INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 7 April 2022

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	IIAC
Dr Chris Stenton	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
Ms Lesley Francois	IIAC
Professor Damien McElvenny	IIAC
Dr Gareth Walters	IIAC
Dr Emily Pikett	DWP Medical Policy
Ms Mandeep Kooner	DWP IIDB Policy
Ms Jo Pears	DWP IIDB Policy
Ms Alexandra Ciupka	DWP IIDB Policy
Ms Catriona Hepburn	DWP Legal Team
Mr Ian Chetland	IIAC Secretariat
Mr Stuart Whitney	IIAC Secretary
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Keith Corkan, Mr Daniel Shears, Professor John Cherrie, Dr Anne Braidwood (MoD), Ms Lucy Darnton (HSE), Dr Rachel Atkinson, Ms Ellie Styles.

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. The Chair welcomed Alexandra Ciupka, an observer, as new member of the DWP IIDB policy team.

1.3. 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.
- Chris Stenton declared he is involved in a legal cases relating to pneumoconisis and COVID-19.
- Damien McElvenny declared he is involved in research projects related to COVID-19

2. Minutes of the last meeting

2.1. The minutes of the last meeting in January 2022 were cleared with minor edits required. The Chair thanked the secretariat for drafting the minutes of meetings.

2.2. The secretariat will circulate the final minutes to all IIAC members ahead of publication on the IIAC gov.uk website.

2.3. All action points have been cleared or are in progress.

3. Occupational impact of COVID-19

3.1. The Chair started the discussion by thanking, again, all members who had contributed to the current draft of the paper which had been circulated in the meeting papers. This report will require a lot of editorial work and the Chair asked that the meeting focussed on discussions and decisions rather than drafting by committee.

3.2. The Chair commented that some of the sections of the paper are not yet complete and some further data are expected which can be included in the final version, e.g. on infection. The section on future work indicates that subsequent papers will follow which may focus on occupations that the Council feels are not applicable at this time, but emerging data may change this. There is a section on 'long-covid' which now has headings that is helpful in illustrating the complexities and uncertainties of this syndrome and why the Council feels it is difficult to prescribe for at this time. The discussion and conclusions sections have been written and the Chair asked that the recommendations section be a focus for discussion at the meeting and that timescales should be considered.

3.3. The Chair moved the discussion on to look at the proposed prescription, the disease entitites involved and the current occupational group impacted. The Chair commented that the disease entities do not have to be described in detail in the prescription as this will be covered in depth in the technical guidance used by DWP staff, but the essentials do need to be covered.

3.4. The proposed prescription has five different complications

3.5. A member commented that they had given the paper a great deal of consideration and felt they had some concerns around the proposed prescription, namely post-intensive care syndrome (PICS) and risk reductions associated with protective measures such as improved PPE or the vaccination programme. The member felt that PICS, whilst the symptoms are real to patients experiencing difficulties, the syndrome is a consequence of treatment. They felt a timeline/restriction should also be included.

3.6. Given these concerns, the member was unable to support the proposed prescription as it stands and asked that this be recorded. The Chair acknowledged the concerns and agreed that timescales are an issue as the data are scarce.

3.7. Another member commented they agreed a timescale would be appropriate but disagreed about PICS as other diseases have treatments which are consequentially harmful but necessary. They felt PICS would be acceptable

with a clear definition of the condition and some discussion on timescales was held.

3.8. The Chair paused discussions to ask if members were in agreement with the proposed prescription with the five disease entites and the occupational group and whether or not it should go ahead. The member who raised their concerns stated the arguments for PICS to be included were persuasive as the patients who were subject to this would likely be dead otherwise. Other members commented they felt that other prescriptions took account of the disabilities caused by the consequence of treatments.

3.9. The Chair noted that no objections to the proposed terms of the prescription were raised and declared progress had been made, with a working version of the prescription being accepted.

3.10. The discussion moved on to the wording of the prescription for the occupational elements (the right-hand side) where it was felt that social workers should also be included. It was agreed this would be included as a footnote to trhe prescription.

3.11. Discussion moved onto to review the disease element (the left-hand side) of the prescription realting to timeframes of developing the conditions such as stroke or embolism. This followed on from some members being aware of a very recent study which found that the risk of developing pulmonary embolism (PE) or stroke could occur up to six months after infection for PE and 2 months for stroke.

