INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the online meeting
Wednesday 14 July 2021

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	IIAC
Professor Neil Pearce	IIAC
Dr Chris Stenton	IIAC
Professor John Cherrie	IIAC
Professor Karen Walker-Bone	IIAC
Mr Doug Russell	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Sayeed Khan	IIAC
Dr Andy White	IIAC
Dr Jennifer Hoyle	IIAC
Dr Max Henderson	IIAC
Ms Karen Mitchell	IIAC
Mr Keith Corkan	IIAC
Ms Lesley Francois	IIAC
Dr Anne Braidwood	MoD (audio)
Ms Lucy Darnton	HSE
Dr Rachel Atkinson	Centre for Health and Disability Assessment
Dr Mark Allerton	DWP Medical Policy
Ms Ellie Styles	DWP IIDB Policy
Ms Jo Pears	DWP IIDB Policy
Ms Kay Baker	DWP IIDB Service Delivery
Mr Ian Chetland	IIAC Secretariat
Ms Dawn Harrison	DWP PPALB team
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Dan Shears, Mr Stuart Whitney, Ms Maryam Masalha

1. Announcements and conflicts of interest statements

1.1. The Chair welcomed all participants and set out expectations for the call and how it should be conducted. Members were asked to remain on mute and to use the in-meeting options to raise a point.

1.2. The Chair welcomed Dawn Harrison from the arm's length body team.

1.3. The Chair announced that a long-serving member had announced their resignation from the Council. This member was thanked for their service of over 8 years to support the work of the Council, several other members stating they would be greatly missed.

1.4. The Chair also announced that another long-serving member will have completed their tenure in September 2021. This member was thanked for their contributions to the work of the Council over the last 10 years.

2. Minutes of the last meeting

2.1. The minutes of the last meeting in April 2021 were cleared. The secretariat will circulate the final minutes to all IIAC members ahead of publication on the IIAC gov.uk website.

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

3. Commissioned review into respiratory diseases

3.1. Since the review was last discussed by the Council, the tender process had concluded. A DWP member of staff had been supporting the Chair and the Council to guide it through the commercial process to appoint a contractor.

3.2. The initial advert on the IIAC website attracted 4 expressions of interest who received bid packs.

3.3. After the deadline for receipt of bids was passed, 1 bid was received.

3.4. The evaluation panel assessed the bid and agreed it was compliant.

3.5. However, further commercial negotiations were carried as the value of the bid did not meet the budget available.

3.6. As a result, a proposal was put to the Council to appoint the Institute of Occupational Medicine (IOM) to carry out the commissioned review. This proposal was accepted by the Council and the process to formally award the contract can now commence.

3.7. Members thanked the DWP staff who supported this exercise.

4. Occupational impact of COVID-19

4.1. A short discussion paper from the Chair was circulated to members which set out some of the key issues to consider. A major issue to address is timing as many people are suffering from the long term effects of having contracted COVID-19.

4.2. As previously stated, it was felt that health and social care workers (HSCW) would be the appropriate group to focus on initially but this could be open to revision and expansion.

4.3. The Chair stated no decisions needed to be made today, but would like views of members to guide the focus over the next 6 months or so and informed decisions will need to be taken on the direction the Council will take.

4.4. After publishing the last position paper, which focussed on mortality, it was agreed to move forward to look at long-covid and its potential impacts on occupations, with a view to prescription. What long-covid is and the symptoms associated with it need to be understood.

4.5. A member reminded the Council, by email, what disability and impairment mean with reference to prescribed diseases.

4.6. There are also aspects of mental health which need to be addressed at some point. The Chair pointed out there are a lot of data available but a strategic focus is required. Transmission and exposure rates have been looked at and initial thoughts have been incorporated into the discussion paper.

4.7. Another member with frontline experience had shared their views on case definition, diagnoses, disability and symptoms. This member addressed the meeting to illustrate how much of a minefield this topic is to look at.

