INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the extraordinary online meeting
Wednesday 16 March 2022

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	IIAC
Dr Chris Stenton	IIAC
Professor John Cherrie	IIAC
Mr Doug Russell	IIAC
Professor Kim Burton	IIAC
Dr Andy White	IIAC
Dr Jennifer Hoyle	IIAC
Professor Damien McElvenny	IIAC
Dr Gareth Walters	IIAC
Mr Keith Corkan	IIAC
Dr Rachel Atkinson	Centre for Health and Disability Assessment
Mr Ian Chetland	IIAC Secretariat
Mr Stuart Whitney	IIAC Secretary

1. Occupational impact of COVID-19

1.1. The Chair opened the meeting by thanking members for attending this special IIAC meeting, which had been organised to focus on COVID-19.

1.2. The Chair explained that another version of the report had been circulated, which would require further editorial work prior to publication. Members had provided comments and suggested wording for a potential prescription which had been collated and circulated.

1.3. The Chair stated that it would be preferable for decisions to be taken and a way forward agreed at the meeting relating to the form of the prescription the Council would potentially recommend. The discussion section has been revised to cover the disparate nature of the available data, with the complications posed by the waves. The Chair reiterated the serious nature of the pandemic with signicant numbers of deaths still being reported, as restrictions continue to be eased. The less than ideal nature of the available data was also reiterated, which has been a real challenge for the Council.

1.4. The main areas to be covered would be:

- if a prescription is to be recommended, what would this look like;
- justification and explanation for the Council's reasoning for arriving at its decisions.

1.5. The Chair asked members to refer to the document which set out the potential prescription and focusses, currently, on health and social care workers (H&SCW). The disease elements of the potential prescription, which describes five potential medical conditions, was discussed first and the Chair asked that a consensus on these conditions be reached.

1.6. Discussion followed on the wording of the disease conditions relating to whether the prescription should read 'following' or 'caused by' but is was agreed that 'sequelae' would be sufficient, given its meaning.

1.7. It was decided that the disease COVID-19 should be referred to rather than infection by SARS-CoV-2.

1.8. Wording relating to throboembolism and the timing of this was also agreed where pulmonary hypertension was persistent – it was felt that explanatory notes and guidance would be required, which would not form part of the prescription.

1.9. The discussion moved onto cardiac/stroke complications related to COVID-19 and a member raised concerns about the relatively non-specific nature of these conditions, the timescale for their application and the evidence linking these to occupation. This member felt clarity was required on what would be a reasonable timeframe for these conditions to have an impact following COVID-19. The Chair responded that the evidence has been well documented and is convincing - other members commented that timescales had been discussed in the wider report and it would be appropriate to include this in explanatory notes rather than have this in a prescription.

1.10. Post intensive care syndrome (PICS) was then discussed and a member stated they had reservations about this condition being included in a prescription as they felt this condition was a loose collective term for health problems which persist following critical care. They also felt this condition was not a disease but a consequence of treatment.

1.11. A member responded that PICS was a recognised disease and was probably the most disabling, including muscle weakness and psycological problems, possibly congnitative issues. It was accepted PICS is a relatively new phenomenon and doesn't have an ICD code. The phyical manifestations such as muscle weakness are relatively straightforward, but the psychological elements are more tricky to quantify. Another member pointed out that PICS is normally diagnosed by a specialist which could be all that is required. PICS can develop as a consequence of intensive treatment not exclusive to intensive care units. Having received ventilatory support would be an important criteria and there was some discussion around whether to use the term PICS or whether to define the physical/psychological conditions associated with this condition.

1.12. The Chair responded by stating that using standard terminology in a potential prescription would be preferable. Another member commented that they were unaware that other prescriptions had a psychological/psychiatric element to them and had concerns that for this potential prescription, the Council would be setting a precedent if psychological/psychiatric conditions were to be considered.

1.13. The Chair pointed out that when claims are assessed, there is consideration given to the psychological/psychiatric contribution to any disability. The member then countered that by asking if that was the case, why does this need to be included in the prescription wording.

1.14. On this point, a member stated that there had been a significant element of psychological/psychiatric involvement in COVID-19, causing problems for patients. Further work would need to be done and it was questioned how common it was to have psychological symptoms without physical issues. If

this instance was rare, then the prescription could focus on the physical elements and the psychological issues could be dealt with under the usual claims assessment process. The member felt the issue of psychological/psychiatric involvement had a significant impact and would need to be dealt with.

1.15. As consideration was being given to including the physical elements of PICS such as muscle weakness/fatigue, a member asked why these types of symptoms as described in 'long-covid' were not being included at this time and asked if they should be. The Chair's response was that there was literature to support PICS being included and this condition has been recognised. The issue of 'long-covid' symptoms which are not being considered in this report will be covered by subsequent reports when data become available. There will be an explanation in the current report setting out the Council's reasoning for not covering 'long-covid' this time around.

1.16. It was agreed that PICS would be included as a disabling condition in the potential prescription, but would be listed separately to the other physical conditions.

1.17. An official commented that the accident provision of IIDB allows for psychological conditions such as PTSD, but it has to be a defined event be that psychological or traumatic – no diagnosis is required in these cases wihich is different to the prescribed diseases. Several claims to the accident provision relating to COVID-19 have been received by the DWP and these have been assessed in individual cases. More claims may be expected.