3.12. A member commented a large Swedish study indicated high risks were extended for 2-3 months for PE which is also supported by other studies. Their view was that the timeframes for the different conditions listed in the prescription should be separated out as the risks are different for PE.

3.13. This member felt that the timeframe for PE should be 3 days before diagnosis and up to 90 days post-diagnosis. They were comfortable with the initial assertion for stroke and myocardial infarction (MI) could remain at 28 days. The timeframe for stroke should be set at 60 days.

3.14. Another member agreed with these views – it was suggested that reference to hospital admittance/discharge be removed along with the footnote referring to furloughed workers. However, it would need to be clear that it was close contact or proximity (not necessarily direct contact) with patients, and not ‘phone contact, which would qualify for the prescription.

3.15. Another member disagreed with close proximity being referred to as they felt this terminology could be misinterpreted and the claimant’s involvement with patients/public could be established at the information gathering stage of the claim.

3.16. The Chair commented that the prescription needs to be worded to ensure all workers within the health & social care (H&SCW) category would be covered but not having minute detail as this would be covered in guidance at the claim stage.

3.17. A member then suggested that the debate around proximity be brought to a close and ‘contact’ be used with that being defined in guidance where some form of physical closeness to patients/public would be required.

3.18. The Chair noted that most evidence would be contained within medical/employment records and whilst it is not the role of the Council to write the guidance, it could be assumed that it may be asked to review what may be written. A sentence reflecting the evidence requirement could be included in the command paper.

3.19. The Chair then asked if members were content with the discussion of the prescription and asked if there were any further comments. As no dissention was observed, the Chair declared the Council had arrived at a prescription and congratulated members on getting to this point.

3.20. The discussion moved onto the discussion/conclusions section and how the Council arrived at its decisions. This included why H&SCW had been recommended for prescription and justification why other occupations had not been included at this point; the Chair felt this section would attract interest. The section on future work expands on this and a member felt this should be revised to reflect the fact that the Council will monitor emerging data on occupation and sequelae of the disease. The Chair commented that other studies on proportional mortality analysis on death data are expected to report where some occupational sectors (e.g. transport) are shown to have consistently high risks throughout the waves. This evidence could be used to inform subsequent recommendations from the Council.

3.21. A member asked if wording around how the infection may have been acquired to reflect that future work may enable distinction between work acquired infection and that from elsewhere. The Chair agreed additional wording such as ‘currently not possible’ or similar along those lines.

3.22. Discussion on the reasons why other occupations are not included in these recommendations followed with the Chair making the point that there are many other studies which are due to report soon which will help inform the Council’s continuing COVID-19 investigation.

3.23. An official congratulated the Council on reaching the milestone of having a prescription and asked if risks (and consequent numbers) could be reduced by prevention/control measures and would this affect the prescription. The Chair responded the Council was unable to predict claim numbers, but more information may be available when various datasets are linked.

3.24. The Chair asked officials about the timescales involved for publishing this command paper and it was stated it would take several weeks to get everything in place for this to happen. This would allow time for the detailed editorial work to be completed without changing the nuances of the paper. The Chair stated they would discuss the timescales with the secretariat and inform the Council.

3.25. A member felt that the section which describes why other employment sectors are not being included in the prescription at this point should be strenthened to state what type of evidence would be required to satisfy the Council’s requirement. The Chair responded by stating rather than drafting sections during the meeting, members should put their suggestions in writing to be included in the next version of the paper.

