INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the extraordinary online meeting
Thursday 24 February 2022

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	IIAC
Dr Chris Stenton	IIAC
Professor John Cherrie	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 Lesley Francois	IIAC
Mr Daniel Shears	IIAC
Professor Damien McElvenny	IIAC
Dr Gareth Walters	IIAC
Ms Lucy Darnton	HSE
Dr Rachel Atkinson	Centre for Health and Disability Assessment
Dr Emily Pikett	DWP Medical Policy
Ms Catriona Hepburn	DWP Legal Team
Mr Ian Chetland	IIAC Secretariat
Mr Stuart Whitney	IIAC Secretary
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Anne Braidwood (MoD), Mr Keith Corkan, DWP IIDB Policy, Ms Karen Mitchell

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. When members were reminded to declare any potential conflicts of interest, the following were noted:

- Raymond Agius stated he is currently acting chair of the BMA occupational medicine committee.
- Damien McElvenny stated he is involved in a number of COVID related projects through the Institute of Occupational Medicine (IoM) and University of Manchester. It should also be noted that Professor McElvenny is leading the IIAC commissioned review as the principle scientist employed by the IoM, who were awarded the contract to carry out the review.
- Chris Stenton declared he is involved in a legal case relating to COVID-19.
- Max Henderson declared he was involved in the epidemiological study ‘The Post-hospitalisation COVID-19 study (PHOSP-COVID)’.

1.3. The Chair explained that as this was now an all-member meeting, the minutes from the RWG meeting held in November 2021 would be circulated by email for clearance by members.
1.4. The main focus of the meeting was COVID-19, but other topics would be covered if there was time.

2. Occupational impact of COVID-19

2.1. The Chair thanked all the contributors to the latest draft of the COVID paper which had been circulated to members.
2.2. The Chair opened up the discussion and invited members to comment on the revised paper.
2.3. The Chair suggested the various sections to be reviewed – the sequelae of infection from SARS-CoV-2 was the first section to be discussed.
2.4. A member explained that 'long-covid' was a rapidly evolving topic and this section of the paper tries to define what is meant by 'long-covd' and to examine the broad range of symptoms which are apparent for this condition and categorise these. Symptoms where there is evidence to suggest these may cause long term disability are discussed in the paper along with symptoms which are less well defined such as fatigue. The latter are difficult to objectively identify the potential long-term effects.
2.5. The Chair noted that the mental health aspects of these conditions would need to be incorporated into the sections.
2.6. The Chair mentioned that this section seeks to define what long-covid is and how this relates to various official definitions. They also stated that there is a section where other issues require consideration, such as timing of the relevant infection or confirmation of a COVID-19 diagnosis. When the Council has considered the wording for other prescriptions, some of these have been less 'prescriptive' where general terms are used and guidance provided for clarity. This may need to be applied in this topic where potential claimants who have clearly been impacted by COVID but may not have all the potential proof to support their claim.
2.7. A member responded to state most claimants would have a PCR test and have a doctor diagnosis and some people may not be covered in this particular paper, but other aspects could be considered when more evidence emerges. However, the member felt that the conditions the Council are considering for prescription which have defined pathophysiologies are likely to be covered by having a confirmed diagnosis.
2.8. Another member referred to a comment on the paper which dealt with furlough or working from home which they felt was too restrictive - they felt being in work 10 days prior to symptoms prompting a diagnosis would be fairer. The Chair commented that there had been a lot of dialogue, and needs to be considered further, around working from home or being on furlough where the latter were not deemed to being in work, though employed.
2.9. A member commented that there is a significant minority who presented with a phenotype of 'long-covid' who had a number of the symptoms before COVID-19 existed, which may impact claims, but they felt the symptoms with

defined pathophysiology symptoms related to COVID-19 were less of an issue as a confirmed diagnosis was likely. This member felt that perhaps in the first instance, if prescription is recommended, the Council may not get it right, but the choices could be making the prescription narrow to start with or have it broader and narrowing it down as claimants move through the process.

2.10. The issue of mental health as a contributing factor to 'long-covid' was revisted and a member agreed to incorporate their views into the sections which deal with symptoms.