- Aside from variable definitions of long-covid and the removal of some symptoms from the definition(s), there are some commonly reported symptoms such as fatigue, which is difficult as it has multiple causes and is difficult to measure.
- There is an emerging body of evidence from the respiratory side with regards to acute consequences of infection. There is a likelihood of ~20 times for developing new respiratory diseases as a consequence of contracting COVID-19.
- Breathlessness has also been reported as a symptom which should be distinguished from diagnosed respiratory conditions. Breathlessness may cause ongoing impairment, but is not always explained by cardiac or pulmonary testing i.e. confirmed respiratory disease and may improve over time.
- Other aspects such as pulmonary and venous-thrombo embolisms show reasonable evidence of developing clots after having developed COVID-19, but reports are varied.
- Cardiac events may be up to 3 times more likely following COVID-19, but there are many confounding factors which makes cardiac injury difficult to define.
- Neurological issues such as stroke may also be elevated, but again these are difficult to assign directly to COVID-19 disease due to complicating confounding issues.

4.8. The Chair thanked the member for their invaluable input and asked, for future consideration, what factors would be important to focus on for the next IIAC paper.

4.9. A member with psychiatric expertise was asked to comment on some of the mental health issues reported as being involved in 'long-covid'.

- Some unexplained conditions can be labelled as psychiatric, which may have a long chain of causality.
- Some employees may be absent from work due to mental health issues, but this may not be related to infection by SARS-CoV2. Examples of this may be PTSD, anxiety etc related to but not caused by COVID-19. This link would need to be clarified.
- A Danish study indicated that some patients who had identified as having long-covid also had a history of some mental health issues beforehand.
- There are also other patients who have psychiatric illness which persists for weeks who also have no previous history of mental health issues.
- Some helpful resources may be available to assist in identifying mental health issues related to COVID-19, but some studies may be of poor quality.
- There may be something for the Council to address, but the member felt it may not be applicable for prescription which has a doubled risk.

4.10. The Chair commented that the doubling of risk criterion may not be achieved especially related to occupation as often this is not recorded on medical records. However, another member stated that this may not be required as the risk of infection may be doubled in certain occupations. The risk for an

occupation overall may not be doubled, however, sub-sections of that occupation at certain times will have risks elevated over 2. Knowing when the data were collected is key to understanding the risks, which makes recommendations for prescription very difficult. Some data from the REACT study by broad occupational groups, which is not yet published, may be a useful source of information for occupation, but needs to be interpreted in relation to when the data were collected.

4.11. A member asked if the Council should focus on recognised conditions which have been diagnosed such as lung disease rather than those which are uncharacterised such as 'brain-fog', fatigue etc. The member felt that defined conditions could be referred to as post-covid complications and the undefined symptoms could be labelled as post-covid syndrome. The Chair felt this was helpful terminology.

4.12. Another member commented it was unprecedented for the Council to have to deal with an issue such as COVID-19 which has such wide occupational scope. This member felt that the data on deaths were the right place to start and then extrapolate to and apply this to occupational cases. It was felt that whilst an update on mortality data may be required, the last position paper covered this and other aspects may now be more applicable, such as modes & rates of transmission etc.

4.13. The issue of COVID-19 being occupationally related was felt to be important to a member because if the disease can be attributed, with certainty, to an occupation then workers in these sectors who go on to develop disabling conditions should then be entitled to claim for that. A complication may be where people have had COVID-19, but not severely and then go on develop long-covid. Some people have been reported to be suffering from less clearly defined conditions which affected their employment, so there may be stakeholder expectations that the Council will cover these.

4.14. It was felt that it was important to ensure that these symptoms are addressed adequately and that IIAC are not perceived to be ignoring the group of people who are impacted by this. It should be made clear that the Council is taking its time to gather the evidence to support its investigation.

4.15. Evidence may be emerging that the occupations identified in the position paper are subject to increased infection rates and that transport/household involvement in transmission may not be as important as previously thought.

4.16. A member made the point that meeting the doubling of risk test may not be possible, however choosing occupations where there is an obvious increased risk from COVID-19 and comparing this with the instance of the disease in the population as a whole may be indicative, which is an ever changing data set. Where there are underlying causes/conditions there are a number of key principles to consider in law.

4.17. Another member commented that some of the medically unexplained symptoms may also be prevalent/common in the general population, which was agreed by other members. It was felt a framework of disability would be appropriate to consider.

4.18. The Chair asked if it might be possible to have a list of symptoms/conditions/syndromes as suggestions for RWG to consider – it was felt respiratory diseases and stroke would be good to consider, but cardiac changes may be more difficult. PTSD post critical-care may also be applicable. Members agreed to give some thought and provide as comprehensive a list as possible.

