Witness Name: Alison Byrne OBE
Statement No.: 1
Exhibits: AB1
Dated: 04 September 2024

UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF ALISON BYRNE OBE

Module 6 of the UK Covid-19 Public Inquiry ("the Inquiry")
Request for Evidence under Rule 9 of the Inquiry Rules 2006
Reference for Request - M6/NRS/01

I, Alison Byrne OBE, Chief Executive of National Records of Scotland (NRS) of 2 Princes Street, Edinburgh, EH1 3YT, will say as follows: -

Introduction

1. On the 27 June 2024 the Chair of the UK Covid-19 Inquiry, Baroness Heather Hallett, requested a corporate statement from National Records of Scotland ('NRS') setting out the statistical evidence NRS has produced relating to the impact of the Covid-19 pandemic on the publicly and privately funded adult social care sector ("the Care Sector") in Scotland. For the purposes of this Rule 9 Request, I have understood that the Care Sector includes adult care and residential homes (including care provided in the home) but does not include care provided in day care centres or supported housing.

2. I hope the following information is of use to the Inquiry.

Background to NRS

3. NRS is a Non-Ministerial office in the devolved Scottish Administration. Our purpose is to collect, preserve and produce information about Scotland's people and history and make it available to inform current and future generations.

4. NRS was established on 01 April 2011, following the merger of the General Register Office for Scotland (GROS) and the National Archives of Scotland (NAS). The Chief Executive of NRS fulfils the roles of two non-ministerial office holders – the Registrar General of Births, Deaths and Marriages for Scotland and the Keeper of the Records of Scotland. As statutory offices in the Scottish Administration, for public finance purposes NRS also has an Accountable Officer who is separate from the holder of those statutory offices. We publish an Annual Report and Accounts and we are audited by Audit Scotland.

5. NRS performs the registration and statistical functions of the Registrar General for Scotland. NRS also provides the archival and public records functions of the Keeper of the Records of Scotland, including maintaining the archives as one of the five National Collections of Scotland.

6. Corporate governance is central to the effective operation of all public bodies. We operate best practice as detailed within the HM Treasury and Cabinet Office Corporate Governance Code of Good Practice, and the 7 principles of public life highlighted within HM Treasury guidance on Managing Public Money. Our Framework Agreement sets out the arrangements for corporate governance matters, including the role of the Accountable Officer, and the duties around financial and budgetary management, risk management, business planning, audit and assurance.

7. Below is a brief overview of our core governance boards and committees, outlining their activities in establishing strategic direction, delivering against objectives and managing risk:

    - Our Executive Management Board (EMB) meets every month and is responsible for setting the strategic direction and organisation of NRS, with management and

oversight of NRS key assets. It sets the strategic financial profile, building organisational capability and capacity through our people, overseeing the use of and safeguarding of information assets and oversees organisational performance.

- Our Strategic Board, which includes our Executive Management Team and Non Executives, meets quarterly and acts in an advisory capacity, providing support and constructive challenge on the strategic work of NRS. The board has a particular focus on the strategic direction of the organisation, checking it is on track to deliver on its purpose and vision. It also considers the balance between business and transformation activities and uses the experience of non-executive directors to identify opportunities and emerging issues that ought to be taken into consideration.

- Our Audit and Risk Committee meets quarterly and supports the Chief Executive and the Accountable Officer in their responsibilities for issues of risk, control and governance and associated assurance. The committee is also attended by our Chief Financial Officer, members of the SG Directorate of Internal Audit and Assurance and external audit colleagues who have an independent advisory role.

8. In line with the wider Scottish Administration, NRS moved to a model of predominantly remote working for staff in March 2020. However, throughout the pandemic, we operated an essential on site services and staff approach. Throughout, our priorities were to minimise risk to staff and customers, to identify and prioritise business critical services and, where necessary, implement changes to processes to allow these to endure.

9. During the pandemic we performed the vital role of providing regular information and analyses to help monitor the impact of the COVID-19 pandemic. Our data helped to inform decision making as part of the wider Scottish Administration response to the pandemic. This included the production of weekly and monthly COVID-19 related deaths statistics and analyses on a range of issues. We also provided daily information on deaths to Public Health Scotland which was required for the daily figures on deaths following a positive COVID-19 test.

10. NRS also implemented under the UK Coronavirus Act the remote registration of deaths, to safeguard limited registration capacity nationally. These provisions were maintained in legislation post pandemic via the Coronavirus (Recovery and Reform) (Scotland) Act 2022.

Data: Adult Social Care

11. Please note, the following responses provide information in relation to deaths in adult care homes which specifically relate to COVID-19 (deaths involving COVID-19 and deaths where COVID-19 was the underlying cause of death). In some cases comparative statistics on all-cause deaths were also provided but the main focus was on COVID-19 deaths.

A. Deaths in care homes

12. Data is provided in our annual Vital Events Reference Tables on (all-cause) deaths by location of death (see table 5.09) [AB/01 - INQ000512525]. Care homes is one of the location categories included in this breakdown. Our weekly deaths publication [AB/02 - INQ000512527] includes a breakdown of deaths by location and cause of death (see table 8 for 2023 onwards). Equivalent data for 2020 – 2022 is available in the weekly deaths archive (see table 7) [AB/03 - INQ000512526]. Our monthly mortality publication included a breakdown of death by location up until December 2023 (see table M5) [AB/04 - INQ000512521].