3.26. A member pointed out that the change in testing procedures could impact the future work of the Council and the Chair added there were no occupational data available for this current wave, despite deaths still being consistently high. This would need to be taken into account for future work.
3.27. In the paper, reference is made to the accident provision of IIDB and it was felt this could be removed as it may not be relevant to the paper. The Chair's response was to suggest to add that the Council was aware some claims using the accident provision had been received by DWP.
3.28. A member came back to comment on the question raised earlier by an official on potential numbers involved. They felt that there may be more cases of occupationally related severe disease in the future as not everyone has been vaccinated. Also, whilst high risk areas within a hospital have good provision of PPE, other areas, where the majority of people work, do not have this level of protection. The official then asked about the level of disability which may be associated with the conditions. The Chair replied that this would be determined by the claims procedure and would be expertly assessed. The Chair also noted it was not the role of the Council to determine levels of disability, but it is always willing to advise.
3.29. A member questioned whether the issue of fatal cases/posthumous claims should be covered in the command paper, but as this was dealt with by the previous position paper, this should be referred to in the command paper.
3.30. The discussion moved onto the issue of 'long-covid'/post-covid syndrome where a member had drafted a separate document which sets out the Council's reasoning and justification for including some of these symptoms in the current prescription.
3.31. The Chair drew the debate on this topic to a close and once again thanked members for their efforts on getting to this stage. The Chair then asked if members were prepared to sign-off, in principle, this command paper. A member asked if the discussion held earlier on time limits for the prescription was a minority view. The Chair felt that it was not appropriate to impose a time limit on this prescription, but a member disagreed with this view as they felt the data on risks showed a decline after protective measures were introduced.
3.32. However, another member pointed out that the data doesn't show a time limit is appropriate, so agreed with the views of the Chair as there are still significant risks apparent to workers.
3.33. The member who felt a time limit should be applied asked that their opposition to this being omitted be noted in the minutes and a vote taken to establish a consensus. The Chair agreed that this would be taken forward.
3.34. A member commented that other prescriptions do not take account of mitigation related to prevention.
3.35. Following the discussion, the Chair asked members to vote if time limits should be applied. There was a minority of members who had this view, so the Chair suggested the command paper go forward without timelimits, but the section where this is covered be expanded with further explanations. The Council agreed, in principle, to sign-off this command paper.

3.36. The Chair drew discussion on this topic to a close and urged members to continue to contribute to sections.

4. RWG Update

Proposed revision of PD A11 – hand/arm vibration (HAVS)

4.1. The Chair introduced the draft command paper, which sets out to recommend changes to the prescription PD A11. The Chair set out the history surrounding this topic and and stated the command paper would be supported by a position paper which reviews the associated epidemiology. The Chair thought the paper was close to a final version and then handed over to the member, who authored the paper, to update members with a view to achieving consensus for sign-off .

4.2. The author stated they had received, from members, many helpful comments and suggestions following the review of previous versions and for the current version they had revisted the feedback received from external experts and its integration into the new document; this has been separated out from the ISO 5349 model.

4.3. An earlier version of the paper had equivalence information relating to measurements involved in occupational deafness, which have now been removed.

4.4. An issue which has emerged is that of presumption as the tools which are listed in the current prescription benefit from presumption whereas new tools included in the recommended updated list would not.

4.5. A threshold for a cut-off related to vibration magnitude (A8 value) has been discussed a number of times, but this is regarded as being too inflexible and would need to be considered alongside the diagnostic and employment questions. Having a fixed A8 value would be problematical for a number of reasons detailed in the paper:

- There may be a range of vibration magnitudes for each tool;
- The intermittency of exposure;
- Whether or not the vibration is impact;
- The hardness of the workpiece;
- Ergonomics; and
- Individual susceptibility.

4.6. The author recommended claims assessments for the new prescription be carried out in the same way as the current prescription and guidance can be updated to reflect the changes. Some examples of vibrating tools vibration magnitude were discussed as detailed in the command paper, which also goes into detail explaining how the expanded list of tools was arrived at.

4.7. Significant exposure is still required and this would be determined in the same way as the current prescription.

4.8. The author invited comments from members; the Chair felt the paper was comprehensive, with a clear explanation of the different approaches considered and why the current recommendations were chosen, which allows

for flexibility within the new prescriptions to take account of changing circumstances relating to tools or work-practices.

4.9. The Chair felt that the issue of presumption for some tools and not others may be tricky and legal views may need to be sought. The claims process would need to ensure a detailed work history was taken which would need to be assessed with the medical history. It was agreed that a follow-up meeting with DWP officials to discuss this issue would be arranged.

4.10. A member representative of employees, along with another, felt the command paper was very good and they welcomed the flexibility to allow for changing conditions without having to revise the legislation. However, they noted that blanching of skin may raise concerns amongst interested parties. The author pointed out that this was no different to the current prescription and had been covered by a previous position paper on this topic.

4.11. A member representative of employers was also supportive of the recommendations as they felt a sensible approach had been taken. They commended the paper as being clear and straightforward.

4.12. No further comments were made so the Chair stated they felt the paper was almost there, subject to comment from DWP officials and minor editing. When this has been finalised, a copy will be circulated to members for final sign-off.

4.13. The Chair thanked the author for all the work which had gone into producing this command paper.

5. Commissioned review into respiratory diseases

5.1. In the previous IIAC meeting, it was confirmed that the Institute of Occupational Medicine (IOM) had been appointed to carry out the commissioned review.

