INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 20 October 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 Max Henderson	IIAC
Ms Karen Mitchell	IIAC
Ms Lesley Francois	IIAC
Professor Damien McElvenny	IIAC
Mr Keith Corkan	IIAC
Mr Daniel Shears	IIAC
Professor John Cherrie	IIAC
Dr Rachel Atkinson	CHDA observer
Dr Anne Braidwood	MoD observer
Dr Emily Pikett	DWP Medical Policy
Ms Anna Bartlett	DWP IIDB Policy
Ms Sania Mushtaq	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Ms Natalie Carolan	DWP Legal Team
Mr Ian Chetland	IIAC Secretariat/scientific adviser
Mr Stuart Whitney	IIAC Secretary
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Jennifer Hoyle, Dr Gareth Walters, Ms Lucy Darnton, 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. Members were asked to declare any potential conflicts of interest which have not been raised at previous meetings.

1.3. The Chair welcomed Anna Bartlett, an observer, as new member of the DWP IIDB policy team along with Sania Mushtaq and Lewis Dixon.

1.4. The Chair bade farewell to Mandeep Kooner from the DWP IIDB Policy team who has moved onto a new role.

1.5. The campaign to recruit new members for IIAC has concluded. Following interviews, 5 appointable candidates were put to the Minister for consideration. A ministerial decision is expected in due course.

2. Minutes of the last meeting

2.1. The minutes of the last meeting in July 2022 were discussed with minor edits required. A point of clarification will be sought with an absent member, relating to an item they raised, where the minutes were not clear.

2.2. The secretariat will circulate the final minutes to all IIAC members ahead of publication on the IIAC gov.uk website. It was agreed that all minutes of future meetings would now be cleared by correspondence ahead of the next meeting, freeing up time on the agenda.

2.3. All action points were cleared or were in progress.

3. Occupational impact of COVID-19

3.1. The Chair stated that COVID-19 would remain a priority for the Council and gave an overview of the meeting papers relating to this topic:

- Monitoring of new publications and the related epidemiology;
- Population and epidemiology;
- Evidence for transport workers.

3.2. The Chair joined the panel of the all party parliamentary group (APPG) on long-covid who were asked to address a series of questions. A further session involved patients with long-covid sharing their experiences, particularly around financial assistance.

3.3. The general consensus was that long-covid was moving towards being a syndrome – there are many symptoms which are not defined, not clearly diagnosed and not something which easily fits into the worker compensation scheme. Another area the APPG is interested in pursuing is making COVID or long-covid a compensatable occupational disease. The Chair also noted that the meeting was being filmed by Panorama for a special programme on long-covid. There was some debate amongst members around what is defined as being a compensatable occupational disease.

3.4. The Equality Act was also discussed by the APPG.

3.5. The Chair moved the discussion on to COVID-19 and stated they had been in contact with the UKHSA and received a definition of an outbreak and an incident, to inform the Council's work. They define an outbreak as an incident where two or more persons have the same disease or similar symptoms and are linked in time, place and/or person association. However, an 'incident' for the UKHSA refers to events or situations which warrant investigation to determine if corrective action or specific management is neededand these often relate to biological or chemical exposures, which may not fit with the requirements of the Council.

3.6. Results from the data on the studies of outbreaks that are being analysed by the HSE is still not available.

3.7. The Chair then asked for an update on the progress of the command paper which had been submitted for consideration by Minsters seeking permission for it to be laid before Parliament.

3.8. The secretariat explained that the Secretary of State for Work and Pensions had asked that the new Minister for Disabled People also consider the

submission requesting permission to lay the command paper. This has been done and a decision is expected soon.

3.9. A member commented that the minutes of meetings are a useful tool to answer questions on this topic.

3.10. At this point in the meeting, it was agreed that future meeting minutes would now be circulated to members to approve the minutes by correspondence rather than waiting until the next Council meeting. The secretariat agreed to put a process in place.

3.11. The Chair then steered the COVID discussion to address how the Council may approach the next phase of this investigation. The Chair felt that interested parties are now interested in 'long-covid' rather than the pathological aspects of post-COVID-19, which were addressed in the command paper. Most of the emerging data are about symptoms which are often self-reported. There are studies based on self-reports coming out which use a standard scoring scale. At the APPG, a British Medical Association (BMA) representative felt long-covid was moving towards being a syndrome, similar to myalgic encephalomyelitis (ME) or chronic fatigue syndrome.

