RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the hybrid online meeting
Thursday 25 November 2021

Present:

Dr Lesley Rushton	RWG Chair
Dr Chris Stenton	RWG
Professor John Cherrie	RWG
Dr Ian Lawson	RWG
Professor Kim Burton	IIAC
Dr Jennie Hoyle	IIAC
Mr Doug Russell	RWG
Professor Damien McElvenny	Observer
Dr Anne Braidwood	MoD
Dr Rachel Atkinson	CHDA
Dr Mark Allerton	DWP Medical Policy
Ms Ellie Styles	DWP IIDB Policy
Ms Mandeep Kooner	DWP IIDB Policy
Ms Jo Pears	DWP IIDB Policy
Ms Faith Phillps	DWP IIDB Policy
Ms Catriona Heburn	DWP Legal Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Ms Lucy Darnton

1. Announcements and conflicts of interest statements

1.1. The Chair explained the protocol for conducting the hybrid online meeting where some members were able to attend in person:
- 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 reminded members to declare any potential conflicts of interests now or when a topic is being discussed.

1.3. The Chair announced that 2 new members would be joining the Council on 1 December, Professor Damien McElvenny and Dr Gareth Walters. Professor McElvenny had previously served on the Council and was in attendance as an observer.

1.4. It was announced that Professor Kim Burton and Dr Jennie Hoyle had agreed to join the RWG. For the time being the RWG will be chaired by Dr Rushton for administrative purposes. When items arise, the Chair will be passed to the member with the lead on that topic.

2. Minutes of the last meeting

2.1. Subject to minor drafting edits, the minutes of the September 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. The Chair summarised the progress of drafting the report which has been restructured to focus on the findings before discussing the disease.
3.2. It was felt it would be helpful to have an explanation and review of the status of the UK pandemic referring to the various restrictions over the time period the Council is looking at as results from studies often need to be checked against what was happening at that time. Different parts of the country were under restrictions at different time.
3.3. A section also describes who was working at the time as some occupations were classed as 'essential' but several of those employees were working from home and not in a workplace. This also applied to those classed as health & social care workers (H&SCW).
3.4. The infection data on H&SCW has been revisted and there is more to do on non-healthcare workers. Other sections have been revised.
3.5. The Chair stated it was felt there was a good understanding of transmissions pathways and those more at risk of infection, coupled with job exposure matrices. There was also a good understanding about who was working at the time, which mirrors that found in the transmission routes.
3.6. It was apparent the risks varied by date, with increased risks for public/patient facing H&SCW but more patchy for other occupations.Transport was a risk for some other occupations, but other studies are due to report soon.
3.7. Mortality data from the previous report has been included, but other studies will be available soon. However, the SAGE transmission group are reported to have disquiet around adjusting these data for various factors.
3.8. RIDDOR is due to report a new set of data soon, so this will be reviewed.
3.9. The disease entities and complications appear to show a clear link to occupation, which is something to consider further.
3.10. The Chair then invited comments and discussion around the restructured paper.
3.11. A member stated they were happy with the restructuring but questioned whether a cut-off point or time-line should be made clear as it has been reported that some patients were claiming to have COVID-related symptoms from late 2019, which predates the pandemic.
3.12. At this point a member declared an interest as they were involved a legal case related to COVID.
3.13. Members commented they thought the paper was very long and sections could be summarised and the relevant detail be assigned to appendices. However, they felt the paper was now correctly structured. The Chair agreed some sections could be condensed and some information be placed in

appendices. It was stated the restructuring was done to build up a picture because of a lack of occupation-related studies.

3.14. A member asked about the importance of the role of aerosols transmission pathways and perhaps this could be be made clearer given the reduced importance of formite transmission. There was debate around the level of exposure in intensive care, but it was pointed out that there is no good evidence for exposure in individual job titles. This highlighted how difficult it is for the Council to recommend prescription.

