021 rural-urban classification of local authorities in England, 2022-24 (Note A-4, Note A-6, Note A-7, Note A-9)

Males are represented in the top chart, and females are represented in the bottom chart.

The two line charts in Figure A-5 show the changes in mortality rates from all causes considered preventable, for majority rural and urban authorities outside of London as defined within the 2021 rural-urban classification; changes are measured between the three-year periods spanning 2013-15 to 2022-24. The left-hand chart highlights male mortality rates whilst the right-hand chart shows female mortality rates.

Overall, mortality rates from all preventable causes were higher for males than females between 2013-15 and 2022-24. For both males and females, overall mortality rates were slightly lower in majority rural authorities than in urban authorities outside London, and the gap has been closing in recent years.

The left-hand line chart in Figure A-5 (representing **males**) can be described as follows:

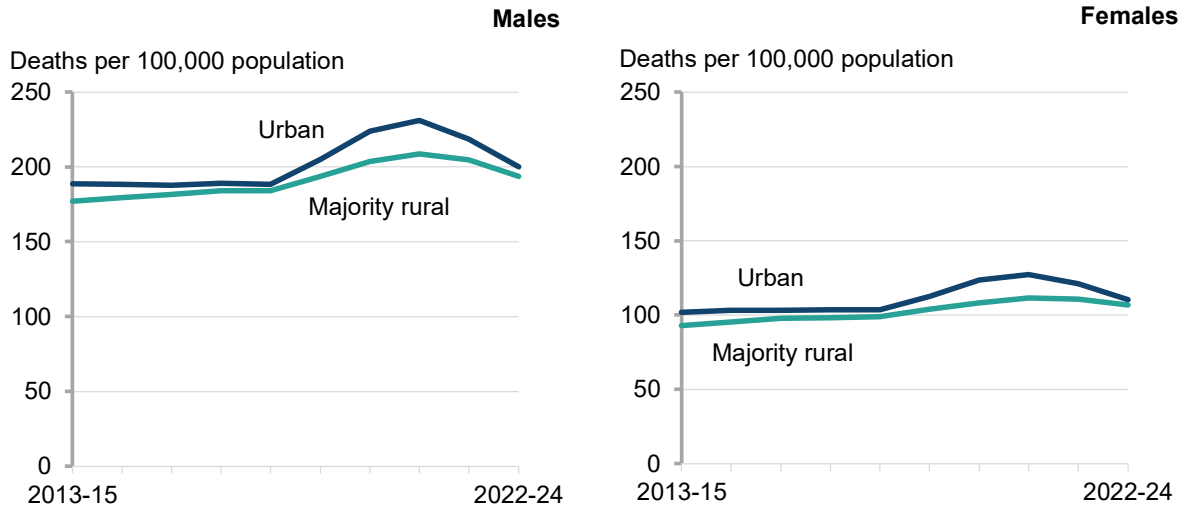
- Between 2013-15 and 2017-19, the overall preventable mortality rate for males increased in majority rural authorities from 177 to 184 preventable deaths per 100,000 population. In urban areas outside London the overall preventable mortality rate was more stable, with around 188 to 189 preventable deaths between 2013-15 and 2017-19.
- From 2017-19, preventable mortality rates increased until 2020-22. In majority rural authorities, overall rates increased from 184 to 209 deaths per 100,000 population. In urban authorities, the increase was greater - from 188 to 231 deaths per 100,000 population.

- Since 2020-22, the preventable mortality rate for males has fallen for both types of authority. In majority rural authorities the overall rate has fallen to 194 preventable deaths per 100,000 population in 2022-24, whilst in urban authorities outside London, the overall rate fell to 200 preventable deaths per 100,000 population.

The right-hand line chart in Figure A-5 (representing **females**) can be summarised as follows:

- For females between 2013-15 and 2017-19, the overall preventable mortality rate for females increased in majority rural authorities from 93 to 99 preventable deaths per 100,000 population. In urban areas outside London the overall preventable mortality rate changed little (between 102 and 104 preventable deaths) between 2013-15 and 2017-19.
- Between 2017-19 and 2020-22, the overall preventable mortality rate for females increased in majority rural authorities it increased by 13 to 112 deaths per 100,000 population, while in urban authorities outside London it increased by 24 to 127 deaths per 100,000 population.
- In 2022-24, in majority rural authorities the overall rate fell to 107 preventable deaths per 100,000 population while in urban authorities outside London the rate fell to 110 preventable deaths in 2022-24.
- For females, throughout the period from 2013-15, the difference between majority rural authorities and urban authorities outside London in the rate of preventable mortality has fluctuated, however rates were consistently lower in majority rural authorities. In 2013-15 the rate was 9 preventable deaths per 100,000 population lower in majority rural authorities. This reduced to a difference of 5 preventable deaths in 2016-18 and 2017-19, then widened to a difference of 16 preventable deaths per 100,000 population in 2020-22, before falling back to a difference of 4 preventable deaths in 2022-24.

Figure A-5: Line charts showing the change in under 75 mortality rates from all causes considered preventable, by sex and 2021 rural-urban classification of local authorities in England, 2013-15 to 2022-24 (Note A-4, Note A-6, Note A-7, Note A-9)
Males are represented in the left-hand chart, and females are shown in the right-hand chart. Analysis for intermediate authorities and London are not included in the line chart but can be found within the Health and Wellbeing supplementary data tables. Urban excludes London. Vertical axis scales differ across the charts in the preventable mortality section.



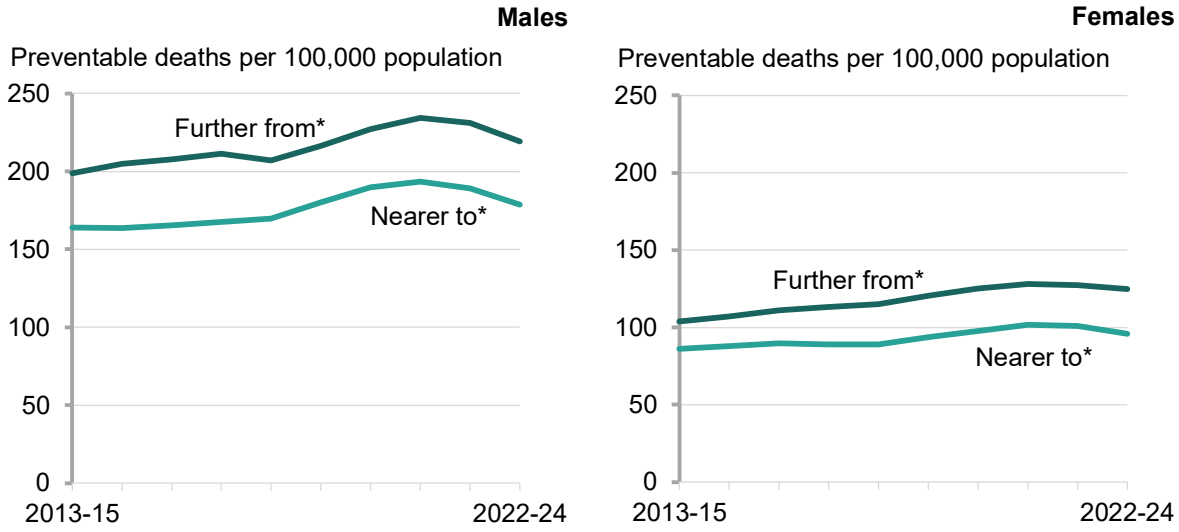
It is also possible to consider the impact that relative access has for those living in majority rural authorities. Relative access indicates proximity to a major town or city for the majority of the resident population (Note A-5). The line charts in Figure A-6 show the changes in mortality rates, by sex and relative access in majority rural authorities, between the three-year periods spanning 2013-15 to 2022-24.

The rate of preventable mortality is generally higher in majority rural authorities where the majority of the population reside further from major towns or cities, for both males and females. In 2022-24, the overall preventable mortality rate for males in these authorities was 219 deaths per 100,000 population: 40 deaths per 100,000 population higher than in authorities where the majority of residents live nearer to major towns or cities. The preventable mortality rate for females was 125 preventable deaths per 100,000 population: 29 deaths per 100,000 population higher than in authorities where the majority of residents live nearer to major towns or cities.

Trends over time follow a similar pattern to those shown in Figure A-5.

Figure A-6: Line charts showing the change in under 75 mortality rates from all causes considered preventable, by sex and relative access in majority rural authorities as defined within the 2021 rural-urban classification, 2013-15 to 2022-24 (Note A-4, Note A-5, Note A-6, Note A-7, Note A-9)

Males are represented in the left-hand chart, and females are shown in the right-hand chart. The labels 'further from' and 'nearer to' refer to majority rural authorities where the majority of the population reside further from or nearer to major towns or cities, respectively. Vertical axis scales differ across the charts in the preventable mortality section.



* a major town or city (for the majority of the population)

Mortality rate from cancer considered preventable

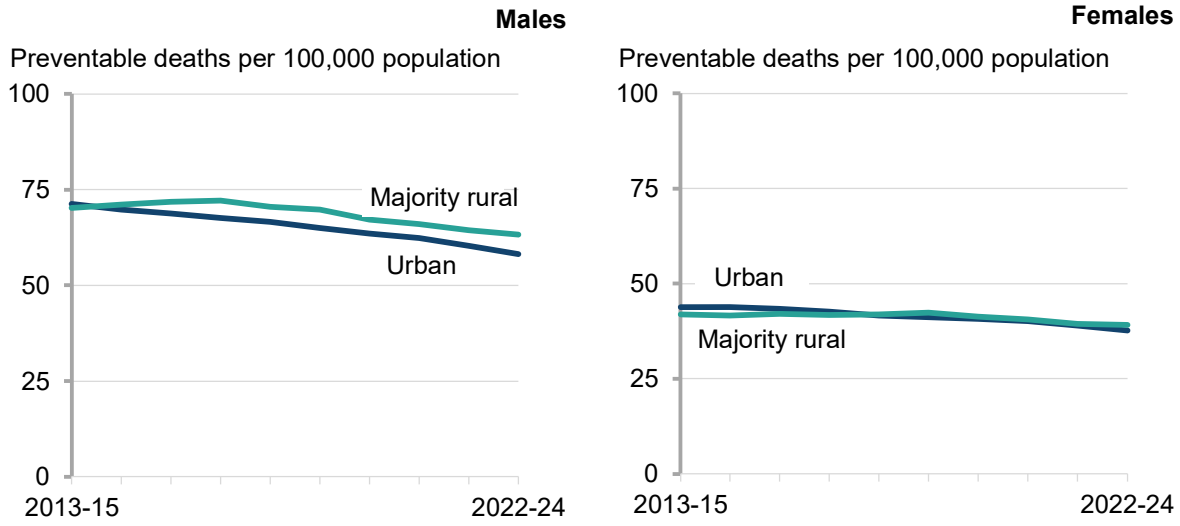
The Department of Health and Social Care publish data relating to the mortality rate from cancer considered preventable, with the following rationale: "Cancer is the highest cause of death in England in under 75s. To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment. The inclusion of this indicator (alongside others in the Public Health and NHS Outcomes Frameworks) reinforces the Government's commitment to reducing avoidable deaths through public health policy

and interventions and sends out a clear signal that prevention of cancer is just as important as treatment."

In 2022-24, for males there were 63 preventable deaths from cancer per 100,000 population (under 75) in majority rural authorities, and 58 preventable deaths per 100,000 population in urban authorities outside London. For females, there were 39 preventable deaths per 100,000 population in majority rural authorities, and 38 preventable deaths per 100,000 population in urban authorities outside London.

The two line charts in Figure A-7 show the changes in mortality rates from cancer considered preventable, for majority rural and urban authorities outside of London as defined within the 2021 rural-urban classification; changes are measured between the three-year periods spanning 2013-15 to 2022-24. The left-hand chart highlights male mortality rates whilst the right-hand chart shows female mortality rates.

Figure A-7: Line charts showing the change in under 75 mortality rates from cancer considered preventable, by sex and 2021 rural-urban classification of local authorities in England, 2013-15 to 2022-24 (Note A-4, Note A-6, Note A-7, Note A-9)
Males are represented in the left-hand chart, and females are shown in the right-hand chart. Analysis for intermediate authorities and London are not included in the line chart but can be found within the Health and Wellbeing supplementary data tables. Urban excludes London. Vertical axis scales differ across the charts in the preventable mortality section.



The mortality rate for male preventable cancer has been consistently higher for those living in majority rural authorities than those living in urban authorities outside London since 2014-16. For females there is little difference between the two types of authority in the rate of preventable mortality from cancer.

The left-hand line chart in Figure A-7 (representing **males**) can be described as follows:

- For males living in majority rural authorities, the mortality rate from preventable cancer showed a small increase of 2 deaths per 100,000 population between 2013-15 to 2016-18, to 72 preventable deaths per 100,000 population (under 75). After that the rate has fallen to 64 preventable deaths per 100,000 population in 2022-24.

- For males living in urban authorities outside London, the mortality rate from preventable cancer has dropped between 2013-15 to 2022-24, from 71 to 58 preventable deaths per 100,000 population (under 75).

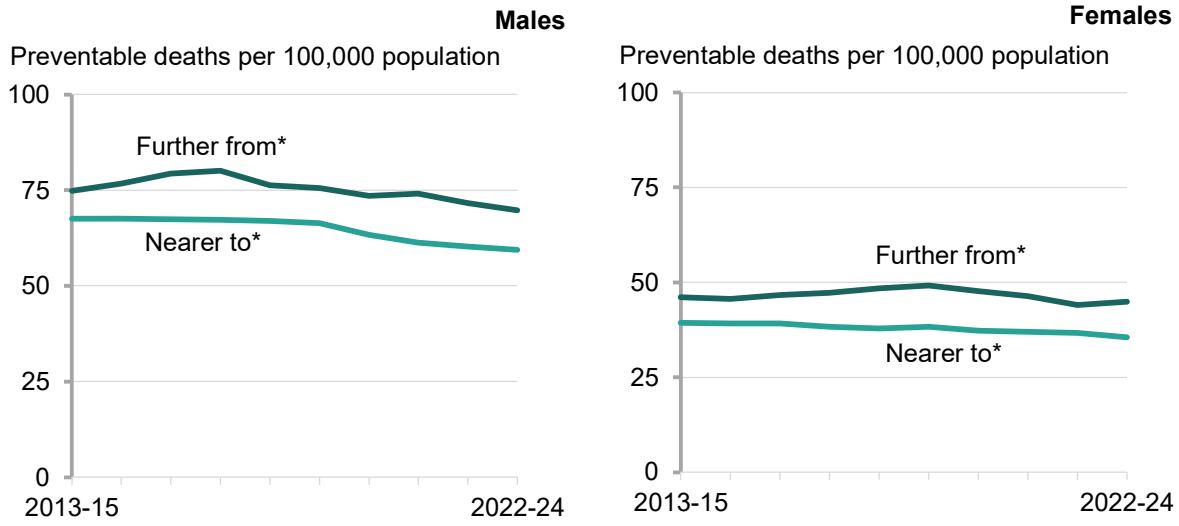
The right-hand line chart in Figure A-7 (representing **females**) can be described as follows:

- For females, the mortality rate from preventable cancer shows little difference between majority rural authorities and urban authorities outside London over the period 2013-15 to 2022-24. In majority rural authorities the rate fell slightly from 42 to 39 preventable deaths per 100,000 population between 2013-15 to 2022-24, while in urban authorities outside London the rate fell from 44 to 38.

It is also possible to consider the impact that relative access has for those living in majority rural authorities. Relative access indicates proximity to a major town or city for the majority of the resident population (Note A-5). The line charts in Figure A-8 show the changes in mortality rates from cancer considered preventable, by sex and relative access in majority rural authorities, between the three-year periods spanning 2013-15 to 2022-24.

Figure A-8: Line charts showing the change in under 75 mortality rates from cancer considered preventable, by sex and relative access in majority rural authorities as defined within the 2021 rural-urban classification, 2013-15 to 2022-24 (Note A-4, Note A-5, Note A-6, Note A-7, Note A-9)

Males are represented in the left-hand chart, and females are shown in the right-hand chart. The labels ‘further from’ and ‘nearer to’ refer to majority rural authorities where the majority of the population reside further from or nearer to major towns or cities, respectively. Vertical axis scales differ across the charts in the preventable mortality section.



* a major town or city (for the majority of the population)

The mortality rate for preventable cancer has declined over time for both males and females but has been consistently higher in majority rural authorities where the majority of the population reside further from major towns or cities. In 2022-24, the mortality rate for preventable cancer in males in these authorities was 70 preventable deaths per 100,000 population: 10 preventable deaths higher than in authorities where the majority of residents live nearer to major towns or cities. The female mortality rate for preventable cancer was 45 deaths per 100,000 population: 9 preventable deaths higher than in authorities where the majority of residents live nearer to major towns or cities.

The left-hand line chart in Figure A-8 (representing **males**) can be described as follows:

- For males living in majority rural authorities where the majority of the population live further from a major town or city, preventable mortality rates from cancer rose to 80 preventable deaths per 100,000 population in 2016-18 after which the rate has shown a downward trend.
- A similar downward trend is seen for males living in majority rural authorities where the majority of the population live nearer to a major town or city, however rates are lower (59 preventable deaths from cancer in 2022-24).

The right-hand line chart in Figure A-8 (representing **females**) can be described as follows:

- Females living in majority rural authorities where the majority of the population live further from a major town or city, saw preventable mortality rates from cancer rise slightly to 49 preventable deaths per 100,000 population in 2018-20 after which the rate has fallen to 45 preventable deaths per 100,000 population in 2022-24).
- A similar trend is seen for females living in majority rural authorities where the majority of the population live nearer to a major town or city, however rates are lower (36 preventable deaths from cancer in 2022-24).