2.11. A member felt it was reasonable to have a broad brush, in a potential prescription, when it comes to the timeline of infection as some symptoms (e.g. stroke) may present before a COVID-19 diagnosis. The Chair responded by stating it might not be possible to be overly prescriptive but felt it would be a good idea to have some illustrative examples in the paper.

2.12. Reference was made to the numbers of hours worked in a week as a qualifying factor for a potential prescription – a member pointed out that some health & social care workers (H&SCW) work part-time or work on a 'bank' basis, along with other high risk workers, which means they would be ineligible to claim. A member responded stating they felt there would have to be rules around having to have been in work before the onset of COVID-19 – this is something the Council needs to agree upon. It was pointed out that the fewer hours time spent in work lessened the risk of catching the virus from work.

2.13. A member made a number of general comments:

- The proposed paper is a very large document, possibly the largest during their tenure on the Council.
- This topic has dominated the work of the Council for some time and there are other serious occupational health issues which are not being covered.
- Discussion is ongoing around how a potential prescription could work but no decision has been taken whether to recommend prescription or not.
- The issue of doubling of risk criteria not necessarily being applied for this topic was a concern as this has been the gold standard for assessing evidence for some time. They felt moving away from that could set a precedence for how the Council would work.

2.14. The Chair addressed the points raised:

- COVID-19 is a serious occupational issue with many thousands of deaths being associated with the disease. There is evidence that a proportion of these deaths occurred as consequence of work. It was acknowledged the data available to the Council is not ideal.
- It was accepted that the investigation has taken a long time, which is something the Council may be criticised for. The length of time taken to arrive at this point is not IIAC's fault – some long-term disability studies have only recently reported.

- This particular type of topic has never been covered by the Council, where new evidence is emerging on a daily basis, making the work of the Council more challenging.
- The reason for changing this meeting to an all-members event was to try to arrive at decisions around potential prescription recommendations, with a view to having a confirmed paper, probably a command paper, by the April members meeting.
- The Chair agreed that there were other pressing topics to investigate and indicated discussions were ongoing with DWP with a view togetting additional scientific support.
- The doubling of risk issue has been the subject of much discussion and a member, by email, reminded the Council that the causation test for attribution in the legislation is reasonable certainty, equating to the balance of probability. There are some epidemiological data which indicates that the doubling of risk criteria has been met for certain occupations, which will be covered later in the meeting.
- The Chair welcomed suggestions for rewording of sections to make things clearer.

2.15. Following on from their comments, the member made several other points:

- The member is losing sight of the end game due to its complexity and size. It would be acceptable if 'long-covid' could be defined to comply with IIDB requirements and the doubling of risk element for some occupations could be established.
- It is a departure from the norm for the Council to include psychiatric effects into a potential prescription which may be the case for this topic. Previous investigations which covered high-stress occupations did not progress. They felt that other conditions, such as silicosis, which have a disabling element, would also have a psychiatric effect.

2.16. The Chair acknowledged these concerns and offered the following:

- The issue of the mental health of a claimant is taken into account at the assessment stage.
- The proposal at the moment is to not cover the less defined symptoms of 'long-covid' due to the lack of a robust definition and the Council is likely to be criticised for this and the paper needs to make it very clear why this is not being taken forward at this time.
- The Council may be heading towards making recommendations for prescription for conditions with definable pathophysiology.
- The Chair agreed the paper is very long and felt a contents page would be required, which is a departure from the usual format. Summaries for each of the sections in lay-language should help, but it is diffcult at the moment to navigate through the paper without a contents page.

2.17. A member agreed with the Chair's comments and raised the point of when a prescription could apply given the different waves of the pandemic. Would a limitation be applied or would it be left open as there are some views that certain variants of the virus cause much less severe disease.

2.18. The Chair responded that in the first wave, other than ONS death data, information was limited. The data from new outbreaks has yet to emerge from HSE, so this issue is likely to be ongoing for several years.