B. Deaths of care home residents (i.e. in places other than care homes)

13. NRS is unable to provide statistics on deaths of care home residents. Our systems are set up to record the address at which the death occurred (place of death) and the usual address of the deceased (place of residence). When processing the deaths data on a daily basis, the place of death address is coded to identify an institution code. These codes can then be used to produce statistical analysis by location of death (e.g. hospital, care home, at home/non-institution or other institution). No such processing takes place on the place of residence address so it is not possible to identify deaths where the deceased was usually resident in an institution. The IT

system for processing death records is set up to include interrogation of the place of death address to enable the assignment of an institution code. The system compares the postcode of the place of death to a list of known institutions and requires the NRS coding team to either (a) confirm the matched institution or (b) to manually select an institution if no automatic match is found. This is carried out on a daily basis as part of the standard processing of death records. The functionality to include processing of place of residence was not part of the initial system design and would require specialist resource for development and testing to implement this kind of system change. Furthermore, this would only make this data available from the point of system change. The coding team would be required to retrospectively add an institution code for place of residence for over 100,000 deaths, in order to provide this data for the period of interest. At the time, resource was already very stretched due to the higher number of deaths being registered, and the priority was the processing of these new daily death records (150-200 per day).

14. ONS are able to produce figures for England and Wales on this basis, and when they began to publish these we received requests for comparable data for Scotland. It was not possible within the timeframes to amend our system to start coding place of residence as part of the daily processing, so we carried out a manual exercise in June 2020 on the deaths which had occurred up to that point.

15. The analysis appears in the list of ad-hoc queries and is entitled "Deaths of care home residents involving COVID-19 (3 June 2020)" [AB/05 - INQ000512515]. It appears sixth from the bottom of the list via the link above. Due to the considerable resource required to produce this analysis manually, it was not repeated after this point. The analysis found that at the time of the week 20 2020 (week commencing 11 May 2020) weekly deaths publication:
    - There were 1,777 deaths of care home residents where COVID-19 was mentioned on the death certificate either as the underlying cause or as a contributory cause.
    - Of these, 154 or 8.7% were people whose usual residence was a care home and who died in hospital.
    - These 154 deaths accounted for 9.3% of the total 1,664 COVID-19 deaths in hospital during the same time period.

- The total COVID-19 deaths which were registered as occurring in a care home during the time period was 1,623, so the additional 154 deaths of people whose usual residence was a care home but who died in hospital increased the total deaths of care home residents by 9.5%.

C. Deaths by pre-existing conditions and location

16. We provided monthly analysis of deaths involving COVID-19 for each location type (hospital, care home, home/non-institution and other institution) by whether the deceased had a pre-existing condition or not. A pre-existing condition was defined as a health condition mentioned on the death certificate which either came before COVID-19 or was an independent contributory factor in the death. Where only COVID-19 was recorded on the death certificate, or only COVID-19 and subsequent conditions were recorded, these deaths were considered to have no pre-existing conditions.

17. This analysis was based solely on the information recorded on the death certificate, and did not link to medical records. It used the same methodology and was consistent with that produced by ONS. This covers the period of March 2020 to February 2023 [AB/06 - INQ000512523]. The analysis appears in the list of ad-hoc queries and is entitled "Pre-existing conditions by location (16 March 2023)". It appears third from the top of the list via the link above.

D. Delays in producing the above data

18. Prior to the pandemic, NRS did not produce or publish weekly death statistics. We published the number of deaths registered by week, but this was only updated on a monthly basis as there was limited demand for data at this frequency. In the early stages of the pandemic we identified a demand for more timely data on deaths, and began work to create a weekly publication of deaths from all causes and deaths involving COVID-19.

19. The first weekly publication was published on 8th April 2020 and related to deaths registered between 30th March and 5th April 2020. The first death involving COVID-19

was registered in the week beginning 16th March, so the weekly deaths publication was set up and published within 2-3 weeks of the first death being registered.

20. There were no location breakdowns in the first weekly publication. After publication of this, it became clear that there was user demand for breakdowns by location of death. This was added to the following week's publication (on 15th April) and was there for all weeks following.

E. Delays in publishing the above data, to include any challenges with regard to transparency

21. The time lag between producing the statistics and publishing them was very short. The registration week ended on a Sunday, the data was processed and coded on the Monday and the statistics produced on the Tuesday and then published at noon on the Wednesday. So the information provided in response to the above question is also relevant.

22. As noted above, we began publishing aggregate data on care home deaths from 15th April 2020. On 2nd October 2020 we received an FOI request asking for a breakdown of COVID deaths by individual care home and care home provider. We did not initially provide an answer to this request on the basis that a) aggregate figures on care home deaths were already provided on a weekly basis and b) we wished to avoid identification of deceased individuals, causing distress to their living relatives.

23. The request was referred to the Scottish Information Commissioner who decided that NRS was not entitled to withhold the information and instructed us to provide the information by 28 June 2021. We then released a table of deaths by individual care home to the requester and published it on our website on 26th June 2021.

F. Data related to the Provisional Outline of Scope the NRS did not and does not hold

24. Data on religion is not recorded on the death certificate and therefore no analysis was possible.

25. Data on ethnicity of the deceased has been collected at death registration since 2012, although this is a voluntary rather than mandatory question. On 8th July 2020 we published analysis of COVID deaths by ethnic group [AB/07 - INQ000512513] (covering the period 12th March 2020 to 14th June 2020).

