INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 12 January 2023

Present:

Dr Lesley Rushton	Chair
Professor Raymond Agius	IIAC
Dr Chris Stenton	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Professor Max Henderson	IIAC
Ms Lesley Francois	IIAC
Professor Damien McElvenny	IIAC
Dr Jennifer Hoyle	IIAC
Dr Gareth Walters	IIAC
Mr Daniel Shears	IIAC
Professor John Cherrie	IIAC
Mr Steve Mitchell	IIAC
Dr Richard Heron	IIAC
Dr Sally Hemming	IIAC
Dr Sharon Stevelink	IIAC
Dr Rachel Atkinson	CHDA observer
Ms Lucy Darnton	HSE observer
Mr Lee Pendleton	DWP IIDB operations
Ms Nicola Hobson	DWP IIDB operations
Ms Parisa Rezai-Tabrizi	DWP IIDB Policy
Mr Garyth Hawkins	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat/scientific adviser
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Keith Corkan, Ms Natalie Carolan (DWP legal team), Dr Charmian Moeller-Olsen (DWP medical policy), Dr Anne Braidwood (MoD observer), Ms Louise Everett (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. Members were asked to declare any potential conflicts of interest which have not been raised at previous meetings. Dr Ian Lawson stated that he had been elected as chair of The Society of Occupational Medicine's special interest group for hand-arm vibration syndrome.

1.3. Dr Charmian Moeller-Olsen, who was unable to attend the meeting has replaced Dr Emily Pickett.

1.4. The Chair welcomed new members to their inaugural IIAC meeting:

- Dr Sharon Stevelink
- Dr Richard Heron

- Dr Sally Hemming
- Mr Steve Mitchell

The new members introduced themselves with a short overview of their expertise.

1.5. The Chair welcomed Parisa Rezai-Tabrizi from the IIDB policy team who has replaced Ellie Styles. The Chair also welcomed Lee Pendleton and Nicola Hobson from the Barnsley IIDB claims team. The Chair mentioned that IIAC members have visted Barnsley, where IIDB claims are processed, as part of their induction and hoped this could be repeated for new members and those who have not had the opportunity to so yet.

Minutes of the last meeting

1.6. The minutes of the last meeting from October 2022 were mentioned briefly as it was agreed at the last meeting that minutes would be cleared by correspondence. The October minutes were shared with meeting papers and members were asked if there were any issues they wished to raise, otherwise comments/revissions should be sent to the secretariat.

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

2. Occupational impact of COVID-19

2.1. The Chair started the topic by stating they had attended a number of meetings of the all party parliamentary group (APPG) on COVID-19 and long-covid. The APPG chair had subsequently asked for an additional meeting to discuss IIAC's difficulty in obtaining occupational data. Correspondence was exchanged with a number of different agencies, culminating in the suggestion to hold a joint meeting to discuss data access, especially around outbreaks of COVID-19. This will be taken forward by the secretariat.

2.2. The Chair also stated that a BBC Panorama programme on long-covid will be aired at the end of January for which the Chair was interviewed. There was interest in the recommendations in IIAC's command paper, but the Chair deferred questions around processes and timescales to the DWP to answer.

2.3. The meeting moved on to discuss transport workers, which is another occupational sector potentially at greater risk for developing disabling conditions following COVID-19. A member had prepared a paper which collated the data for transport workers. Some UK studies have shown doubled risks of COVID-19 infection, hospitalisation or death in transport workers. Others have not shown a doubled risk, shown that the risk is less than doubled when adjusted for covariates, or shown a less than doubled risk.

2.4. One of the issues is that most of the studies report transport workers as a whole rather than individual occupations and there is likely to be a hierarchy of risk amongst this sector. Taxi and bus drivers, train conductors (closest contact with the public) may be at higher risk than train drivers or pilots. It was felt that the data may be there for individual jobs, but it has yet to be published.

2.5. There doesn't appear to be a consistent pattern in the data in relation to time or grouping and a dilution of the higher risks in some groups may be apparent. The member felt that the choice of reference population in studies may be a concern as this can have an impact on the relative risks. Adjustments to the data for covariates such as ethnicity, socioeconomic factors can also have an impact on the relative risks in some instances.

