INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid-online meeting
Thursday 21 October 2021

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	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 Andy White	IIAC
Dr Jennifer Hoyle	IIAC
Dr Max Henderson	IIAC
Ms Karen Mitchell	IIAC
Mr Keith Corkan	IIAC
Ms Lesley Francois	IIAC
Mr Daniel Shears	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 Faith Phillips	DWP IIDB Policy
Mr Adrian Nicol	DWP Disability Services: Products
Ms Catriona Hepburn	DWP Legal Team
Mr Ian Chetland	IIAC Secretariat
Mr Stuart Whitney	IIAC Secretary
Ms Catherine Hegarty	IIAC Secretariat

Apologies: None

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.

2. Minutes of the last meeting

2.1. The minutes of the last meeting in July 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. A verbal update was given to confirm that the Institute of Occupational Medicine (IOM) had been appointed to carry out the commissioned review. Contracts had been signed, allowing work to commence. The meeting schedules will be agreed and the Council will then receive regular updates.

4. Occupational impact of COVID-19

4.1. The Chair started the discussion by thanking members for their input, into the draft paper, over the summer. It was stated that now something more substantial needs to be written and some decisions need to be made, though progress has been made.

4.2. A draft flow diagram, showing the IIDB process, was compiled by a member and circulated with the meeting papers. This was thought to be useful to explain the approach the Council has taken with COVID-19.

4.3. A draft report, building on the previous version, was also shared with members. Sections were highlighted which required input from members as it is a work-in-progress document. A great deal of work has been undertaken on infections and a new section on prevention has been provided, which will require input from HSE.

4.4. COVID-19 poses a serious occupational health risk and studies directly linking the condition to occupation are scarce , which makes IIAC's work more difficult. Consequently, IIAC has to use other data, such as mortality, to evaluate risks. The approach taken in risk assessment where the weight/balance of evidence is considered a route the Council could take. It would appear robust epidemiological data linked to occupation is unlikel to be available to the Council.

4.5. It has been suggested that IIAC should dividing the sequelae of COVID into complications where there is clear pathophysiology and then investigate the syndrome termed 'long-covid', which is a concern to a great number of people. If the Council does not consider it has sufficient evidence to recommend prescription, it has to explain this very carefully.

4.6. The other major issue is the occupations impacted by COVID-19 – it had been agreed previously that health and social care workers (H&SCW) should be a priority. However, there is a pressing case to look at other key workers, which would need to be defined. The Council needs to decide whether to look at other occupations and if this is not possible, the reasoning behind this must be clearly explained.

4.7. Sections of the draft paper were then discussed. A member queried a suggestion that 'best evidence synthesis' was a new concept for IIAC and felt it needed to be examined more closely. The Chair explained this approach was used widely in toxiocological methodologies and is used by IARC. In this instance, IIAC would use this approach to assess risks. Where doubling of risk is apparent, this is straightforward for the Council, however, where this is lacking, other approaches need to be considered.

4.8. The Chair stated it was recognised this approach would need further clarification and it was suggested that, in the near future, a paper be written to

set out the views of the Council. It was suggested a working group be set up to look at this in the future. However, in the meantime, there is an immediate need to consider other approaches. A member agreed with the Chair and stated that this 'best evidence synthesis' approach had been used to develop evidence statements around a topic and these statements are then graded on a 3-star system depending on the strength/quality of that evidence.

4.9. Another member asked if the change in approach being proposed was a one-off or is a precedent being set for the future of IIAC's work? The member felt that if this approach was to be adopted by the Council, then it needs to be explained properly. The Chair agreed and stated for the COVID-19 paper, a hybrid approach may need to be adopted.

4.10. Other members expressed concern that treating the COVID-19 paper as 'special' would be wrong and leave the Council open to additional criticism, but also agreed that a working group needs to be established to examine, in detail, the approach being suggested. However, they felt it was a positive opportunity for the Council to examine the evidence it has to work with, using COVID-19 as an example. It was also pointed out that this could strenthen the Council's assertions that occupation recording be mandated in studies involving healthcare settings. The Chair stated they may approach the Royal Statistical Society, who have an expert group discussing future data collection to try to influence their thinking on data collection and occupation.

4.11. A member suggested that in this instance the Council isn't moving away from doubling of risk as the 'more likely than not' approach as this has been used in previous investigations.

4.12. A member commented that when identifying jobs where prescription could be appropriate, then H&SCW has relatively strong evidence to support doubling of risk. However, using a different approach for other occupations would be needed as finding exact jobs where 'more likely than not' applies could be difficult to sustain. The Chair agreed and added that additional information on key workers could be obtained from transmission pathways and using information from ONS data. Other occupational groups show elevated risks, but H&SCW are the most studied.

4.13. A member commented that they agreed with the outlined information in the paper and discussions so far, but felt the order should be changed and start with same assertions made in the first COVID-19 position paper around occupations at risk and not focus too much on 'long-covid'.

