Research Working Group
of the Industrial Injuries Advisory Council

Minutes of the online meeting
Thursday 20 May 2021

Present:

Dr Lesley Rushton	RWG
Professor Neil Pearce	RWG Chair
Dr Chris Stenton	RWG
Professor John Cherrie	RWG
Professor Karen Walker-Bone	RWG
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Jennie Hoyle	IIAC
Mr Doug Russell	RWG
Dr Anne Braidwood	MoD (audio)
Ms Lucy Darnton	HSE
Dr Mark Allerton	DWP Medical Policy
Ms Ellie Styles	DWP IIDB Policy
Ms Mandeep Kooner	DWP IIDB Policy
Ms Maryam Masalha	DWP Legal
Mr Ian Chetland	IIAC Secretariat
Mr Stuart Whitney	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Sayeed Khan

1. Announcements and conflicts of interest statements

1.1. The Chair explained the protocol for conducting the online meeting.
- Members were asked to remain on mute until they want to speak
- Members were asked to not use the chat function to make any points but to use the 'raise hand' function.

2. Minutes of the last meeting

2.1. Subject to minor drafting edits, the minutes of the February 2021 meeting were cleared. The secretariat will circulate the final cleared version of the minutes to all RWG members ahead of publication on the IIAC gov.uk website.

2.2. All action points have been cleared or are in progress.

3. Covid-19 and its potential occupational impact

3.1. A member started the discussion by stating that several members had given much thought to the next COVID-19 paper, but nothing had been committed to writing. It was suggested it would be good to have a draft ready to discuss at the July IIAC meeting. The strategy for moving forward with this next publication was discussed.

3.2. Given the recent media interest in IIAC's work in this area, it was suggested the Council is under pressure to move forward with the next stage of this investigation, which may be to set out, again, the Council's position. It was felt the Council should not be forced into prescribing because of external pressures. It was acknowledged that any recommendations for prescription could take up to a year or even longer to implement.

3.3. In the previous position paper, it was established that certain exposures and occupations are of concern, regarding mortality, transmission and infection.

3.4. A member made the point that the Council hasn't tackled a topic such as this which has moved so fast, where data and information are changing. The challenge is that it is simply not possible to accurately identify where an infection was contracted.

3.5. It was felt by some members that there may not be enough good occupational data on the long term effects of COVID-19 and if this did emerge, it might not be for a long time.

3.6. The Council needs to look at developing a strategy which takes this into account and have a 'more likley than not' approach. Historically, not all prescriptions have been based around the doubling of risk critera and have used professional judgement. It was suggested the Council think more broadly about their approach and data. The first challenge will be to decide which conditions and/or symptoms are of most concern and how these can be investigated. The use of a 'multi-system' impact of COVID-19 infection seemed to be favoured which leads to a disabling condition that can be easily identified and linked, such as respiratory/cardiac conditions.

3.7. Another challenge is to determine if contracture of COVID-19 was 'more likely than not' due to work. Investigating transmission, infection and exposure will be key areas to feed into the next report.

3.8. A member with expertise in 'long-COVID' gave their views on the current understanding of this condition. Some published papers have removed people who have had a recognised complication after 12 weeks from their definition, which could make it tricky for IIAC as the Council would want to include these patients due to the disabling nature of those conditions. So care needs to be taken when defining the condition.

3.9. Many 'long-COVID-19' symptoms may be difficult to explain and the question of diagnosis is a complex issue to consider. Some patients who have been treated on critical care will have a defined diagnosis whereas others who didn't have a test or weren't treated in hospital and went on to develop long-COVID will be more difficult to define. This may rely on clinical history.

3.10. Another question to consider will be how to define disablement based on disease – some published papers have referred to occupation and the ability to work, but there is a lack of data in this area. Other conditions such as epilepsy which develops as a result of COVID-19 may not be outwardlly

disabling but will have an impact on the type of job that claimant can do e.g. HGV driver.