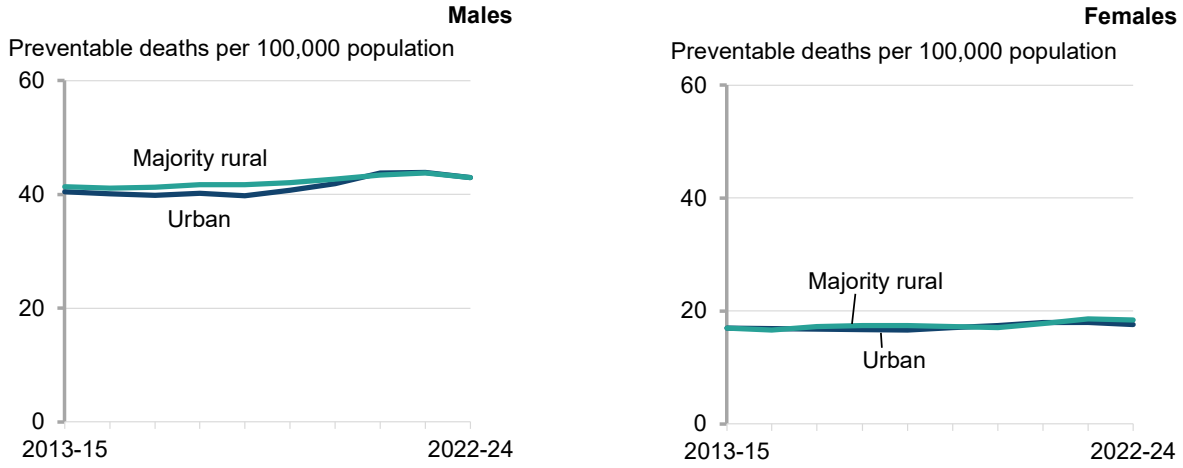
Mortality rate from cardiovascular disease considered preventable

The Department of Health and Social Care publish data relating to the mortality rate from cardiovascular disease considered preventable, with the following rationale: “Cardiovascular disease is one of the largest causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for cardiovascular disease and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from cardiovascular disease, there needs to be concerted action in both prevention and treatment. The inclusion of this indicator (alongside others in the Public Health and NHS Outcomes Frameworks) reinforces the Government’s commitment to reducing avoidable deaths through public health policy and interventions and sends out a clear signal that prevention of circulatory disease is just as important as treatment.”

In 2022-24, for males there were 43 preventable deaths from cardiovascular disease per 100,000 population (under 75) in majority rural authorities, and the same in urban authorities outside London. For females, there were 18 preventable deaths per 100,000 population in majority rural authorities, and the same in urban authorities outside London.

The two line charts in Figure A-9 show the changes in mortality rates from cardiovascular disease considered preventable, for majority rural and urban authorities outside of London as defined within the 2021 rural-urban classification; changes are measured between the three-year periods spanning 2013-15 to 2022-24. The left-hand chart highlights male mortality rates whilst the right-hand chart shows female mortality rates.

Figure A-9: Line charts showing the change in under 75 mortality rates from cardiovascular disease considered preventable, by sex and 2021 rural-urban classification of local authorities in England, 2013-15 to 2022-24 (Note A-4, Note A-6, Note A-7, Note A-9)
Males are represented in the left-hand chart, and females are shown in the right-hand chart. Analysis for intermediate authorities and London are not included in the line chart but can be found within the Health and Wellbeing supplementary data tables. Urban excludes London. Vertical axis scales differ across the charts in the preventable mortality section.



The mortality rate for male preventable cardiovascular disease shows little difference between those living in majority rural authorities and those living in urban authorities outside London between 2013-15 and 2022-24 for both males and females.

The left-hand line chart in Figure A-9 (representing **males**) can be described as follows:

- For males living in majority rural authorities, the mortality rate from preventable cancer cardiovascular disease has shown little change across the period 2013-15 to 2022-24, fluctuating between 41 and 44 preventable deaths per 100,000 population.
- For males living in urban authorities outside London, the figures are similar to those for males living in majority rural authorities.

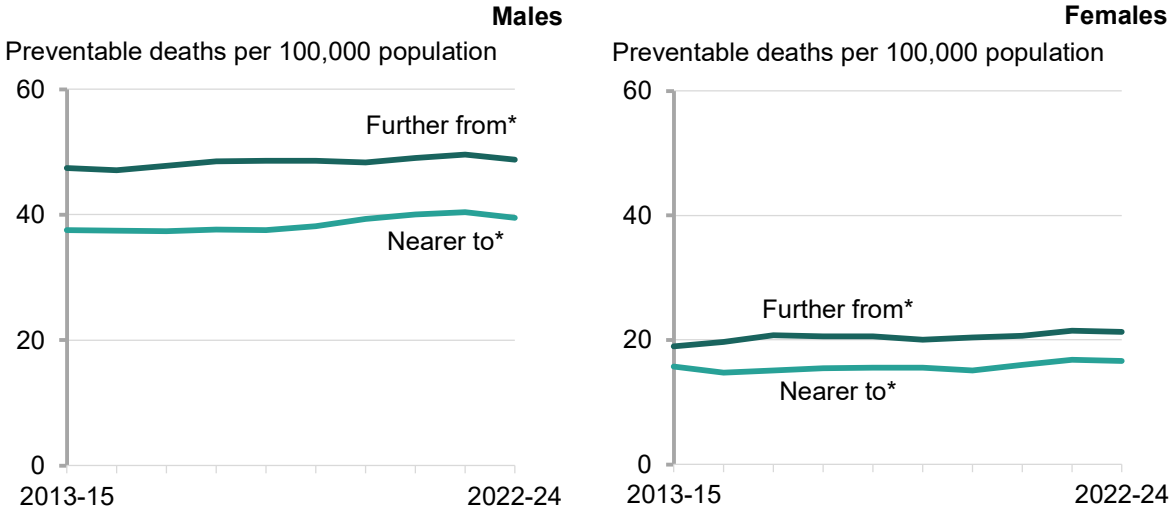
The right-hand line chart in Figure A-9 (representing **females**) can be described as follows:

- For females, the mortality rate from preventable cardiovascular disease shows little difference between majority rural authorities and urban authorities outside London over the period 2013-15 to 2022-24. Both types of authority have seen little change in the rate of preventable deaths from cardiovascular disease, ranging from 17 preventable deaths per 100,000 population in 2013-15 to 18 preventable deaths in 2022-24.

It is also possible to consider the impact that relative access has for those living in majority rural authorities. Relative access indicates proximity to a major town or city for the majority of the resident population (Note A-5). The line charts in Figure A-10 show the changes in mortality rates from cardiovascular disease considered preventable, by sex and relative access in majority rural authorities, between the three-year periods spanning 2013-15 to 2022-24.

Figure A-10: Line charts showing the change in under 75 mortality rates from cardiovascular disease considered preventable, by sex and relative access in majority rural authorities as defined within the 2021 rural-urban classification, 2013-15 to 2022-24 (Note A-4, Note A-5, Note A-6, Note A-7, Note A-9)

Males are represented in the left-hand chart, and females are shown in the right-hand chart. The labels 'further from' and 'nearer to' refer to majority rural authorities where the majority of the population reside further from or nearer to major towns or cities, respectively. Vertical axis scales differ across the charts in the preventable mortality section.



* a major town or city (for the majority of the population)

The mortality rate for preventable cardiovascular disease has been consistently higher in majority rural authorities where the majority of the population reside further from major towns or cities for both males and females. Both types of authority show the same trends over time as those described for Figure A-9 however the difference between the two types of authority is greater for males (between 9 to 11 preventable deaths per 100,00 population) than for females (between 3 to 6 preventable deaths per 100,000 population).

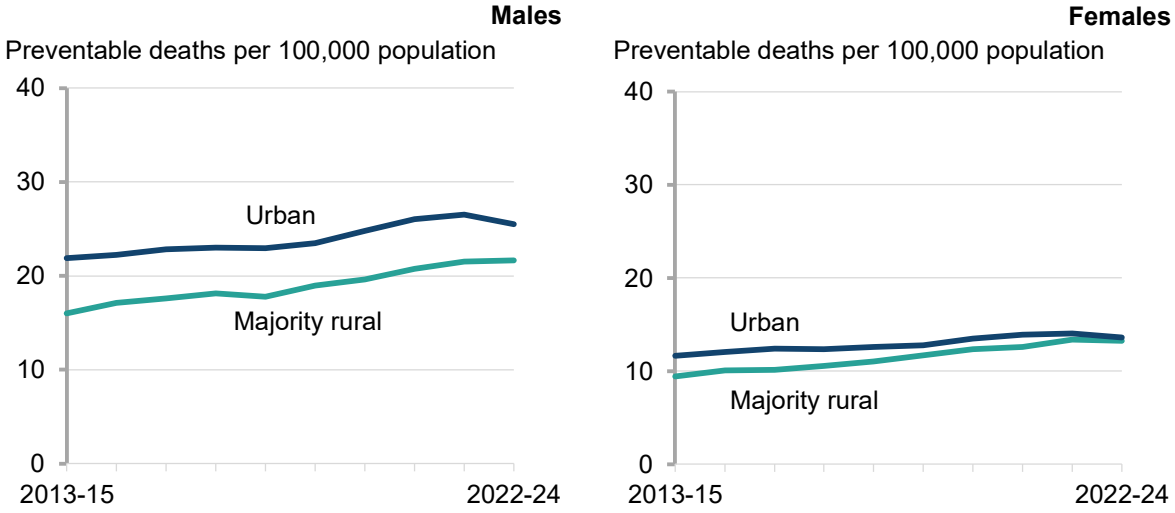
Mortality rate from liver disease considered preventable

The Department of Health and Social Care publish data relating to the mortality rate from cardiovascular disease considered preventable, with the following rationale: "Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable and much is influenced by alcohol consumption and obesity prevalence, which are both preventable through public health interventions. The inclusion of this indicator (alongside others in the Public Health and NHS Outcomes Frameworks) reinforces the Government's commitment to reducing avoidable deaths through public health policy and interventions and sends out a clear signal that prevention of liver disease is just as important as treatment."

In 2022-24, for males there were 22 preventable deaths from liver disease per 100,000 population (under 75) in majority rural authorities, and 25 preventable deaths per 100,000 population in urban authorities outside London. For females, there were 13 preventable deaths per 100,000 population in majority rural authorities, and 14 preventable deaths per 100,000 population in urban authorities outside London.

The two line charts in Figure A-11 show the changes in mortality rates from liver disease considered preventable, for majority rural and urban authorities outside of London as defined within the 2021 rural-urban classification; changes are measured between the three-year periods spanning 2013-15 to 2022-24. The left-hand chart highlights male mortality rates whilst the right-hand chart shows female mortality rates.

Figure A-11: Line charts showing the change in under 75 mortality rates from liver disease considered preventable, by sex and 2021 rural-urban classification of local authorities in England, 2013-15 to 2022-24 (Note A-4, Note A-6, Note A-7, Note A-9)
Males are represented in the left-hand chart, and females are shown in the right-hand chart. Analysis for intermediate authorities and London are not included in the line chart but can be found within the Health and Wellbeing supplementary data tables. Urban excludes London. Vertical axis scales differ across the charts in the preventable mortality section.



The mortality rate for male preventable liver disease has been consistently lower for those living in majority rural authorities than those living in urban authorities outside London over the period 2013-15 to 2022-24. The same is true for females at the start of the period, however the gap has closed and latest data shows there was little difference between the two types of authority in the rate of preventable mortality from liver disease.

The left-hand line chart in Figure A-11 (representing **males**) can be described as follows:

- For males living in majority rural authorities, the mortality rate from preventable liver disease increased by 6 deaths between 2013-15 to 2021-23, to 22 preventable deaths per 100,000 population (under 75) and remained at that level in 2022-24.
- For males living in urban authorities outside London, the mortality rate from preventable liver disease increased by 4 deaths between 2013-15 to 2021-23, to 26 preventable deaths per 100,000 population (under 75) before dropping to 25 preventable deaths in 2022-24.

The right-hand line chart in Figure A-11 (representing **females**) can be described as follows:

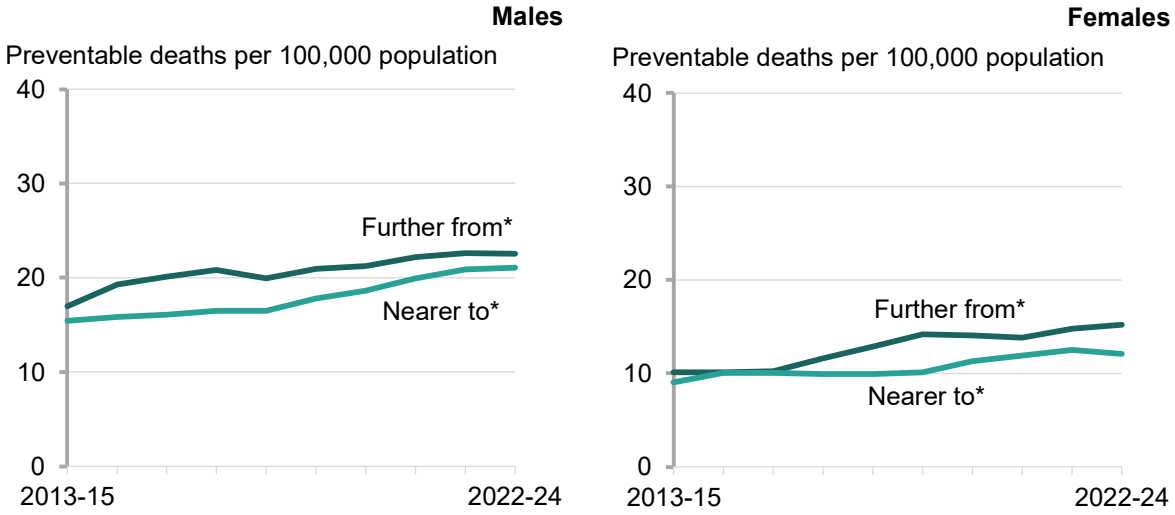
- For females, the mortality rate from preventable liver disease has increased between 2013-15 and 2022-24, but more so for majority rural authorities than for urban authorities outside of London. In majority rural authorities, rates increased from 9 to 13 preventable deaths per 100,000 population, whereas in urban authorities, rates increased from 12 to 14

preventable deaths per 100,000 population. This means that in 2022-24, mortality rates were similar between majority rural and urban authorities.

It is also possible to consider the impact that relative access has for those living in majority rural authorities. Relative access indicates proximity to a major town or city for the majority of the resident population (Note A-5). The line charts in Figure A-12 show the changes in mortality rates from liver disease considered preventable, by sex and relative access in majority rural authorities, between the three-year periods spanning 2013-15 to 2022-24.

Figure A-12: Line charts showing the change in under 75 mortality rates from liver disease considered preventable, by sex and relative access in majority rural authorities as defined within the 2021 rural-urban classification, 2013-15 to 2022-24 (Note A-4, Note A-5, Note A-6, Note A-7, Note A-9)

Males are represented in the left-hand chart, and females are shown in the right-hand chart. The labels 'further from' and 'nearer to' refer to majority rural authorities where the majority of the population reside further from or nearer to major towns or cities, respectively. Vertical axis scales differ across the charts in the preventable mortality section.



* a major town or city (for the majority of the population)

The mortality rate for preventable liver disease has been consistently higher in majority rural authorities where the majority of the population reside further from major towns or cities for males; for females it has been the same or higher.

The left-hand line chart in Figure A-12 (representing **males**) can be described as follows:

- Rates of preventable mortality from liver disease for males have increased for both authorities with a majority further from and nearer to a major town or city by 6 per 100,000 between 2013-15 and 2022-24. However, the difference between them has fluctuated, ranging from a difference of 4 preventable deaths per 100,000 population in 2015-17 and 2016-18 to a difference of just 1 in 2022-24.

The right-hand line chart in Figure A-12 (representing **females**) can be described as follows:

- For females living in majority rural authorities where the majority of the population live further from a major town or city, preventable mortality rates from liver disease increased by 5 preventable deaths per 100,000 population between 2013-15 to 2022-24. For those

where the majority of the population live nearer to a major town or city preventable deaths have increased by 3 per 100,000 population.

- Mortality rates due to preventable liver disease have increased between 2013-15 and 2022-24 in majority rural authorities. Towards the start of the period, there was little difference between authorities where the majority of the population live nearer to major towns or cities, and those where the majority live further away. Between 2015-17 and 2018-20, the gap between mortality rates in these two types of authority widened, after which it has fluctuated.

