RESEARCH WORKING GROUP
of the Industrial Injuries Advisory Council

Minutes of the online meeting
Thursday 25 February 2021

Present:

Dr Lesley Rushton	RWG
Professor Neil Pearce	RWG Chair
Professor Raymond Agius	IIAC
Dr Chris Stenton	RWG
Professor John Cherrie	RWG
Professor Karen Walker-Bone	RWG
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Sayeed Khan	RWG
Mr Doug Russell	RWG
Dr Anne Braidwood	MoD
Dr Mark Allerton	DWP Medical Policy
Ms Victoria Webb	DWP IIDB Policy
Ms Mandeep Kooner	DWP IIDB Policy
Mr Ian Chetland	IIAC Secretariat
Mr Stuart Whitney	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Ms Maryam Masalha (DWP), Ms Lucy Darnton (HSE)

1. Announcements and conflicts of interest statements

1.1. None recorded

2. Minutes of the last meeting

2.1. Subject to minor drafting edits, the minutes of the last meeting were cleared. The secretariat will circulate the final cleared version of the minutes to all RWG members ahead of publication on the IIAC gov.uk website.

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

2.3. The minutes were amended to reflect that the declaration from a member declaring a potential conflict of interest was not considered to be so.

3. **Neurodegenerative diseases in footballers**

3.1. Dr William Stewart, consultant neuropathologist and the author of an influential paper on this topic, was invited to attend this meeting, but was unable to accept due to a prior commitment. He has accepted an invitation to attend the next full Council meeting on 15 April.

4. Covid-19 and its potential occupational impact

4.1. The draft position paper was edited and finalised for publication. The secretariat has put in motion the required process to move towards publication.

4.2. The Council will be notified when the paper has been published and a link provided.

4.3. It was agreed to update the IIAC gov.uk to reflect the fact a position paper has been drafted and is awaiting publication.

4.4. The Chair opened the discussion to formulate a strategy to take this topic forward.

4.5. In the meeting papers was a report on ethnicity, which was provided for information only as it contains more up to date information than is included in the position paper.

4.6. The findings of the position paper were discussed where the relative risk was more than doubled for a number of occupations. It was suggested that each of the occupations be selected to review all available evidence as a starting place for future work.

4.7. It was remarked that there are inconsistencies in the different data sets available and give different answers, so careful review would be required. It may mean some occupations drop off the list but others could be added. There are other data sets which need to be considered alongside mortality.

4.8. A member stated they have been involved with other groups who have looked at the ONS mortality data, but taking the analyses further by adjusting for different elements, such as region, deprivation, ethnicity etc.

4.9. Where data have been adjusted for region, some of the relative risks drop below 2 without taking deprivation into account. These adjusted data should be considered, alongside other evidence from emerging studies.

4.10. It was stated that healthcare workers overall did not show sufficiently elevated risks, perceived to be partly due to inclusion of workers with a wide range of potential for exposure and partly due to the coroner reporting process where deaths from this occupational group may not have been counted adequately. However, infections in healthcare workers identified from the BioBank information show this group are significantly impacted. This may be influenced by easier availability of testing.

4.11. A member stated they would like healthcare workers to be considered for an exception to the doubling of risk criterion. Other members suggested ensuring other aspects of the challenges faced by healthcare workers such as inadequate or insufficient PPE.

4.12. Another member suggested taking a step back and adopt a different strategy as more data are emerging on many aspects of this pandemic and the position paper focussed on mortality. More data on this will follow for the second wave where there were more deaths. This will be the case for the UK and other countries. Post COVID-19 syndrome and how this impacts on disability longer term must be considered as this is the main remit of IIAC. An alternative way of looking at this is through exposure and transmission where analyses might be able to determine exposure to the virus and subsequent COVID-19 related to occupation together with the impact of non-occupational exposure. Currently this is assessed by proxy measures and there are no adequate proxy measures for non-occupational exposure. That member suggested taking the occupations at higher risk, listed in the position paper,

and designating a group of members to be responsible for certain aspects of data evaluation, such as mortality, occupation etc. Guidelines would need to be established to support searching of the literature yielded managable numbers.