26. There were data quality issues around the ethnicity data collected at death registration which led us to conclude that accurate analysis could not be carried out using death registration data alone. To make analysis possible, death records were linked to 2011 census records, allowing census data on self-reported ethnicity to be used, increasing the quality of the analysis.

27. This analysis was then repeated in November 2021 [AB/08 - INQ000512514] using data on deaths between 12th March 2020 and 30th September 2021. Neither the original analysis in June 2020 or the follow-up in November 2021 included a breakdown of ethnicity AND location of death. Due to the complexity of the analysis required, it was not possible to revisit this and include a location breakdown.

28. Similarly, we produced analysis of COVID-19 deaths by disability [AB/09 - INQ000184679] which also involved linkage with census records (disability status is not recorded on the death certificate). This also did not include a breakdown of disability AND location of death. Due to the complexity of the analysis required, it was not possible to revisit this and include a location breakdown. In order to make robust and reliable comparisons between disabled and non-disabled groups, the analysis was based on age-standardised mortality rates (ASMRs). This is a well-recognised method of comparing death rates between different groups, accounting for different age-compositions and population sizes, to allow meaningful inferences from any analyses. This is particularly important when carrying out analysis by disability as the characteristics of disabled and non-disabled groups are likely to differ. It is not possible to calculate ASMRs for people who died in different locations (e.g. hospital, care home, at home etc.) because no reliable data exists on the population (and age-structure) in each of these locations. Population data (broken down by 5 year age group) is a necessary element of calculating ASMRs and they cannot be produced without it.

29. No information on care received at home is recorded on death certificates so no analysis was possible. NRS is responsible for the arrangements for registering births, deaths, marriages, civil partnerships and other life events. As a result, the publication of death statistics (based on information collected at the point of death registration) is the responsibility of NRS. NRS do not collect information on individuals receiving care in the home and is unable to clarify whether this data existed within other organisations in Scotland. This analysis would have required linkage of death data to other such sources of data on care received at home, and is beyond the remit of NRS.

30. Analysis by occupation was first published on 17th June 2020 and covered the period March 2020 to May 2020. This was repeated monthly thereafter. Breakdowns were provided by SOC Major group (1 digit) and SOC Sub-major group (2 digit). Two bespoke occupational categories were also created for health care workers and social care workers. This analysis included deaths from all causes and deaths involving COVID by occupation, and included people who were aged 20-64 and not retired at the time of death and for whom a valid occupation was provided at death certification. 'Healthcare worker' and 'social care worker' categories were created by ONS by combining specified 4 digit SOC codes. More information on the codes used to create these groupings is available on the ONS Website (see 'Definitions' tab) [AB/10 - INQ000512522]. Analysis by major occupation group (of deaths involving COVID-19 of people aged 20- 64 years old) showed that the highest rate of death occurred among process, plant and machine operatives (213 deaths and an age-standardised death rate of 46 per 100,000 population) followed by skilled trades occupations (220 deaths, 34 per 100,000 population). For context, there were 1,248 COVID-19 deaths in this age group across all occupations, with a death rate of 20 per 100,000 population. People in professional occupations had the lowest death rate (91 deaths, 6 per 100,000 population). Compared to the average COVID-19 death rate for all occupations, health care workers had a lower death rate (9 per 100,000 population) whilst social care workers had a higher rate (25 per 100,000 population). It is important to note that these are the occupations as stated on the death certificate. It does not mean that the individuals contracted the virus while at work, merely that this was their occupation at the time of their death.

G. The production of death/mortality statistics and the role of the NRS

31. NRS is responsible for the arrangements for registering births, deaths, marriages, civil partnerships and other life events. As a result, the publication of death statistics (based on information collected at the point of death registration) is the responsibility of NRS.

H. How death registration data is accessed

32. Deaths are registered at local registration offices and information is returned to NRS on a nightly basis for all deaths registered that day. This data is used to form the official record of death registrations, but a copy is also passed to NRS statisticians who use the data to create mortality statistics.

33. The data is processed (quality assurance, adding codes for occupation, location of death, cause of death etc.) by a coding team the day after registration has occurred and is then made available to statisticians for analysis on the following day. Statisticians therefore have access to death registration data 2 days after the registration was carried out.

I. Any limitations in the underlying data or otherwise

34. Death registration policy in Scotland is that all deaths should be registered within 8 days of occurrence and that is required by section 23 of the Registration of Births, Deaths and Marriages (Scotland) Act 1965. This includes deaths which are referred to the Procurator Fiscal (PF) for investigation (equivalent of Coroner elsewhere in the UK). Where deaths are referred to the PF a death certificate is still completed within 8 days so the fact of death is recorded. This differs from the rest of the UK where deaths referred to a coroner are not registered until the investigations are complete and therefore do not appear in the statistics until months later.

35. In some cases (but not all) the cause of death recorded at the initial registration will be revised at a later stage when the PF investigations are complete. So data we publish on cause of death at an early stage (as we do with the weekly death

statistics) can be highly provisional and subject to change. We mark this clearly in our published statistics to warn users of the provisional nature of the data.