2.6. The member summarised the paper and stated it was for IIAC to decide if there are any groups which may meet the threshold for prescription amongst transport workers.

2.7. The Chair commented that often the uncertainties around the relative risks as demonstrated by the magnitude of the confidence intervals are not considered. Also, similar to other occupational groups, there is less on infection data compared with health and social care workers, so more reliance may have to be placed on death data as indicated in IIAC's position paper on this topic.

2.8. It was felt there could be obvious groups which may qualify for prescription if the totality of the evidence is considered and the potential for exposure, which is likely to be substantial face-to-face contact with the public.

2.9. A member commented that they agreed that the choice of comparator population was important and that the impact this may have on the relative risks needs to be covered in the next paper. Also, timelines may have an impact as there were greater risks at the beginning of the pandemic before control measures were introduced. It was pointed out that excess deaths remained high in transport workers well into 2022.

2.10. At this point, Dan Shears declared an interest as the GMB Union represents workers in many transport-related sectors. He agreed that there is a hierachy of risks amongst workers and risks/infections were very high for many workers until lockdown. He felt that bus drivers stood out above others as control measures/guidance were not consistent.

2.11. Another member stated they felt that taxi drivers and bus drivers had the highest exposures and when the COVID job exposure matrix (JEM) was applied, bus & taxi drivers had similar scores to health and social care workers (H&SCWs). The Chair felt that this was an important point and should be covered in the next IIAC report.

2.12. A member pointed out that H&SCWs were dealing with COVID-19 patients rather than the general population, so their risks were higher. They also pointed to additional sources of data in manufacturing, which continued throughout the pandemic, where employers should hold details of infections. Also, professional bodies such as the International Air Transport Association (IATA) or airline companies may have their own data on infection rates(e.g. British Airways or BALPA for pilots). Jaguar Landrover also worked with Public Health England on case prevention, so could be a source of data. Variants of the virus were mentioned and the Chair covered that by stating this had been covered, to some extent, in the command paper but wasn't aware of data related to specfic variants, other than the timeline or geography of the pandemic.

2.13. A member commented that the situation related to taxi drivers would vary according to geography and control measures would not have been the same in different parts of the country and would vary by county. This reinforced the wide variation in the transport sector as with the H&SCW sector.

2.14. A member commented that perhaps the impact of the consequences of COVID-19 on women's health, especially menopausal symptoms, which may be accelerated in long-covid. They commented that this may be a topic for a potential scoping review into women's health, which would be covered later.

2.15. A member agreed that the control group for comparisons is important and felt that the risks should not be compared with the working population as a whole as attenutation of risks may occur due to some exposure during their work. It was also important to avoid the healthy worker effect as this could influence risks. This member also requested that DWP provide a running update on accident claims related to COVID-19. This would help inform the Council's investigation as acceptance of these claims for occupations outside of IIAC's current recommendations could give insight into potential issues. Also, the a distribution of medical conditions for which the claim was accepted would be useful.

2.16. This member also reminded the Council that it should continue to monitor how the definitions, terminology and diagnostics are developing for long-covid, what are the disease entities, diagnostic criteria and timeframe. It was felt an update from the RWG on this would be useful which may allow the Council to be able to respond to criticisms. This has been covered to some extent by the lack of objective/diagnostic testing, but this isn't the whole answer as some prescribed diseases don't require this. For the current investigation, the member felt that a position paper on transport workers would be the best way forward with a view to publishing a command paper later.

2.17. The Chair agreed with many of the points and stated long-covid wasn't being ignored but would welcome guidance from members how monitoring and gathering the information on long-covid should be undertaken as there is a great deal out there, much of which is simply symptom reporting. Priorities need to be established as the Council has a full work-programme. This would probably need to be considered at RWG, but also at the next Council meeting.