4.19. The meeting moved on to discuss viral exposure and it was evident that a key job-related aspect was proximity to other people in the workplace**.** Frequent contact, high density in the workplace, confined space & poor ventilation and lack of controls/protective equipment were all thought to be contributory. Healthcare workers were thought to be at most risk. Some other occupations may have higher/lower risks dependent on the virus circulating at the time.

4.20. Many aspects of the work of the Council on this topic will be dependant of what was happening with viral infections in the general population at various times, making it difficult to assess for prescription purposes.

4.21. Plausibility of COVID-19 being occupationally related could be drawn from cluster outbreaks in the workplace or that observed in prisons where temperature, humidity and ventilation are important factors.

4.22. The risk of using public transport and households for contracting the virus were not considered to be high risk, but could cause clusters. Also for consideration would be virus variants and susceptibility.

4.23. It was suggested that HSCW be looked at first from an occupational perspective, linked to when their risks were highest i.e. time-related. It was felt this was not possible as it would be too complicated to administer. However, a member pointed out that if HSCW had double the number of contacts than those working in different occupations then their risks were doubled regardless of the prevalence of the virus circulating. HSCW comprise a wide-ranging diverse types of jobs, which will have variable risks, making it diffcult to assign for prescription.

4.24. A member commented that in other IIDB prescriptions, such as noise-induced hearing loss, PPE is not taken into account and the risks to workers for the different waves of the pandemic remain, albeit mitigated. Another member pointed out that geographical differences in risks could make prescription a challenge as it would be difficult to assess based on locality. Also, claims may be affected if risks are mitigated and no longer doubled due to PPE provision. This may require a time-frame to be introduced into a potential prescription.

4.25. However, another member made the point that time should not be a factor. If a worker was at doubled risk and the prevalence of the virus was low, then the risk would be doubled low risk as the people they come into contact with are unlikely to be infected. The same applies when the prevalence is higher, its just doubled at high risk. The only instance when time matters is where the nature of the work has changed, such as provision of PPE. However, PPE availability may not be as good as it should be.

4.26. The Chair acknowledged this is a difficult topic, thanked all members for their contributions and encouraged contributors to have sections ready, if possible, for the RWG meeting in September. The Chair agreed to circulate a strategy

to all members for comment.

5. Discussion on occupations missing from PD A11

5.1. The Chair introduced the topic and handed over to a member who has written a draft command paper outlining the need to revise the current prescription for PD A11, hand-arm vibration syndrome (HAVS).

5.2. Initially a discussion document on equivalence modelling was produced which was shared with DWP IIDB operational staff and the assessement centre for their views. Although deemed to be a workable solution, there were practical issues which hindered its implementation. Also feedback from experts indicated the equivalence modelling approach may not be the best course to take.

5.3. The history of the PD A11 presciription was reviewed and consequently the draft command paper for discussion at the meeting proposed to extend the list of vibrating tools grouped into 7 different categories, assisted by external experts. The member gave examples of the types of tools which would be covered.

5.4. The paper also recommends that wording of the prescription be generic, removing specific tools and placing the 7 categories into guidance for claim processing requirements. Each group/category would list specific tools, the total of which is currently circa 100.

5.5. The member suggested a time-frame for the use of vibrating tools could be included, in-line with that used by the HSE.

5.6. The member then asked the Council if it was in favour of the approach taken and to decide on how to proceed. The member stated they have been working on a document which would help gather occupational history and supplement operational guidance. Suggested wording of the prescription was not provided as the member wanted to ensure the Council was comfortable with the methodology proposed.

5.7. The Chair asked if the list of tools was flexible as names change and are known by different names locally.

5.8. A member commented they were fully supportive of the approach proposed and asked for some minor changing to wording to ensure readers understand the doubling of risk criterion is still relevant. The Chair noted that this approach is necessary when then is a lack of epidemiological data to support a proposed change to a prescription.

5.9. A member asked if the tools listed on the current prescription are included in the extended list and will this likely lead to an increase in claims. The response was that the current tools are listed along with new additions. The point was made that revising the prescription will allow claimants who had previously been disallowed, because they had not met the occupational requirement, to now be eligible to claim provided other criteria were satisfied, such as work history.

