RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the extraordinary online meeting
Thursday 9 December 2021

Present:

Dr Lesley Rushton	RWG Chair
Dr Chris Stenton	RWG
Dr Ian Lawson	RWG
Professor Kim Burton	RWG
Professor Raymond Agius	IIAC
Dr Jennie Hoyle	RWG
Mr Doug Russell	RWG
Ms Ellie Styles	DWP IIDB Policy
Ms Jo Pears	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Professor John Cherrie, Dr Max Henderson, Dr Mark Allerton

1. COVID-19 and its potential occupational impact

1.1. The Chair introduced the extraordinary RWG meeting which was called to focus on the COVID-19 report and to have a version for review at the next full Council meeting in January 2022.

1.2. The Chair gave an overview and suggested that the discussion should start with the disease section as this has gaps. The Chair stated they felt decisions had been made around the complications and felt the evidence was good enough to potentially recommend prescription for certain complications following infection with the SARS-Cov2 virus. The diagnosis question seemed clear-cut and there were some good indications of timings when these complications would have occurred. Also we had a handle on timing on the infection, but further discussion was needed in relation to occupation.

1.3. The complications indicated may not cause long-term disability, but that doesn't mean they won't.

1.4. The post-covid issue required further discussion and the Chair felt a recognised definition should be adopted. It was suggested that there is insufficent good quality evidence, at this point, to state what the issues are and which could be clearly be diagnosed and which may cause long-term disabilities. This may change with time and may end up as a 'syndrome' similar to myalgic encephalomyelitis (ME). Whilst the current available evidence is not good enough, this may change in the future.

1.5. A member agreed with the summary provided and stated that they felt there was sufficient evidence for some of the respiratory complications and for post-ITU syndrome. The member felt that the National Institute for Health and Care Excellence (NICE) definition of 'long-covid' was useful and that information could be drawn from their recently published report. This report also supports

the view that much of the literature published in this area is not peer reviewed and the evidence available can be poor quality.

1.6. It was suggested to refer to other definitions of ‘long-covid’ but use the NICE versions for the purposes of the IIAC COVID paper.

1.7. A member suggested it was important to acknowledge that it is disabling for people who have the extreme tiredness associated with ‘long-covid’ even though the evidence may not support recommdending for prescription at the present time. The chair agreed and stated there was a long section on the prevalence and was aware of self-reporting studies which give indicative evidence, so it was felt this issue was covered.

1.8. Another member stated there were a number of reasons, such as no objective features which allow diagnosis, why ‘long-covid’ is unsuitable for prescription due to the requirements of industrial injuries disablement benefit regulations (IIDB).

1.9. A member agreed to summarise the current understanding of ‘long-covid’ for the paper.

1.10. The discussion moved on to the complications which may be appropriate to recommend for prescription. A member stated that some of the pulmonary complications, such as fibrosis, were rare enough to warrant linkage to COVID in working-age people. However, there is overlap with breathlessness which is often reported as being a sympton of ‘long-covid’. It was therefore important to have a clear diagnostic criteria.

1.11. A member stated they felt it was vital for each complication to be listed in a potential prescription which sets out clearly the necessary requirements for eligibility, necessary for claimants and for the IIDB claims process. It was agreed that members would work collaboratively to more clearly define the respiratory complications and requirements for potential prescription.

1.12. There was some debate around the pathological presentations of the respiratory conditions and it was stated that X-rays/CT scans would not produce a pathological diagnosis. There was also some concern that a large cohort of those with breathlessness could create an elevated demand for CT scans. It was also pointed out that the diagnostic criteria would need to be made very clear to ensure the IIDB claims process is not overwhelmed with inappropriate claims should any recommendations be accepted for prescription. The Chair stated that a new member with respiratory disease expertise had been appointed to the Council and asked that they be included in discussions.

1.13. The cardio-related complications are also not thought to be be clear-cut due regarding the terminology used and patho-physiology, so it was agreed that an expert cardiologist would need to be consulted and a member agreed to take this forward.

1.14. Post ITU syndrome was discussed as a complication for consideration and whilst some members thought this was relatively straightforward from a diagnostic perspective, another asked how this could be assessed for IIDB puroposes as the neurological components could be vague. Another member responded by stating they felt this could be along the same lines as post-traumatic stress disorder (PTSD) and it was agreed to determine how this was carried out by consulting the assessment process for IIDB. It was suggested that there is an official definition of post ITU syndrome and this should be sourced and used.