Mortality rate from respiratory disease considered preventable

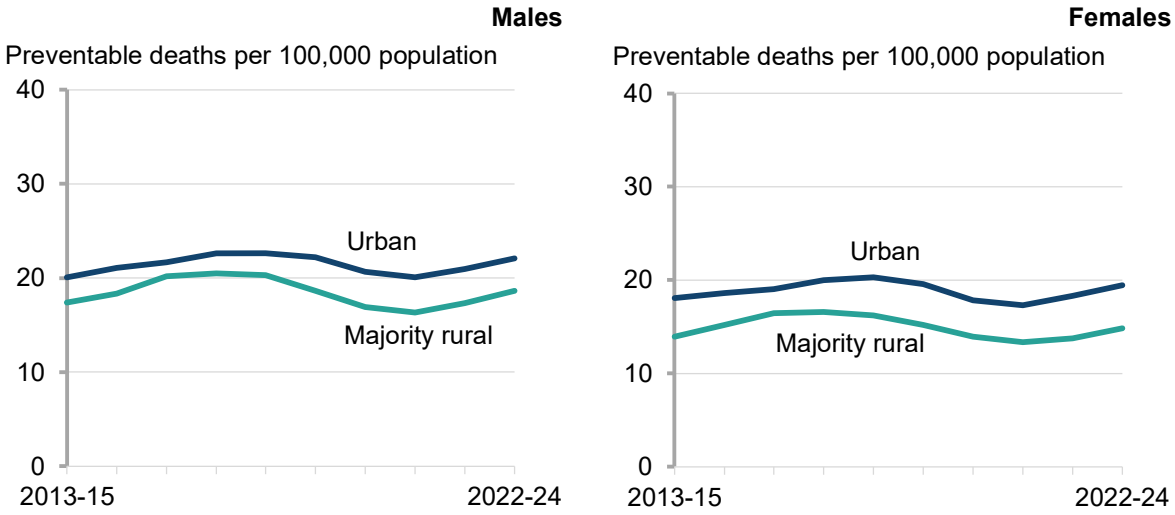
The Department of Health and Social Care publish data relating to the mortality rate from cardiovascular disease considered preventable, with the following rationale: “Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases. This indicator will focus public health attention on the prevention of smoking and other environmental factors that contribute to people developing respiratory disease. The inclusion of this indicator (alongside others in the Public Health and NHS Outcomes Frameworks) reinforces the Government’s commitment to reducing avoidable deaths through public health policy and interventions and sends out a clear signal that prevention of respiratory is just as important as treatment”.

In 2022-24, for males there were 19 preventable deaths from respiratory disease per 100,000 population (under 75) in majority rural authorities, and 22 preventable deaths per 100,000 population in urban authorities outside London. For females, there were 15 preventable deaths per 100,000 population in majority rural authorities, and 19 preventable deaths per 100,000 population in urban authorities outside London.

The two line charts in Figure A-13 show the changes in mortality rates from respiratory disease considered preventable, for majority rural and urban authorities outside of London as defined within the 2021 rural-urban classification; changes are measured between the three-year periods spanning 2013-15 to 2022-24. The left-hand chart highlights male mortality rates whilst the right-hand chart shows female mortality rates.

The mortality rate for preventable respiratory disease has been consistently lower for those living in majority rural authorities than for those living in urban authorities outside London over the period 2013-15 to 2022-24 for both males and females. Patterns over time are the same with increasing mortality rates early on in the period, falling back around COVID-19 and then increasing again at the end of the period.

Figure A-13: Line charts showing the change in under 75 mortality rates from respiratory disease considered preventable, by sex and 2021 rural-urban classification of local authorities in England, 2013-15 to 2022-24 (Note A-4, Note A-6, Note A-7, Note A-9)
Males are represented in the left-hand chart, and females are shown in the right-hand chart. Analysis for intermediate authorities and London are not included in the line chart but can be found within the Health and Wellbeing supplementary data tables. Urban excludes London. Vertical axis scales differ across the charts in the preventable mortality section.



The left-hand line chart in Figure A-13 (representing **males**) can be described as follows:

- For males living in majority rural authorities, the mortality rate from preventable respiratory disease increased between 2015-17 to 2017-19 to 20 preventable deaths per 100,000 population, then fell to 16 deaths in 2020-22 after which it increased to 19 deaths per 100,000 population in 2022-24.
- For males living in urban authorities outside London the pattern was similar, as the mortality rate from preventable respiratory disease increased between 2016-18 and 2017-19 to 23 preventable deaths per 100,000 population, it then decreased to 20 deaths in 2020-22 after which it rose to 22 deaths per 100,000 population in 2022-24.

The right-hand line chart in Figure A-13 (representing **females**) can be described as follows:

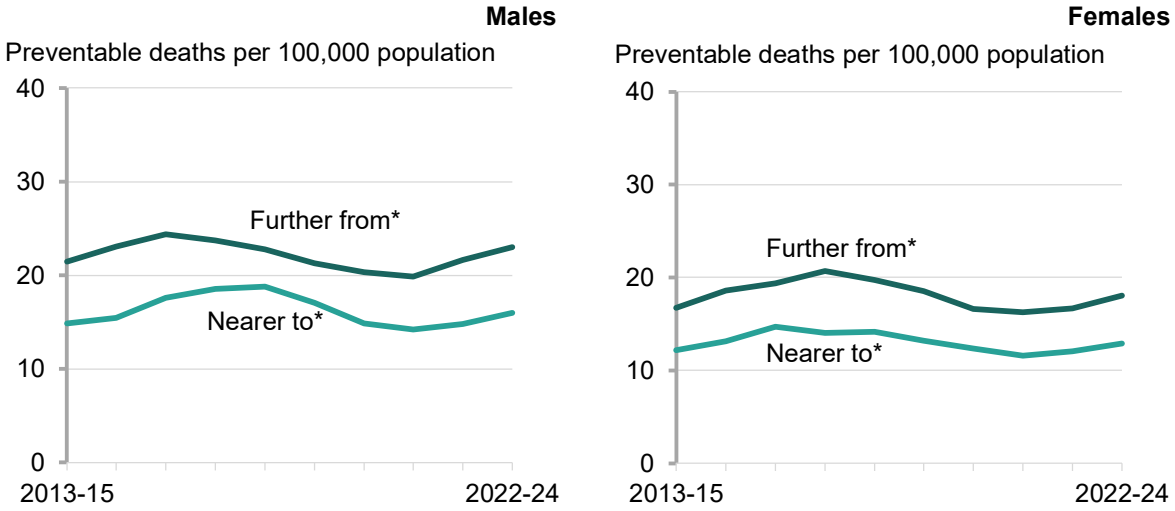
- For females living in majority rural authorities, the mortality rate from preventable respiratory disease rose to 17 preventable deaths per 100,000 population in 2016-18, then fell to 13 deaths in 2020-22 after which it rose to 15 deaths per 100,000 population in 2022-24.
- For females living in urban authorities outside London the pattern was similar, as the mortality rate from preventable respiratory disease rose between 2016-18 to 2018-20 to 20 preventable deaths per 100,000 population, it then fell to 17 deaths in 2020-22 after which it rose to 19 deaths per 100,000 population in 2022-24.

It is also possible to consider the impact that relative access has for those living in majority rural authorities. Relative access indicates proximity to a major town or city for the majority of the resident population (Note A-5). The line charts in Figure A-14 show the changes in mortality rates

from respiratory disease considered preventable, by sex and relative access in majority rural authorities, between the three-year periods spanning 2013-15 to 2022-24.

Figure A-14: Line charts showing the change in under 75 mortality rates from respiratory disease considered preventable, by sex and relative access in majority rural authorities as defined within the 2021 rural-urban classification, 2013-15 to 2022-24 (Note A-4, Note A-5, Note A-6, Note A-7, Note A-9)

Males are represented in the left-hand chart, and females are shown in the right-hand chart. The labels 'further from' and 'nearer to' refer to majority rural authorities where the majority of the population reside further from or nearer to major towns or cities, respectively. Vertical axis scales differ across the charts in the preventable mortality section.



* a major town or city (for the majority of the population)

The charts in Figure A-14 show that those living in authorities where the majority of the population live further from a major town or city consistently have higher rates of preventable mortality from respiratory disease than those that live further away. This is true for both males and females.

- Trends over time follow a similar pattern to those shown in Figure A-13 with rates increasing at the start of the period, then dropping to their lowest in 2020-22, after which they have started to increase again.

Infant mortality rate (IMR)

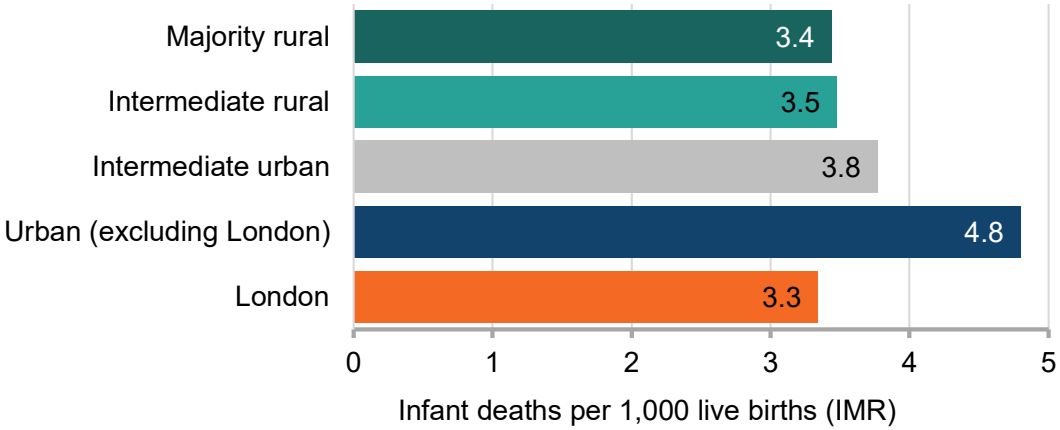
The infant mortality rate (IMR) is the number of infant (under one year old) deaths per 1,000 live births. There are many factors that can influence the IMR, including birth weight, mother's age, and socio-economic status.

The bar chart in Figure A-15 shows the infant mortality rate, by 2021 rural-urban classification of local authorities, in 2022-24. The chart shows that generally, London aside, the more rural the area, the lower the infant mortality rate. The following bullets discuss the chart in more detail.

- In the three-year period spanning 2022 to 2024, there were 3.4 infant deaths per 1,000 live births in majority rural authorities; in absolute terms, this is equivalent to 477 infant deaths.

- In comparison, there were 4.8 infant deaths per 1,000 live births (or 4,238 infant deaths in absolute terms) in urban areas outside London. This is higher than for other types of authority.
- There were 1.4 fewer deaths per 1,000 births in majority rural authorities than in urban authorities outside London.
- The lowest infant mortality rates were in London, with 3.3 infant deaths per 1,000 live births.

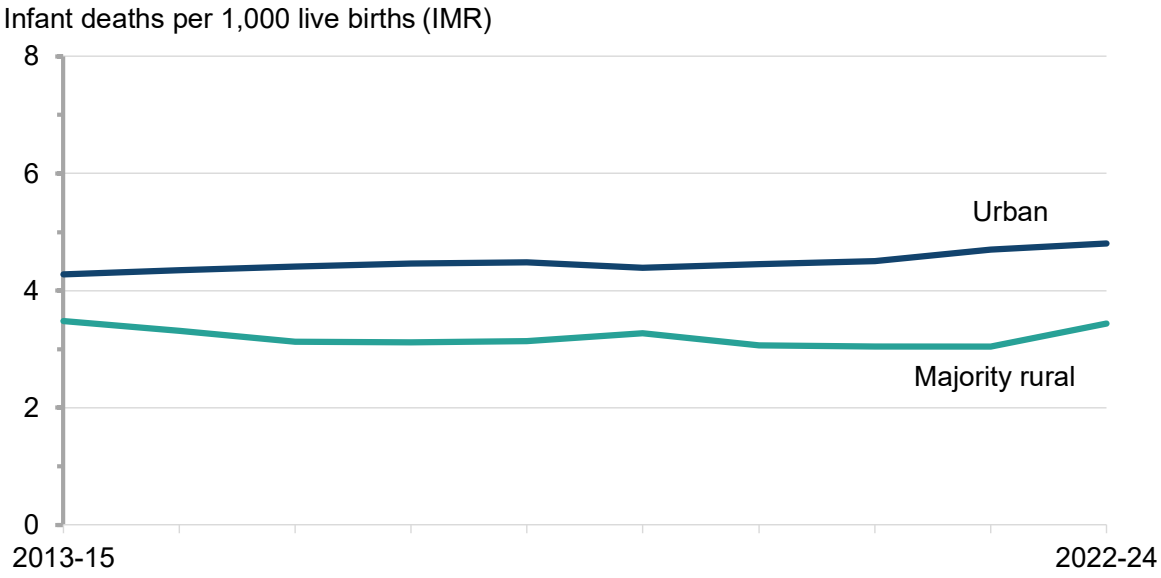
Figure A-15: Bar chart showing the infant mortality rate, by 2021 rural-urban classification of local authorities in England, 2022-24 (Note A-8, Note A-9)



Statistics regarding infant mortality rates can be found within the Health and Wellbeing supplementary data tables.

The line chart in Figure A-16 shows the change in infant mortality rate between 2013-15 and 2022-24, for majority rural authorities and urban authorities outside London.

Figure A-16: Line chart showing the change in infant mortality rate, by 2021 rural-urban classification of local authorities, England, 2013-15 to 2022-24 (Note A-7, Note A-8, Note A-9)
Analysis for intermediate authorities and London are not included in the line chart but can be found within the Health and Wellbeing supplementary data tables, along with data back to 2001-03.
Urban excludes London.

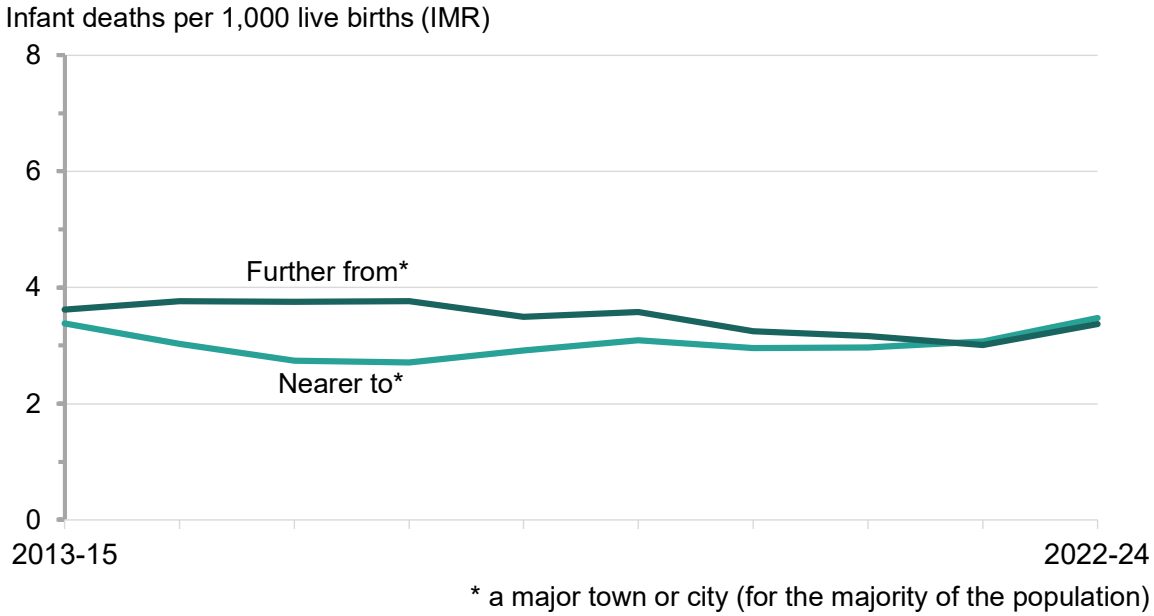


The line chart can be summarised as follows:

- There were consistently fewer infant deaths per 1,000 live births in majority rural authorities than in urban authorities outside London between 2013-15 and 2022-24.
- Between 2013-15 to 2022-24 the rate of infant mortality has seen little change in majority rural authorities, from 3.5 infant deaths per 1,000 live births in 2013-15 to 3.4 infant deaths per 1,000 live births in 2022-24. Urban authorities outside London have also seen little change over the same period, from 4.3 infant deaths per 1,000 live births in 2013-15 to 4.8 infant deaths per 1,000 live births in 2022-24.

It is also possible to consider the impact that relative access has for those living in majority rural authorities. Relative access indicates proximity to a major town or city for the majority of the resident population (Note A-5). The line chart in Figure A-17 shows the changes in the rate of infant mortality by relative access in majority rural authorities, between the three-year periods spanning 2013-15 to 2022-24.

Figure A-17: Line chart showing the change in infant mortality rate by relative access in majority rural authorities as defined within the 2021 rural-urban classification, 2013-15 to 2022-24 (Note A-5, Note A-8, Note A-9)



Since 2021-23 there has been little or no difference in the rate of infant mortality in majority rural authorities whether the majority of the population live further from or nearer to major towns or cities. Prior to then, the rate was higher in those authorities where the majority of the population live further from major towns or cities.

In 2022-24 the infant mortality rate in majority rural authorities where the majority of the population lived further from major towns or cities was 3.4 infant deaths per 1,000 live births (170 infant deaths in absolute terms) and for those that live nearer to major towns or cities the rate was 3.5 infant deaths per 1,000 live births (307 deaths in absolute terms). Caution should be used when considering these results due to the relatively small numbers involved in some authorities.

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 includes all deaths that were assigned an 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: 1981 to 2024 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.

Long-term suicide rates

Suicide rates are calculated using the number of registered suicides and the usual resident population aged 10 years and over. These crude rates allow comparisons between types of area but are influenced by the age distribution of the population. Areas with more people in higher-risk age groups may have higher overall rates, even where underlying risks are similar. As these rates are not adjusted for population structure, comparisons should be interpreted with caution. Data on registered suicides are based on the person's usual residence.

In 2024, there were around 11.6 suicides registered per 100,000 population in majority rural authorities; this is similar to the rate seen in urban authorities outside of London (11.7 suicides per 100,000 population). The line chart in Figure A-18 shows the changes in suicide rates between 2014 and 2024, focussing on majority rural local authorities as defined in the 2021 rural-urban classification.