3.12. The Chair asked members for ideas for a strategy to guide the continuing COVID-19 investigation.

3.13. A member felt that long-covid could be difficult to prescribe for the Council as this comprises a set of symptoms with no discernible test to confirm.

3.14. A member pointed out that in Europe, an inflammatory marker test had been given a CE (*"conformité européenne"* or European conformity) mark, but this is not widely used in the UK, so the difficulty of diagnosis remains.

3.15. The Chair commented that it was noted at the APPG that many patients presenting with long-covid now were not the cases of COVID-19 treated in hospital, rather milder cases.

3.16. A member drew the attention of the Council to two papers which could be of interest:

- Analysis of performance football players – a small drop in performance was noted after 8 months of having had COVID-19, and
- UCL COVID-19 study had questionaire data before and after the pandemic. It indicated that those who reported poor sleeping before contracting COVID-19 were more likely to suffer long-covid-type symptoms. Smoking was also implicated in increasing the risk and, being more active prior to having COVID-19 decreased the risks of developing long-covid.

3.17. A member agreed that long-covid was likely to be regarded as a syndrome which may not be useful to the Council, and felt more occupational data should be sought in the follow-up to the command paper. They felt that subsequent papers should succintly address the difficulty in prescribing for a syndrome, drawing analogies with similar diseases with the same short-comings.

3.18. Another member asked if the timescales of the current recommendations in the command paper needed to be revisited. A member responded that the timescales were drawn up based on data available from NHS staff. Another

member commented that if the recommendations were accepted, to monitor the claims to check the potential prescription's intent was being applied.

3.19. Based on discussions, the Chair felt that there were three main areas to focus on:
- Other occupations, such as transport.
- Monitor the literature for long-covid-type symptomology by occupation.
- Monitor how the definitions, terminology and diagnostic criteria are developing for long-covid. What are the disease entities, the diagnostic criteria, timeframes and are there good data by occupation?

3.20. The Chair stated the Council was nowhere near addressing any of these points. It was noted that the probability of developing long-covid has not been linked to occupation at this time.

3.21. Prevention and the vaccination programme was also discussed at the APPG as obtaining vaccinations could have been more difficult for certain occupations, which were mostly public-facing.

3.22. A member commented that the pathway into long-covid was COVID-19 and if excess risks for occupations can't be established for COVID-19, then it would be unlikely that links to occupation for long-covid would be determined. The Chair responded by stating that this depends on the data. The APPG indicated that people with mild COVID-19 were developing long-covid, so that assertion by the member may not apply. However, read-across from other data may be possible in some occupations.

3.23. A member felt that the vaccination programme could influence the likelihood of developing long-covid, so this may become less of an issue.

3.24. The Chair commented that the situation has been complicated by waves of infection and data coming at different times.

3.25. The Chair closed the discussion on this topic by stating they felt it should be discussed fully at the next RWG meeting and would prepare a suggested strategy in conjunction with the RWG chair.

4. Accident claims relating to COVID-19

4.1. The Chair invited a DWP official to give an overview of the claims to the accident provision of IIDB which were related to COVID-19.

4.2. Claims to the accident provision of IIDB, which related to COVID-19, were monitored in the initial phases of the pandemic.

4.3. An overview of 24 claims was presented with 18 being accepted or adjourned. The 18 cases represented a variety of occupations, but mostly from the health and social care sector.

4.4. A wide spread of disabilities, ranging from 8% to 125% in the accepted cases was reported. Most of the cases related to long-covid and most of the lower percentage disability cases had returned to work.

4.5. Some of the lower percentage disabilities cases reported symptoms including:
- Fatigue
- Impaired respiratory function
- Shortness of breath
- Brain fog

- Breathlessness, aches & pains.

4.6. Similar symptoms for the mid-range of percentage disability were reported, along with anxiety & depression and sleep disruption.

4.7. The higher percentage disability symptoms were more serious and included requiring hospital admission for pneumonitis, cardiac problems and mental health issues.

