8. All vulnerable people would therefore require additional support from trusted individuals (and/or the social care system) to ensure they had the medication and care they needed. Those in the most vulnerable groups as a result of health conditions would be contacted directly over coming days to ensure they had bespoke advice. Those whose life circumstances were particularly difficult – including, but not limited to the homeless, rough sleepers, young people in care, prisoners, or those in residential care – would require also particular attention, particularly where they also had underlying health conditions.

9. The mobilisation and reconfiguration of health services around the country continued (*SC(20)9th Conclusions refers*), in order to respond to the national emergency. NHS Boards were working initially to double intensive care unit capacity by providing the necessary staff training and repurposing facilities, and it was also planned to double the number of ventilators in hospitals. Boards were also planning to add 3,000 new beds to the existing bed capacity of around 13,000. To achieve this, non-urgent elective procedures were being cancelled and outpatient services suspended, with alternative arrangements put in place where possible.

10. NHS staff would be moved, transferred or given different responsibilities as required, and work was continuing to look at how to replace those who might fall ill – including allowing student nurses and trainee doctors to work in the NHS at their current level of competence. Health staff who had retired within the previous 12 months were being invited to return on a voluntary basis. Training was also being offered within the health service to allow staff to transfer from one branch to another in order to make a contribution to matching resources to clinical need. The General Medical Council and the Nursing and Midwifery Council had been approached for assistance, with some initial success.

11. Additional ventilators had been ordered from a supplier in Germany – there was, however, some doubt as to whether (or when) the order would be fulfilled, given the spread of the COVID-19 outbreak across Europe. A higher proportion of hospital beds in Germany were already fitted with ventilators, but the situation remained uncertain, and the NHS across the UK was looking at backup options.

12. Social care presented particular problems, including those associated with residents in care homes and similar settings. COSLA had been invited to provide a co-ordination role across Scottish local authorities' social care services, and bodies such as Scottish Care were already working with COSLA to achieve the best outcomes for those in care.

13. The Chief Medical Officer informed Cabinet that the significant increase in the number of cases in London was one of the major factors that had led to the previous day's decision to move more rapidly to put in place the further restrictions that had been envisaged. It was clear that the outbreak had moved into sustained community transmission, and the virus was highly infectious. Scotland was probably only days behind England in the spread of infection, and a 'zoned' response in different parts of the UK had been assessed as unsafe, given the risk of confusion over mixed messages. Ventilators would be a vital tool in tackling serious cases, given the extent to which the virus penetrated into the lungs, and obtaining additional respiratory equipment would be a national priority.

(c) Very active consideration was being given to the possible closure of schools and other educational establishments, but the evidence was not yet clear. The epidemiological evidence did not suggest that this measure would slow the transmission of COVID-19 down to a great extent (and might in fact cause some additional infections – for example by increasing children's exposure to grandparents over 70);

(d) Although the young generally appeared to suffer only mild symptoms if infected by the COVID-19 virus (unlike for influenza), there were children in 'at risk' groups, such as those suffering from asthma, and the effect on NHS capacity would not be negligible if a high proportion of them became infected. It was also unclear whether or not children and young people played a significant role in the transmission of the virus, even if they remained asymptomatic. These were difficult questions to weigh up in deciding whether or not to keep schools open;

(e) Practical considerations would also intervene. For example, if parents chose not to send their children to school, or if staff were to fall ill, or had to self-isolate as a result of an existing health condition or caring responsibilities, there would be little alternative but to close some schools, at which point questions of consistency would come into play, within and between local areas. In order to maintain public support, it would not be desirable for the impression to arise that the process of school closures was occurring in a disorderly and uncontrolled fashion. The importance of retaining the confidence (and compliance) of the general public in the national response to COVID-19 should not be lost from view;

(f) There was therefore a very difficult balance to maintain, and hard decisions lay ahead: some children (particularly those living in challenging domestic circumstances) would remain better off – safe, well fed, and clean – in a school environment, despite the risks arising from the virus. In addition, keeping the children of essential workers (especially NHS staff) at home might reduce effective staffing capacity and thereby compromise efforts to counter the outbreak;

(g) The debate on school opening was ongoing, and it seemed likely that the balance of evidence would change – possibly over coming days. Mr Swinney had spoken to his counterpart, the UK Secretary of State for Education, and this remained a live and challenging issue for the four UK nations. The challenge across the UK would be to keep children safe, educated, and fed, while also allowing emergency workers to do their jobs;

(h) If schools were to close in the near future (as seemed very possible), it would be hard to see them opening again before a considerable period had elapsed – perhaps not even in the autumn – and this would have profound implications for the examination diet, university and college admissions, and for childcare – notably for parents in the health professions and other essential occupations – so any step in this decision would need to be considered very carefully. Discussions about options were ongoing with COSLA, the Association of Directors of Education in Scotland and the professional associations;

19. **Cabinet agreed** that:

(a) All those involved in the response to COVID-19, led by the Chief Medical Officer, the Deputy Chief Medical Officer and the National Clinical Director, should be thanked for their tireless efforts to date and for the invaluable advice and detailed work which they continued to take forward;

(b) The availability of ventilators and other essential equipment and the status of orders already placed on behalf of NHSScotland should be pursued as a national priority;

(c) Measures to identify and protect those deemed most vulnerable to the effects of COVID-19 should be put in place as rapidly as possible;

(d) The advantages and drawbacks of closing schools and other educational establishments should be considered further over coming days in light of emerging evidence across the UK; and

(e) A meeting should be organised involving key Economy Ministers and the First Minister to discuss the impact of the COVID-19 outbreak on the economy, and any necessary action to mitigate its worst effects (particularly in areas such as transport, tourism, hospitality and the performing arts).

(Action: Cabinet Secretary for Health and Sport; Chief Medical Officer; Population Health Directorate)

[Removed]