

INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the online meeting
Thursday 15 April 2021

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	IIAC
Professor Neil Pearce	IIAC
Dr Chris Stenton	IIAC
Professor John Cherrie	IIAC
Professor Karen Walker-Bone	IIAC
Mr Doug Russell	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Sayeed Khan	IIAC
Dr Andy White	IIAC
Dr Jennifer Hoyle	IIAC
Dr Max Henderson	IIAC
Mr Dan Shears	IIAC
Ms Karen Mitchell	IIAC
Mr Keith Corkan	IIAC
Ms Lesley Francois	IIAC
Dr Anne Braidwood	MoD (audio)
Ms Lucy Darnton	HSE
Dr William Stewart	Participant
Dr Mark Allerton	DWP Medical Policy
Ms Ellie Styles	DWP IIDB Policy
Ms Mandeep Kooner	DWP IIDB Policy
Ms Kay Baker	DWP IIDB Service Delivery
Ms Maryam Masala	DWP Legal
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Ms Victoria Webb DWP IIDB Policy

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 Ellie Styles who has joined the DWP IIDB policy team.
- 1.3. The Chair also welcomed Dr Rachel Atkinson, Clinical Project Lead for the Centre for Health and Disability Assessments (CHDA).
- 1.4. Dr William Stewart was expected to join the call at some point. Dr Stewart was invited to share his experience of neurodegenerative diseases in footballers, being the author of a well-received paper on this topic.

2. Minutes of the last meeting

- 2.1. The minutes of the last meeting in January 2021 were cleared. The secretariat will circulate the final minutes to all IAC members ahead of publication on the IAC gov.uk website.
- 2.2. All action points have been cleared or are in progress.

The Chair gave an overview of the papers for discussion at the meeting, which had been circulated previously. The agenda was adjusted to allow Dr Stewart to join the call.

3. Commissioned review into respiratory diseases

- 3.1. Since the review was last discussed by the Council, the tender process is now fully underway.
- 3.2. The initial advert on the IAC website attracted 4 expressions of interest who received bid packs.
- 3.3. The deadline for receipt of bids has now passed. As we are still under the tender process, we do not disclose how many bids were received.
- 3.4. The evaluation panel will be assessing the bids and this process will commence week commencing 19 April.
- 3.5. Further updates to follow.

4. AOB

Nocebo effect

- 4.1. The Chair stated that a former IAC member had been asked to independently review a claim where DWP and CHDA needed input.
- 4.2. The outcome of this review was that the adverse event which the claimant suffered caused symptoms which were likely due to a nocebo effect. An accident claim was allowed, but the claim for prescribed disease was disallowed.
- 4.3. A Nocebo response can occur as a result of someone's perception that exposure to particular substance is harmful rather than as a result of a causative ingredient.
- 4.4. An observer commented that in this instance, it was thought the adverse event caused the symptoms irrespective of exposure to harmful substances.
- 4.5. Members debated the potential inferences of this decision to award and commented that they felt this topic was not for the Council to focus on given the complexities and other influences of this effect. It was not thought a paper was required as this may adversely impact its work. It was felt that the correct action was taken by DWP in referring the claim to an independent expert.

Public Meeting

- 4.6. Due to COVID-19 restrictions, it has been decided to not hold a public meeting this year, but the IAC meeting will go ahead with its scheduled members meeting.
- 4.7. It was felt that a forum, such as a webinar, could be held to allow the public to have more insight into the Council's work and a variety of options were discussed, perhaps by inviting written questions from stakeholders. It was

commented on that by holding an online event, there may be greater attendance.

- 4.8. The secretariat offered to look into using new ways of online conferencing which have been recently introduced by DWP.