4.13. A member returned to the question of exceptions to the doubling of risk criterion for healthcare workers, stating that other occupations (for example teachers) would need to be considered. They felt this was a sensitive issue and would require careful handling. This member pointed out that an all Parliamentary group has called for 'long COVID' to be recognised as an occupational disease, possibly by way of a separate scheme.

4.14. A member pointed out that it may be years before the full extend of post COVID-19 syndrome may become apparent as this condition is not well characterised. This may not be feasible for IIAC to do anything within a reasonable timescale – would an emergency, interim bespoke scheme be more appropriate rather than IIDB?

4.15. An observer pointed out the DWP is currently considering how to approach this and is considering a number of options, such as IIDB. It has been suggested another round of additional compensation for frontline health workers may be carried out.

4.16. It was pointed out that occupation or job may not be the main determinant of exposure or risk of infection – area or region may have more impact. It was also pointed out that the risks in certain occupations from the first wave may not be apparent for the second wave due to additional measures having been put in place. It was stated that the HSE are gathering data on occupation & exposure which may be useful for the Council.

4.17. The use of the accident provision of IIDB was discussed to compensate some workers with respect to post COVID-19 syndrome. It was pointed out that no legislative changes would be required and claims have already been made under this provision relating to COVID-19 under the existing framework.

4.18. Members debated further around moving forward with making recommendations for prescription, but it was pointed out some of the occupational groups are very broad and cover a multitude of jobs, some of which are at far higher risk, so sub-group analysis would be important. Also, in some cases, the risk of contracting COVID-19 from co-workers was greater than contracting from patients. A publication from the ILO was discussed which illustrated how different countries have approached compensation for occupationally related COVID-19 (post meeting note – this was circulated to members after the meeting had concluded). This gives an insight into how data have been used elsewhere to make their decisions.

4.19. IIAC may need to adopt a different approach to that which has been accepted in the past due to the difficulty in accessing studies which provide the data required. IIAC has to comply and work within the legislation in place.

4.20. A member showed unpublished data which showed when ONS data (which adjusted for age) are further adjusted, deprivation is shown to be important and the relative risks drop below 2. Prescription can be made for working impacts, but not for deprivation. Sub-group analyses will be important to consider as some jobs will have higher risks than others, with health & social care workers being a good place to start.

4.21. A member commented that occupation defines a person, defines how much money they have, their living coniditions etc. These are highly correlated

variables, occupation correlated with income, living conditions, the type of people they live with etc. As these variables are present, it is necessary to understand the impact of adjusting or correcting for these. It is also important to know what the comparison population is when making these adjustments. Another member agreed that care needs to be taken when assesssing adjusted data and having the original data available to make a comparison.

4.22. It was suggested that the following be considered for the next phase of the work on this topic:
- Collect data on wider group of workers;
- Use the structure of the current position paper as a base;
- Obtain guidance on how more information on infection data by occupation may be obtained;
- Look at the definition and evidence on what the disabling effects are, including how the searches for these data can be achieved;
- Occupational data - both mortality and morbidity.

4.23. A revised strategy for data gathering from literature searches would be helpful; the current method is to use broad search terms which can yield large numbers of hits then disregard irrelevant papers. A suggestion was made to look at the NICE definition of post COVID-19 syndrome to inform a search strategy.

4.24. An observer gave an overview of some of the work around compensation payments in the armed forces relating to infectious diseases.

4.25. The Chair summarised the main points of the discussion:
- Keep collecting information across the range of occupations;
- Make a start on health & social care workers.

4.26. A member commented that approach was fine for the time being and made the point that the next main Council meeting will be held on 15 April and asked what would be appropriate to have ready by then. The Chair asked if the sub-groups who contributed to the position paper would be willing to continue in the same vein. A brief outline of the available evidence for each section would be fine at this point for discussion at the main Council meeting.

5. Reviewing the prescription for D1 – silicosis/pneumoconiosis

5.1. Several members worked collaboratively to put togther a comprehensive review paper of the history, background and the D1 prescription.

5.2. This paper was presented to the group and a member systematically described each section, setting out the proposed rationale for change, which would need to be reviewed by the full Council.

5.3. The member stated there was not a precise definition of pneumoconisis disease. Time was spent reviewing the current PD D1 prescription and very little has changed over the last 75 years.