2.19. The discussion moved onto the disease complications section where the Chair asked how much work the DWP would need to do if the physical conditions, such as lung fibrosis, would be prescribed, given these types of conditions are covered by other prescriptions. An official responded that the DWP would need to cover the recommendations in a command paper and produce guidance packs for the healthcare professionals to follow. It is a complex process from recommendtions in a command paper through to implementation of a prescription.

2.20. A member asked if it is the claimant's responsibility to produce medical evidence and an official replied that decision makers may ask if the claimant has any evidence, but if the eligibility criteria are met, then medical evidence would be sourced at the assessment stage.

2.21. A member then asked if the Council is going to recommend prescription and if so, what would this entail? The Chair's response was that, if possible, decisions should be reached today. As previously discussed, there were 5 potential conditions which may be suitable to recommend for prescription and various sub-groups had met on a number of occasions to discuss these. The conditions with the clearest evidence are:

- Pneumonitis/lung fibrosis/scarring
- Stroke
- Pulmonary thrombo-embolism
- Myocardial infarction
- Post-intensive care syndrome.

2.22. A member put a proposal to the Council around the five conditions above which asked:

- Should any of these conditions not be recommended for prescription if circumstances for prescription are correct?
- Do members have any other suggestions?

If the answer to both those questions are 'no', then it is a matter of refining the wording for the prescription.

2.23. There was further discussion on the proposed conditions and the consequential disability these may cause and how long this may persist.

2.24. A member made the point that the other symptoms associated with 'long-covid' which are not easily explainable with a diagnostic test require more investigation, making this group particularly difficult for the Council.

2.25. A member pointed out that provided the occupational and diagnostic elements of the prescription are met, then the degree of disablement is then assessed by the DWP, which is covered, to some extent, in the paper. Discussion on the degrees of disabilities and how long these persist followed. Officials provided clarity of the eligibility criteria for certain prescriptions, how these are assessed and what would trigger a payment.

2.26. The Chair clarified that the Council is not proposing to recommend prescription for COVID-19 (or infection by SARS-CoV-2) – the subsequent conditions which develop after the infection has passed, which cause disfunction and disability, are being considered.

2.27. A member asked about the degree of read-across which would be acceptable, given the sparcity of data related to occupation. If data exist for a particular occupation but none exist for an occupation with similar risks, the use of a job exposure matrix (JEM) may be useful in these instances. A member then gave an overview of the work they have carried out on risks and JEMs related to occupation where data are limited. This indicated that some of the occupations would have the equivalent of doubled risk. The Chair reiterated the current paper is an interim report and further papers will discuss any relevant developments. Another consideration for the current paper would be whether or not presumption may apply.

2.28. The Chair then asked members to consider making decisions on occupations where sufficient information would justify recommending for prescription when the meeting adjourned for a short break.

2.29. The discussion then moved onto reviewing the occupational sections where the Chair gave an overiew how this section had been drafted. The biggest section is on H&SCWs as this group has been studied the most and a doubling of risk for this group is apparent. Other groups discussed include key workers, transport, education, protective services and leisure/retail. Excess deaths were discussed, but this information was provided in confidence.

2.30. A member commented they believed excess risks which would warrant prescription extends beyond H&SCWs to other occupations. However, they believed the Council should be pragmatic and start with recommending prescription for H&SCWs, stating the Council is aware of risks to other occupations which would be followed up later. Another commented that care needed to be taken with the terminology used as within this occupational group there would be types of jobs which did not have excess risks. Similar issues exist within the transport group. A comment was made that perhaps an interaction with the public or patients should be specified along with close worker contact, which is important in the workplace outbreaks.

2.31. A member asked if the provision of PPE in the early stages of the pandemic would have a bearing on any potential prescription, but it was felt this would be too difficult to administer and may not be relevant, but would have contributed to exposure risks.

2.32. It was pointed out that the risks for public-facing occupations were reduced when compared to patient-facing occupations, so this needs to be considered. The Chair felt it would be difficult to distinguish between the type of contact and time period, as data are insufficiently robust to support this.