36. Most of the deaths where the cause of death involved COVID-19 were unlikely to be revised substantially following PF investigations so the provisional nature of the cause of death data did not greatly impact on the estimates of COVID-19 associated deaths. Many of the deaths referred to the PF are external cause deaths (e.g. drugs, suicides, accidents) and early data on these causes is not reliable as they are very likely to change when investigations are complete. For this reason, the cause of death breakdowns we included in the weekly and monthly publications included only a high level breakdown into a small number of categories and we would not provide any figures on external cause deaths at this early stage in the data cycle.

37. Each week/month when we published new figures we would revise previous periods to account for any revisions following information received after the initial registration. Death data are frozen 4-6 months after the end of the calendar year in which the death is registered. After this point, no further revisions to the back series are made.

38. There are no specific concerns about the data quality of the Medical Certificates of Cause of Death (MCCDs). Scotland has a system in place (the Death Certification Review Service) whereby a proportion of death certificates are randomly selected for review by a team of expert reviewers to improve the quality of information recorded on MCCDs. The coding team at NRS will also liaise with certifying doctors if they have any concerns about the accuracy of data recorded on the MCCD.

J. Subsequent coding of the cause of death and whether using the ICD-10 framework

39. NRS code cause of death using the ICD-10 framework and have done so since 2000.

K. Quality Assurance

40. Details of our quality assurance procedures are described on our website [AB/11 - INQ000512524].

L. Distinction drawn between a Covid-19 related death and a Covid-19 death (with Covid as the underlying cause)

41. Our analysis in weekly and monthly publications provided data on two definitions – deaths involving COVID-19 and deaths where COVID-19 was the underlying cause of death. Deaths involving COVID-19 are defined as those where COVID-19 is mentioned on the death certificate, either as the underlying cause of death or as a contributory cause. Deaths where COVID-19 was the underlying cause of death count only those deaths where COVID-19 was given as the underlying cause of death on the death certificate.

M. Place of Death (POD)/location categories and data

42. Public Health Scotland (PHS) maintain a list of institutions across Scotland – mostly health-related but it also includes prisons, schools etc – and they give each institution a code. The list is publicly available via Public Health Scotland [AB/12 - INQ000512519]

43. NRS uses this list to assign an institution code to the place of death on each death record. The last letter of the institution code designates the type of institution. Below is the full list:

B	GP Surgery, health centre, medical centre
C	Clinic Premises
H	NHS Hospital
J	Joint User Hospital
K	Contractual Hospital
L	Primary schools
M	Non NHS Maternity
N	Non Institution
P	Prisons

R	Home for the Elderly
S	Other Home
T	Miscellaneous Premises
U	Care Home
V	Private Nursing Home, Private Hospital
W	School

44. For the purposes of NRS death statistics:

- hospitals are counted as codes ending in H;
- care homes as codes ending in J, K, R, S, T, U, and V (as highlighted in the list above);
- home/non-institution codes ending in N;
- other is everything else.

The codes used for care homes are not an exact match. V contains some non-NHS hospitals, and J and K contain some hospitals but mainly care homes. This is considered the closest grouping achievable with the PHS institution code structure and, importantly, is consistent with previous practice. As noted in Section E, we published a response to an FOI request on deaths by individual care home on our website on 26th May 2021. The published table provides the codes for each individual institution listed, including the final letter which can be used to provide the required disaggregation. The time period covered is deaths registered between 16th March 2020 and 23rd May 2021.

Type of institution	**Final letter of institution code**	**Deaths involving COVID**
Joint User Hospital	J	1
Contractual Hospital	K	23
Home for the Elderly	R	529
Other Home	S	9
Private Nursing Home, Private Hospital	V	2721

45. As noted above, NRS uses institution codes as maintained by PHS to ensure statistical consistency with both the wider health sector in Scotland and previous organisational practice. Further information on the designation of an institution code and the applicability of each category, would be within the remit of PHS. It should also be noted that there is no separate category for hospices. In some cases, hospices have a code which means they are counted in the care home category, but in other cases are counted in the hospital category.

46. It is not possible to separate hospices into a category of their own under the current PHS institution coding structure.

N. The identification of care homes as a POD/location, definitions and allocation within the pandemic

47. As outlined previously, it was not possible to separately identify nursing and residential homes so an overall category of care homes was used.

O. Care home data across the four nations

48. NRS are unable to provide exact details of how care homes were defined in other nations but are aware that there was not consistency across all nations of the UK. For example, ONS include a hospice category which we are unable to provide. The inclusion of some hospices in our care homes category (and not in the ONS figures) therefore means that the two figures are not comparable.

49. No information was available on care need as this was not recorded on the death certificate. As noted previously, NRS is responsible for the arrangements for registering births, deaths, marriages, civil partnerships and other life events. As a result, the publication of death statistics (based on information collected at the point of death registration) is the responsibility of NRS. NRS do not collect information on individuals receiving care in the home and is unable to clarify whether this data existed within other organisations in Scotland. This analysis would have required linkage of death data to other such sources of data on care received at home, and is beyond the remit of NRS.

50. There were discussions between the four nations on the production of statistics on care home deaths and we worked closely with ONS, NISRA and Welsh Government on the production of ONS' reports on UK care home deaths. We met frequently with other statistical agencies throughout the pandemic to discuss our approaches to providing statistics and to attempt to make our statistics as comparable as possible. Where inconsistencies in our statistics were identified, we provided explanations for users to caution them against making direct comparisons.