4.8. It was noted that some of these claimants would not have been covered by the recommendations in the command paper as they either didn't work in the correct occupational setting or did not have the suggested pathological conditions. There was some concern that if the Council's recommendations for prescribed disease (PD) are accepted, there may be a large increase in claims to the accident provision from claimants who may not qualify for the PD. A member felt this could be detrimental to the Council and suggested a handling strategy be devised.

4.9. The Chair responded that the Council may well face a backlash from occupational sectors not covered by the command paper, but reiterated that new data from occupational settings were very sparse and were a source of great frustration.

4.10. Claims have continued to be submitted for COVID-related conditions to the accident provision, but current numbers were not available.

4.11. A member asked about the 6 claims which were turned down – this was for a variety of reasons including using the incorrect form, no follow-up from claimants or for unfeasible/unsustainable reasons.

4.12. A member with legal expertise had reviewed the legislation related to accident-related claims and gave an overview of their findings:

- An injury must result from an identifiable accident and not from process;
- Typically this is an unlooked for mishap or an untoward event which is neither expected nor designed;
- Any analysis should involve a common sense understanding of the natural every day sense of the word accident;
- The accident should be identifiable as something distinct from the injury to which it gives rise;
- The injury must have been caused by an accident happening because of the claimant's work as opposed to injury brought about by some non - work related event;
- This can be a single identifiable accident or a series of accidents; and
- The injury must have been caused by contact with the employer's plant, premises or machinery or some other aspect of the employment.

4.13. It was stated that internal discussions around the accident provision of IIDB were continuing.

4.14. The Chair thanked the official for a very interesting overview.

4.15. At this point, the Chair reminded all members to declare any potential conflicts of interest as this should have been done at the start of the meeting.

5. Respiratory diseases commissioned review

5.1. An overview of progress to date was given which referenced a recent meeting between IOM and selected IIAC members to assist with prioritisation of conditions/occupations for the next phase of the review. A suggested template for a table of evidence was also provided. Agreed topics to take forward for further consideration and prioritisation included:

- Silica and lung cancer
- Silica and COPD
- Work in farming/agriculture/with pesticides and COPD
- Work as a cleaner and COPD
- Hexavalent chromium and lung cancer
- Cadmium and lung cancer
- Asbestos and lung cancer
- Diesel engine exhaust and lung cancer
- Work in farming/agriculture/with pesticides and lung cancer

5.2. Members were asked if they disagreed with the topics which had been agreed to take forward or if there were any additions to go on the list. Members were supportive of the topics discussed.

6. Audit of PD A15 (Dupuytren's) claims

6.1. An official briefly discussed the history of the PD A15 prescription and referred to when the amended prescription came into force in March 2022.

6.2. In order to check that the prescription was working as intended, an audit of 26 claims had been carried out and an overview of the findings was given.

6.3. Key findings included:

- 54% of claims accepted by the decision makers resulted in diagnosis of PD A15
- 2 of the 26 cases (8%) were captured by the 28/3/22 amended prescription (they would not have met the prescription from 9/12/19)
- Disablement percentages vary, but seem to be aligned with the flexion deformity recorded
- Medical practitioner's advice on the disablement percentage is robust and correlates with the suggested disablement.

6.4. In conclusion:

- Is the amended prescription working?
    - Yes, the evidence suggests that the amended prescription is working. It captures individuals with sole interphalangeal joint (IPJ) involvement, sole metacarpophalangeal joint (MCPJ) involvement and those with both IPJ and MCPJ involvement. The clinical picture tends to be more complex than the involvement of a single digit / joint. Practitioners understand the prescription and diagnose PD A15 as appropriate (as well as not diagnose PD A15 when appropriate).
- Are the outcomes reasonable/appropriate and do they reflect the disability?
    - Yes, in the cases diagnosed with PD A15, the advised disablement percentages are appropriate and can be justified. They seem to vary

depending on the cumulative Total Flexion Deformity, the number of digits involved and the severity of flexion deformity of particular digits. One point that does appear to be clear is that claimants frequently present with fixed flexion deformity of more than one digit, which accounts for why the percentage disablement figures may appear to be quite high in some cases.

- A question was posed around the occupation history – does it have to fit 2 hours a day for 3 days a week over 10 years? Members agreed to take this away for review, but felt the 10 year requirement was probably correct. However, they would review the papers which informed that point of the prescription. They thought it would be unlikely a relaxation of that requirement would be necessary, but would check.