4.14. Regarding the 'best evidence synthesis', a member commented that doubling of risk is a specific scientific definition and evidence is not always readily available to support this, but the balance of probabilities can be applied when this is the case. However, they saw the prevalence of COVID-19 in the wider population and comparing that to occupation was an issue for this paper as it is complicated and constantly changing. They felt more information was required on the non-occupational impacts of COVID-19.

4.15. A member felt that the first stumbling block to overcome was to establish if any infections were caused as a result of work. The main defining factor needs to be 'more likely than not' rather than doubling of risk. On the back of

this, a member felt that there was evidence of doubling of risk in some occupations and that should be the premise of the next paper, along with the decision on whether or not to prescribe.

4.16. The Chair responded by stating there was a lot of evidence, especially with H&SCW group and a 'more likely than not' assertion may need to used. The Chair commented that studies which are being published now tend to be focussing on the impacts of vaccines and the Council is looking at a yet to be defined period of time where vaccines were not readily/widely available.

4.17. A member, who had commented earlier, felt that the proposed change of approach is fundamental and feels reactive without having considered all the implications. The Chair commented that they had not experienced any situation like COVID-19 before where data are so varied and new, often contradictory and with evidence constantly emerging, so it is challenging methodologically. IIAC methodology may not fit the challenges presented by COVID-19.

4.18. The Chair thanked members for their views and moved the discussion onto different sections of the paper where the sequelae from infection and definitions were listed. The issue of clinical codes was mentioned but the main focus was on the various definitions of heirarchy of symptoms and which should be adopted. A member commented that the issue with many of the definitions focus on the syndrome of 'long-covid' where the symptoms can't be explained other than the fact the patient has had COVID-19. So for IIAC, there are 2 categories:

- Those who have acute sequelae of infection – e.g. well defined conditions such pneumonitis, or lung fibrosis.
- Those where the symptoms are difficult to explain.

4.19. The discussion moved onto the listed of range of complications in the paper which can be measured and if linked to occupation, could be the basis for recommending prescription. A member stated it would be difficult for IIAC to recommend prescription where there is no clinical/physical sign or objective test to confirm symptoms. A potential list of applicable complications is listed in the draft paper which was discussed. A member felt that there was sufficient evidence to suggest at least 3 of the conditions listed could be considered for prescription, but some of the others would require careful consideration. Other conditions/symptoms which develop post-12 weeks infection may also need to be described, which are listed in the literature, but which may not be applicable for prescription at this time and the reasoning for this would also need to be explained.

4.20. The Chair made the point that for prescription, the diagnoses of conditions/symptoms would need to be clearly explained for IIDB administration purposes, including loss of faculty and potential for degree of disability. It was accepted that when considering the conditions to establish wording for a prescription, a degree of extrapolation would be required as epidemiological evidence may not be available. Some discussion around the onset of symptoms was held and it was stated that the clear distinction between the different groups (sequelae of infection vs 'long-covid') would

need to be made clear. It was also pointed out that some conditions may pre-date the onset of infection (pre-existing condition); however, other symptoms/conditions are very rare in the general population. It was felt that the symptoms listed in the paper can, with a degree of certainty, be associated with COVID-19. A member asked if these conditions could be demonstrated to be linked to occupation (more likely than not) – it was thought that for some conditions, epidemiological evidence was there but for others a degree of extrapolation would be required.

4.21. A member with experience of psychiatric /mental health conditions and who had drafted the flow diagram to assist IIAC's decision making, made the following points:

- Currently, the literature doesn't broadly support prescribing for psychiatric illness related to COVID-19.
- In psychiatry (related to occupation), diagnostic tests can be subjective, not objective which can hamper recommendations for prescription.
- The broad category of H&SCW may dilute the risks faced by some workers as certain sectors within this broad category may be at higher risk for developing mental health problems. During the pandemic, an increase in depression in the general population has been observed, hence the link with occupation may decline.
- The issue around loss of faculty where diagnosis of depression has been confirmed is challenging as the literature suggests this condition can be resolved relatively quickly, so being able to demonstrate 15 weeks of loss of faculty may be difficult.
- The most likely prescribed condition may be a depressive disorder as PTSD may be nichely related to certain aspects of healthcare and anxiety is a symptom with little chance of being doubled in risk.

4.22. A member asked if there may be wider applications to consider for other prescriptions where the condition leads to serious decline in mental health – this may be something for the Council to consider in future. It was also pointed out that many COVID-19 patients who were seriously ill probably also developed poor mental health and this would need to be addressed.

4.23. The Chair asked if the contribution on mental health conditions could be summarised and put in writing to include in the paper.

4.24. The discussion moved on to consider the impacts of 'long-covid' and the Chair asked if an appropriate definition of this aspect of COVID-19 complications could be clearly defined.

4.25. The prevalence of 'long-covid' is included in the draft paper and the Council needs to agree what should be included under the umbrella term 'long-covid' i.e. what this consists of. There is a lot in the literature and a member suggested the definition put forward by the World Health Organisation (WHO) may be useful.