1.18. The Chair stated that the Council will continue to look at this topic as more data are expected to emerge from the ONS and HSE. Evidence from studies into 'long-covid' and occupation may also emerge.

1.19. A member commented they still had reservations and felt a time limit should be applied to the prescription as workers would have had the opportunity to be vaccinated and this programme has had a positive impact. They felt that the risks would have declined after a year of the pandemic, so it would be prudent to apply a time limit on the prescription.

1.20. However, the Chair pointed out that there were still signifcant numbers of deaths being reported, which may have been patients who were unvaccinated, but IIDB is a no-fault scheme which would not consider vaccination status. Other members agreed with the Chair and felt that the risks are still very real.

1.21. Another member felt that a time-limit should be applied, not from a vaccination perspective, but that employers would have implemented significant control measures which would have reduced the risks. This member also commented on data which indicated that workplace outbreaks appeared to have been mostly in the first wave and when effective control measures were introduced, outbreaks appeared to be contained.

1.22. The Chair responded by stating this was an area where the Council would expect further data to emerge and would be covered in subsequent reports, but may have an impact on the accident provision.

1.23. Another member commented that control measures are not taken into account for other other prescriptions.
1.24. A member felt that there was an argument to apply a time limit and whilst there was still signicant COVID-19 disease, the question on how this relates to occupation is important for the Council to consider and other prescriptions have a time limit applied. They felt that risks declined significantly as the pandemic progressed, even for H&SCW.
1.25. However, the Chair did not agree with that assertion as they felt that some of the studies which may support this were based on small numbers when analysed down to detailed occupational levels and the data are uncertain. The Chair acknowledged the risks changed, but the uncertainty gave wide confidence intervals, so they felt there was no substantial data to show the relative risks changed a great deal.
1.26. There was more debate around whether to apply a time limit or not with arguments for and against. One member pointed out that whilst control measures and vaccinations have had a postive impact, the virus is still having a significant detrimental effect on people's lives and is not yet endemic, so it is not appropriate to apply a time limit yet. They felt that whilst it may not be appropriate to have a prescription for the sequelae of COVID-19 in the future, it is warranted with the current conditions. Another member pointed out that other prescriptions cater for conditions which are considered endemic and they felt it would be inappropriate to apply a timeline at this present time.
1.27. A member suggested that if the prescription does not have a timeline applied, then it may be appropriate to specify a review date where the prescription could be reassessed. It was agreed this was something for further consideration.
1.28. After a short break, the meeting went on to discuss the occupational aspects of the potential prescription. A member suggested that the wording should reflect care home workers and home care workers rather than home carers which may give the wrong impression. This member went on to say they felt the potential prescription appears simple and straightforward, but had some concerns around the discussion and conclusion sections of the wider report which deals with the Council's reasoning for not recommending prescriptions for other occupations where these were identified as being at higher risk. They felt there would be comeback from workers in these occuaptions and so the Council needed to be very clear why only H&SCW would be covered initially. This member felt the Council needs to state that it recognises these occupations were at greater risk but must state that the evidence available was insufficiently robust at this time to recommend prescription.
1.29. Another issue this member wanted to raise was around significant workplace outbreaks where this may not be covered by the current potential prescription but claims may be received through the accident provision. They felt this needs to be addressed and reflected in the wider report.
1.30. The Chair acknowledged these concerns and reflected the fact that the current recommendation for prescription for H&SCW was correct but the Council must explain why this is the case and why other occupations are not

being considered at this time and all this centres around the evidence available.

1.31. There was some discussion around patient/client contact or worker contact and the nature of the work carried out. It was pointed out that the chain of infection was difficult to trace with many factors having an influence. A member indicated that there were good data to indicate that the infection rates for hospital inpatients were significantly higher that those in the general population so workers in that environment would have been subjected to much great risks, making the case for H&SCW. It was felt that specifying contact with other workers would be difficult to justify given that workplace outbreaks would not be eligible under the current proposed prescription, so this would be dealt with in subsequent reports when further data would be available.

1.32. The Chair summarised the discusssion by stating there was evidence to support recommending prescription for H&SCW and invited members to draft a succinct paragraph which sets out the reasoning for not including other occupations at this time. A member gave the view that H&SCW were a unique group given the higher risks they faced and evidence was available to support recommending prescription. For other occupations, there was no real certainty, that the disease was contracted as a consequence of their work and this was made more difficult by the absence of studies.

1.33. Discussion then centred around exposure levels in workplaces where there are no substantial data to inform the Council's views. A member commented that for H&SCW there was evidence of reasonable certainty that the disease was contracted because of their work but for other occupations where workers may have been exposed in settings outside of work, the degree of certainty was not sufficiently evidenced. The Chair asked members who contributed to this discussion to draft a paragraph setting out their views which will be circulated for comment.

1.34. When discussing exposure levels, a member commented that job exposure matrices which had been developed, raised a practical issue around prescribing for occupations outside of H&SCW. These highlight jobs which may have high risk, but not all workers in those sectors have the same risk.

1.35. Concerns were again raised around not including workplace outbreaks, but the Chair responded by reiterating that further data are expected for outbreaks and the Council will look at this for subsequent reports. At this time, these workers may not be covered by a prescription, but may be covered by the accident provision of IIDB.

1.36. The discussion drew to a close and the Chair asked if members could submit any agreed contributions in time for the next full IIAC meeting in April where final decsions could be made. There was a brief discussion around publication of the command paper and the secretariat agreed to look into the timsecales involved.