5.4. Diagnostic tools have changed significantly over the years and consideration was given to diagnosing the condition, which is far from obvious. There are 2 aspects to consider:
- Does the individual have diffuse lung fibrosis – chest X-rays are unreliable in early/milder stages of the condition;
- Does this individual have this condition as a result of exposure.

5.5. Currently, ~98% cases are related to exposure to coal/asbestos/silica. The member felt the wording of the current prescription was prohibitive and misleading and is cluttered by work practices which are no longer relevant.

5.6. There is an open category which is not straightforward and difficult to interpret.
5.7. The proposal in the paper is to simplify the prescription and limit the categories to:
- Asbestosis;
- Silicosis;
- Coal workers pneumoconiosis;
- Mixed dust pneumoconiosis, mainly comprised of silica, aimed at construction workers;
- Silicates – talc, mica, kaolin, but no recent claims for these.

5.8. Graphite pneumoconiosis has been allowed for claims to IIDB – this type of exposure doesn't easily fit into the proposed classifications.
5.9. The other aspect which doesn't easily fit this categorisation is hard metal disease caused by cobalt which has distinct features and may warrant its own category/prescription, similar to berylium.
5.10. The member stated they have attempted to produce wording of a revised prescription to reduce it to shorter descriptions of each of the categories.
5.11. The diagnostic standard was discussed, and whether CT scans would be more appropriate and also having a diagnosis from a specialist clinic.
5.12. A member asked if the suggested categories were similar to that used in other countries – this will be checked.
5.13. A DWP observer broadly welcomed this review of PD D1 as it is currently complex to deliver. They also welcomed advice that diagnosis from a specialist would be required. There have been cases where PD D1 has been awarded but subsequent evidence has shown the criteria for this prescription was not met.
5.14. There have also been cases where the assessment centres have diagnosed these conditions whereas there is a view this should lie within the NHS to do so.
5.15. The DWP observer stated they had been working with other respiratory disease experts to overhaul the assessors handbook and agreed to share the draft with the member who produced the paper. It was also suggested that the member engage with the clinical lead for the organisation responsible for carrying out assessments to help inform this work. They stated it may be helpful to separate out COPD from the current prescription.
5.16. A member commented that they fully support the work presented but felt that 'mixed dusts' should be 'mineral dusts' and felt grinding of graphite needs to be looked at more closely. The member also commented that they felt 'substantial' exposure should be more definitive and that we may need to have a list of jobs with this type of exposure, possibly through a job exposure matrix.
5.17. Idiopathic pulmonary fibrosis (IPF) was also discussed as most of the compensated cases were for asbestosis and a question was raised around misdiagnosis of IPF. In some cases it is difficult to establish if a condition is asbestosis or idiopathic disease.
5.18. Some of the diseases covered by the curent prescription such as silicosis, are thought to only occur due to exposure levels encountered in the workplace, so can easily be considered to be work-related. Similiarly for coal workers pneumoconiosis. Other exposures may be quantifiable.

5.19. Another member gave their views that they thought this paper was helpful and constructive, the outcome of a revised prescription should make it more accessible for claimants and assist the assessment process. It was pointed out that there are a lot of misdiagnoses of silicosis and to some extent, a lack of expertise in this area.

5.20. It was agreed that further interaction with the DWP and assessment organisation would be helpful to inform a future prescription.

5.21. A member asked if there was a work-stream to evaluate hard metal disease with a view to having its own categorisation. It was stated that these conditions are unlike silicosis or asbestosis and have distinct features. It may be better to have a separate approach for these types of conditions, but should be flagged as a risk and further thought given to it.

5.22. To progress this to the next stage will be to further refine each section in this research paper and consult with relevant experts with a view to discussion at a full IIAC meeting. It was agreed that the respiratory disease experts would meet to discuss how the discussion paper could be progressed. The proposal would be to draft a command paper where the Council would make recommendations for changes.

6. **PD A11 and occupations – exposure equivalence discussion**

6.1. Several members collaborated to draft the research paper which was circulated to RWG members for discussion. This introduced the concept of a risk prediction model using PD A11 as an example. External experts have been consulted, their views will help inform the discussion.