4.26. A member commented that they felt it would be difficult to prescribe for 'long-covid' type condition without having COVID-19 prescribed, for certain occupations, first. They also felt that other key workers may need to be considered and whether oubreak/clusters could be an industrial disease,

without limiting it to a specific occupation, but including this under the key-worker category. The Chair felt that the definition of key worker was important but made the point that IIAC is not responsible for defining what an industrial disease is as its remit is limited to that which could be relevant to the industrial injuries scheme and related legislation.

4.27. The chair summarised the discussions and stated that if the Council makes the decision to prescribe, it needs to make the recommendations practical and be able to be appiled to IIDB. The Chair then asked the Council to consider 'long-covid' and what should be included in the paper. A member responded by saying whilst there are definitions of 'long covid', the difficulty for IIAC is the symptoms which persist after other causes have been ruled out.

4.28. It was agreed that the RWG should look at the complications, defining 'long covid' and separating post-acute complications from other chronic conditions – clearly explaining the reasoning. A member suggested that 'long covid' complications/symptoms should not be included without defined pathophysiology at this stage, clearly explaining the rationale. It was accepted that the symptoms are real, but it is difficult to assign loss of faculty to something which cannot be accurately diagnosed nor measured.

4.29. A member pointed out that whilst they agreed with the reasoning, they felt that the IIDB scheme may not fit this type of condition which is difficult to define and measure. This should be made clear in the paper. This member also pointed out that there is a campaign underway to have 'long covid' recognised as a disability, which is unrelated to the work of the Council and IIDB.

4.30. A member stated that loss of faculty is well defined within the legislation, so felt the potential exclusion of some 'long-covid' symptoms needs to be investigated further. Another commented they felt there was a distinction between the presence of a symptom and its impact on being able to function. This member also felt that if the Council does decide to not recommend prescription, then this has to be clearly explained as they felt simply stating that COVID-19 or 'long-covid' doesn't fit the IIDB model does the Council a disservice.

4.31. The Chair thanked everyone for conributing to the coherent discussions so far and made a plea for those speakers to summarise their views in writing and circulate to members.

4.32. The discussion moved onto other sections of the paper such as occupations and transmission pathways where a member felt that transmission pathways and job exposure matrices (JEM) were an important source of background information.

4.33. The section referring to infection data is long and requires editing down. Key workers have been reported on by the ONS, which gives useful information on other occupations which went out to work during the lockdown phases. Some occupations deemed at high risk using a JEM but this risk has not been borne out by testing data. A member asked why certain occupations were omitted from the paper, but it was explained that data was not available as it had not been collected. It was felt this needs to be clearly explained in the paper.

4.34. The work on outbreaks was updated as the Chair has had conversations with external researchers who may be able to provide additional information. Further analyses of work-related outbreaks is expected soon. The issue of defining an outbreak/cluster was raised as this varies. It was felt that this issue needed more work as there is likely to be public interest. It was felt that updated mortality data needs to be included, including anything from RIDDOR. A draft section on prevention has been provided, which will require input from HSE.

4.35. The Chair brought the discussion on this topic to a close and again urged members who have contributed during the meeting to write down their views and circulate. It was agreed that H&SCW, likely patient facing, should be the main focus but the timescale (related to the waves) to which this refers needs to be decided, but this is going to be very difficult. The RWG will take up the discussion when it meets in November 2021.

5. Discussion on revising the prescription PD D1

5.1. The Chair introduced the topic and asked a member to give a verbal update on progress on revising the prescription.

5.2. The draft command paper has been edited and sent out to external experts for comments.

5.3. It is anticipated comments will be received before the next full Council meeting in January 2022.

6. RWG Update

6.1. The Chair stated that discussions were ongoing around how the RWG should be chaired and a further update will be provided in due course.

6.2. A brief discussion was held on occupations missing from PD A11 where a member gave a verbal progress report. The draft command paper was presented at RWG along with a review of the epidemiology and potential guidance if recommendations to change the prescription are accepted. It was felt the epidemiology review was detailed enough to form a position paper. The draft guidance will be put on hold until the paper progresses. This willl be reviewed again at RWG and members will get a further update at its January 2022 meeting.

7. AOB

Update from DWP IIDB policy

7.1. The Chair introduced a paper authored by DWP IIDB policy staff, shared with IIAC members, detailing the process IIAC recommendations have to follow in order to prescribe for a disease.

7.2. Each recommendation has to be impacted and costed and the detailed, evidence-based work which IIAC carries out is essential to this process.

7.3. Implementation also has to be fully considered as does cost which has to be negotiated with HM Treasury.

7.4. A member commented that when IIAC makes its recommendations it is important that each section is broken down to allow costings and choices to be made.

Public Meeting

7.5. Some discussion around roles and responsibilities for the public meeting was held along with the process for dealing with questions.

Correspondence

7.6. The Council received a critical letter from a stakeholder which will be responded to and fully discussed at the next RWG meeting in November 2021.

Farewell

The Chair made a heartfelt thanks to Professor Karen Walker-Bone for her exceptional contribution to the work of the Council. Karen is stepping down from the Council to pursue a career opportunity and members wished her well.

Date of next meetings:

RWG – 25 November 2021
IIAC – 13 January 2022