2.18. The paper on transport workers was complimented and the member felt that the approach taken for H&SCWs be applied (and shown to be applied) to the investigation for transport workers. Some of the issues are the same for transport workers such as variety of jobs, fluidity between jobs and the risks faced. It was suggested that the tabular structure used for H&SCWs be adopted and used for the evidence acculmulated for transport workers. The Chair agreed and suggested that the format of the previous command paper on H&SCWs be adopted for transport workers.

2.19. There were comments on the timing of the next report and references were made to the process the Council's recommendations have to go through in order to get to prescription.

2.20. Going back to the hierarchy of risks with transport workers, a member stated within the food retail sector, andecdotally outbreaks occurred in staff working

in the distribution centres, in close proximity, which were not necessarily reflected in the lorry drivers as they were generally able to isolate in the cabs of their lorries.

2.21. A member commented that further complications to the interpretation of data are where accomodation, which was often crowded, was provided as part of the job.

2.22. A member pointed out that there would have been a large increase in taxi/private hire drivers as workers would have elected to do this if their own work had dried up.

2.23. The Chair drew the discussion to a close, thanking members for their input and stating that the implications of COVID-19 on occupation was an unprecedented and complex task. The next steps will be discussed along with the structure of the next report, with members being asked to input as appropriate.

3. Respiratory diseases commissioned review

3.1. For the benefit of new members, the Chair gave a brief overview of the topic and asked the Institute of Occupational Medicine (IOM) to give an update of progress to date.

3.2. Members were reminded that priority disease/exposure combinations were agreed to collate tables of evidence. These included:

- Silica & COPD
- Silica & lung cancer

The literature searches have been completed and work has begun on compiling tables of evidence which may be ready for review at the next RWG meeting.

3.3. The other associations which have not yet been progressed:

- Cleaners and COPD, which may include occupations which have an large element of cleaning such as nurses.
- Farmers, pesticide spraying, lung cancer and COPD
- Hexavalent chromium and lung cancer
- Asbestos and lung cancer – as the literature for this topic is vast, more recent publications may be selected first to help compile tables of evidence (as is being done for silica and lung cancer).

3.4. A presentation will probably be circulated amongst members.

3.5. The Chair commented that presently lung cancer following silica exposure is prescribed for when there is a presence of silicosis, which should be reviewed as recent literature may suggest silicosis is not a requirement for developing lung cancer.

3.6. Regarding asbestos, a member asked about the timeline in the literature until the the criteria for a doubling of risk is attained. It was stated there has been correspondence where significant asbestos exposure has occurred for which there is no direct epidemiological evidence, which will need to be considered. It may be thre are occupationas where there is no direct evidence of an increased risk but there might be evidence about exposures which can be

used to determin the risk. Currently, occupations such as those involved in construction are not covered and may involve a high degree of asbestos exposure.

3.7. A member commented that pleural plaques, whilst not covered by prescription, may give an indication of asbestos exposure, so may be useful as evidence.

3.8. The application of a job exposure matrix (JEM) was suggested would be useful when considering asbestos exposure risks for occupations not covered by prescription. Another member agreed with this approach. Council will return to this point when the table of evidence is presented.

4. Revision of PD D1, pneumoconiosis

4.1. The Chair introduced the topic and gave an overview of the history of this review. A number of iterations of a draft command paper have been circulated previously and a final version sent to a panel of external respiratory disease experts for their views, which were collated and circulated in meeting papers. Some comments from the reviewers were not in agreement.

4.2. Taking account of the external reviewers, the command paper was amended and circulated to members for comments, which included suggestions for a revised prescription.

4.3. The author of the paper was asked to take members through the proposals due to the complexities. The member explained the current prescription is complex and difficult to navigate, so simplifying it is necessary. Also considered were the diagnostic elements and it is proposed that a specialist diagnosis should be a requirement. It is also proposed to remove the automatic award where pneumoconiosis is present but not disabling, bringing the PD D1 prescription inline with others.

4.4. The author commented that the proposals were generally welcomed by the external experts, although there were differences of opinions.