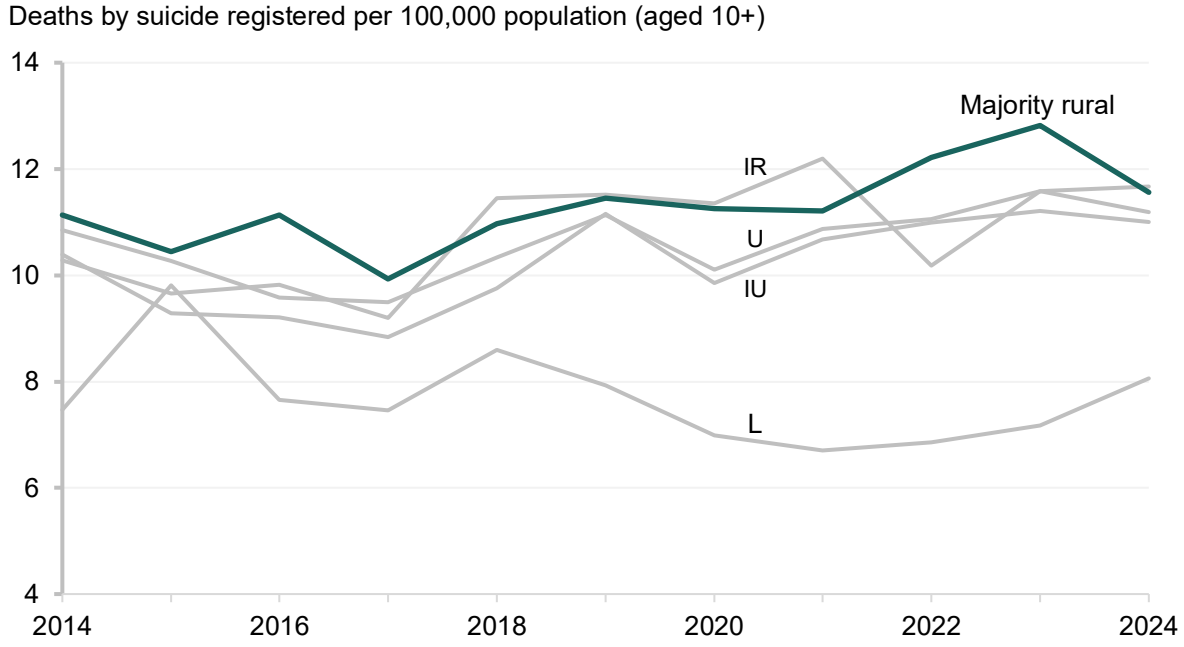
The line chart in Figure A-18 can be described as follows:

- Overall suicide rates were higher in majority rural authorities than in other types of authority across most years between 2014 and 2024.
- Rates in majority rural authorities fluctuated over the period but showed a slight overall increase, reaching a peak of around 12.8 deaths per 100,000 population in 2023 before dropping slightly in 2024. The lowest overall suicide rate across the period in majority rural authorities was 9.9 deaths per 100,000 population in 2017, indicating a variation of around 3 deaths per 100,000 population over the period.
- Overall suicide rates in urban authorities outside of London showed similar fluctuations, ranging between around 9 and 11 deaths per 100,000 population, before rising to 11.7 deaths per 100,000 population in 2024.

- Overall rates in intermediate urban authorities were similar to those in urban authorities outside of London, but did not increase in 2024. In intermediate rural authorities, overall rates showed more fluctuation, ranging between 9 and 12 deaths per 100,000 population.
- The lowest overall rates throughout the period were observed in London, which remained below other types of authority in most years between 2014 and 2024; suicide rates in London fluctuated between 7 and 10 deaths per 100,000 population.

Figure A-18: Line chart showing the number of suicides per 100,000 population aged 10 and over, by 2021 rural-urban classification of local authorities in England, 2014 to 2024 (Note A-11, Note A-12, Note A-13)

The line representing majority rural authorities is coloured to draw focus. The underlying data for this chart can be found in Table AH within the supplementary data tables. Urban excludes London.



Comparator areas: Intermediate rural (IR); Intermediate urban (IU); Urban (U); London (L)

Health outcomes 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 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**

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

- **Note A-4**

Three-year periods are used instead of single-year figures in order to increase precision and reduce annual fluctuations caused by seasonal events. The three-year periods are based on calendar years, so 2022 to

2024 would be January 2022 to December 2024. For more information, please visit: Health state life expectancies, UK Quality and Methodology Information - Office for National Statistics (ons.gov.uk).

- **Note A-5**

'Nearer to a major town or city' is defined as being within a 30-minute drive of a major town or city (built-up area with a population of at least 75,000 residents). Conversely, 'further from a major town or city' is defined as being more than a 30-minute drive away from these built-up areas.

- **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 source: Public Health Outcomes Framework | Fingertips | Department of Health and Social Care (phe.org.uk).

- **Note A-10**

The infant mortality indicator used in this analysis is based on the year in which the death was registered. As per ONS guidance, rates for local authorities were not calculated where there were fewer than 3 deaths; rates based on such low numbers are susceptible to inaccurate interpretation. These small death count figures have been included in the summary analysis when calculating death rates for each category of authority in the 2021 rural-urban classification of local authorities in England.

- **Note A-11**

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.

- **Note A-12**

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-13**

Whilst rates can be compared over time, it should be noted that there was a change in the standard of proof used to determine a suicide in July 2018. This is likely to have contributed to an increased number of deaths recorded as suicide.

- **Note A-14**

This publication was developed using support from generative AI tools to assist with drafting. All analysis, interpretation and final wording were produced, checked and quality-assured by Defra statisticians in line with the Code of Practice for Statistics.

- **Note A-15**

Registered suicide rates have been rounded to the nearest 0.1 deaths per 100,000 population.

B. Wellbeing

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

Key findings – Wellbeing

Rural residents responded more positively about their wellbeing than Urban ones

- 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.
- In 2022/23, on all four metrics the average value for respondents from Predominantly Rural areas was more favourable than the average score for respondents from Predominantly Urban areas.
- In Predominantly Rural authorities, respondents rated their wellbeing as follows: (1) 'life satisfaction': 7.6; (2) 'life is worthwhile': 7.8; (3) 'happiness': 7.5; (4) 'anxiousness': 3.1.

Average estimates of wellbeing changed little over the period 2018/19 to 2022/23

- In 2022/23, in both Predominantly Rural and Predominantly Urban areas all four wellbeing metrics indicated less favourable average scores than they did immediately prior to the COVID-19 pandemic (2018/19).
- Anxiety is the metric that changed the most over this 5-year period; it became less favourable by 0.3 out of 10 in Predominantly Rural areas and 0.4 out of 10 in Predominantly Urban authorities. The second biggest change over this period was for life satisfaction which became less favourable by 0.3 out of 10 in both Predominantly Rural and Predominantly Urban areas.

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.

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.

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.

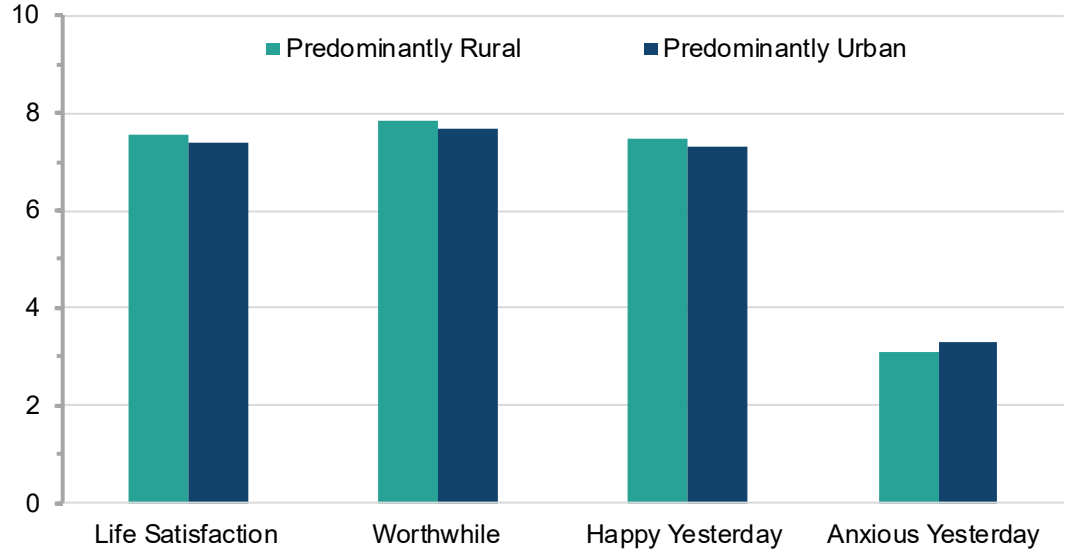


Table B-1 summarises the 2022/23 wellbeing results. When wellbeing for those living in Predominantly Rural areas is compared to those living in Predominantly Urban areas, the data showed the following differences.

- 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.

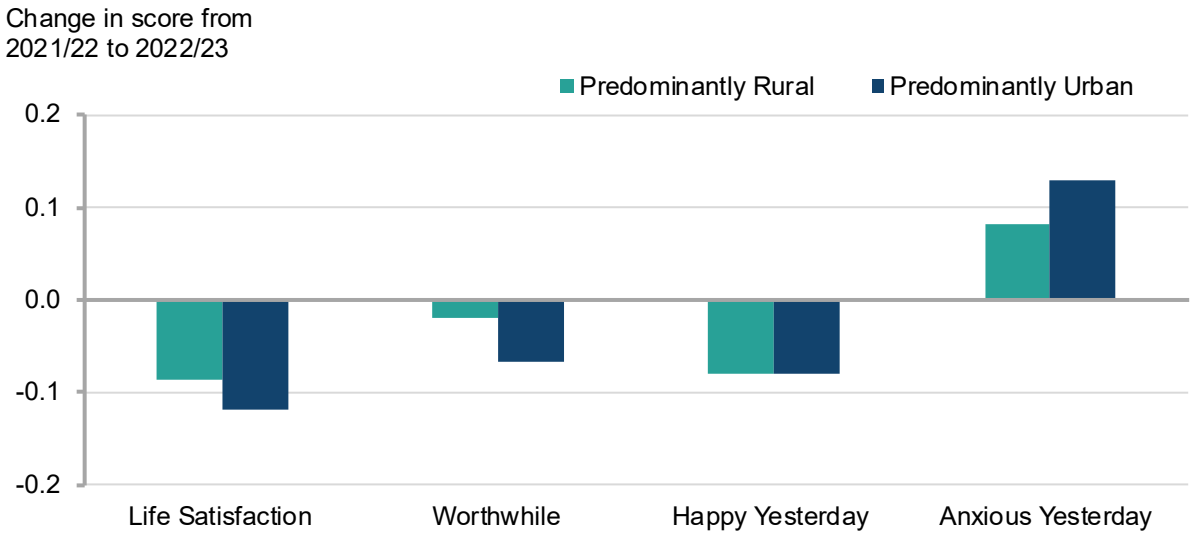
	Overall, how satisfied are you with your life nowadays?	Overall, to what extent do you feel the things you do in your life are worthwhile?	Overall, how happy did you feel yesterday?	Overall, how anxious did you feel yesterday?
Predominantly Rural	7.6	7.8	7.5	3.1
Urban with Significant Rural	7.6	7.8	7.5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

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.

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**

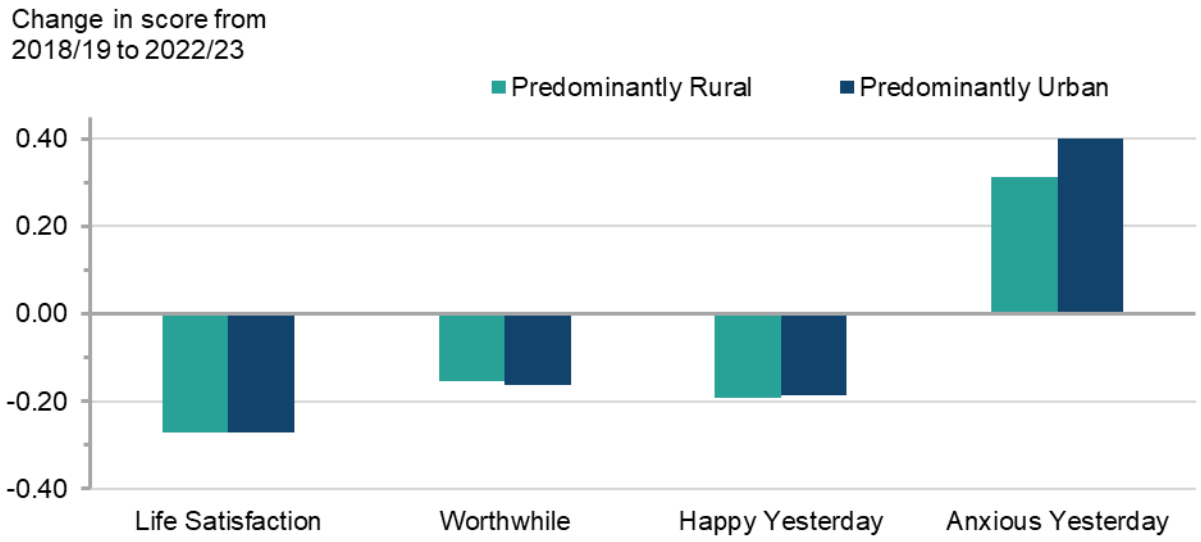
Table B-5: Average ratings (out of ten) on the question "Overall, how anxious did you feel yesterday?", by Local Authority Rural-Urban Classification in England, 2018/19 to 2022/23 (Note B-4, Note B-5)

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**

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**

Average wellbeing estimates are for Rural and Urban areas by weighting 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, the dataset was examined for this effect and it was 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.

However, 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

On average, the proportion of people recently visiting a dentist is lower in majority rural authorities than in urban authorities outside of London.

Key findings – NHS Dentistry

Proportionally fewer people living in majority rural local authorities have visited a dentist recently

- 36% of adults living in majority rural authorities had been seen by an NHS dentist within the last 2 years, as of year ending March 2025. This compares with 41% of adults living in urban authorities outside of London.
- 55% of children living in majority rural authorities had been seen by an NHS dentist within the last year, as of year ending March 2025. This compares with 58% of children living in urban authorities outside of London.

Summary

This section examines access to NHS dental care in England, using administrative data published by the NHS Business Services Authority. The analysis focuses on NHS dentistry only, as comparable data on private dental care are not routinely available at a national or local authority level. As a result, the findings presented do not reflect all dental care received in England.

Outside of London, the more rural the type of authority, the lower the proportion of adults who have visited an NHS dentist recently. 36% of adults living in majority rural authorities had been seen by an NHS dentist in the 24 months to 31 March 2025. This compares with 41% of adults living in urban authorities outside of London.

A similar pattern is observed for children: outside of London, the more rural the type of authority, the lower the proportion of children who have visited an NHS dentist recently. 55% of children living in majority rural authorities had been seen by an NHS dentist within the 12 months to 31 March 2025. This compares with 58% of children living in urban authorities outside of London.

People may visit a dentist where they live, while others may visit a dentist near their place of work or elsewhere. However, the analysis presented within this section focuses on the residence of the patient, rather than the location of the dental practice.

Background information

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. Analysis within this section focuses on NHS dentist visits only and therefore excludes private dentistry. NHS dentistry statistics are published annually by the NHS Business Services Authority (NHSBSA).

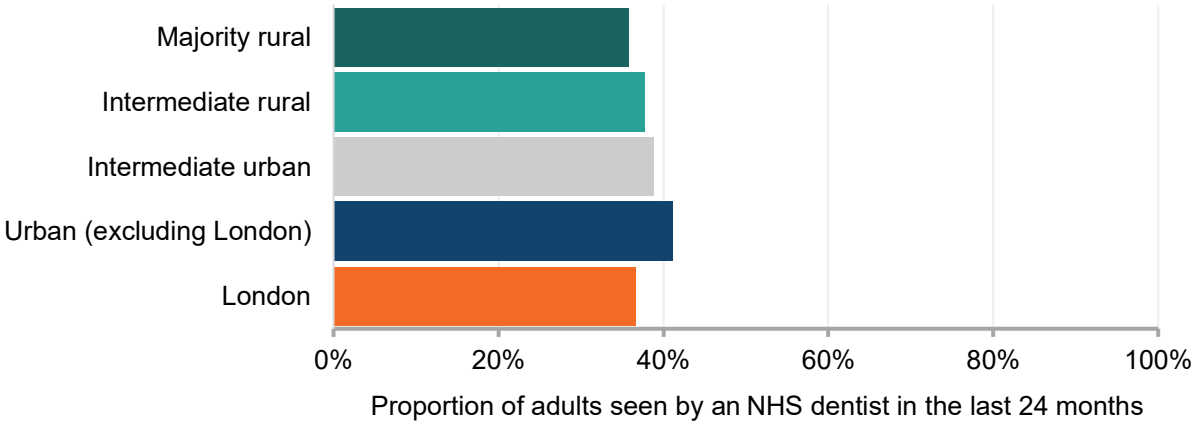
The measure of 'patients seen' is the number of adult patients who received NHS dental care in the previous 24 months. For children, 'patients seen' is the number of child patients who received NHS dental care in the previous 12 months. The 24-month time period for adults and 12-month period for children are aligned with the longest interval between dental checks recommended by the NHS.

Orthodontic patients (those requiring teeth realignment) are included in the 'patients seen' counts, however it is not possible to determine which patients were seen for orthodontic visits as opposed to dental health visits.

Adult dental patients

The bar chart in Figure C-1 shows the proportion of adults who have been seen by an NHS dentist within the 24 months to 31 March 2025, by 2021 rural-urban classification of local authorities in England.

Figure C-1: Bar chart showing the proportion of adults who had seen an NHS dentist in the 24 months to 31 March 2025, by 2021 rural-urban classification of local authorities
The underlying data for this chart can be found in Worksheet CA within the supplementary data tables.



Outside of London, the more rural the type of authority, the lower the proportion of adults who have visited an NHS dentist recently.