Data and Analysis: Deaths in Care Homes and Deaths of Care Home Residents

A. The production and analysis of statistics relating to deaths in care homes and those of care home residents

51. As noted previously, NRS is responsible for the arrangements for registering births, deaths, marriages, civil partnerships and other life events. As a result, the publication of death statistics (based on information collected at the point of death registration) is the responsibility of NRS.

52. Other organisations (such as Public Health Scotland) publish death statistics – often using NRS data enhanced by linkage to other sources.

53. Prior to the pandemic, NRS did not produce or publish weekly death statistics. We published the number of deaths registered weekly, but this was only updated on a monthly basis as there was limited demand for data at this frequency.

54. In the early stages of the pandemic we identified a demand for more timely data on deaths, and began work to create a weekly publication of deaths from all causes and deaths involving COVID-19.

55. The first weekly publication was published on 8th April 2020 and related to deaths registered between 30th March and 5th April 2020. The first death involving COVID-19 was registered in the week beginning 16th March, so the weekly deaths publication was set up and published within 2-3 weeks of the first death being registered.

56. Due to the tight timescales and the high demand for this data, the first weekly publication included minimal data. The key focus was to release data on the number of deaths involving COVID-19 as quickly as possible, minimising the lag from the reference period. Following the first publication, we received requests from users of the data (Scottish Government officials, Ministers, media, members of the public etc.) for data broken down by location of death. This breakdown was added to the following week's publication (on 15th April 2020) and remained in all publications thereafter.

57. There were further enhancements to the weekly publication and these were generally based on responding to feedback from users and our assessment of the demand for additional statistics, balanced with our knowledge of data availability and resources available to us.

58. Additional monthly analysis was added to the report on 13th May 2020. Monthly analysis allowed more in depth breakdowns to be produced due to the larger numbers of deaths. The types of additional analysis included in the monthly publication were: age-standardised mortality rates, leading causes of death, pre-existing conditions of people dying with COVID-19, deprivation and urban-rural breakdowns.

59. A set of ad-hoc tables, prompted by user demand, were also added to our website. Direct requests for analysis that were not already routinely produced (either through a customer enquiry or a FOI request) were published on the ad-hoc queries page (in addition to providing to the requester). Allowing all users access to that information, whilst also reducing the demands on the team for repeat requests. For example, soon after the publication of the pre-existing conditions analysis, a sub-Scotland analysis was requested, by location of death and by age group. Conscious of the increasing size and scope of the monthly publication, we chose to add these as ad-hoc tables to our website and updated them in line with the monthly publication schedule.

60. The key challenges in producing analyses were the high demand for information, and the expected timescales for provision of these. As noted previously, there were requests for analysis on care home residents which we were unable to provide.

There were also other requests that we could not fulfil, mostly due to them requiring data which NRS did not hold.

61. The following publications by NRS are relevant to the Provisional Outline of Scope:
    - Deaths registered weekly in Scotland | National Records of Scotland (nrscotland.gov.uk) [AB/13 - INQ000512518]
    - Monthly mortality analysis, Scotland | National Records of Scotland (nrscotland.gov.uk) [AB/14 - INQ000512520]
    - COVID-19 deaths | National Records of Scotland (nrscotland.gov.uk) [AB/15 - INQ000512516]
    - Deaths involving coronavirus (COVID-19) in Scotland | National Records of Scotland (nrscotland.gov.uk) [AB/16 - INQ000512517]