5. Neurodegenerative diseases in footballers

- 5.1. Dr William Stewart joined the meeting and was welcomed by the Chair who introduced the topic by giving a brief overview why the Council is considering this topic, following correspondence from stakeholders and wide-spread interest in the media. Dr Stewart was the author on an informative paper which had been circulated to members ahead of the meeting.
- 5.2. A member took the lead and asked Dr Stewart to give a brief overview of the paper and the main findings, including strengths and weaknesses. The member commented that they thought the paper was excellent, but the Council doesn't prescribe for an occupational disease based on one study, all of the evidence is considered.
- 5.3. Dr Stewart went on to say his paper was one form of evidence for a question which has been raised for some years whether participation in contact sports, in this case professional football, may be associated with an elevated risk of neurodegenerative disease.
- 5.4. Many of the previous studies contributed to the body of evidence, but may not have been robust from a population level, so for this paper the approach taken was to try to answer the question with a study which had comparable population level data with sufficient numbers.
- 5.5. As there are multiple reasons why people develop dementia, the study also looked at wider health outcomes, including the wider mortality in professional footballers.
- 5.6. The study examined a cohort of professional footballers who were born from 1900-1976, so 40+ years of age. Circa 8000 Scottish footballers were selected and matched to general population of same age and similar levels of deprivation.
- 5.7. In several measures, some lower death rates were observed for the footballers e.g. cardiovascular disease, lung cancer, but neurodegenerative disease mortality was around 4 fold higher. Overall, it appeared footballers were living longer, which is a prerequisite of dementia. By adjusting for this, the overall underlying risk of developing neurodegenerative disease was 3.5 times higher in footballers, with twice the risk for Parkinson's disease, 4 times for Motor neurone disease and 5 times for Alzheimers. Mental health was also considered and it was stated this is generally better in professional footballers.
- 5.8. A member asked if the risks for neurodegenerative diseases was the same across all ages groups or was it more focussed in older footballers. Dr Stewart responded by stating the risk was the same, i.e. 3.5 times, across all ages.
- 5.9. Another member asked what the potential exposure might be. The discussion that followed included yet to be published information which was not applicable to be disclosed in the minutes due to confidentiality. However, the

risk of developing neurodegenerative disease may be linked to head impacts or brain injury. The risks may also vary dependent on the position played on the field and the length of time played.

5.10. A member asked several questions:

- if there were sufficient cases to refine the era of football played and did this decrease over time;
- was neurodegenerative disease listed as the primary or underlying cause of death and;
- what is the mechanism which is consistent across each of the neurodegenerative diseases, given they are all very different.

5.11. Dr Stewart responded by stating that players younger than 40 were unlikely to show signs of developing neurodegenerative diseases, but this may become apparent in years to come. The rest of the discussion was not for disclosure in the minutes as references were made to unpublished data which is under review.

5.12. The causes of death were considered and neurodegenerative diseases where recorded as the primary cause showed the 3.5 times higher risk. Some of the conditions examined only had small numbers of cases, e.g. MND, which because they are quite rare, can yield strong data. Other studies on MND in footballers where there are much lower numbers show much higher risks.

5.13. Regarding the mechanism, Dr Stewart alluded to 2 factors which may contribute to this;

- the death certificate was incorrect – pathology investigations often give a different diagnosis after death than that given in life, however it is not difficult to distinguish between MND and Alzheimer's;
- the observations from this study may lead to a better understanding of the neurodegenerative disease states in general, its causes and progression. Is there a common pathway driving these diseases?

5.14. A member asked for clarification around the status of players – were the games exclusively played in Scotland, has the time played been considered i.e. games played versus just training and was semi-professionalism considered as part-time players were likely to have other jobs?

5.15. Dr Stewart responded that whilst the data set for footballers allowed the study to access a great deal of data, there were some elements which were missing and these questions may be answered by follow-up studies.

5.16. A member with expertise in mental health asked;

- when the careers of the footballers cohort began and did the analyses pick up the periods when football ceased during the 2nd world war;
- has alcohol been considered given the apparent link to this for after-match drinking, and;
- how reliable were the records for mental health conditions?

5.17. Dr Stewart stated the average age for footballers entering the game was 18, previous to this, no data were available. The war years were not able to be assessed due to the small scale of the Scottish population. The mental health records were reliant on hospitalisations, which are robust and reliable and include outpatient visits. The issue of alcohol was not supported in the data

- sets and on average, footballers were recorded as having fewer cases than the general population.
- 5.18. Another member asked about how ball technology could have impacted the results. Dr Stewart was able to explain that whilst football technology has developed over the years, there is no evidence that this has affected the risk over time. Early leather balls were able to absorb water and retain mud hence would be heavier but also would travel more slowly. It is thought that the speed of the impact was more important than the weight. It is thought that the risk of neurodegenerative diseases is not affected by the type of ball.
- 5.19. A member asked if epilepsy had been found in the cases studied as this may also be related to head injury. Dr Stewart stated that other questions such as epilepsy would be addressed in subsequent analyses of the data, which is being progressed at the moment.
- 5.20. A member stated that having appropriate control populations was important and wondered if having a control group of elite athletes which are non-contact sport related would make a difference. They also asked if a more formal case control analyses within the football players had been carried out with respect to exposure risk. Dr Stewart stated it was difficult to recruit subjects and that type of control group would be almost impossible to recruit. Several studies had been carried out which found no link to neurodegenerative disease in non-contact sports. With the numbers involved in the study, it may be possible to analyse the data further to look into variable risks, but follow up studies will be better informed in terms of risk factors now as a link to neurodegenerative disease has been established.
- 5.21. A point about concussion and heading the ball was brought up by a member who asked if there was a distinction between these 2 conditions? Dr Stewart thought it was repetitive exposure of the head hitting a ball which was likely to be the risk, borne out by studies of sports where concussion is common. Cognitive function was also brought up where this has been demonstrated to be important in dementia. Dr Stewart stated that earlier studies had not been that informative and some of the subtle changes would not be picked up by cognitive tests.
- 5.22. A member stated from a Council perspective, it has a responsibility to consider all the evidence on this topic to recommend prescription and Dr Stewart was asked what other key evidence is relevant and if any other studies were in the pipeline to help inform the Council's decision making. Dr Stewart thought there was compelling evidence that there is an increased risk in contact sports, especially football players, backed up by studies of American football players. Other studies in the pipeline include one of rugby players in New Zealand although this may have stalled. Others are looking at longitudinal studies in mid-life, but these may take some time to yield results.
- 5.23. The Chair thanked Dr Stewart for his very useful contribution to the meeting, which was very enlightening.
- 5.24. This topic will be taken up by the RWG who may elect to examine pathology data along with anything which is highlighted by literature searches. A