- In majority rural authorities, 36% of adults had been seen by an NHS dentist in the 24 months to 31 March 2025. This compared to 38% of adults in intermediate rural authorities.
- In urban authorities outside of London, the overall proportion of adults who had been seen by a dentist recently (41%) was higher than for other types of authority. In 2024/25, the proportion of

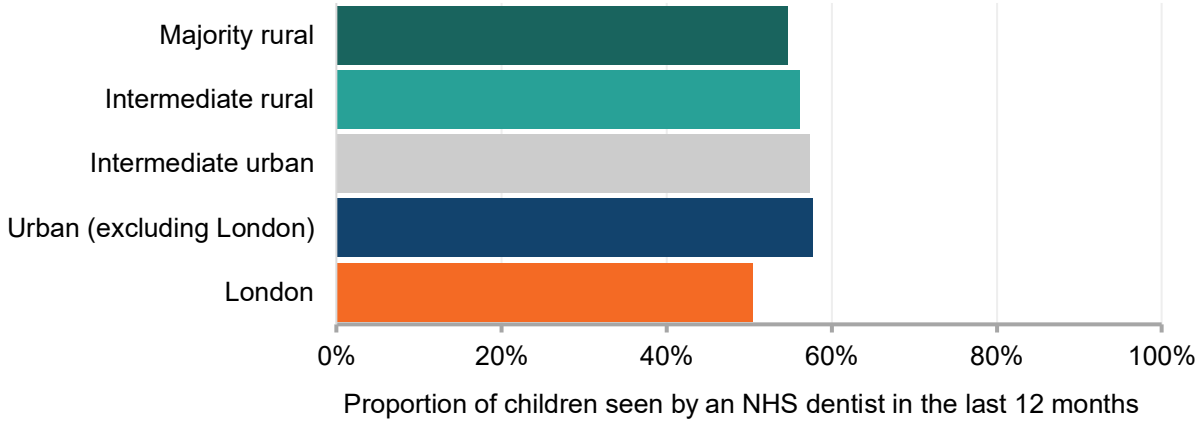
adults living in majority rural authorities who had seen an NHS dentist recently was 5 percentage points lower than in urban authorities outside of London.

- The proportion of adults living in London who had been seen by an NHS dentist recently was similar to that in majority rural authorities, at 37%.

Child dental patients

It is important for children to visit the dentist regularly as their teeth and jaws develop rapidly and data on attendance are for visits within the last 12 months. The bar chart in Figure C-2 shows the proportion of children who had seen an NHS dentist in the 12 months to 31 March 2025, by 2021 rural-urban classification of local authorities in England.

Figure C-2: Bar chart showing the proportion of children who had seen an NHS dentist in the 12 months to 31 March 2025, by 2021 rural-urban classification of local authorities
The underlying data for this chart can be found in Worksheet CB within the supplementary data tables.



Outside of London, the more rural the type of authority, the lower the proportion of children who have visited an NHS dentist recently.

- In majority rural authorities, 55% of children had been seen by an NHS dentist in the 12 months to 31 March 2025. This compared to 56% of children in intermediate rural authorities.
- In urban authorities outside of London, the overall proportion of children who had been seen by a dentist recently (58%) was higher than for other types of authority. In 2024/25, the proportion of children living in majority rural authorities who had seen an NHS dentist recently was 3 percentage points lower than in urban authorities outside of London.
- The proportion of children living in London who had been seen by an NHS dentist recently was lower than in majority rural authorities, at 50%.

NHS Dentistry explanatory notes

- **Note C-1**

The 2021 rural-urban classification of local authorities has been applied, based on patient residence. However, patients might not attend a dentist in the area in which they live.

- **Note C-2**

Source: Defra analysis of Dental statistics – England 2024/25 | NHSBSA

- **Note C-3**

Tables of the data seen in this section are available in the health and wellbeing supplementary data tables.

- **Note C-4**

Figures in this section have been rounded to the nearest 1%.

- **Note C-5**

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-1 and Figure C-2, 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-6**

Statistics in this section relate to NHS dental care only and are based on administrative data published by the NHS Business Services Authority. Data on private dental care are not routinely available at national or local authority level and are therefore not included in this analysis.

Dental care in England can be provided through a mix of NHS and private services, and some patients may use both. Work is ongoing to improve understanding of the private dental market. For example, the Competition and Markets Authority (CMA) has launched a review of private dentistry, which includes considering access to private dental services. Findings from this work may help to inform future analysis where suitable data become available. For more information, see CMA launches review of private dentistry - GOV.UK.

- **Note C-7**

This publication was developed using support from generative AI tools to assist with drafting. All analysis, interpretation and final wording were produced, checked and quality-assured by Defra statisticians in line with the Code of Practice for Statistics.

D. NHS General Practices

On average, patients at rural general practices were more likely to attend appointments and to have face-to-face consultations, although they experienced slightly longer wait times than those at urban practices.

Key findings – NHS General Practice

The more rural the area, the higher the proportion of face-to-face appointments

- In smaller rural settlements, 68% of general practice appointments were physical in the year ending March 2026, meaning they were either face-to-face at the practice, or were home visits.
- This compares with 67% in larger rural settlements, 64% in urban areas outside of London, and 60% in London.

The more rural the area, the higher the appointment attendance

- In both smaller rural and larger rural settlements, 91% of general practice appointments were attended. This compares with 90% in urban areas outside of London, and 88% in London.
- Just 3% of general practice appointments in smaller rural and larger rural settlements were wasted in that the patient did not attend. This compares with 4% in urban areas outside of London, and 6% in London.

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 private practice.

In year ending March 2026, patients were most likely to be seen on the same day or the next day after requesting an appointment, corresponding to 47% of appointments in rural areas and 52% in urban areas. Around 86% of patients at rural general practices were seen within 3 weeks, leaving 14% who waited more than 3 weeks compared with 11% in urban areas.

Physical appointments – either face-to-face within the practice, or home visits – were slightly more common in rural areas than in urban areas, at 67% and 64%, respectively. Remote appointments were less common, representing 30% of appointments in rural areas, and 34% in urban areas. The more rural the area, the higher the proportion of physical appointments, and the lower the proportion of remote appointments. For a small proportion of appointments, the mode was unrecorded.

Appointment attendance was slightly higher in rural areas than in urban areas, at 91% and 89%, respectively. A slightly smaller proportion of patients wasted their appointments by not attending in rural areas (3%) than in urban areas (4%). The more rural the area, the higher the appointment attendance.

Background information

General practice (GP) is usually the first point of contact for healthcare. GP appointments support the assessment and management of health concerns and enable referrals to specialist services when needed. Whilst healthcare can also be accessed through services such as hospitals and urgent treatment centres, this analysis focuses on GP appointments only. Appointments may be with a general practitioner or another member of the general practice team, such as a nurse. Data within this section focuses on NHS GP appointments only, and therefore exclude private practice. NHS GP appointments statistics are published monthly by NHS England Digital.

From October 2025, all general practices in England were required to keep online consultation tools available throughout core hours, allowing patients to request appointments and submit queries online. This change to access routes falls within the period covered by this analysis; however, it had limited impact on annual trends so far.

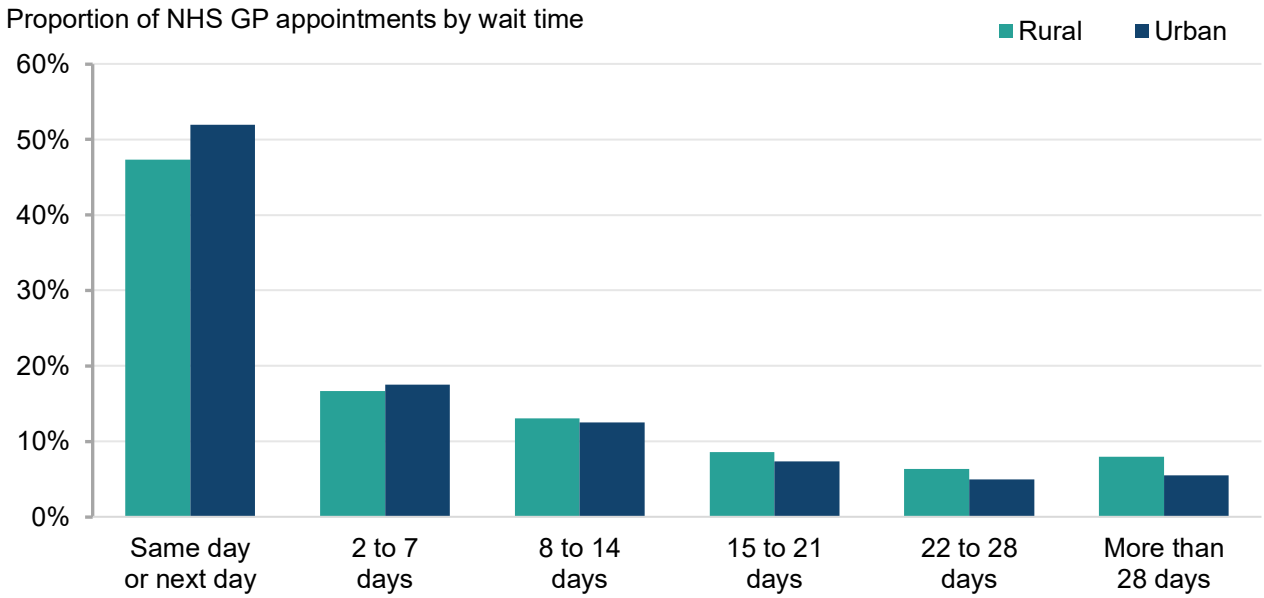
Appointment waiting times

Waiting times for a GP appointment can vary for many reasons, including patient demand and staff shortages. The bar chart in Figure D-1 shows the proportion of NHS GP appointments by wait time band and 2021 rural-urban classification of practice location in year ending March 2026.

Patients were most likely to be seen on the same day or the next day after requesting an appointment. Waiting more than three weeks for an appointment was uncommon: around 86% of patients at rural general practices were seen within 3 weeks. This compares with 89% of patients at urban practices.

Figure D-1: Bar chart showing the proportion of NHS general practice appointments, by wait time band and 2021 rural-urban classification of practice location, England, year ending March 2026

The legend is presented in the same order and orientation as the clusters of columns. The underlying data for this chart can be found in Worksheet DA within the supplementary data tables.



The bar chart in Figure D-1, which presents the distribution of wait times for GP appointments in year ending March 2026, can be described as follows:

- Patients at rural practices generally had slightly longer wait times for an appointment compared with those in urban practices.
- Around 47% of GP appointments in rural areas took place on the **same day or the next day**, compared with around 52% in urban areas.
- Appointments within **2 to 7 days** were similar in rural areas (17%) and urban areas (18%).
- The proportion of patients waiting between **8 and 14 days** for an appointment was similar between practices in rural and urban areas (13%).
- For longer waits of 15 days or more, rural areas had higher proportions of appointments than urban areas across each wait time band.
- 8% of patients in rural practices had to wait **more than 28 days** for an appointment; this compared with 6% in urban areas.

Mode of appointment

General practices offer appointments in a range of formats, including physical and remote consultations, providing patients with different ways to access care. “Physical” includes face-to-face appointments at the practice, and home visits. “Remote” includes telephone and video conference/online appointments.

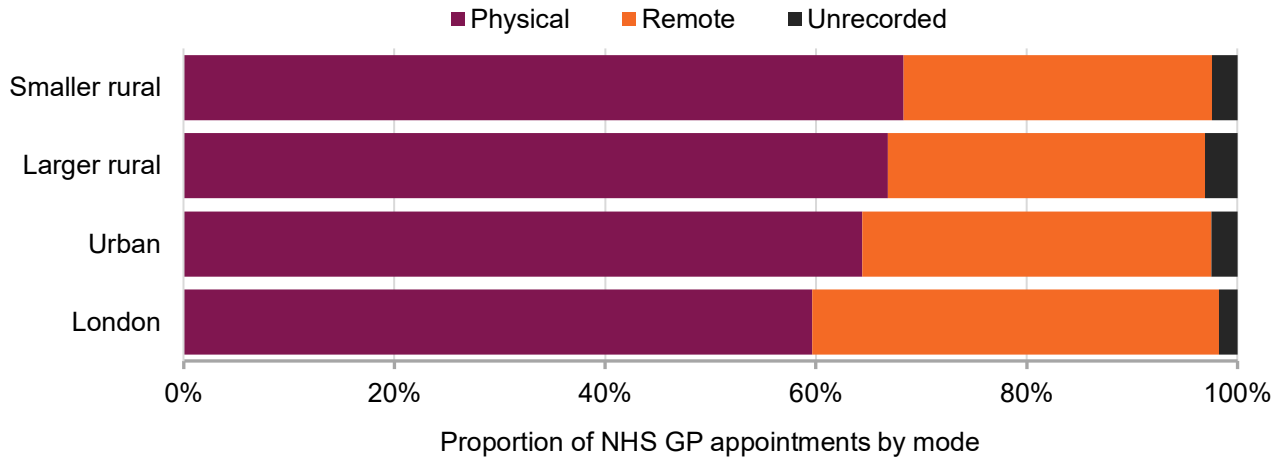
Physical appointments were slightly more common in rural practices than those in urban areas, at 67% and 64% respectively. Remote appointments represented smaller proportions: 30% of GP appointments in rural practices were remote, compared with 34% in urban practices.

A small proportion of appointments did not have a recorded mode, corresponding to 3% in rural areas and 2% in urban areas. These represent appointments where the method of consultation was not recorded in the source system or could not be mapped to a standard category. This reflects data quality limitations rather than a distinct type of appointment activity.

The more rural the area, the higher the proportion of physical appointments at general practices. The bar chart in Figure D-2 shows the proportion of NHS GP appointments by mode and detailed 2021 rural-urban classification of practice location in year ending March 2026.

Figure D-2: Bar chart showing the proportion of NHS general practice appointments, by mode of appointment and detailed 2021 rural-urban classification of practice location, England, year ending March 2026

The legend is presented in the same order and orientation as the stacked bars. The underlying data for this chart can be found in Worksheet DB within the supplementary data tables.



The bar chart in Figure D-2, which presents the distribution of GP appointments by mode in year ending March 2026, can be described as follows:

- The more rural the area, the higher the proportion of physical GP appointments, and the lower the proportion of remote appointments.
- In smaller rural settlements, 68% of GP appointments were **physical**, meaning they were either face-to-face at the practice, or were home visits. This compares with 67% in larger rural settlements, 64% in urban areas outside of London, and 60% in London.
- 29% of GP appointments in smaller rural settlements were **remote**, meaning they occurred via telephone or were video/online appointments. This compares with 30% in larger rural settlements, 33% in urban areas outside of London, and 39% in London.
- Across all area types, 2% to 3% of appointments did not have a recorded mode.

Appointment attendance

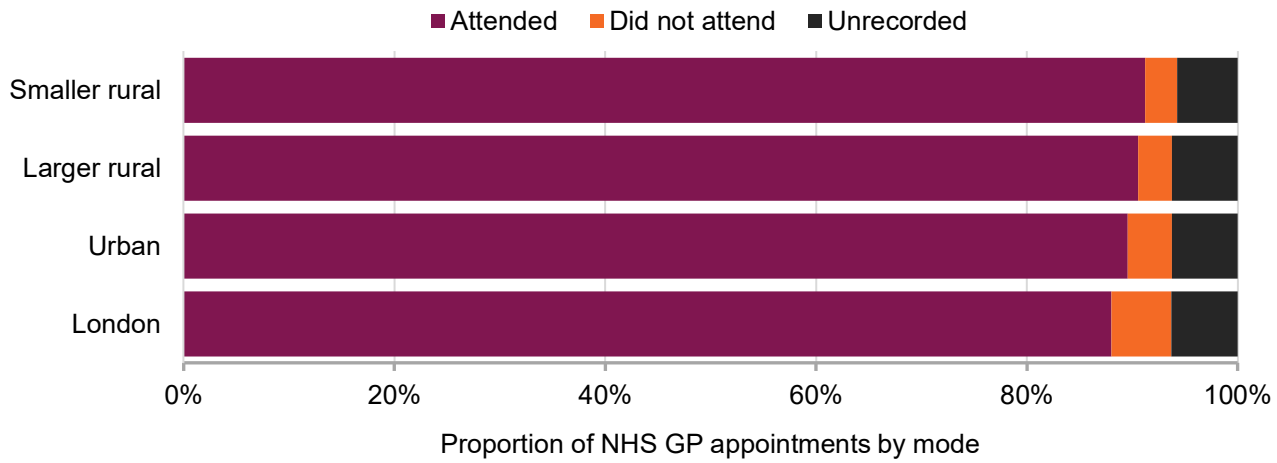
Recording appointment attendance provides context on how appointments are used and may help to interpret potential impacts on waiting times. ‘Did not attend’ appointments – sometimes referred to as wasted appointments – represent those where a patient does not attend their scheduled appointment, which may affect availability for other patients. ‘Unrecorded’ appointments generally refer to those which have not yet taken place; after the scheduled time, these are typically updated to ‘attended’ or ‘did not attend’. In a small number of cases, appointments remain unrecorded after the scheduled time, meaning it is not possible to determine from the data whether the patient attended.

The proportion of patients wasting their appointments by not attending is similar between rural and urban areas, at 3% and 4%, respectively. Proportionally more patients attended their appointments in rural areas than in urban areas (91% and 89%, respectively).

The more rural the area, the higher the GP appointment attendance. The bar chart in Figure D-3 shows the proportion of NHS GP appointments by attendance status and detailed 2021 rural-urban classification of practice location in year ending March 2026.