1.15. There was also discussion around the degree of ventilation involved in post ITU syndrome as intubation would be considered more invasive that other techniques. It was agreed that an intensive care expert be consulted and a member agreed to take this forward. There was also some discussion around reaching out to other bodies to seek advice.
1.16. The Chair summarised the discussion by stating members were content with the list of complications listed in the paper which may be appropriate for prescription, and we would notadd to this list at the moment but ensure the requirements for the prescription are clearly described. The Chair made the point that all aspects of diagnoses don't need to be listed, but if a specialist diagnosis is required, then this can be specified in any prescription.
1.17. The Chair commented on the restructuring of the COVID paper and then discussion moved on to the occupational aspects of the COVID paper. The Chair stated that currently there is a great deal of information in the sections, but these can be edited and some information moved into appendices for reference.
1.18. A member stated that non-healthcare related occupational data will be of interest to a number of sectors and it would be relevant to try to draw out out any potential elements where prescription could be recommended.
1.19. It was pointed out that it will be important for the paper to point out where the data are coming from ('grey literature'), the lack of peer review and how this can have an impact due to the apparent variation. The paper also needs to explain, from the start, what happened during the pandemic, with waves and the impact of tiers and restrictions. This had an impact on the data which emerged. The other apects which need to be considered and addressed are inequalities, which can be related to occupation where access to healthcare can be limited (e.g. nightshift workers).
1.20. There are also some studies which indicate that vaccination records linked to census records show lower vaccination rates in the same occupational groups where there are higher death rates. It is a difficult task to distentangle the effect of inequalities/ethnicity from occupational impacts and attribute 'cause' in terms of exposure.
1.21. A member stated they thought the mortality data should be excluded from the current paper as it has been covered by the earlier publication, but there wasn't wide agreement for this.
1.22. The Chair stated that the paper should try to build up a picture of what was happening at various times during the pandemic, such as those who went out to work and those who worked from home, who were exposured theoretically.
1.23. A member stated they have updated the section of RIDDOR data and another report is expected to be published mid January 2022, so those data will be included in the report. They also stated they would engage with the Coroner's Office again to try to access further data.
1.24. The meeting went of to discuss the timescale of infection given the waves. The end of January or March 2020 was suggested as the start date, but the end point is difficult to define. The issue of testing at the beginning of the pandemic was raised as this was limited at that time – this would be important to have a confirmed diagnosis for prescription purposes. There was also variation in approaches to testing across different hospitals.
1.25. The Chair stated it is important to understand how a person would have been diagnosed with COVID-19 and there would have been a cohort who were not

confirmed to have the disease (not admitted to hospital/not tested) but went on to develop complications later. Members felt diagnosis would have to be either a positive test or confirmed by a doctor. It was suggested an end date would need to be driven by the data. Another member gave the view that it would be difficult to define an end date as deaths from COVID-19 are still occuring and at what point does 'more likely than not' apply for occupations?

1.26. A member stated they thought that due to amelioration, the risks declined after the first wave of the pandemic across many occupations. The impact of potentially contracting the disease at home is also difficult to disentangle with little good data on index cases.

1.27. A member asked if it would be appropriate to consider the characteristics of jobs and whether there was any inherent risk regardless of any amelioration. This could be applied to not only public/patient-facing jobs but also those which took place in the background as these workers were in proximity to each other and this is borne out by workplace outbreaks. A member also pointed out that the regulations state that 'it could be reasonably assumed' rather than more likely than not.

1.28. Another member commented it should be acknowledged that spending time with work colleagues is an integral part of many jobs, so exposure to the virus in this context would be occupationally related. The job exposures matrices which have been devised have taken account semi-quantitative assigning risks to jobs. This would give a theoretical estimate of risks for those jobs.

1.29. The other difficulty the Council may face is how specific it makes the prescription in terms of risks they faced, i.e. the workers would have to have had risk potential exposure as part of the job. This is likely to be public/patient contact and worker/worker contact.

1.30. Regarding end dates, a member was clear that they thought the Council should not be specific about this and phrase any wording in a cautious manner stating the Council was guided by various factors and timelines. This would allow any further emerging evidence to be incorporated and guide the Council further. The Council could state it stopped reviewing data after a certain point and state the important factors such lock-down, working from home etc but not be categoric.

1.31. This would be important as the impacts of new variants of the virus are unknown with the potential for new waves and the effectiveness of vaccines.

1.32. A member commented that it would be useful to review the ONS data to look again at the risks in H&SCW for later in the pandemic and to bear in mind that it is likely that workplace outbreaks will continue. Further data on outbreaks will be available soon, which will help inform the COVID paper.

1.33. The Chair summarised the discussions of the meeting where most of the topics were discusssed. Actions were agreed and contributing members were asked, where time permits, to have these actions cleared for the next IIAC meeting in January 2022. The Chair thanked members for attending this additional RWG meeting.

Forthcoming meetings:
IIAC – 13 January 2022
RWG – 24 February 2022