3.15. The discussion moved onto the terminology used to describe the post-viral infection complications loosely termed ‘long-covid’ and the definitions around this. The difficulty faced by the Council is that definitions are evolving. Ultimately the decision was taken to adopt the NICE definition and the wording of the paper will be amended. However, it was noted this condition may evolve into a syndrome. It was thought the paper could benefit from a section on ‘long-covid’ to explain the complexities of this set of symptoms/conditions and how the understanding of this is changing.

3.16. A member thought the term ‘long-covid’ should not be used as the general public may view this as the ME-type symptoms only and the situation is more complex than that. Post-covid syndrome, which covers all conditions, would be a more useful term to use. The Chair pointed out IIAC is unique in its approach to this topic and puts a different slant on the issues/consequences of having COVID. It was pointed out NICE has recently published a new document which may help.

3.17. Other sections of the paper were discussed and the Chair asked if the section on patterns of infection would benefit from having illustrative graphs. It was thought H&SCW should be included in detail under the section ‘exposure environments’ as this group had the greatest risks.

3.18. The section ‘occupation and infection rates’ has been revised for H&SCW. A member considered initial risks for H&SCW were more than doubled, later in the timeline these risks reduced and now appear to hover around the doubled mark. The impact of the early vaccination of H&SCW makes comparisons with other workers groups more difficult. This member was of the opinion there is a clear case for recommending prescription in this occupational group depending on the timeline up to the end of December 2020, after which it’s not clear. Other factors which have an impact on assessment of evidence are whether the studies were local or national and what restrictions were in place at the time.

3.19. A member pointed out the different variants of the virus may have an impact as some symptoms changed when the virus mutated. The impact of the vaccination programme on the variants is also a complicating factor as symptoms may have changed as a consequence. It was suggested this issue be covered by the report and acknowledge this can complicate the matter.

3.20. A member asked if the report should specify patient-facing H&SCW roles, to include ancillary workers, would be covered by any potential presription. The Chair agreed that terminologly would be important and commented that in other occupations, public-facing would need to be considered. Also close contact with other workers, for example in food processing or large offices, would also need to be considered. Those working at home would not be covered and this would need to made clear in the report.

3.21. A member raised the point that they thought H&SCW were disproportionately impacted by the risks from the virus. The Chair stated studies had been carried out where people were asked where they thought they had contracted the virus and if in work, where.
3.22. A member suggested a flow chart would be useful to establish potential eligibility and to eliminate those not occupationally infected. This was accepted as a good idea, but thought to be more relevant to guidance should the Council decide to recommend prescription and it was accepted.
3.23. The discussion moved onto sickness absence and a member provided a great deal of useful information.
3.24. Workplace outbreaks was discussed and the Chair stated they would be engaging with HSE to gather more information. It was mentioned that a new report on this topic is likely to be published very soon. A member felt this was an important section and would be useful to have a working definition of what constitutes an outbreak, which could be available from the HSE who is pulling together information from multiple sources.
3.25. A member suggested the triangulation of sources of information to determine risks and likelihood of occupational link to COVID for a number of different occupations and cluster outbreaks. The Chair considered this was sensible and stated there appeared to be increasing evidence for elevated risks in non-healthcare related occupations.
3.26. The mortality data will be updated when ONS release their next report. The Chair made the point that much of the information the Council is using for its reports has not been peer reviewed, so called ‘grey literature’ and the Council is carrying out that function, so needs to be taken into account. A number of reports, including one from the BioBank study, have indicated how difficult it is to disentangle the various other factors that are associated with risk of exposure, such as ethnicity. The Chair stated that formal adjustments which are not biologically related would not normally be taken into account by IIAC. A member stated that in clinical situations, ethnicity is not a contributing factor to patients who are reporting symptoms of ‘long-covid’, however this is just an observation.
3.27. The SAGE committee transmission group indicated that blanket-adjustments are not recommended due to the interelationships between occupation and deprivation etc.
3.28. A member mentioned that in previous IIAC reports, ethinicity and diversity were covered, so it is important to be aware of the sensitivities around this.
3.29. Discussion moved onto the infection stage of the paper where post-covid sequelae of infection are described. It was felt that it should be stated, upfront, that the term ‘long-covid’ is an evolving and developing entity. There are certain sequelae which are measurable and well-described that cause disability - this would be important for prescription and difficult to assess for ‘long-covid’ where symptoms are unexplained. The paper should reflect the fact there are some data for the general prevelance of ‘long-covid’ syndrome, but this tends to be self-reported syptoms. Members were aware of patients with this condition who have long-term poor health conditions but there is currently a paucity of evidence clearly relating this to occupational exposure, which the Council requires to recommend prescription. The Council would continually monitor emerging literature.