3.11. Another member commented they had been working with a UK university on the impact on work of COVID-19 and a paper is due to be published which looks at some of the issues described. They asked if IIAC should focus on systems and actual diagnosible conditions and whether it could be accepted, where symptoms which are common amongst the general population emerge after a time-lag, post-infection, where these symptoms may have arisen anyway.

3.12. A member stated that papers are emerging on rehabilitation to get people back to work and some publications focusing on sickness absences are available. It was questioned whether the symptoms could be evaluated over a different time-frame. A member responded by stating the question of diagnosis is important as some symptoms may be difficult to attribute solely to COVID-19 and could be as a result of co-morbid conditions indicated by medical history.

3.13. A member asked if the debiliating consequences of COVID-19 could be covered under the accident provision of IIDB. This was backed by another member who stated if a patient had lost the use of an organ or digit they could claim under the accident provision of IIDB.

3.14. An observer stated that if a prescription was complex, this also made assessments complex which can be difficult to administer.

3.15. A member stated some of the more complex long-covid cases will have some explanation of disability such as neurological, pulmonary or cardiac. However, someone with general fatigue could be difficult to prescribe for but easier for those with critical illnesses.

3.16. The discussion moved back to the next paper where a member with exposure expertise offered to take the lead for this section of the paper with input from other members. It was suggested that this section should include:

- Transmission and exposure pathways
- Risk factors – the SAGE review indicated factors such as density of people in an area, aerosol transmission related to proximity and poor ventilation were important.
- Workplace, transport, social circumstances also need to be addressed.
- When people were told to work from home, transmission in these circumstances need to be understtod.
- Objective measurements in air on surfaces have not made the situation clear.

3.17. Job exposure matrices (JEM) may also be important and related to social distancing. This may give an indication or a route to identify high risk jobs.

3.18. Outbreaks in workplaces would need to be considered and the evidence evaluated – it can be difficult to determine where and how a person contracted COVID-19 but needs to be assessed on the balance of probabilities. It was thought the JEM model could be a useful source of evidence as it is based on exposure information. A member shared an example of a JEM and stated this could be applied to the ONS data available which may contribute to the general discussion section of the next paper.

3.19. A member suggested that the pathway to produce the next IIAC paper on COVID-19 be split into 3 areas:

- Exposure/transmission – perhaps in public-facing jobs, need to review, which may help to identify job priorities.
- Focus on health & social care workers (H&SCW).
- Consequences of infection.

3.20. To come up with a potential prescription may require a degree of professional judgement to be used as there may not be the right data available to conclusively prove a link between COVID-19 and occupation, especially in relation to H&SCW.

3.21. A member pointed out that whilst it is important to look at H&SCW, transport workers have been identified as having high death rates so it is vital that other occupations be considered and not disregarded. A member felt that there are more data for H&SCW, and should be the priority but other occupations should not be dismissed – this could result in a backlash.

3.22. Another member felt that whatever IIAC does there will be a backlash as there will always be groups who feel they have been disadvantaged. For example teachers – the schools were mostly closed during the 1st wave, but this was different in the 2nd wave. It was again emphasised that if the Council are considering prescription, it needs to be reasonable to administer and enforce. If a complex prescription is put forward, the Council may need to continually have input in defining the parameters for administration and assessment.

3.23. It was pointed out that the DHSC has an occupational scheme for its workers. Also the extent of the impact of the vaccination programme may have an impact.

3.24. A member agreed there may be a degree of professional judgement and presumption – in the early stages of the pandemic, testing was unreliable and not available to everyone. Also time will be an important factor as claimants may not remember all of the circumstances which were apparent at the time.

3.25. A member suggested that if the Council decides to prescribe that it works closely with DWP IIDB staff and assessment staff to arrive at workable solution.

3.26. A member, playing devil's advocate, stated that the Council could state that under IIDB it would be impossible to prescribe and suggest that a different, separate scheme be set up to offer compensation.