6.2. A member started the discussion by stating that unless a claimant has worked in a recognised listed occupation, if they develop the condition as result of work they are not considered eligible for IIDB.

6.3. The magnitude of vibration from tools was considered previously but was discounted due to too many individual variables. However, a similar approach has been adopted for noise-induced hearing loss. The risk prediction model might be applied in individual cases – if the background risk for Raynaud's is 5% in the general population for men then a 10% prevalence could be a doubling of risk. However, there are issues around this – if there is a prevalance of 10%, this means 90% will not have had finger blanching.

6.4. This doesn't take into account other aspects of the condition such as sensoneural symptoms which are important.

6.5. There are a number of papers of dose response models which indicate over- or under-reporting with this model.

6.6. The issues which probably need to be discussed, such as magnitude, daily use or years of exposure - these are incongruous with the current prescription because the occupation in which these have occurred is not listed and the claim won't proceed to assessment.

6.7. A model where risks might be assessed (from a supporting technical paper) was discussed, but may be complex for IIDB decision makers. It would also rely on claimants providing relevant information, which can be practically flawed.

6.8. For claimants who are in occupations not listed, an approach could be to take a detailed work history at claim submission stage, with details of the tools

used. This would then get them over the initial hurdle and on to the stage where their condition can be examined by medical assessors. At this point, exposure equivalence could be established using the technical brief. Alternatively, IIAC could further research the dose equivalence as it would traditionally do for each occupation as they emerge.

6.9. Another approach may be to have an open category for this prescription and use the technical brief to determine exposure equivalence. This may make the claim process more complex for IIDB, with decision makers having to translate technical information.

6.10. A member commented this was an interesting approach. An example where this has been observed is the HSE list for occupations where vibration has an impact which mentions estate management (eg maintenance of grounds, parks, water courses, road and rail side verges) – in this instance, local authority gardeners would be excluded, which is where this investigation originated. They stated it would be preferable to have a process to evaulate claims which lie outside the prescription, for example would a referral to an expert help in the claims process? But, of course, the initial claim rejection would need to be overcome.

6.11. A member pointed out that IIAC had evaluated this approach previously but rejected it and commented that the technical brief was informative but questioned how large the the confidence intervals might be.They also questioned how easy it might be for claims assessors to utilse the technical information.

6.12. The member leading the discussion acknowledged the short-comings of the proposal, but pointed out there is already some vagueness in HAVS assessment outcomes, but perhaps a little relaxing of the initial requirements of the prescription might prevent certain claimants from being disadvantaged.

6.13. Another member expressed their support for the discussion paper as the main determinant of risk was the tools used not just the job of the claimant.

6.14. Another member expressed their support and commented suggesting perhaps a pilot could be set up to evaluate any new proposed assessment process.

6.15. The discussion followed where it was suggested that the members involved in drafting this discussion paper engage with the organisation responsible for carrying out assessments on behalf of DWP to discuss the issues raised and look for a way forward.

6.16. A DWP observer suggested that there might be some concern if the Council were to suggest changes which made the claim process more complicated and welcomed the suggestion of Council members working with the asssessment organisation to collaborate on a way forward.

6.17. A member commented it has been useful to have a history of the prescription, similar to that produced for the PD D1 discussion paper as adds context. Previously, a list of tools had been suggested, but this was not taken forward.

6.18. It was agreed that the members involved in drafting the discussion paper would work up a proposed protocol which would be fully discussed at a meeting with the assessment organisation.

7. AOB

7.1. Correspondence was received from a stakeholder asking if spinal stenosis in mineworkers could be investigated as a potential industrial disease.

7.2. A member commented they had recently published a paper on occupational spinal stenosis. They found an association in Japanese agricultural workers but the risk was not doubled. The published literature on this topic was very limited with no real evidence reported for any other occupations. However, it may warrant further consideration.
7.3. Another commented it might be feasible for spinal stenosis to be caused by heavy work in the past, but felt unlikely to be the case in current times due to modern working practices. A member offered to share their findings to help inform a response.
7.4. It was agreed that members with musculoskeletal expertise would help draft a response to the correspondent setting out the views of the RWG.

Forthcoming meetings:
IIAC – 15 April 2021 – online
RWG – 20 May 2021 - online