4.5. The proposed prescription was discussed where the disease entity (pneumoconiosis) is specified and then qualifying exposures defined. It was explained that pneumoconiosis has a statutory definition dating back to the 1950s where the now outdated ‘dust reticulation’ term was used. For prescription purposes, it is proposed to keep the broad term pneumoconiosis and define the relevant exposures which can cause the condition, such as asbestos, coal or coal mine dust, silica-containing dusts, non-fibrous silicates (e.g. talc, mica etc but there is a long list of these, which some researchers don’t think causes pneumoconiosis), hard metal (e.g. tungsten carbide with cobalt) and beryllium (chronic beryllium disease = pneumoconiosis with some unique features) which currently has its own prescription.

4.6. A challenging issue is the potential inclusion of the category of exposure termed ‘any other dust’, which could be thought to negate the necessity for defining the other known exposures.

4.7. The paper author asked for comments on the proposed prescription, particularly around the ‘other dusts’ potential category of exposures.

4.8. There was discussion around the terms used in the current prescription which states “pneumoconiosis – includes silicosis and asbestosis” and are not included in the proposed prescription and may have been included for the purposes of non-specialists. Some members thought the broad term could be misunderstood without specifying further whilst others thought the broad term was correct. Reference was made to the presence of fibrosis which can be misdiagnosed, even by some professionals. There is therefore a need to be clear that we mean pulmonary or lung fibrosis rather than pleural fibrosis.

4.9. A member commented that the term ‘other dusts’ needs more thought as it could amount to claims being made where dusts containing elements which aren’t thought to cause pneumoconiosis. Also, specification of the metals which may cause pneumoconiosis needs careful consideration as it may exclude some claimants who would be covered by the current prescription.

4.10. The Chair stated that there needs to be a balance in the level of detail which is included in a prescription for the practicalities of the scheme to function i.e. to reach the claimants who may be eligible and to not encourage nugatory claims. The wording of the prescription needs to made clear so as to be specific enough for claimants.

4.11. A member asked if the proposed prescription would include the term ‘substantial exposure’ which is an ill-defined term. The author responded they didn’t feel this was needed in the proposed prescription as it is not quantified and if it was quantified, this would lead to difficulties in administration.

4.12. A member asked if the revised prescription was accepted and put into legislation, would current claimants have to be reassessed. The Chair said that this was not the aim of the revision and that they felt it would apply only to new claims.

4.13. There was discussion around work history and diagnosis as pathogically the condition can appear to be identical to other conditions (e.g. sarcoidosis) so the history is important.

4.14. There was wider debate around eligibility for prescriptions, where claimants may not meet the thresholds. It was felt that rare exposures, where strong epidemiological evidence may be absent, should be covered. Precedent was discussed in relation to existing prescriptions and how this could be taken forward for revised or new prescriptions. It was commented that perhaps IIAC may sometimes take too much account of the downstream requirements needed to operate the industrial injuries scheme. Reference was made to the prescription for asthma PD D7 which has a catch-all category for exposure, which is perceived to give rise to issues. The Chair accepted the point about precedent and commented that IIAC’s role is purely advisory and it is not within its remit to seek to change the process of legislation. As IIAC is an independent advisory body, it is important that it maintains the separation from DWP policy and should continue to investigate topics of its own choosing.

4.15. A member made a number of comments related to the proposed changes to PD D1 around the wording of the revised presciption related to the inclusion of silicosis and asbestosis. Also, whether ‘bystander’ asbestos exposure (and a

catch-all category) would be covered for occupations not recogised by the current prescription. Another point raised was whether engagement with external stakeholders had been undertaken.

4.16. The author responded:

- No strong feelings around retaining the terms in the prescription.
- 'Bystander' exposure would probably be covered by presenting with the disease (asbestosis) if exposure had been significant. The issue would be to ensure the condition was caused by the asbestos or if was idiopathic and would be for a specialist to determine. A proposed requirement would be a specialist (respiratory physician) diagnosis of the condition.
- There has been correspondence with external stakeholders.

4.17. The author stated they felt it would be beneficial to raise some of the issues posed by the proposed revision of PD D1 at a meeting of respiratory specialists and the Council agreed.