decision will need to be reached about the scope of the investigation as other contact sports may be impacted.

6. Occupational impact of COVID-19

- 6.1. The position paper on this topic was published on 25 March 2021 and the Chair thanked everyone for their input. This paper focussed on mortality but information relating to infection, exposure etc was also included.
- 6.2. There are now more papers published on COVID-19 and longer term effects and it was agreed that this would be IIAC's focus for the next paper.
- 6.3. A short discussion paper from the Chair was circulated to members which set out some of the key issues to consider. A major issue to address is timing as many people are suffering from the long term effects of having contracted COVID-19.
- 6.4. One issue is to consider which are the actual diseases to look at – are there physical symptoms such as permanent cardiovascular or lung changes, diabetes etc. The same concern applies to the selection of occupations to focus on.
- 6.5. It had been suggested that the occupations at the top of the list for elevated mortality risks should be looked at first, particularly health & social care. However, if prescription for a particular occupation is recommended, the impacts on other occupations will need to be considered, especially those involving contact with the general public of patients.
- 6.6. The Chair felt that the new report should focus on disabling diseases but incorporate supporting information on transmission, mortality, hospitalisation, severe disease, sickness absence etc.
- 6.7. An issue to also consider is whether the doubling of risk criteria is appropriate to address the 'more likely than not' criteria when considering prescription. There will be limited studies on the long term disabling elements of COVID-19, so assessing risks by expert evaluation within the totality of the evidence could be an approach to consider. As studies into long term effects may take years to come out and for the Council to produce a useful document, time is of the essence.
- 6.8. The long-Covid team at the the Department of Health & Social Care has written to the Council with a view to sharing ideas.
- 6.9. Members went on to discuss how to define disabling conditions and disease. A member with respiratory disease expertise shared some observations from working on the front line.
 - What is clear is there are a range of symptoms which tend to improve over time.
 - A number of patients with symptoms with ongoing breathlessness/fatigue plus a number of other related conditions such as dizziness, postural hypotension, tend improve over over time.
 - A small minority are left with symptoms after the 12 week mark with a number of different diagnoses. In some instances, breathlessness may be due to dysfunctional breathing which may be self-limiting. Some other

cases may be due to defined conditions such as interstitial pulmonary fibrosis or pulmonary embolism which may be caused by COVID-19.

- 6.10. It was noted that the placebo effect may be apparent in some cases of post-COVID-19 syndrome as patients may have been preconditioned to expect to be ill.
- 6.11. The disabling elements which could be apparent may include loss of the use of a limb following a stroke or breathlessness due to interstitial lung disease or cardiomyopathy.
- 6.12. A member asked if conditions which have true pathology could be defined as an element for further investigation for potential prescription and this was confirmed.
- 6.13. There was a debate with members and observers around conditions which can not be reversed and those, such as pulmonary embolism, which can be resolved with medication. There may also be conditions, such as diabetes, which develop as a consequence of COVID-19 which may not be disabling at the present time but may do so in the longer term. It was suggested that a list of disabling conditions linked to COVID-19 be drawn up and perhaps to focus on these. However, one member thought that a list of conditions would be too limiting as symptoms may be more important to focus on.
- 6.14. Discussion moved to chronic fatigue, commonly reported following COVID-19 infections, which may also be accompanied by comorbid conditions, but this is unproven and may take some time to investigate – there is no evidence to report on the long term effects on this condition, so the initial focus of looking for conditions for which to prescribe may wish to steer away from chronic fatigue in the short term. An observer noted that excluding chronic fatigue may generate some concern from stakeholders. However, it was pointed out that chronic fatigue may have other influences such as medication and comorbidities which when addressed, cause improvements.
- 6.15. The issue of anxiety in long-covid was thought to be important and would need to be considered as some symptoms may be due to a placebo effect but could also be due to neurological effects e.g. mini-strokes. However, not much data are available.
- 6.16. The discussion moved to occupations where it was disclosed the Department for Health & Social Care (DHSC) was interested in working with the Council on long-covid and the occupations impacted by this.
- 6.17. A member thought it was important to start with health and social care workers (H&SCW) as there are more data available on this group. Given the complexities of the information available, it would be better to focus on this group before considering other occupations. It was pointed out that H&SCW had different risks at different times and this was also dependant on the type of job undertaken and the availability of PPE. However, deprivation and region also played a significant role in the pandemic which need to be considered.
- 6.18. A member pointed out that, regardless of the provision of PPE, the risks were still apparent and in some prescribed diseases, PPE is not taken into account if the exposure was present.