Figure D-3: Bar chart showing the proportion of NHS general practice appointments, by attendance status and detailed 2021 rural-urban classification of practice location, England, year ending March 2026

The legend is presented in the same order and orientation as the stacked bars. The underlying data for this chart can be found in Worksheet DC within the supplementary data tables.



The bar chart in Figure D-3, which presents the distribution of GP appointments by attendance in year ending March 2026, can be described as follows:

- The more rural the area, the higher the attendance of GP appointments, and the lower the proportion of wasted appointments ('did not attend').
- In both smaller rural and larger rural settlements, 91% of GP appointments were **attended**. This compares with 90% in urban areas outside of London, and 88% in London.
- Just 3% of GP appointments in smaller rural and larger rural settlements were wasted in that the patient **did not attend**. This compares with 4% in urban areas outside of London, and 6% in London.
- Across all area types, around 6% of appointments were recorded as 'booked' and had not yet taken place, and therefore did not have a final attendance status.

NHS General Practice explanatory notes

- **Note D-1**

The 2021 rural-urban classification of Lower-layer Super Output Areas – based on the postcodes of the NHS general practices – has been applied. However, it should be noted this is not based on the resident population: although it is typical, patients might not attend a practice in the area in which they live.

For the detailed classification, 'urban' excludes London.

- **Note D-2**

Source: Defra analysis of Appointments in General Practice, March 2026 - NHS England Digital.

- **Note D-3**

Tables of the data seen in this section are available in the health and wellbeing supplementary data tables.

- **Note D-4**

Figures in this section have been rounded to the nearest 1%.

- **Note D-5**

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.

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

- **Note D-6**

Statistics in this section relate to NHS general practice only and are based on administrative data published by NHS England. Data on private practice are not routinely available at national or sub-national level and are therefore not included in this analysis.

- **Note D-7**

This publication was developed using support from generative AI tools to assist with drafting. All analysis, interpretation and final wording were produced, checked and quality-assured by Defra statisticians in line with the Code of Practice for Statistics.

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.

Key findings – Childcare provision

Childminders are still the most common type of childcare provider

- In 2022, childminders accounted for 47% of childcare providers in Predominantly Rural areas and 46% of providers in Predominantly Urban areas. The second most common provider type was childcare on non-domestic premises (nurseries) which accounted for 41% of providers in Predominantly Rural areas and 40% of providers in Predominantly Urban areas.
- Over the period 2015 to 2022, there was a shift in the distribution away from childminders and towards childcare on non-domestic premises. In 2015, childminders accounted for 53% of childcare providers in Predominantly Rural areas and 56% of providers in Predominantly Urban areas.

The number of childcare providers is declining faster than the number of places

- The number of active childcare providers in Predominantly Rural areas decreased by 28% between 2015 and 2022, whilst in Predominantly Urban areas the number of providers decreased by 21%. In March 2022, 13,000 childcare providers were in Predominantly Rural areas and 47,300 were in Predominantly Urban areas.
- The Early Years Register (EYR) is an estimate of the number of children that can attend the provision at any one time. In 2015, there were 270,000 childcare places on the EYR in Predominantly Rural areas; by 2022, the number of places had fallen by 5.1% to 255,000. In Predominantly Urban areas, the number of places on the EYR increased by 2.7% from 860,000 in 2015 to 885,000 in 2022.

The vast majority of childcare providers are rated as good or outstanding

- Between 2015 and 2022, the percentage of childcare providers judged to be ‘Good’ or ‘Outstanding’ in Predominantly Rural areas increased from 87% to 97% of the inspected providers. In Predominantly Urban areas, the proportion judged to be ‘Good’ or ‘Outstanding’ increased from 83% to 96%.

Childcare costs slightly less in rural areas

- For 3-year-old or 4-year-old children, in 2022, the median hourly childcare fee was £4.79 in Predominantly Rural areas and £4.93 in Predominantly Urban (excluding London) areas.

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

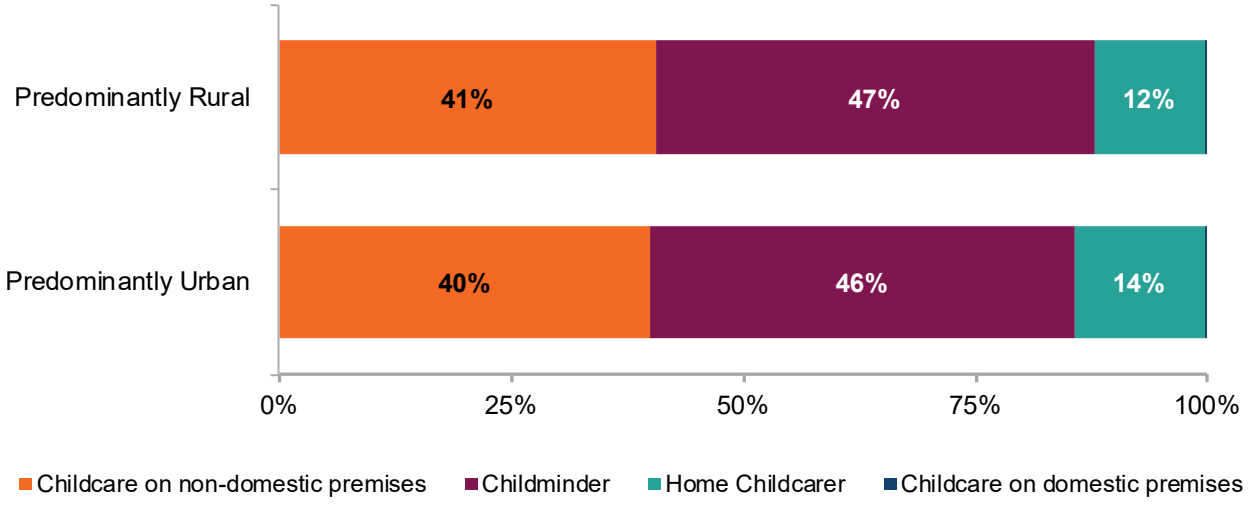
In England it has become common for both parents, or the single parent, to be in employment rather than the child having a full time stay at home parent. Formal childcare then becomes an important service to allow parents to balance parenting and earning. Many parents need to use formal childcare such 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.

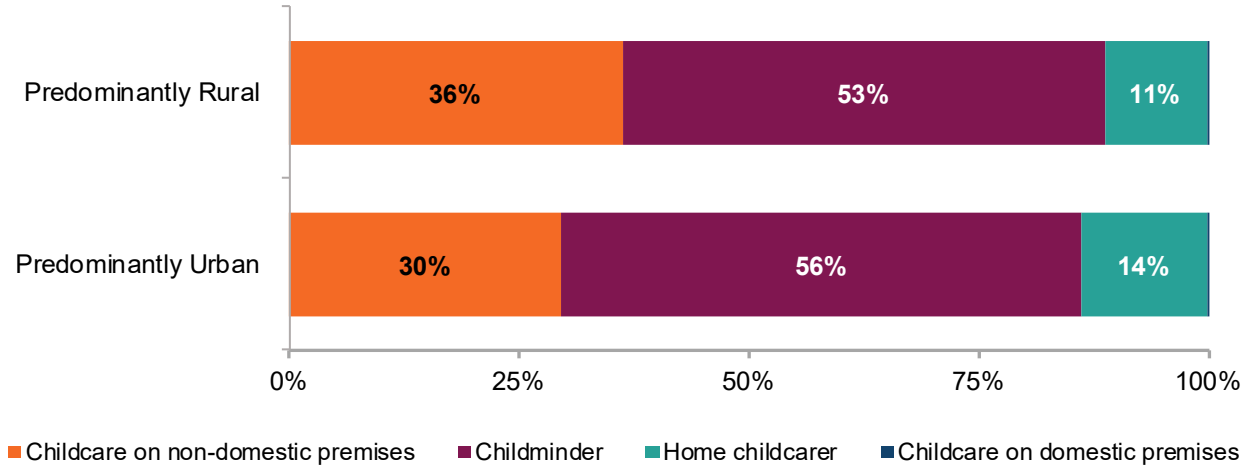
Figure E-1 is a stacked bar chart which shows that in 2022 childminders were the most common form of childcare provider in both Predominantly Rural and Predominantly Urban areas and accounted for 47% and 46% of providers respectively. The second most common provider type was childcare on non-domestic 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

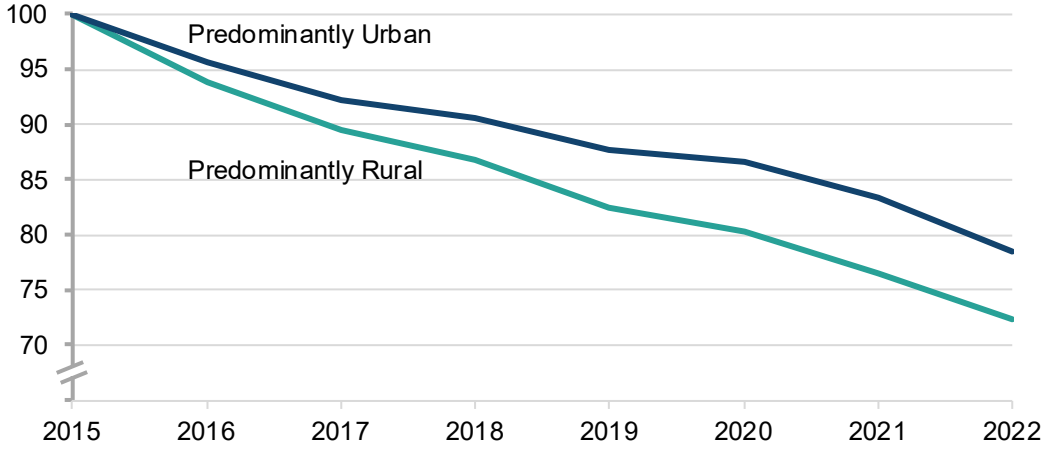


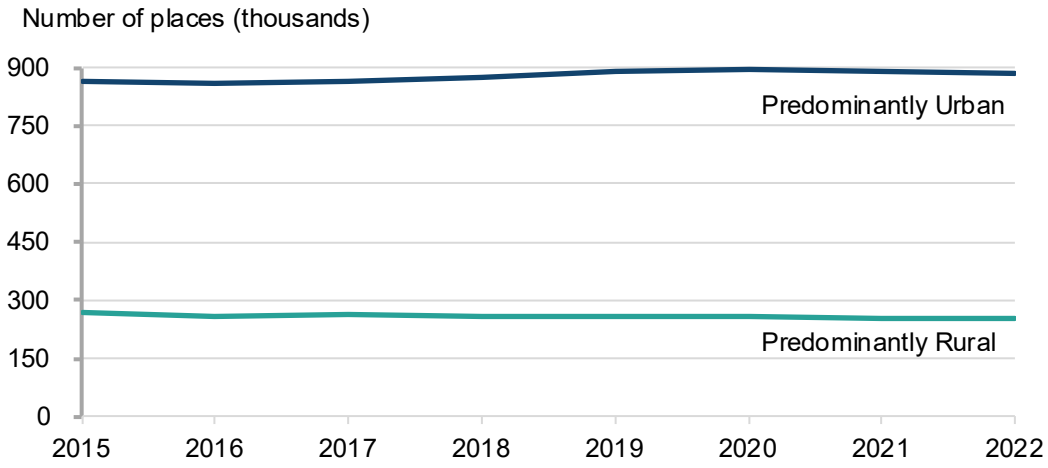
Table E-3: Index of change in Childcare Providers (2015 = 100), by Rural-Urban Classification, March 2015 to March 2022, England (Note E-3)

	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.

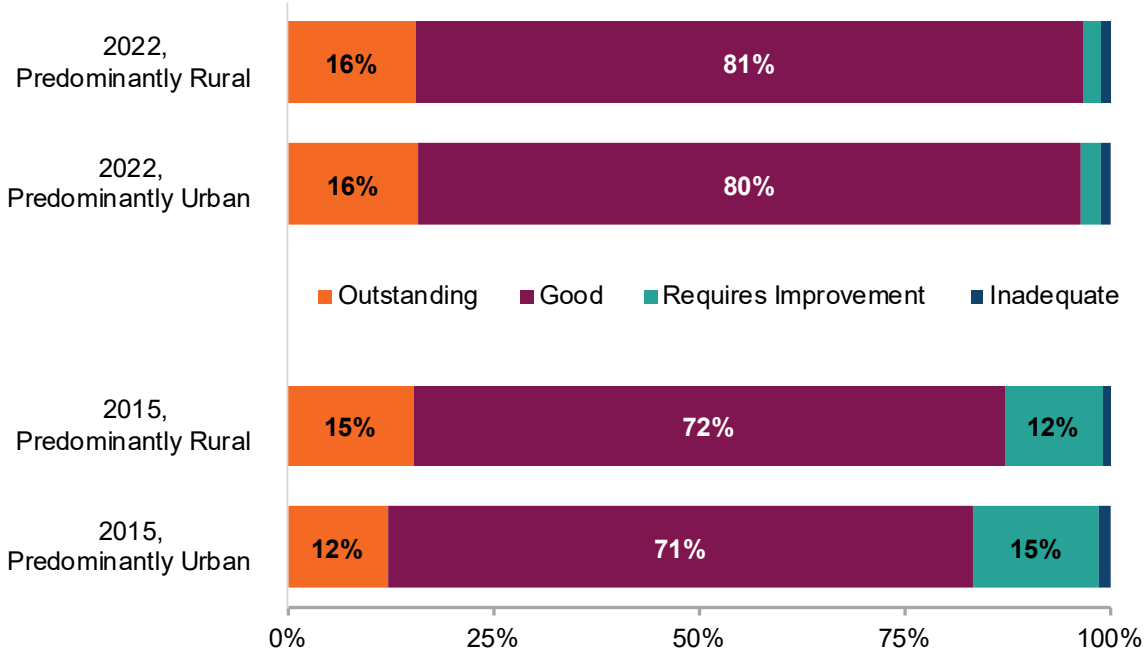


Table E-4: Number of Early Year Registered child carers most recent inspection outcome, by Rural-Urban Classification, 2015 and 2022, England

	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.

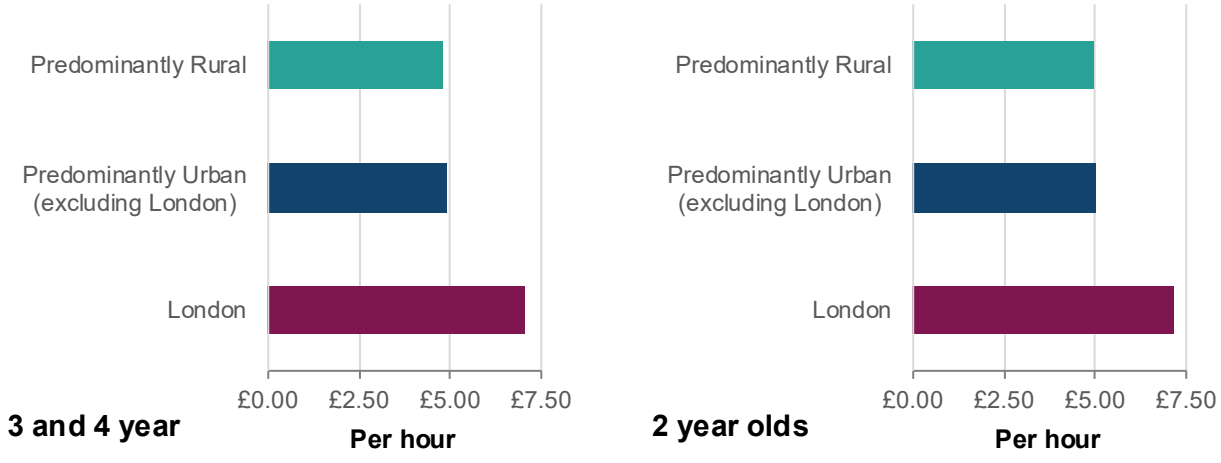
The 2022 survey collected the average hourly fee at (Upper Tier) Local Authority level (Note E-7) for both 2-year-old children and 3- or 4-year-old children. Both the mean and the median hourly cost was collected. For most Local Authorities the mean cost was higher than the median cost and for more than 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.

Key findings – Loneliness

Rural residents are lonely less often than urban ones

- One in every four people living in Rural areas reported that they never feel lonely compared with one in every five people in Urban authorities. Furthermore, 16% of people living in Rural areas reported feeling lonely some of the time, compared with over 19% of people living in Urban authorities.
- The proportion of respondents who reported feeling lonely often or always was similar in Rural and Urban areas.

Communication with friends and family is similar 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. It is a quick and easy way to stay in touch and was used on a weekly basis by 84% of respondents in Rural areas and 87% in Urban areas.
- In Rural areas, there was a marginal preference for meeting up in-person with friends and family when compared to Urban areas. On a weekly basis, 73% of respondents from Rural areas met up with friends or family compared to 70% in Urban areas.
- In Urban areas, there was a marginal preference for phone and/or video calls with friends and family when compared to Rural areas. On a weekly basis, 80% of respondents from Rural areas had a phone or video call with friends or family compared to 83% in Urban areas.

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 a person has, and those that they 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 levels of loneliness are assessed 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. In Rural areas 24% of people reported that they never feel lonely whilst 20% of those living in Urban authorities reported that they never feel lonely. 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”; (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.

