RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the online meeting
Thursday 9 September 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	RWG
Professor Kim Burton	IIAC
Dr Jennie Hoyle	IIAC
Mr Doug Russell	RWG
Dr Max Henderson	IIAC
Dr Anne Braidwood	MoD (audio)
Ms Lucy Darnton	HSE
Dr Rachel Atkinson	CHDA
Dr Mark Allerton	DWP Medical Policy
Ms Jo Pears	DWP IIDB Policy
Ms Catriona Heburn	DWP Legal
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Stuart Whitney

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.

1.2. The Chair welcomed Jo Pears from DWP IIDB policy and Catriona Heburn from DWP legal.

1.3. Dr Ian Lawson will be the new employer representative on RWG replacing Dr Sayeed Khan who has stepped down from IIAC.

1.4. A member declared they had been invited to take part in a case related to COVID-19 in a nurse, as part of their medical/legal work.

2. Minutes of the last meeting

2.1. Subject to minor drafting edits, the minutes of the May 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 a great deal of work on this topic had taken place over the summer.

3.2. More data, evidence and literature are becoming available and sections of the draft paper have been updated accordingly and a summary of the current status of the paper was provided.

3.3. There are draft paragraphs on what 'long-covid' appears to be and a long list of associated health complications. A lot of work has been done on the potential transmissions pathways, including household transmission. The impact of transmission via transport will also be considered. Occupational vs non-occupational transmission was not thought to be fully understood.

3.4. It was reported that there was a lot of evidence on household transmission, but there was an issue with occupation not being recorded.

3.5. There are a lot of data now available for infection rates particularly in health & social care workers (H&SCW), but less in other occupations. Increased mortality has been reported, but related to prevalence of the virus in the 'waves'.

3.6. Outbreaks in workplaces have been looked at and contacts have been made with HSE staff who may have more data on this topic, which could be made available to the Council.

3.7. The member leading the discussion went on to say it would be important to address the key issue of whether there are any complications or long-term effects of being infected or having 'long-covid' which could potentially be relevant for IIDB. The member stated perhaps the group should consider what IIDB is intended for, which is mainly for long-term disablement and not for a one-off payment. The member referred to a published letter, which was critical of the approach IIAC is taking to this topic.

3.8. IIDB is covered by social security law and has to adhere to Parliamentary process in order to effect any changes, which can be time consuming.

3.9. A member commented that it is very difficult with this new disease. They stated there was no precedent to recommend prescription on the basis of symptoms alone, generally there has to be a specified disease. The member also stated it would be impossible to deal with every reported complication of 'long-covid' as these are now too numerous.

3.10. It was suggested that the options for the Council in terms of recommending prescription could be:

- Deal with a small number of important complications such as vascular (thrombo-embolisms, stroke, cardiovascular disease) or respiratory (fibrosis, ongoing inflamation) or psychiatric (depression, PTSD)
- Express the Council's intentions in vague terms by stating disability arising from COVID-19 infection and allow the interaction to be assessed by others.

3.11. A member pointed out that whichever route the Council takes, it has to be transparent and justify the approach it has taken. Given the limitations of IIDB, the Council cannot recommend prescription based on symptoms. An overview of IIDB may need to be included in the next paper to add context to the Council's decisions.

3.12. An observer commented that International Classification of Diseases (ICD) are assigning an unused code to post-covid syndrome from 1 October. However, the syndrome ('long-covid') has yet to be fully described by

responsible bodies such as CDC or NICE. This code was only to be used when describing the aftermath of a serious COVID-19 infection. The observer wondered if the Council could use this code as a method of recommending prescription. This could be used as an interim measure until the 'long-covid' issue becomes clearer.

3.13. A member commented that 'long-covid' could be regarded as being similar to myalgic encephalomyelitis (ME) and it might end up being classified similarly, which may change over time.

3.14. A member commented that they agreed that an explanation of IIDB would be important to include to justify the Council's approach to prescription, as fatigue is likely to be a major complication of 'long-covid'. This type of symptom is very difficult to cover under the IIDB scheme as it is not quantifiable. This member also stated they felt it was very important to firstly establish if there are any occupations which are more likely than not that the infection was caused by their occupation. Anything else is irrelevant if this cannot be proven.

3.15. The issue of psychiatric disorders symptoms, reported as a complication of 'long-covid' where "objective" tests are available, these conditions can be diagnosed with a good deal of confidence, particularly PTSD and depression.