5.10. An observer asked if it was possible to estimate how many more claims a revised prescription might attract and this was covered off by stating it was impossible to predict. It was also asked if it is appropriate to have a time-

frame associated with the use of tools and subsequent development of the conditions. The member responded by stating that some tools vibrate at a higher magnitude and may cause the conditions to develop sooner. The author stated this may be possible to include this but futher work would be required. Some additional eligiblility criteria may be required to filter claims which may need to be included in guidance when a work history is available. Individual susceptibility will also have an impact.

5.11. There was some further debate and it was agreed to circulate new list of proposed tools. HSE were asked if a prevention section could be drafted. The Chair asked if the Council supported the proposal and consequently agreement was secured to proceed to the next stage which would be for further review at RWG in September.

6. Proposed revision of PD D1 – pneumoconiosis/silicosis

6.1. The member who was leading this topic gave a brief verbal overview of the proposal to change the PD D1 prescription. As agreed at RWG, the draft command paper recommended 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, all supported by a specialist clinical diagnosis.

6.2. A separate prescription for hard-metal disease is also proposed.

6.3. The paper is undergoing minor revisions and it is anticipated a version will be available for review at RWG in September prior to external respiratory disease experts for their views. The external expert panel is yet to be determined.

6.4. Members will have the opportunity to review the paper again.

7. RWG update - Neurodegenerative diseases in footballers

7.1. Dr. Judith Gates, Head for Change, Coaches Across Continents has been in contact (circulated to members) and has offered IIAC an extensive archive of references from the 1850s to the 2000s which are highly relevant – collated by her colleague, Professor Stephen T. Casper, Clarkson University, USA.

7.2. Dr Stewart, author of the paper which alerted IIAC to the issue, joined the last IIAC meeting in April and discussed the evidence presented in his paper. He answered questions from members and offered to engage with the Council further during its investigation.

7.3. At RWG in May, it was felt that the investigation should be widened to include other sports which feature contact with the head.

7.4. The Council were grateful to Dr Gates for the offer of access to the archive and it was felt that aspects of this may be useful but the Council does not have the resources to sift through numerous papers, many of which may not be relevant and not meet the requirements of the Council. It was suggested that the Chair respond to Dr Gates setting out the type of reports which the Council could use. It was felt that the search strategies used to identify relevant literature were adequate and would unlikely miss important papers.

8. AOB

Update from DWP

8.1. Observers from DWP were invited to give an update on aspects of the Council's work such as:

- Aircrew and melanoma
- Dupuytren's implementation
- Thermal Aesthesiometry and Vibrotactile TA/VT testing in sensorineural PD A11
- Is the DWP looking at compensation options for COVID-19/long-covid outside of the remit of IIDB?

8.2. An observer stated that resources had been diverted to look at ways to assess claims whilst face-to-face activities had ceased due to the pandemic.

8.3. Proposals have been submitted to Ministers and HMT to bring the services back up to pre-pandemic status.

8.4. Other topics which the Council have been involved with will gradually be taken forward as soon as resources allow.

8.5. The Chair was grateful for the update and looked forward to continuing dialogue with DWP.

8.6. A member asked if IIAC members had any insight into whether negligence claims against employers were ongoing or if any had been successful. A member responded that it was probably too early to provide any real details at this stage.

8.7. A member provided an update on the work they had done to support testing for PD A11.

8.8. A DWP observer stated that there was a cross-government group looking at the wider possibilities of a compensation scheme outside of IIDB, but at an early stage. Some COVID-related claims for the accident provision of IIDB had been received, but none successful as no proof of how/where the virus was contracted.

Public Meeting

8.9. Due to COVID-19 restrictions, it was decided not to hold a public meeting this year in the normal format.

8.10. It was felt that a forum, such as a webinar, could be held to allow the public to have more insight into the Council's work and a variety of options were discussed, perhaps by inviting written questions from stakeholders. It was commented on that by holding an online event, there may be greater attendance. It was suggested this could take place after the next RWG or IIAC meeting in the autumn.

8.11. The secretariat offered to look into using new ways of online conferencing which have been recently introduced by DWP and will advise members what could be achieved.

Date of next meetings:
RWG – 9 September 2021
IIAC – 21 October 2021