5.2. The review has commenced and Professor Damien McElvenny is leading this from the IOM – this had been previously declared as a potential conflict of interest.

5.3. The Chair reminded members that a presentation on the topic had been circulated with meeting papers and gave an overview of progress to date as Professor McElvenny had temporarily dropped out of the meeting.

5.4. The results of the searches carried out by IOM were shown which consisted of reviews, systematice reviews and meta-analyses. In the absence of a review, separate searches will be carried out for any key studies. The Chair reminded members that the remit of the review was to look at mainly respiratory cancers and COPD.

5.5. The review found a great deal on occupational lung cancer and COPD and some studies on laryngeal cancer. The occupations most reported, were miners, along with agriculture, construction, transport and healthcare workers. The causative substances which came out on top included diesel engine exhaust fumes, asbestos, pesticides and naturally occuring radon. The agents/substances were shown against the diseases. Also occupations were shown against diseases and some which the Council may wish to consider are agriculture, construction, cleaning, transport, amongst others.

5.6. IOM had previously asked what prioritisation criteria should be used to focus their efforts and some suggestions were:
- Looked at by IIAC in the past but recent significant epidemiological evidence;
- Not previously considered by IIAC but recent significant epidemiological evidence;
- Relevant for the UK; and
- High estimated number of cases attributable to occupation.

5.7. Professor McElvenny rejoined the meeting and asked for feedback on the main prioritisation critera, namely which areas should be reviewed in more detail and whether there are particular associations that should be included. It was suggested 12-15 disease/exposure combinations be selected with a view to looking at around half of those in more detail to see if there's an important body of epidemiological evidence that needs summarising. Some of these may not have sufficient epidemiological evidence to warrant taking forward.

5.8. The Chair invited input from members and a suggestion was made that 'asbestos and airflow obstruction' was of interest. This member was also surprised that 'welding fume and COPD' had not come up in the review so far.

5.9. The Chair made the point that COPD is only prescribed for miners and welding fume had been considered by IIAC from a cancer perspective.

5.10. A member made the point that there have been recent media reports into pesticides and Parkinson's disease, so felt this could be taken forward. Also environmental tobacco smoke where people working in bars had been impacted.

5.11. Another member suggested going down a disease-specific route (e.g. COPD) first and assessing the causes as this ties into the current investigation on PD D1 . They also felt that woodworkers is a category which should be looked at, especially with respect to fibrosis.

5.12. A member commented that as well as consulting the clinicians on the Council, other systematic approaches could be:
- DWP should be invited to comment as there may be issues highlighted from correspondence etc;
- DWP assessment panels and guidance where clarity may be required;
- The length of time which has elapsed since a review was carried out on a topic; and
- New data/epidemiology.

5.13. The Chair thanked members for their input and commented that some of these criteria had been taken into account by IOM.

5.14. IOM noted they had been literature-focussed, but had also considered charity websites and sought input from HSE and other respiratory physicians. They felt there was a wider pool of respiratory physicians to consult, so invited the clinicians on the Council to submit any suggestions.

5.15. Another member felt that asbestos lung cancers (not mesothelioma) could be looked at along with the relationship of tobacco smoke with asbestos. The Chair commented that smoking is a big issue and the prescription for COPD

includes smokers and this may not be satisfactory – IOM have been asked to review this.

5.16. A member suggested consulting with the association of personal injury lawyers to seek their input. Professor McElvenny replied they were aware of cases relating to brake dust and mesothelioma. It was also suggested that the health and safety unit of the TUC be consulted.

6. AOB

Update from DWP IIDB policy

6.1. The Chair invited DWP officials to give an update to members;

- An official thanked members for their input and help with the laying of Dupytren's contracture.
- The secretariat was thanked in supporting a query received from the Welsh Government on COVID-19.

Correspondence

6.2. Correspondence has been received from the Asbestos Victims Support Group Forum (AVSGF) raising concerns around the taking of medical histories and % disabilities associated with PD D1.

6.3. The Chair felt that this letter should be referred to DWP to consider and in the meantime, the secretariat was asked to draft a holding response to the AVSGF and arrange a follow-up meeting to discuss in detail.

6.4. The Chair thanked everyone for attending and participating and drew the meeting to a close.

Date of next meetings:
IIAC – 7 July 2022
RWG – 19 May 2022