6.5. The Chair and a member thanked the official for the work put into this review and commented it was helpful for the Council to see its recommendations working in real life.

6.6. Another member mentioned that where the involvement of multiple joints was observed, the disability is significant, so awards should reflect that and the prescription appears to meet the needs of claimants.

7. Revision of PD D1, pneumoconiosis

7.1. The Chair asked a member, the author of a command paper, to give an overview of this review.

7.2. A paper was presented to the Council at the July 2020 meeting suggesting restructuring and simplification of the pneumoconiosis prescription, and bringing it into line with other prescribed diseases. The paper was then shared with external respiratory disease experts for review and their responses didn't all agree, but the consensus was that it was appropriate to review the prescription. The external comments provided by the external respiratory disease experts will be shared with members who are interested.

7.3. Further work on the paper has been delayed because of the amount of time taken to deal with COVID-19 related issues but the subgroup of respiratory disease experts now needs to reconsider the command paper.

7.4. The member advised that there were 2 aspects to revise in the command paper:

- Include hard-metal disease rather than having that as a separate prescription
- Consideration needs to be given to combining some of the categories. For example there is little practical distinction between silicosis and mixed mineral dust pneumoconiosis, and the two might be combined in a 'pneumoconiosis caused by silica-containing dusts' category. Pneumoconiosis associated with silicates (insofar as it exists) is probably usually caused by contaminating silica and so might fall into the same category.

7.5. IIAC respiratory disease experts will be invited to a meeting to discuss the points raised.

8. RWG update

Work programme update

8.1. The Chair stated that the Council has a full programme of work, but other issues raised by members and other stakeholders are being considered, which include:

- IIDB accident provision
- Mental health
- Operation of the IIDB scheme
- Review of the infectious disease prescription group – last looked at in 2003

8.2. A major question to consider is women's occupational health, which has never been specifically considered by the Council as a stand-alone topic. Members were asked for views on commissioning a scoping review as this is a substantial topic. A member offered their support for proceeding with this topic, to be discussed further at RWG.

8.3. An official commented that a review into mental health aspects would be welcomed. The Chair added that a separate meeting to discuss how this could be structured would be useful in order to determine how the Council could proceed. A member commented this was a vast field and would require a measured approach. A suggestion was made to consider what the outcome might be and work from there.

Neurodegenerative diseases in professional sportspeople

8.4. A member introduced this topic by stating it had been on IIAC's radar for some time. It was decided to consider the epidemiological literature in this area, and to see if there now exists a sufficient body of evidence to recommend prescription for any neurological condition in professional sportpersons.

8.5. This had been discussed at RWG where this work would begin by looking at recent (systematic) reviews in this area in order to determine which sports and which neurological diseases should be looked at in more detail. A number of issues were raised which require further discussion such as whether to focus initially on sports impacted or neurological outcomes.

8.6. It was suggested that it may be appropriate to consider engaging with a neurological disease expert to assist with this investigation and it was agreed this should be given more thought.

8.7. A question was asked about widening the scope of the investigation (as football and rugby are very topical), what is known about the exposure and what depth of evidence for other sports is available?

8.8. The member leading the investigation commented that rugby and football have limited epidemiological evidence, but American football has been studied but not widely played in the UK. However, the evidence/data from these studies could be useful for read-across to other sports.

8.9. It was agreed that the starting point would be to assemble a table of evidence starting with reviews. A member commented there didn't appear to be good

quality information about the exposure various sports receive. Also there is some debate about the causal exposure. There are also a number of very different neurodegenerative diseases to consider, which may complicate a potential prescription. How the diseases are recorded may also be a complication.

9. **AOB**

9.1 A member asked about a previous command paper on melanoma in aircrew. This is still being considered by the DWP, but may be paused to focus resource onto COVID when the command paper is laid and published.

9.2 The Chair closed the meeting by expressing their thanks, that of the Council and of the secretariat to Karen Mitchell, Doug Russell and Andy White as these members were leaving the Council. Their substantial contributions to the work of IIAC were acknowledged.

Date of next meetings:
IIAC – 12 January 2023
RWG – 24 November 2022