3.16. The member pointed out that IIAC have to be very clear about what its intentions are and the reasons for this approach. They felt that starting with 'long-covid' and allowing that to evolve was a sensible appraoch, however, clear evidence of a disability was required to comply with IIDB requirements. They also reiterated that proven links to occupation need to be established otherwise this is not for IIAC to consider. This member felt a flow chart describing how 'long-covid' could be considered would be useful and other members agreed. This could then help focus the Council's efforts and provide an aid to help it come to informed decisions around prescription. This could also be useful in explaining to a wider audience how the Council dealt with 'long-covid' complications.

3.17. The discussion moved on, again, to ICD codes where a plea was made to disregard these due to their unreliability and that physicians rarely use these. ME/'long-covid' are both equally very difficult to properly diagnose reliably and provision should be made for patients who may have been in intensive care for some time and are no longer able to walk. A member felt that focussing on known, evident conditions should be a priority with the other less-easily definable conditions following later. However, the member agreed with the assertions of others that a link to occupation must be proven i.e. 'more likely than not'.

3.18. A member with exposure expertise felt that the data on transmission of the virus showed doubling of risk for hospital and healthcare workers, but beyond that the evidence declines. They felt that data on workplace outbreaks/clusters from HSE would be useful to establish if occuptional risks could be evaluated.

3.19. It was suggested that the table of 'long-covid' complications which potentially could be considered for prescription and had been drawn up to help inform the discussion be reviewed. A member stated that IIAC is not the appropriate body to define 'long-covid' as this should be left to those who's responsibility it is to do so. If the Council was to decide to recommend prescription for 'long-covid' then a standard definition could be used, as a loose term, recognising

that the symptoms may change over time. A member commented that certain pulmonary conditions such as pnemonitiis or fibrosis could reasonably be attrributed to COVID-19 as these conditions were rare in the general population. Other conditions such as hyper-coalgulation may require longer-term treatment post-discharge from hospital. A decision needs to be taken by the Council whether to focus on 'long-covid' or to just concentrate, at this stage, on more clear-cut conditions which can reasonably be attributed to be a complication of COVID-19.

3.20. Regarding the next paper from the Council on this topic, a member stated they felt at this stage, which is work in progress, the Council should state that it has identified a set of complications associated with COVID-19 and that it recognises 'long-covid', but IIAC is waiting for this condition to be properly defined and how this relates to occupation and disability.

3.21. It was felt that something should be done for people who have suffered disabling effects of COVID-19, such as those who have developed disabling conditions. The member suggested that H&SCW would be the best groups to start with.

3.22. The issue of the wide spectrum of disability associated with 'long-covid' should be recognised and the issue of doubling of risk was discussed. It was suggested that 'long-covid' may be too complicated to recommend for prescription and if that is the case, then a very clear explanation would be required. It was felt that having the requirement for a doubling of risk may be too restrictive and the totality of the evidence should be considered, so 'more likely than not' should be used instead, which was supported by other members.

3.23. An online IIAC public meeting will be held on 21 October and COVID-19 will be a presentation topic, so having a flow-chart or a hierarchical description to help inform the discussion would be useful.

3.24. A member shared data which showed a link between occupation and hospitalisation due to COVID-19 where patient-facing H&SCW were impacted the most and reiterated their point that they felt this group should be the main thrust of the next paper. Another member pointed out that workers supporting H&SCW activities such as porters/cleaners were also at increased risk. Also, during the waves, many staff were redeployed to support frontline activities which may complicate any recommendations for prescription, which needs to be easy to administer. Also, being able to define a loss of function/faculty would be important and also to predict any potential resultant disablement as this would be important for assessments of claims.

3.25. A member indicated that further data would be available soon which linked testing to the census, giving a route to examine infections to broad occupational groups. This member also shared unpublished data which appeared to show some H&SCW were more at risk than others, related to the waves (timescale) of the pandemic and the provision or lack of PPE.

3.26. A member pointed out that occupation data from the real-time assessment of community transmission (REACT) study could be useful to help guide the Council's thinking and may approach the co-ordinators for further information. These data showed that workers were at increased risk dependent on the status of the pandemic where H&SCW go up and down – if assessed over a longer time period, the risks flatten out due to the highs and lows. For potential prescription purposes, the timeline would be very important.

3.27. A member shared their views on workplace outbreaks where food processing workers overall did not have elevated risks, but there is increased risk where there has been an outbreak – this is something which would need to be resolved if prescription were to be recommended. This is something to be taken forward with HSE staff who have been involved in monitoring defined outbreaks.

3.28. A list of actions and associated contributors will be drawn up and shared with members.

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

4.1. A member gave a verbal update on the current status of the draft command paper, which has not substantially changed since it was reviewed at the last full IIAC meeting in July 2021.

4.2. When formatted, it will be send to external reviewers for comment. When this has been completed, the paper will be circulated to the full Council for discussion.