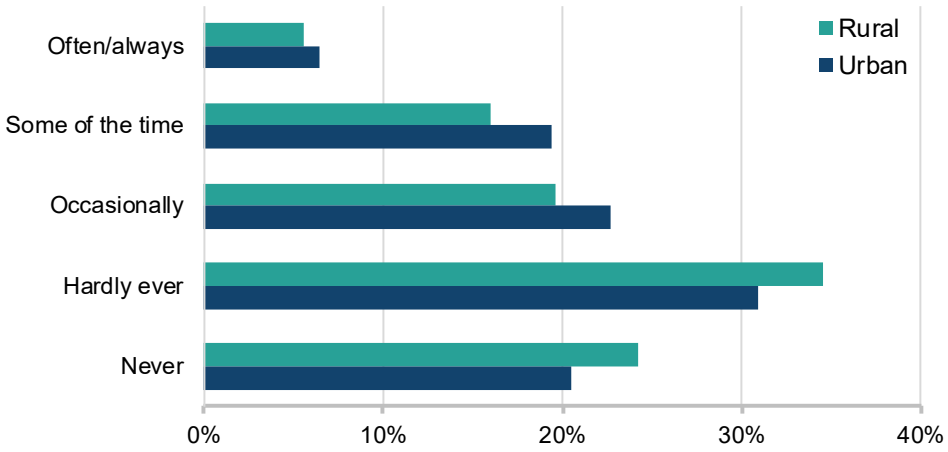
Frequency of loneliness

As explained in the Loneliness Strategy, loneliness is "a subjective, unwelcome feeling of lack or loss of companionship. It happens when a person has a mismatch between the quantity and quality of social relationships that they have, and those that they 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 the bar chart in Figure F-1 shows that 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. In Rural areas roughly 1 in 4 people (24%) reported that they never feel lonely compared with 1 in every 5 people living in Urban areas (20%).

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: Bar chart showing the 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

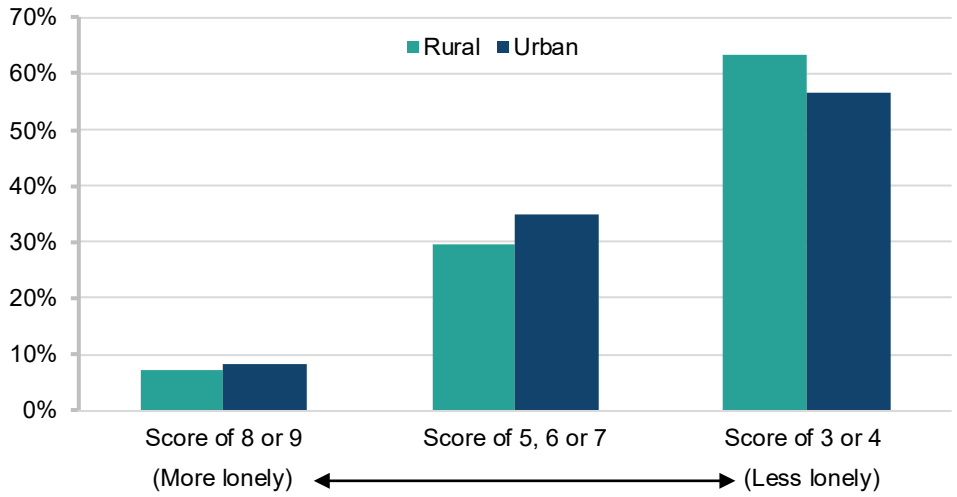
There is variation in how people understand the term "loneliness" and some people or groups of people within society might be reluctant to admit to loneliness. A multi-item measure that does not mention loneliness directly can be helpful to address these two issues. The University of California developed 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"; (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. This

is shown as a bar chart in Figure F-2 where 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: Bar chart showing the 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)

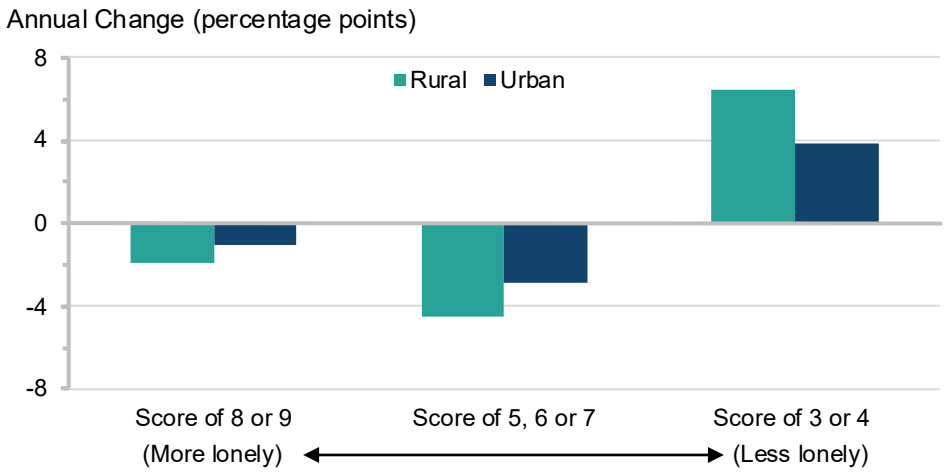
The legend is presented in the same order and orientation as the clusters of columns.



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: Bar chart showing the 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. 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.

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. In rural areas there was a marginal preference for meeting up in person with friends and friends and family when compared to urban areas. On a weekly basis 73% of respondents from rural areas met up with friends or family compared to 70% in urban areas. In urban areas there was a marginal preference for phone and / or video calls with friends and friends and family when compared to rural areas. On a weekly basis 80% of respondents from rural areas had a phone or video call with friends or family compared to 83% in urban areas.

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 estimates for the proportion of respondents meeting up in person 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. These restrictions resulted in an increase in audio and video calls between family and friends.

Figure F-4 is a bar chart showing the proportion of respondents who spoke on the phone, or had a video call, with friends or family at least once a week over the period 2018/19 to 2021/22. 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 in a personal context (Note F-6). Figure F-4 shows 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. In 2021/22, the proportion of people in Rural areas that 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.

Figure F-5 is a bar chart that shows that most people felt that they had access to support networks when needed. 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-4: Bar chart showing the proportion of respondents who spoke on the phone, or had 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.

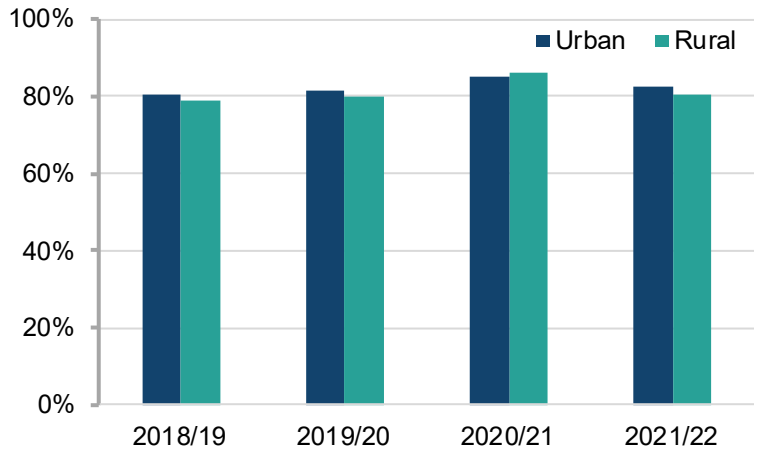
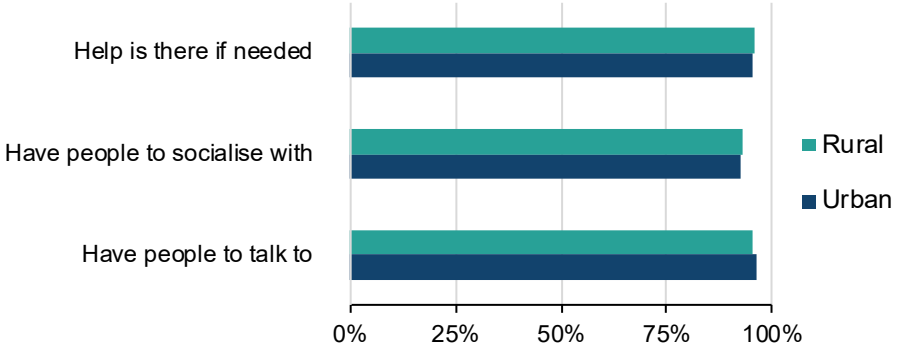


Figure F-5: Bar chart showing the proportion of people agreeing with statements about their access to support networks by Rural-Urban Classification, England, 2021/22 (Note F-4)

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

A higher proportion people in rural areas said they had volunteered within the last year, than in urban areas. Similarly, a higher proportion of people in rural areas said they had given to charity in the past four weeks, compared to those in urban areas.

Key findings – Volunteering and charity

A higher proportion of people in rural areas volunteer than in urban areas

- In 2023/24, 59% of people in rural areas reported volunteering at least once within the last year (either formally or informally) compared to 53% of people living in urban areas.
- In 2023/24, 36% of respondents living in rural areas reported volunteering at least once a month in the year prior to completing the survey, compared to 32% of respondents living in urban areas.

The proportion of people volunteering has fallen over the last decade

- For at least the last decade (2013/14 and 2023/24), a greater proportion of people in rural areas volunteered than did so in urban areas.
- However, the proportion of respondents who reported that they had volunteered at least once a year fell by 16 percentage points in both rural and urban authorities over the period 2013/14 to 2023/24. Across the same period the proportion who volunteered at least once a month in in the year prior to completing the survey has fallen by 11 percentage points in rural areas and 12 percentage points in urban areas.

A higher proportion of people give to charity in rural areas than in urban areas

- In 2023/24, 73% of people living in rural areas reported giving to charity in the past four weeks, compared with 66% of those in urban authorities.
- Over the last decade (2013/14 and 2023/24), a greater proportion of people in rural areas gave to charity than did so in urban areas.

The proportion of people giving to charity is lower than prior to COVID-19

- Between 2019/20 and 2020/21, the proportion of people reporting that they gave to charity in the previous four weeks fell by 16 percentage points in rural areas and 10 percentage points in urban areas. Since 2021 the proportion reporting that they recently gave to charity has risen but the proportions are still lower than prior to the COVID-19 pandemic in both rural and urban authorities.

Summary

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

In 2023/24, 59% of people in rural areas reported volunteering at least once within the last year (either formally or informally) compared to 53% of people living in urban areas. Also, 36% of respondents living in rural areas reported volunteering at least once a month in the year prior to completing the survey, compared to 32% of respondents living in urban areas who volunteered on a monthly basis. A greater proportion of people said they volunteered in rural areas over the period 2013/14 to 2023/24 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. The proportion of respondents who reported that they had volunteered at least once a year fell by 16 percentage points in both rural and urban authorities over the period 2013/14 to 2023/24. Volunteering is likely to reflect socio-economic factors, which differ between Rural and Urban areas.

In 2023/24, 73% of people living in rural areas reported giving to charity in the past four weeks, compared with 66% of those in urban authorities. For every year with data between 2013/14 and 2023/24, a greater proportion of people in rural areas said they gave money to charity than did so in urban areas. Between 2019/20 and 2020/21, the proportion of people reporting that they gave to charity in the four weeks prior to completing the CLS fell by 16 percentage points in rural areas and 10 percentage points in urban areas. The COVID-19 pandemic will have reduced both the opportunity and the ability to give. Since 2021 the proportion reporting that they recently gave to charity has risen but the proportions are still lower than prior to the COVID-19 pandemic in both rural and urban areas.

The Community Life Survey

The Department for Culture, Media and Sport (DCMS) has run and published data from the Community Life Survey (CLS) since the 2016/17 data collection (Note G-5). The most recent survey is for 2023/24 and covers the following themes:

(1) loneliness and support networks,
(2) neighbourhood and community,
(3) civic engagement and social action, and
(4) volunteering and charitable giving.

For the 2023/24 survey DCMS partnered with the Ministry of Housing, Communities and Local Government (MHCLG). Time taken to develop a new survey with a larger sample size resulted in the data gap for 2022/23 seen on all-time series charts in this section (Note G-6). Unlike the earlier years where the survey reflects the financial year, the 2023/24 survey reflects the period October 2023 to March 2024.

The 2023/24 Community Life Survey was published on 4 December 2024. This publication predated 2021 Rural Urban Classification, therefore all rural and urban averages presented in this chapter use the 2011 Rural Urban Classification. This approach protects the integrity of the time-series and allow comparisons with earlier years. Where references have been made to specific authorities, these authorities have been classified according to the latest 2021 Rural Urban Classification (Note G-8). Changes between years should be treated with caution. Within their publication, DCMS made an assessment change between 2021/22 and 2023/24 using confidence

intervals (Note G-9). Within this publication changes are only discussed where DCMS has assessed the difference as an increase or decrease.

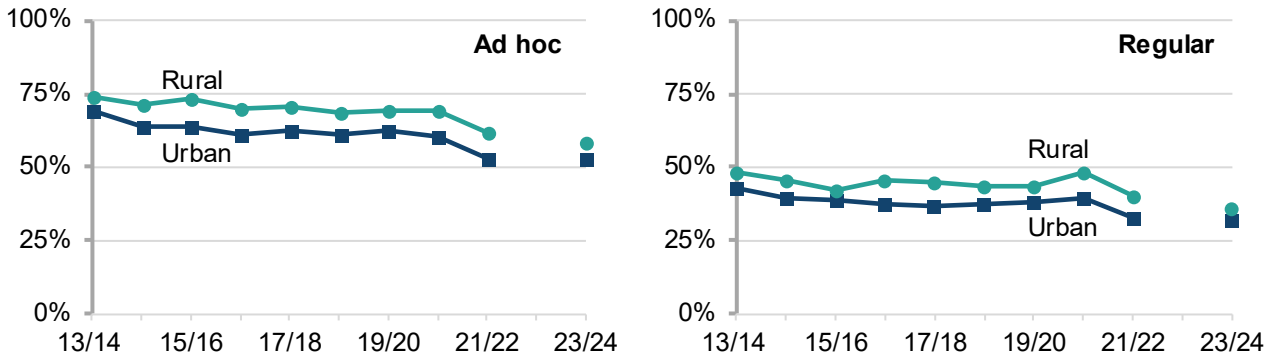
Volunteering

Many activities within local communities in both rural and urban areas could not happen without the help of volunteers. The Department for Culture, Media and Sport (DCMS) includes questions on volunteering on the Community Life Survey (Note G-5). On the survey they distinguish between formal and informal volunteering (Note G-1) and collect data on regular (monthly) and ad hoc (at least once a year) volunteering. Regular activities are often also formal and associated with groups or clubs, like running the local Scouts group. Formal volunteering can also be one-off tasks like helping to organise a fête. 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.

Figure G-1 is a pair of line charts shows that a greater proportion of people say they volunteered in rural areas over the period 2013/14 to 2023/24 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 on a regular basis (at least once a month) in the 12 months prior to their survey response (Figure G-1 right-hand chart).

Figure G-1: Line charts showing the 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, by 2011 rural-urban classification, 2013/14 to 2021/22 and 2023/24 (Note G-5, Note G-6, Note G-7, Note G-8)

The left-hand chart shows the proportion who volunteered at least once during the 12-month period prior to competing the survey, this is indicated as "**ad hoc**" volunteering. The right-hand chart shows the "**regular**" volunteers who are volunteering at least once a month basis during the 12-month period prior to competing the survey. On the x-axis years have been abbreviated to the form yy/yy because of space constraints.



In 2013/14, 74% of people in rural areas reported volunteering (either formally or informally) at least once 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 was 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 that reported they had volunteered fell a further 7 percentage points in rural areas and a further 8 percentage points in urban areas. In 2021/22, 62% of people in rural areas reported volunteering (either formally or informally) within the last year, compared to 53% of people living in urban areas.

In 2023/24, 59% of people in rural areas reported volunteering (either formally or informally) within the last year, compared to 53% of people living in urban areas. CLS is a sample survey and therefore all estimates have a confidence interval attached to them that assesses their precision. At present within the levels of confidence, there is insufficient change to be certain of a reduction in the proportion of people in rural authorities volunteering between 2021/22 and 2023/24.

Overall across the period 2013/14 to 2023/24, the proportion of people who volunteered at least once a year dropped by 16 percentage points in both rural and urban areas.

In 2023/24, 36% of respondents living in rural areas reported volunteering (either formally or informally) at least once a month in the year prior to completing the survey. This is a larger proportion than the 32% of respondents living in urban areas who reported volunteering at least once a month. In 2021/22, 40% of respondents living in rural areas reported volunteering (either formally or informally) at least once a month in the year prior to completing the survey. This was a statistically significant decrease in the proportion of respondents regularly volunteering in rural authorities. However, in urban areas the drop in the proportion of regular volunteers from 33% in 2021/22 to 32% in 2023/24 is not statistically significant.

Overall across the period 2013/14 to 2023/24, the proportion of people who volunteered at least once a month in in the year prior to completing the survey has fallen from 49% to 26% in rural areas and from 43% to 32% in urban areas. These represent falls of 11 percentage points and 12 percentage points respectively.

In 2023/24, on average 59% of respondents in rural authorities volunteered at least once a year. Table G-1 shows the 10 authorities that recorded the lowest proportion of respondents who had volunteered in the last year. In 7 of these majority rural authorities, 50% or fewer respondents had volunteered. The authority of ‘King’s Lynn and West Norfolk’ authority was the majority rural authority where the lowest proportion of respondents had volunteered (47%). Overall, most of the majority rural authorities that reported low engagement in volunteering were in eastern England: 4 were in Lincolnshire, 2 were in East Anglia and one was in Essex.

Two intermediate rural authorities, County Durham and Bolsover, also recorded that just 47% of respondents had volunteered within the 12 months prior to completing the survey. The authorities where the lowest proportion of people had volunteered within the 12 months prior to completing the survey were the urban authorities of Stoke-on-Trent and Sunderland where 43% had volunteered.