2.33. Another member then agreed with the previous comment around making recommendations for prescription for H&SCWs (patient facing) as they believed the data are strong. However, they stated that this may not fit with the legislative process as the Council may want to amend the prescription some months later to include additional occupational groups. This member felt it would be better to try

to come up with as a definitive list of occupations as possible at this stage. The Chair agreed with that point, but explained that this could only be achieved if the evidence was strong enough to support the addition of other occupations.

2.34. A member felt that the timeline of infection should be considered as risks and evidence for H&SCWs was much stronger in the first wave of the pandemic, less so in subsequent waves where risks may not have been doubled. The Council was not necessarily in agreement with this view and it was suggested that no time limit should be applied. Another member argued that the remediation in place did not take account of aerosol transmission.

2.35. The issue of variants was raised where the omicron version was considered to be less harmful, so a member stated this could be used to establish a timeline for a potential prescription.

2.36. Another member spoke up in favour of having a timeline as they felt risks diminished in the later phases of the pandemic. The Chair stated that the death data, including excess deaths, was not robust for recording occupation for subsequent waves.

2.37. The issue of omicron variant was discussed further with some disagreement that this variant was less harmful and this member felt that the emergence of further variants might cloud the issue and be difficult for the Council as the potential prescription would need to be revised to take account of this.

2.38. There was further discussion around the application of a timeline and the omicron variant where a member felt the Council should be using the doubling of risk as a criterion as they felt the risks were dependent on the time of the wave. Risks were greatly reduced now compared to what they were earlier in the pandemic and they felt this should be reflected in the prescription. The Chair commented that whilst deaths have decreased, the data are very limited for occupation in later waves, so it is difficult to estimate risks.

2.39. Presumption was briefly discussed with no real consensus.

2.40. As discussion proceeded, the Chair asked members if they were content for a prescription to be constructed for H&SCWs without a time limit and a caveat or public/patient facing requirement. The Chair asked for a show of hands and the majority of members voted in favour.

2.41. It was agreed that a potential prescription for H&SCWs would be drafted and shared with members – it was noted that an extraordinary meeting had been scheduled for 16 March 2022 which could be widened to include other members.

2.42. The Chair then asked if members would like to proceed with other occupations, such as transport (where there are a lot of data, some doubling of risk), education (data are not clear nor helpful), leisure & retail and protective services. A member commented they felt this was related to direct evidence and how much could be read-across. They felt there was direct evidence for some of the occupational groups but not all and where evidence was good, the prescription should not be limited to H&SCWs. Transport workers was suggested as being appropriate, others perhaps would need more scrutiny.

2.43. The Chair stated that it might be more appropriate at this time to focus on occupational groups where there was direct evidence. Another member commented that where direct evidence was limited, the JEM model may need to

be used to determine risk and where this had been applied, education-related jobs were high on the list – epidemiological data for this sector are limited and risks for the initial wave of the pandemic were reduced as many workers in this sector would not have been exposed.

2.44. A member commented they felt there was a case for transport workers early in the pandemic but insufficient evidence to prescribe for other sectors such as education. The Chair agreed to look again at the unpublished excess death data for transport workers.

2.45. Another member pointed out that most teaching assistants were in work on a rotor basis as children of key workers were in school.

2.46. The Chair commented there appeared to be little support for transport or education and asked for opinions on protective services. A member pointed out that this was a broad category as it included other jobs such as educators as well as prison officers. A member felt the evidence was limited for this sector with the great risks being to prison officers, but these were likely to be regarded as outbreaks. The Chair commented that outbreaks might be difficult for the Council to assess as these cover a large number of occupations where data are limited. The HSE are expected to publish a report on this soon, but no date yet.

2.47. The Chair summarised the decisions:

- Draft a prescription for the five conditions described earlier with respect to H&SCWs.
- Consider the data for transport workers.
- No other sectors appropriate for consideration for prescription at this point.

2.48. It was also noted that the prevention section of the paper had generated a lot of discussion by correspondence and a request was made for HSE to review the narrative.

2.49. The extraordinary IIAC meeting scheduled for 16 March was opened up for any member to attend. A member stated it would be helpful for members to have the opportunity to share views on aspects which may be contentious. It was agreed that when a prescription was drafted, a list of key issues could be circulated to allow members to comment.