B. Statistics, analysis and trends

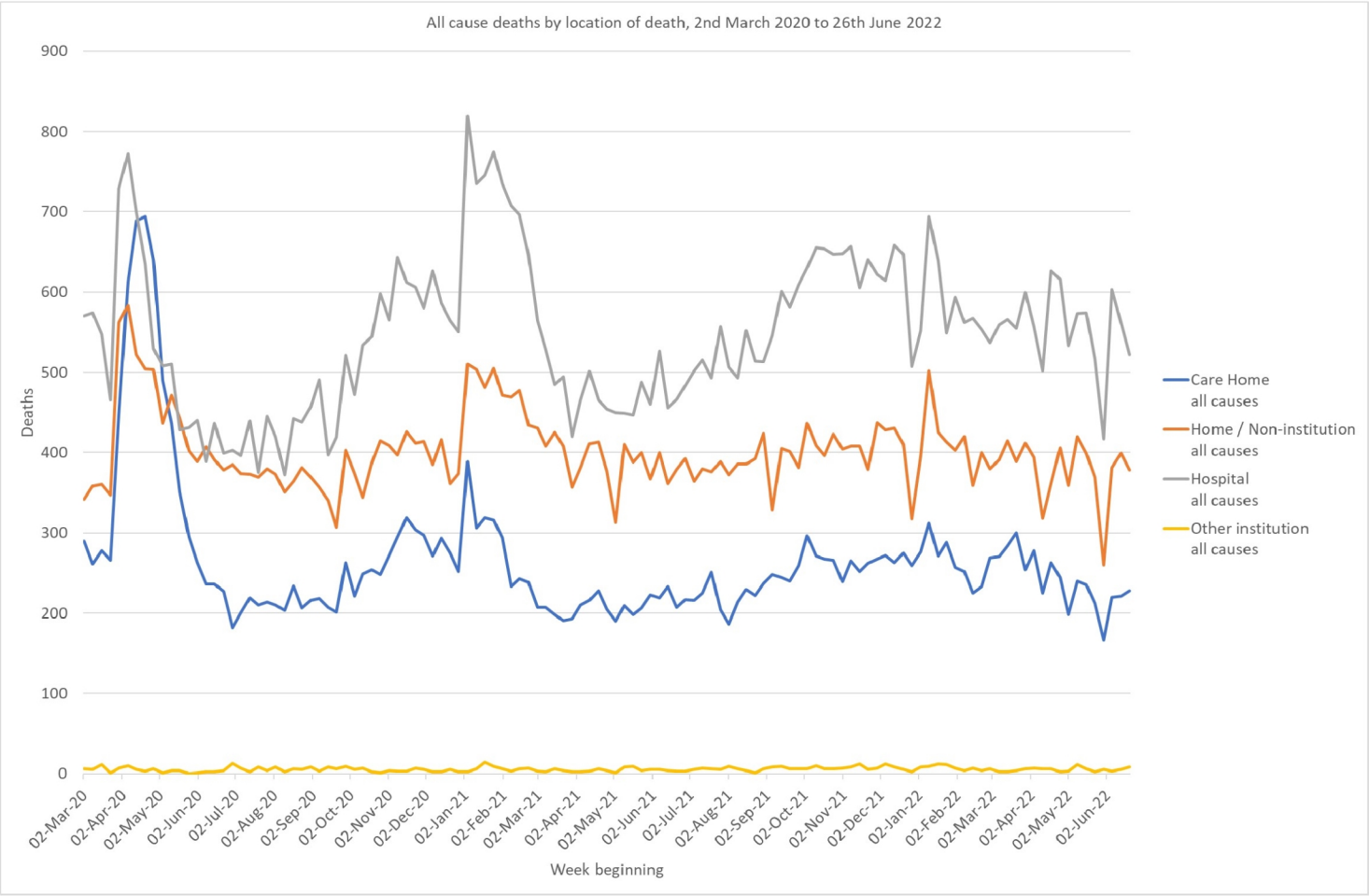
62. Weekly analysis covers the period from 2nd March 2020 to 26th June 2022. These are the closest dates from our weekly reports which tie in with the dates requested (1st March 2020 to 28th June 2022).

C. Deaths in care homes (place of death/location)

63. Table 7 contains weekly deaths in care homes (and other location types) by cause of death (all cause and death where COVID-19 was mentioned) [AB/02 -INQ000512527]. No age and sex breakdowns were produced for this analysis.

64. Figure 1 shows the trends in deaths (from all causes) by location of death. Prior to the beginning of the pandemic most deaths occurred in hospitals, followed by home / non-institutional settings and then care homes. In the initial weeks of the first wave, there was a spike in deaths in all locations, but more so in care homes. By week 17, there were more deaths in care homes than in any other location. Thereafter, deaths in care homes fell sharply and by week 20 they had fallen back below the level of hospital deaths and home / non-institutional deaths.

Figure 1.



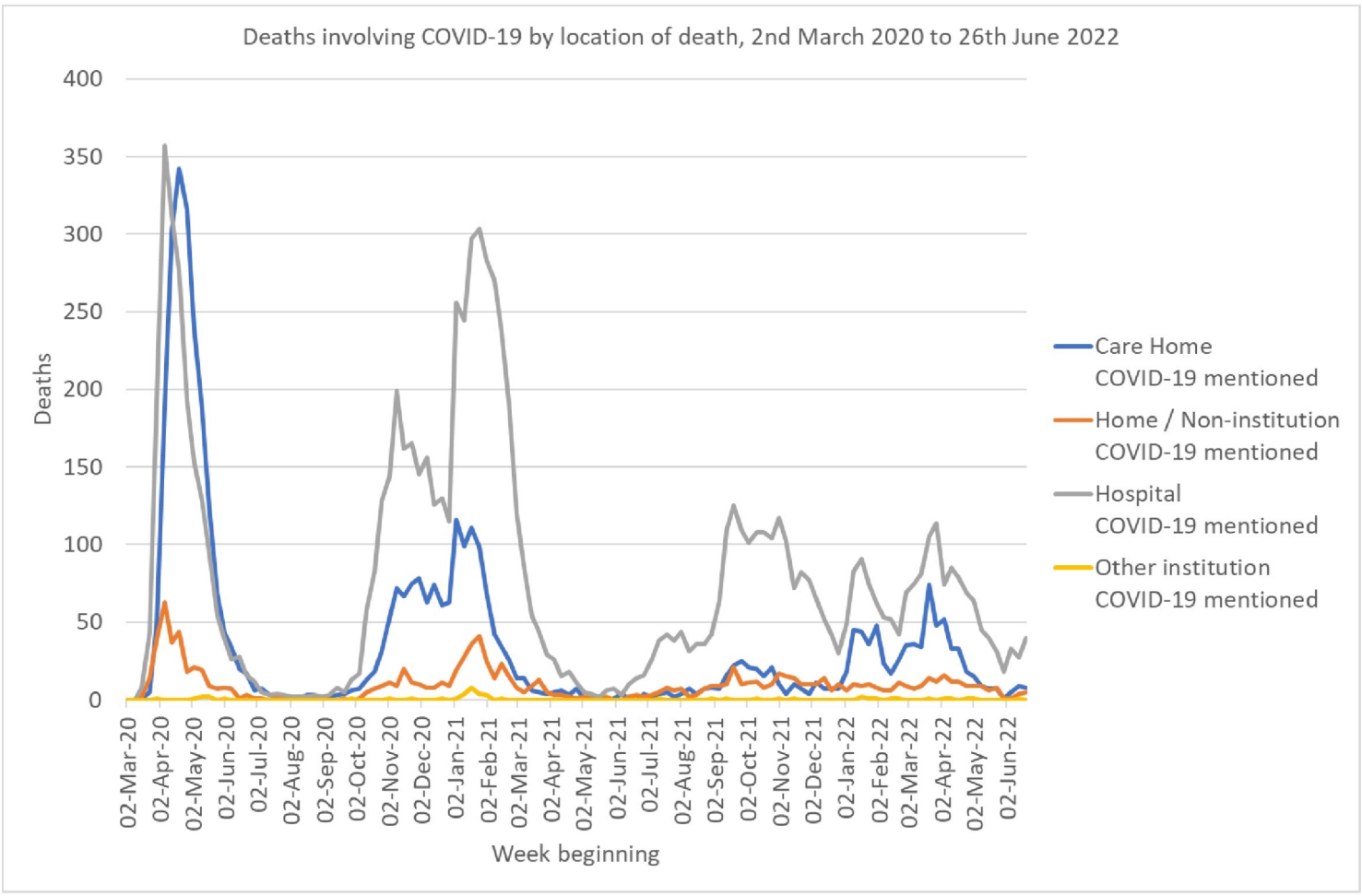
65. For the remainder of the period, care home deaths were lower than hospital and home / non-institutional deaths. The spike in deaths which occurred in the second wave in January 2021 was clear across all three locations, but was most prominent in hospital deaths.