Table G-2 shows the 5 majority rural authorities with the highest proportion of respondents saying they had volunteered during the year prior to completing the survey. In all 5 authorities, at least 65% of respondents said they had volunteered. Three of these authorities in Table G-2 were in the South West region. Amongst the intermediate rural authorities, the greatest engagement in volunteering at least once a year was in Sevenoaks and the Vale of White Horse; both recorded that 64% had volunteered in the last year. The highest recorded proportion volunteering at least once a year in urban authorities was 63%. This was recorded in 3 affluent authorities to the south west of London (Waverley, Elmbridge, and Richmond upon Thames).

Table G-1: The 10 majority rural authorities with the lowest proportion respondents claiming that they volunteered (either formally or informally) at least once in the year prior to completing the 2023/24 survey (Note G-5, Note G-6, Note G-8)

Authority	Proportion who volunteered (%)
King's Lynn and West Norfolk	47
East Lindsey	49
Cumberland	50
North Warwickshire	50
South Norfolk	50
South Holland	50
West Lindsey	50
North Kesteven	54
Maldon	54
Forest of Dean	55

Table G-2: The 5 majority rural authorities where at least 65% of the respondents volunteered (either formally or informally) at least once in the year prior to completing the 2023/24 survey (Note G-5, Note G-6, Note G-8)

Authority	Proportion who volunteered (%)
Rutland	65
East Devon	65
South Oxfordshire	66
South Hams	67
Isles of Scilly	68

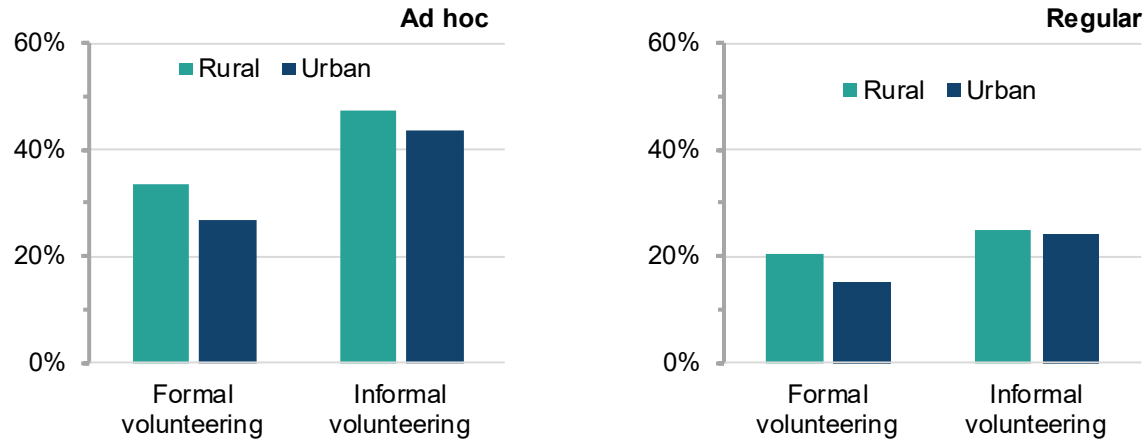
Thus far, no distinction has been made between formal and informal volunteering (Note G-1). The bar charts shown in Figure G-2 do distinguish between formal and informal volunteering and they show that for both regular (at least once a month) and ad hoc volunteering a greater proportion volunteer informally than formally. However, there is a smaller difference in the proportion who volunteer for formal and informal activities if the volunteering is regular than when it is ad hoc. For example, in rural areas 21% reported regularly volunteering on a formal basis and 25% reported regularly volunteering on an informal basis, a difference of 4 percentage points. For ad hoc volunteering, in rural areas 33% reported volunteering on a formal basis at least once a year and 47% reported volunteering on an informal basis at least once a year. This was a difference of 14 percentage points.

A new finding that these charts reveal is that the difference in the proportion who volunteer between rural and urban areas is bigger for formal volunteering than for informal volunteering irrespective of whether this is regular or ad hoc volunteering. This suggests that people view formal volunteering as a greater commitment and that in rural areas respondents were more likely to enter into such a commitment. Specifically, the data shows the following differences:

- participation in informal volunteering at least once a year, was reported by 47% of rural respondents and 44% of urban respondents, a difference of 4 percentage points;
- participation in formal volunteering at least once a year, was reported by 33% of rural respondents and 27% of urban respondents, a difference of 7 percentage points;
- participation in informal volunteering at least once month during the last year, was reported by 25% of rural respondents and 24% of urban respondents, a difference of 1 percentage points;
- participation in formal volunteering at least once month during the last year, was reported by 21% of rural respondents and 15% of urban respondents, a difference of 5 percentage points.

Figure G-2: Bar charts showing the percentage of people in rural and urban areas of England, assigned according to the 2011 rural-urban classification, reporting that they volunteered within the year prior to completing the 2023/24 survey (Note G-5, Note G-6, Note G-8)

The left-hand chart shows the proportion who volunteered at least once during the 12-month period prior to competing the survey, this is indicated as "**ad hoc**" volunteering. The right-hand chart shows the "**regular"** volunteers who are volunteering at least once a month basis during the 12-month period prior to competing the survey.

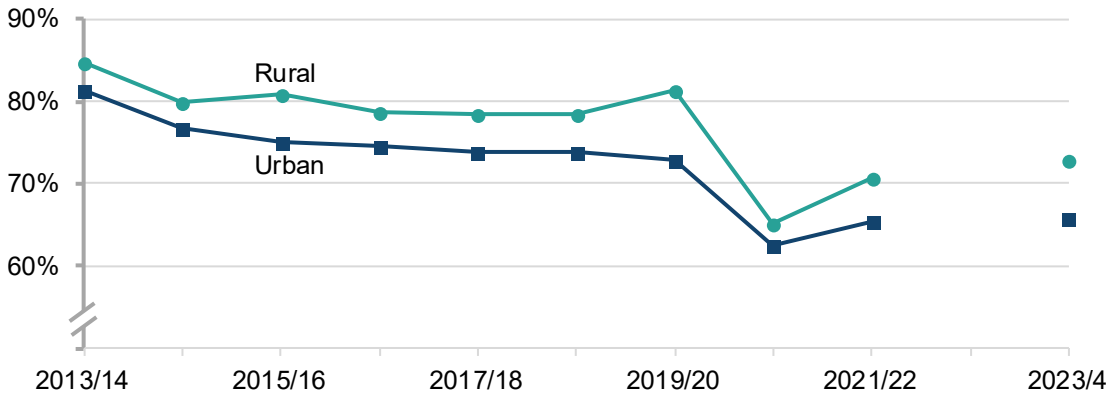


Donating to charity

There are numerous charities in England in both rural and urban areas. The Community Life Survey has questions on giving to charity. In 2023/24, 73% of people living in rural areas reported giving to charity in the past four weeks, compared with 66% of those in urban areas and had changed little from 2021/22.

Figure G-3 is a line chart that shows that in every year between 2013/14 and 2021/22, and in 2023/24, 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. Overall, there has been a long-term decline in giving. The proportion of people reporting having given to charity in the last four weeks fell by 12 percentage points in rural areas and 15 percentage points in urban areas between 2013/14 and 2023/24

Figure G-3: Line chart showing the percentage of people in rural and urban areas of England reporting that they had given to charity in the four weeks prior to completing the survey, 2013/14 to 2020/21 and 2023/24 (Note G-5, Note G-6, Note G-7, Note G-8)



Between 2019/20 and 2020/21, the proportion of people reporting that they gave to charity in the previous four weeks fell by 16 percentage points in rural areas and 10 percentage points in urban areas. The COVID-19 pandemic will have reduced both the opportunity and the ability to give. Since 2021 the proportion reporting that they recently gave to charity has risen but the proportions are still lower than prior to the COVID-19 pandemic in both rural and urban areas.

In 2023/24 on average in rural authorities, 73% of respondents reported giving to charity in the four weeks prior to completing the survey. With the boosted CLS sample size, it is now possible to consider which authorities were well above and well below average in terms of their giving to charity. Overall, there was 51 authorities where at least three in every four respondents (75%) gave to charity, Table G-3 shows the 9 authorities where at least 80% of the respondents had given to charity in the previous four weeks. Of these 9 authorities, 3 were majority rural authorities, 2 were urban authorities and the remainder were intermediate authorities. The majority rural authority where the highest proportion reported giving to charity was Ribble Valley in Lancashire, here 82% reported giving to charity.

Table G-3: The 9 local authorities, and the 2021 Rural Urban Classification, where at least 80% of respondents gave money to charity in the 4 weeks prior to completing the 2023/24 survey (Note G-5, Note G-6, Note G-8)

Local authority	RUC 2021	Proportion who gave to charity (%)
Bracknell Forest	Urban	80
Stroud	Intermediate (urban)	80
Tewkesbury	Intermediate (urban)	80
Wyre	Intermediate (urban)	81
Stratford-on-Avon	Majority rural	81
South Oxfordshire	Majority rural	81
Wealden	Intermediate (rural)	82
Waverley	Urban	82
Ribble Valley	Majority rural	82

In 22 authorities, fewer than 60% of respondents reported that they had given to charity in the four weeks prior to completing the survey. Three of these 22 authorities were classified as intermediate authorities, and the remainder were urban authorities. The 3 authorities where the lowest proportion of respondents reported giving to charity are included in Table G-4.

Table G-4: The 3 local authorities, and the 2021 Rural Urban Classification, where less than 55% of respondents gave money to charity in the 4 weeks prior to completing the 2023/24 survey (Note G-5, Note G-6, Note G-8)

Local authority	RUC 2021	Proportion who gave to charity (%)
Hounslow	Urban	48
Basildon	Urban	51
Lincoln	Urban	54

There were no majority rural authorities where fewer than 60% reported giving to charity in the four weeks prior to completing the survey. Table G-5 includes the 10 majority rural authorities where the lowest proportion of respondents reported giving to charity. South Holland in Lincolnshire, with 60%, was the majority rural authority where the lowest proportion reported giving to charity in the previous four weeks. Overall, 6 of the 10 majority rural authorities where fewer than 69% of respondents reported giving to charity in the previous four weeks were in Lincolnshire (Table G-5).

Table G-5: The 10 majority rural authorities, with the lowest proportion of respondents reporting that they gave money to charity in the 4 weeks prior to completing the 2023/24 survey (Note G-5, Note G-6, Note G-8, Note G-10)

ITL 2 name	Local authority	Proportion who gave to charity (%)
Lincolnshire	South Holland	60
Berkshire, Buckinghamshire and Oxfordshire	West Oxfordshire	63
Herefordshire, Worcestershire and Warwickshire	North Warwickshire	65
Lincolnshire	North Kesteven	67
Devon	North Devon	67
Cumbria	Cumberland	67
Lincolnshire	West Lindsey	68
East Anglia	Broadland	68
Shropshire and Staffordshire	Shropshire	68
Lincolnshire	East Lindsey	68

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. Examples of informal volunteering include babysitting or caring for children, keeping in touch with someone who has difficulty getting out and about, or helping someone with their household tasks such as cleaning, laundry or shopping.

- **Note G-2**

Tables detailing rates of both formal and informal volunteering broken down by broad rural-urban Classification covering 2013/14 to 2021/22 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 the period from 2016/17 to 2021/22. For this period, the survey collected data for financial years from April to March the following year. The CLS moved to a self-completion online and paper mixed method approach from 2016-17 onwards, with an end to the previous face-to-face method. The survey is currently run by Verian (previously Kantar Public) on behalf of the Department for Culture, Media & Sport.

It should be noted that fieldwork for 2020/21 and 2021/22 (particularly during the first quarter of the 2021/22 survey), took place during the COVID-19 pandemic. It is unclear what effect the COVID-19 pandemic, associated lockdown measures and associated media coverage may have had on relevant public behaviours, attitudes and perceptions. This should be taken into consideration when interpreting comparisons from these years to results from 2023/24.

More information on the survey is available at: https://www.gov.uk/government/collections/community-life-survey--2.

- **Note G-6**

In 2023/24, DCMS partnered with the Ministry of Housing, Communities and Local Government (MHCLG) to boost the Community Life Survey to be able to produce meaningful estimates at the local authority level. For the 2023/24 survey 187,500 surveys were returned, around 10,700 failed quality control checks leaving 176,900 respondents in the final dataset. Of these responses 19,000 were paper forms (11%) and the remaining 157,900 (89%) were online forms.

The questionnaire for 2023/24 was developed collaboratively and adapted to meet the needs and interests of both DCMS and MHCLG. This resulted in some new questions and changes to existing questions, response options and definitions in the 23/24 survey. Where there has been a change, DCMS have highlighted where a comparison with previous data can or cannot be made.

Fieldwork for 2023/24 was delivered over two quarters (October to December 2023 and January to March 2024). The earlier portion of 2023/24 was spent developing and implementing the new boosted survey design. The annual publication used here therefore reflects the period October 2023 to March 2024.

For more details see the Community Life Survey 2023/24 annual publication and the CLS 2023/24 technical report.

- **Note G-7**

Data series start at 2013/14 when the push-to-web data collection started on the Community Life Survey. There was no CLS data collected and published for 2022/23; so any time-series show a gap before the 2023/24 results. 2023/24 results have boosted sample sizes.

- **Note G-8**

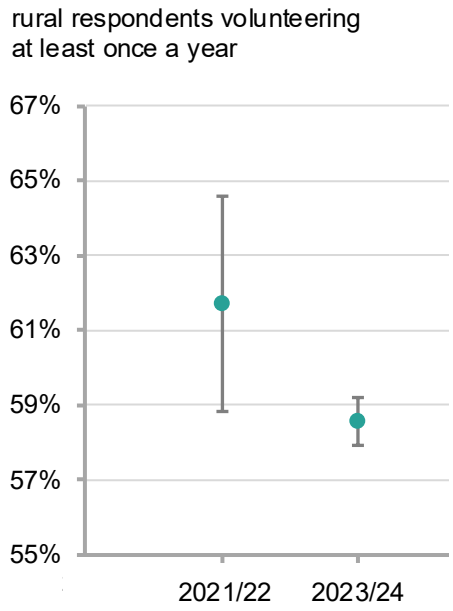
The 2023/24 Community Life Survey was published on 4 December 2024. This publication predated the publication of the 2021 Rural Urban Classification. The rural and urban averages presented in the chapter, and therefore all of the charts use the 2011 Rural Urban Classification. This approach protects the integrity of the time-series and allow comparisons with earlier years.

Where data tables and commentary relate to specific authorities, these authorities have been classified according to the latest 2021 Rural Urban Classification that 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

- **Note G-9**

Given that CLS is a sample survey DCMS publish upper and lower bounds for each value. Where question wording is consistent and it is possible to do so, DCMS assessed change between 2021/22 and 2023/24 using this confidence interval. Within this publication changes are only discussed where DCMS has flagged the difference as an increase or decrease. Box G-1 uses an example question to explain how the increased sample size for 2023/24 reduces uncertainty of the latest estimate, but the confidence intervals for the two most recent data points still overlap due to the wider confidence interval in 2021/22. Despite the best estimates for this variable appearing to differ, statistically there is insufficient confidence that they are not the same.

Box G-1: Using the 2021/22 and 2022/23 estimates for the proportion of people in Rural areas who reported volunteering (either formally or informally) within the last year to explain overlapping confidence intervals



The increased sample size in the 2023/24 survey improved the precision of the estimate, relative to the 2021/22 survey. The is shown with the chart to the left where the circle marks the best estimate and the “error bars” indicate the level of uncertainty associated with that For the 2023/24 estimate DCMS recorded the best estimate as 58.6% based on their sample. After taking account of uncertainty due to sampling, they were also 95% confident that the “true” value for people in rural areas volunteering lies between 57.9% and 59.2% meaning that the value was 58.6% ± 0.7.

For the 2021/22 survey the lower sample size resulted in a less precise estimate for the proportion of people in rural areas that volunteered at 61.7% ± 2.9. In other words, DCMS were 95% confident that the true rural value for 2021/22 lies between 58.8% and 64.5%.

As shown on the chart the lower bound for 2021/22 is lower than the upper bound for 2023/24, so the confidence intervals for the two estimates overlap. Given the sampling uncertainty it is possible, for example that the true value in both 2021/22 and 2023/24 was 59.0%. We therefore record the difference between the two years as no change.

In future years, if CLS retains the higher sample sizes and therefore higher levels of precision year-on-year changes will be detected more reliably.

- **Note G-10**

Prior to EU exit the UK used the Eurostat geographical classification known as the Nomenclature des Unités territoriales statistiques (NUTS). Following the UK's withdrawal from the EU on 31 December 2020, these were replaced with International Territorial Levels (ITLs). ITLs adopt the conventions used by the Organisation for Economic Co-operation and Development (OECD) member countries and therefore align with international standards.

Within England ITLs operate at the following 3 levels:

1. ITL 1: Regions;
2. ITL 2: Counties, Combined Authorities and groups of counties; and
3. ITL 3: Counties and groups of unitary authorities.

More information on ITLs is available on: the ONS methodology pages under international geographies.

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: Small area-based
B. Population: Constituency-based
C. Population: Local Authority-based
D. Internal migration
E. Census 2021: Population

2. Housing

A. Housing stock: age and type
B. Housing stock: additions and affordable housing
C. Housing market
D. Second and empty homes
E. Homelessness
F. Land use change for housing
G. Housing quality

3. Health and Wellbeing

A. Health outcomes
B. Wellbeing
C. NHS Dentistry
D. NHS General Practice
E. Childcare provision
F. Loneliness
G. Volunteering and charity

4. Communities and Households

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

5. Connectivity and Accessibility

A. Broadband
B. Mobile coverage
C. Average travel patterns
D. Access to vehicles and charging infrastructure
E. Transport connectivity
F. 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. Unemployment-related benefits
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. Central heating
E. Energy Consumption
F. Estimated carbon dioxide (CO_2) emissions from domestic properties
G. Boiler Upgrade Scheme (BUS) take up

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.