3.27. An observer suggested a set of filtering questions may help IIDB/assessment staff if prescription was recommended.

3.28. The Chair started to wrap up the discussion but a member raised the issue of mental health and PTSD – this has been the subject of a number of papers, 'brain-fog' being one example. It was felt that the forthcoming paper should cover this issue and suggested that an IIAC member with expertise in this area be consulted with a view to them having an input. It may be the case that this could be touched on but may be complex to assign, with confidence, to the COVID-19 issue. Other neurological conditions such as 'mini-strokes' may be easier to discuss, however, conditions such as epilepsy or diabetes will be more difficult as discussed previously. These may not be outwardly disabling but will have an impact on a patient's life. The persisent loss of taste or smell will also have an impact on occupation for some.

3.29. The Chair thanked everyone for their input and felt the 3 suggested strands to progress the paper could be worked on simultaneously with a view to discussing this at the July IIAC meeting.

4. Reviewing the prescription for PD D1 – silicosis/pneumoconiosis

4.1. Several members worked collaboratively to put togther a comprehensive review paper of the history, background and the D1 prescription – this has been reviewed by the full Council and RWG in previous meetings. The paper is now in a form which could be shared with external experts for comment, subject to tidying up.

4.2. This paper was drafted to recommend simplification of the PD D1 prescription, which was considered to be antiquated, and to do away with the generic term 'pneumoconiosis' – focussing on silicosis, asbestosis, coalworker's pneumoconiosis, mixed mineral dust pneumoconiosis and silicate pneumoconiosis. Silcates may not be needed as not thought to be widespread.

4.3. The author of the paper invited comments from members.

4.4. A member commented that they thought the paper was very good but felt additional work was needed on qualifying the extent of exposure in relation to risk of disease. This would be needed to accurately define the prescription.The author agreed and asked the member if they could have input into that section of the paper. Silica could be an issue as exposure could be slight or of magnitude, some disease-causing exposures could be quantified but for others it would be difficult.

4.5. There was some discussion around stochastic vs non-stochastic disease and thresholds.

4.6. A member commented on composition of dusts containing silica which may cause disease – an overlap in was thought be necessary as the silica content of dust is often not known.

4.7. A member asked if specialist diagnoses would incur a cost, but it was felt that the NHS network of specialists would likely provide this as part of the NHS 'business as usual' diagnosis/treatment regime. It was felt that no-one should be claiming under this prescription without a specialist diagnosis.

4.8. A DWP observer felt the draft paper was very positive and welcomed the simplification of PD D1.

4.9. There was some misunderstanding whether the draft command paper would require peer review. This was not necessary but having external input from experts who are familiar with the IIS was deemed to be advantageous. It was suggested that members with resipiratory disease expertise meet via videoconference to discuss some of the finer points to finalise the paper with a view to having something ready for IIAC to review in the Autumn. It was also thought it would be good practice to share with CHDA for comment.

4.10. Another member commented that they felt it was important to include a prevention section in the paper and to perhaps engage with stakeholders to get their views.

4.11. Discussion moved onto hard metal disease which was thought to be distinct enough to warrant its own prescription, so a 2nd separate command paper on this disease condition will be produced, again with comments from external experts.

5. PD A11 and occupations – exposure equivalence discussion

5.1. Several members collaborated to draft the research paper which was circulated to RWG members in a previous meeting for discussion. This introduced the concept of a risk prediction model using PD A11 as an example. External experts have been consulted, who have now given their views. The proposed model was also shared with DWP IIDB/CHDA staff as a consultation to gather their views from an implementation perspective.

5.2. DWP IIDB feedback stated they thought it was relatively simple to implement but cautioned it would require correct input of data and extra time to process claims, so would be subject to planning and impacting.

5.3. Feedback from recognised external experts stated that whilst they thought the concept of the model was good, it would be impractical to use at an operational level. They considered it would be difficult to gather the correct information from claimants and interpret this correctly. Other experts felt it was not the correct model to use as there are other systems to use for measurement of vibration.