66. Figure 2 shows the trend in deaths involving COVID-19 (either as underlying cause or a contributory cause) by location of death. In the early stages of the pandemic (April 2020) there was a large spike in COVID-19 deaths in both hospitals and care homes with relatively few in home / non-institutional settings. By week 18 (end April), deaths had begun to fall sharply, and throughout June to August COVID-19 deaths in all settings were very low.

67. They began to rise again in September / October 2020 at the beginning of the second wave. In this wave, deaths in hospitals were much higher than any other

setting although there was still a noticeable spike within care homes and, to a lesser extent, in home / non-institutional settings.

Figure 2.



68. After falling to very low levels in May and June 2021, deaths began to rise again but to a much lesser extent than previously. At this point, most of the COVID-19 deaths were in hospitals although there were noticeable peaks in COVID-19 care home deaths during the first 3 months of 2022.

D. Covid-19 deaths of care home residents

69. This is not available for the reasons set out previously.

E. Excess mortality and Covid-19 related deaths by place of death

70. Table 8 contains excess deaths by all causes and specified causes of death (including COVID-19). Please note that the methodology used in this table to calculate excess mortality has now been superseded.

71. Excess deaths – measured using the previous methodology by subtracting the 5 year average from the current year – were high throughout the period, as shown in Table 8. In weeks 10-53 of 2020 there were 6,743 excess deaths, a further 5,959 in 2021 and 1,104 in the weeks 1-25 of 2022. These figures compare to an average of 2,126 excess deaths per year over the five years 2015-2019 (taken from Figure 4 data of the Vital Events Reference Tables for 2022). COVID-19 accounted for 6,048 (90%) of excess deaths in weeks 10-53 of 2020, 4,832 (81%) of excess deaths in 2021 and 1,486 (70%) of excess deaths in weeks 1-25 of 2022.

72. All COVID-19 deaths were counted as excess deaths over the period . Trends in COVID-19 deaths by place of death have been described in 8a above.