- 6.19. A member pointed out that statistically, there has to be proof that it was more likely than not that the exposure happened at work and not at home. Currently, the epidemiology doesn't support that.
- 6.20. Large scale outbreaks in workplaces need also to be considered as these have caused concerns.
- 6.21. The discussions moved onto exposure and a member pointed out that quantitative data on exposure to the virus is poor but a good place to start would be with H&SCW. Job exposure matrices are being developed which may have reasonable predictability but may have poor sensitivities. Pathways of transmissions may be productive in helping to assess exposure.
- 6.22. It was decided that literature searches would be carried out and members were encouraged to have input into the terms to be used. Various members were asked to look at different aspects of the next paper with a view to having drafts ready for the next IIAC meeting in July 2021.

7. Discussion on occupations missing from PD A11

- 7.1. This topic was discussed at the last IIAC meeting in January 2021 and for this meeting a summary paper, a discussion paper and a process diagram was circulated to members prior to the meeting.
- 7.2. The member who drafted the paper explained that the proposal, in wider terms, was intended to be used as a potential surrogate to the doubling of risk criteria.
- 7.3. Essentially, the tools which had been used would be identified and the vibrational magnitude determined. The years these tools had been used would then be established and used to assess whether there had been sufficient occupational exposure to be eligible for IIDB.
- 7.4. Other external experts in this field have been consulted to seek views on the validity of this proposal. An expert concluded the model proposed was pragmatic but may under- or over-estimate some exposures depending on the frequency. Other experts consulted have yet to respond.
- 7.5. In order to check whether this proposal could easily be incorporated into IIDB processes, a meeting has been arranged with DWP IIDB staff to seek their views.
- 7.6. A proposal to draft a position paper followed by a command paper was not thought necessary as a command paper could suffice. Alternatively, the prescriptions for PD A11 and A12 be combined and simplified, but the benefit of presumption, currently only applied to A12, may be lost, which would need to be clarified.
- 7.7. A member felt that a compromise could be reached by extending the schedule of occupations, which was recommended by the Council in 1995. Other claims where the occupation wasn't listed could then be covered by the new proposal being discussed, provided it was easy to apply by DWP staff. The Chair was aware that the current list of occupations does not match that of the HSE.
- 7.8. An observer from the DWP stated that in the case of builders, many use different tools for differing lengths of time each day, so might be complicated to implement, but feedback from DWP IIDB staff would be crucial. A test or

pilot run was suggested to trial the proposed process before making firm recommendations via a command paper.

7.9. Further feedback will be provided when the views of DWP IIDB staff are known.

8. Pneumoconiosis/Silicosis

8.1. PD D1 which covers respiratory conditions such as pneumoconiosis/silicosis has not been reviewed for some time and it was felt it was important to reassess and restructure its qualifying criteria to make it simpler for claimants and IIDB decision makers. DWP and CHDA observers had broadly welcomed the proposal to simplify the prescription.

8.2. A draft amendment to the prescription is in progress and close to completion, but this was not shared with the Council at the meeting; however, 3 papers outlining the proposal were circulated to members.

8.3. The proposal outlines an amendment to the PD D1 prescription:

- simplify to 4 or 5 categories;
- to change the prescription to require a specialist opinion for diagnoses, such as a CT scan;
- suggest removing some conditions such as hard metal disease as this has distinct pathology from other pneumoconiosis, and possibly have a separate prescription for these types of conditions.

8.4. The author suggested that several questions would probably need advice from external experts.

8.5. A member stated they had several comments around some of the proposal and it was agreed a separate conference call would be arranged to allow a detailed discussion to take place.

9. AOB

9.1. A DWP observer stated that assessments for PD D15, Dupuytren's disease, would be restarting soon and clarification was sought over the involvement of some of the joints. The Chair referred to the Council's information note which clarified the joints involved with Dupuytren's. A member with musculoskeletal expertise was asked to review the CHDA guidance for this prescription.

Date of next meetings:

RWG – 20 May 2021

IIAC – 14 July 2021 (pm)