5.4. Based on this feeback, the author reflected that perhaps this model may not be the best way to proceed.

5.5. The question was asked if the list of occupations or tools used could be updated and extended? A previous publication of the Council in 1995 recommended a longer list and this could be reconsidered.This was felt to be plausible but would need to use professional judgement to some extent as there may not be sufficient scientific evidence to definitively prove the case. There could be a case for having certain inclusions and exclusions.

5.6. Based on the feedback received and the option to extend the current list, the author suggested to members that their proposed model not be taken forward and to concentrate on extending the current prescription.

5.7. A member commented that they thought this had been an interesting exercise and it was useful to have the views of external experts. It was suggested that the HSE would have a guidance for inspectors, so it would be useful to have sight of that.

5.8. It was acknowledged that the list of tools and their names may have changed since 1995 so a review would be needed in their applicability to a variety of occupational scenarios. When this was complete, CHDA would be consulted for comment.

5.9. Members discussed the various options and agreed that amending the prescription with a definitive list of percussive tools would be the best way to proceed. Having broad categories of tools would then allow occupations currently not listed to be covered.

5.10. The member who initiated this topic agreed to produce a draft command paper for discussion at the July IIAC meeting.

6. Neurodegenerative diseases in footballers

6.1. Dr William Stewart, consultant neuropathologist and the author of an influential paper on this topic, attended the last IIAC meeting in April 2021.

6.2. Dr Stewart gave a brief overview of the paper and the main findings, including strengths and weaknesses. It was commented that the paper was excellent, but the Council doesn't prescribe for an occupational disease based on one study, all of the evidence is considered.
6.3. It was agreed Dr Stewart's contribution was invaluable and provided insight into the topic. Dr Stewart was asked what other key evidence is relevant and if any other studies were in the pipeline to help inform the Council's decision making. Dr Stewart thought there was compelling evidence that there is an increased risk in contact sports, especially football players, backed up by studies of American football players. Other studies in the pipeline include one of rugby players in New Zealand. Others are looking at longitudinal studies in mid-life, but these may take some time to yield results.
6.4. It was agreed that literature searches would be carried out with members suggestions for terms to be used. RWG may want to examine pathology data along with anything which is highlighted by literature searches.
6.5. Given the interest from other areas of sport such as rugby, RWG should discuss whether the scope of this investigation should be broadened to include other contact sports.
6.6. It was noted that this topic had attracted a great deal of interest in the media and the Council had received a number of emails.
6.7. A member who is active in this area thought the scope of the investigation should be expanded to include other contact sports, but recognised that head micro-trauma from heading balls would be unique to football.
6.8. That member then shared information with members which was not appropriate be minuted due to the data not yet being published, but covered cognitive function tests in sportspeople related to age.
6.9. It was agreed that literature searches would be carried out and members asked to have input. There may be appropriate search terms in Dr Stewart's paper, so this may be a place to start.
6.10. It was suggested that there may be enough information available to put out an interim information note, but it was not felt that was the best way to proceed at the moment. It was agreed to look across all contact sports and review all available published information.

7. AOB

7.1. A member stated they and other MSK experts had been engaged with DWP staff on clarifying the guidance for PD A15, Dupuytren's contracture, to assist in administering this prescription in practice. It was agreed that a claim would be allowed if something resembling Dupuytren's, rather than actual contracture, developed whilst working in a job exposed to hand-transmitted vibration and then within 10 years fulfilled the prescription. It was felt that initially changing guidance would be the best approach, but if this was still causing issues then it may be the prescription would need to be revised. However, it was felt that the information note published by the Council in 2019 covered this adequately. A DWP observer thanked the MSK group for their input.
7.2. A recent programme on Radio 4, File On 4, describing the impact of COVID-19 on workers, included contributions from several members.

7.3. To assist with the COVID-19 research, the secretariat was asked to share the search terms used for the literature searches carried out for the last position paper. This will allow members to have input into the forthcoming literature searches.
7.4. The Chair thanked everyone for their contributions.

Forthcoming meetings:

IIAC – 14 July 2021 (pm) – online
RWG – 9 September 2021 - online