5. **PD A11 and occupations – A review of the assessment of vibration exposure in Prescribed Disease A11, hand arm vibration syndrome (HAVS)**

5.1. Several papers were circulated to members to support the recommendations contained in the draft command paper and the discussion started by the author introducing this.

5.2. A section has been included which states that this work has been carried out on the basis that the dobling of risk criteria had been met in previous investigations. The original command paper (cm8350) was revisted and athough the 'research literature was studied' and advice was sought from the Health and Safety Executive the actual epidemiological evidence forming the basis for the list was not actually reported.

5.3. To ensure consistency, the author reviewed the relevant epidemiology to support the current work on HAVS. This was circulated to members as a separate paper. Other occupations such as gardners/dentists/orthopedic surgeons were included to establish if any data were available for these occupations relating to HAVS.

5.4. It was proposed by the author that the original exposure equivalence model, discussed in previous meetings, could be used to assist in the assessment of claims, so they drafted guidance to support this process, which was also circulated in the meeting papers.

5.5. Members debated the recommendations made in the proposed command paper and the following points were raised:

- Changes to the text to reflect that exposure equivalence may be applicable in a broader context for other investigations where epidemiology data are limited.
- It was felt that when looking at the HSE guidance that for assessment purposes, the 50th centile for exposure would be more relevant for IIDB rather than the 75th centile recommended.
- A member asked if the process for the list of tools recommended to be included could be simplified by stating the time of exposure required to cause the condition.

5.6. The author felt the assessor needed to have flexibility to consider all the evidence from the detailed work history and when the symptoms developed. This would ensure that claimants were not disadvantaged by not getting to the assessment stage – some claimants may develop symptoms earlier than others.

5.7. Observers commented that the list of tools was useful and generally supported the recommendations in the paper, but they felt it would be an onerous task for assessors to have to work out exposure equivalence based on tools used, it would be better to have a guide around the length of time these tools would have had to be used for symptoms to develop. The author responded that the exposure equivalence model provided in the proposed assessment guidance was only a suggestion and need not be adopted if it was deemed to be difficult.

5.8. Another observer commented they felt the command paper was robust but also felt the proposed assessor guidance was too complicated. It was suggested that the guidance be discussed separately at another time.

5.9. It was felt that the guidance provided may be premature as the draft command paper was making recommendations to change the prescription for PD A11 and these proposals would need to be accepted, then the regulations would need be changed.

5.10. An observer stated they felt is was very important for IIAC members be involved in developing guidance with the Centre for Health and Disability Assessments (CHDA) when recommendations for change are made. In this instance, there may be some issues with the suggested guidance which could be worked out further down the line.

5.11. The author responded by stating the guidance was optional and would not necessarily need to be adopted.

5.12. It was agreed the suggested guidance was not relevant to the draft command paper, so would be put to one side at the moment.

5.13. There was some debate on the epidemiology paper whether to include this as an appendix to the command paper, but it was suggested there was sufficient information, with some minor further work, to publish this separately as an information note which would further strengthen the command paper. It was agreed that this would be reviewed at the next full Council meeting in October 2021.

6. **Neurodegenerative diseases in footballers and other contact sports.**

6.1. No papers were cirulated for this topic, but a member suggested a study they were involved in would be published, on rugby players, in the near future. This may help inform the Council's work on this topic as it was previously agreed to expand the investigation to include other contact sports.

6.2. It was also reported that Dr William Stewart, who had previously partipated in a Council meeting to discuss his paper on footballers, has published a follow-up paper. This covered the same data-set, but further analyses had been carried out which found differences between goal keepers and other team members.

6.3. It was reported that further correspondence from a stakeholder, asking why a full investigation had not started, had been received to which the IIAC chair responded stating the investigation had been widened to include other contact sports. It was also stated that the Council is aware of other ongoing studies which expect to report soon, so it will continue to monitor outputs on this topic but ongoing investigations would need to be completed first before embarking on a full review in this area.

7. AOB

Online public meeting

7.1. The secretariat updated members on the current status of the online public meeting to be held in the afternoon of 21 October. Several requests to attend this event had already been received and further mailshots would be carried out to promote attendance at the online meeting.

7.2. As pandemic restrictions have been eased, it may be possible for members presenting topics to attend Caxton house as a room had been booked, but technical aspects were being investigated.

RWG chair retirement

7.3. The RWG chair, Professor Neil Pearce, has completed the full 10 year tenure as a member of IIAC and is standing down. Dr Lesley Rushton, IIAC Chair, expressed her thanks for Professor Pearce's valued contributions to the work of the Council, which was echoed by other members.

Forthcoming meetings:

IIAC – 21 October 2021 (am) – public meeting (pm) - online
RWG – 25 November 2021 - online