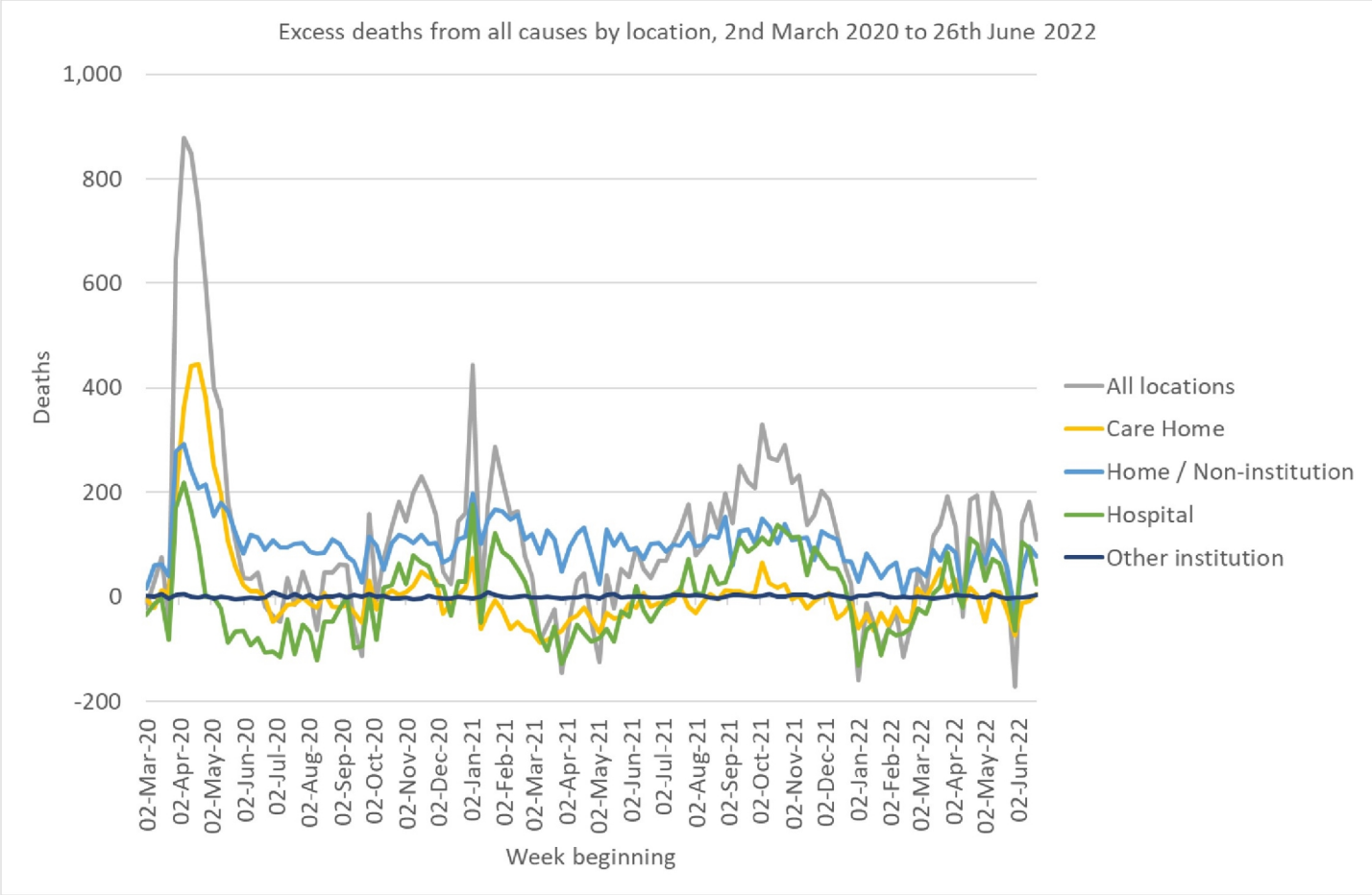


Figure 3.

73. Figure 3 shows the number of excess deaths from all causes by location for the period of 2nd March 2020 to 26th June 2022. The number of excess deaths were highest during the early stages of the pandemic, with the majority of the initial spike in excess accounted for by deaths in care homes. By the end of April 2020 excess deaths had begun to fall and remained at a relatively lower level until the beginning of the second wave in September/October 2020. During this second wave excess deaths were higher in home/non-institutional settings and hospitals than in care homes, though the spike in excess deaths was much lower than during the first wave.

74. After falling to lower levels after this second wave, excess deaths began to rise again until a peak in October 2021, at which point they began to fall until a number of smaller spikes over the first half of 2022. Following the initial wave, excess deaths in care homes remained generally lower than in home/non institutional settings and in hospitals.

F. Comparative mortality rates with regard to the broader population

75. The analyses in tables 7 and 8 also include a category for all locations, so comparisons can be made between care homes (and other locations) with mortality as a whole.

Lessons learned and recommendations

76. As noted previously NRS use the Public Health Scotland (PHS) maintained list of institutions across Scotland to assign an institution code to the place of death on each death record. The codes used for care homes are not an exact match to the list of services regulated by The Care Commission. However, this is considered the closest grouping achievable with the PHS institution code structure and, importantly, is consistent with previous practice.

77. In terms of limitations, as noted, it is not possible to separate hospices out into a category of their own under the current coding structure maintained by PHS. Likewise, it was not possible to separately identify nursing and residential homes so an overall category of care homes was used.

78. NRS are unable to provide exact details of how care homes were defined in other nations but we are aware that there was not consistency across all nations of the UK. For example, ONS include a hospice category which we are unable to provide. The inclusion of some hospices in our care homes category (and not in the ONS figures) therefore means that the two figures were not comparable.

79. We appreciate that such differences in coding definitions will have been made for good reasons, however, there may be a point of reflection here on how best to align across organisations to allow for more comparable UK statistics.

80. As an organisation, we have been able to apply some of the lessons learned from the pandemic to make improvements to our other routine demographic statistics publications and how those are communicated. For example, finding ways to divert resource to prioritise maximising the speed at which data and analysis could be

delivered when critical to decision making. By presenting key findings through a clear narrative, NRS are able to ensure impartial and accessible information reaches as many users, stakeholders and members of the public as possible.

A. Recommendations

81. No recommendations have been made by NRS in relation to the response of the adult social care sector to the pandemic. Our function is to produce relevant analysis and statistics as required by legislation, or where a necessary need is identified. We understand that this information may inform relevant policy related interventions by the Scottish Government, the UK Government and/or the Devolved Administrations, however no recommendations to this effect have been made.

82. We do not believe there are any further recommendations we would ask the Chair of the Inquiry to consider as relevant to the issues raised by Module 6. However, I trust that this information is of use. I would be very happy to provide further evidence to the Inquiry, if required.

Statement of Truth

83. I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Alison Byrne OBE, Chief Executive, National Records of Scotland

Signed: 

Dated: 27 November 2024