3.30. Having a confirmed diagnosis of COVID-19 and the related timeline would also be important for the Council to recommend prescription and this would need to be made clear in the report.
3.31. Mental health conditions related to COVID-19 were discussed and a member with expertise in this area, provided a summary of the literature which indicated there was insufficient evidence for prescribing this as a separate disease entity.
3.32. It was suggested to help members, that recommendations be drawn out and summarised, along with sections of the paper, which will be circulated.
3.33. As time was short, it was suggested having a separate RWG to focus on COVID-19 and the secretariat agreed to look into arranging this.

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

4.1. Several papers were circulated to members which comprised of the second draft of a command paper and a position paper which sets out a review of the epidemiology to support the command paper.
4.2. The command paper has been revised to have summarised sections and to include more information in the appendices for those who wish to read the detail. The paper also includes feedback from external experts and from internal, DWP, stakeholders.
4.3. The command paper also contains a conclusion and recommendation, which includes suggested wording for a revised prescription. This includes everything covered by the current prescription but also allows for exposure equivalence for additional tools in common use.
4.4. Having given an overview of the command paper, the author then asked for feedback from members. They pointed out that guidance has been written for IIDB processing staff should the recommendations be accepted. The epidemiology paper requires further work to incorporate information from a literature search.
4.5. A member asked if reducing the threshold for exposure, for example for precussive drills, would increase the number of claims. The author stated that the revised, proposed prescription would be a filtering tool to allow claims from those previously excluded. The claims would then be assessed to determine if sufficient exposure had occurred in much the same way as currently carried out.
4.6. There was some discussion around which equipment could be excluded, such as low frequency tools, which may not cause damage. An observer asked if multi-tools could be included as these are now commonly used in current working practices as well as in the domestic DIY situation. The observer stated the revised list would satisfy the requirements for both claims processing and claimants.
4.7. It was noted a prevention section would be required and the author agreed to work with the HSE to draft this section.
4.8. The command paper and epidemiology position paper will be reviewed by the full Council at its next meeting in January if time allows.

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

5.1. As time was short, a member gave a verbal update on the current status of the draft command paper to state that comments had been received from some external experts and when all feedback had been received, the author will bring this back to the Council for further review.

6. Mental health assessments for IIDB

6.1. An observer gave an overview of the current process for assessing claims which involve mental health conditions. The current framework for carrying out these types of conditions is out of date and would benefit from being updated.

6.2. It was agreed that this topic would be added to the IIAC workplan for an evidence-based review and a small working group be established to take this forward. It was agreed that DWP staff would draft a short paper setting out the the current concerns and requirements from the Council.

7. PD A15 Dupuytren's contracture legislation

7.1. The regulations for PD A15 have been redrafted, in conjunction with IIAC musculoskeletal experts, and shared by correspondence with all Council members to ensure the proposed change to legislation met with its intent.

7.2. Members were asked to respond by the deadline.

8. AOB

Online public meeting

8.1. The secretariat updated members on the procedures for the rescheduled online public meeting being held following the RWG meeting. Participating members were reminded of their roles

Correspondence

8.2. The Council has received correspondence from a stakeholder around the requirements of the prescrition for PD A14, osteoarthritis of the knee, in respect of various jobs in underground mining.

8.3. It was agreed to review previous responses and refer any procedural aspects for the DWP to review.

Forthcoming meetings:

IIAC – 13 January 2022
RWG – 24 February 2022