4.18. A member raised a potential issue around lump-sum compensation schemes and the requirement of qualification for PD D1 as a criterion. If the automatic award is removed, claimants may no longer be eligible for the lump-sum. The Chair commented that the automatic award of 10% was introduced to help miners with loss of wages who were no longer able to work underground if pneumoconiosis had been found on an X-ray. The proposals would apply to new claims and wouldn't seek to remove benefit from those already in receipt.

4.19. The Chair brought discussions to a close and summarised the way forward, thanking everyone for their contribitions;

- Engagement with external respiratory disease (RD) experts at forthcoming meeting.
- IIAC RD experts to disease experts will be invited to a meeting to discuss the points raised before next RWG.

5. RWG update

Neurodegenerative diseases (NDD) in professional sportspeople

5.1. The Chair introduced this topic by stating it had been decided to expand the remit of the investigation to include other sports with an element of contact.

5.2. A member leading the topic stated a literature search had been carried out which yielded a number of useful papers, but would probably need to be repeated to include motor neurone disease, amyotrophic lateral sclerosis, Parkinson's disease and possibly cognitive impairment.

5.3. The Chair stated that this will involve a lot of work for one member, so would consider how help could be provided. Data extraction is likely to be the most time consuming task.

5.4. Prioritisation of the conditions involved would be helpful, initially to possibly start with chronic traumatic encephalopathy (CTE) as the NDDs are likely to have more disabling consequences.

5.5. At a previous meeting, it was suggested to engage with a NDD specialist, but this has been put on hold for the time being. The Chair stressed that impartiality would be an essential requirement.

5.6. It was suggested that the topic be fully discussed at RWG with a view to prioritisation in order to structure the investigation. A member commented that previously CTE was only considered to be diagnosed post-mortem. However, recent literature suggests this may now be possible to do this when the person is alive.
5.7. Decisions would need to be taken on how to partition the literature by sport or by disease – exposure will be varied according to the sport. Other issues such as shaking of the brain which may not involve direct head contact need to be considered. Intense exercise is thought to play a role and it is also important to consider the 'healthy worker effect'.
5.8. A table will be produced which will cross classify outcome by sport to establish where the evidence is concentrated.
5.9. A reply to correspondence received from the Professional Footballers Association (PFA) will be drafted setting out the Council's views. The Chair noted that the all party parliamentary group (APPG) on this topic was very active, with the PFA participating.
5.10. A member asked if a JEM had been developed to apply to this topic, but nothing was yet available.

Work programme update

5.11. The Chair stated for new members that the Council has an ongoing programme of work, which is published on an IIAC webpage, which incorporates a wide range of issues.
5.12. A major question to consider is women's occupational health, which has never been specifically considered by the Council as a stand-alone topic. It was suggested to look at non-malignant diseases in women and reproductive conditions were considered to be relevant.
5.13. In order to understand the topic better, it was suggested that a scoping review be carried out and a short paper summarising the proposed approach was circulated in meeting papers.
5.14. The other issue to consider was cancers in women and it was suggested to not consider breast cancer at this stage due to its complexity and potential involvement of non-occupational causes – this would probably warrant its own investigation. Asbestos and ovarian cancers may be looked at. Recent meta-analysis, which can be subjective, was circulated for interest as asbestos and ovarian cancer have been added to the German occupational compensation list. Further information in the meta-analysis has been requested, but not yet received.
5.15. The Chair stated menopausal and reproductive health, along with miscarriage and ergonomic issues, could be considered. It was agreed to approach IOM to discuss the potential for a general scoping review.
5.16. A member commented that definitions around women's health, from a diversity and inclusion perspective, are being grappled with. Workplace injuries for women, aligned with domestic violence and assaults in the workplace are also something to consider.

5.17. Cosmic radiation and cancers may also be something to consider along with risks of firefighting encountered by women.

6. AOB

a) Update from DWP IIDB policy

6.1. The DWP is now considering the recommendations set out in the COVID-19 command paper and is working through the processes required. The Chair offered to help the policy teams if required.

b) Public meeting

6.2. The Chair stated the last face-to-face meeting was held in Leeds 2019 which was well attended. The next scheduled meeting has been arranged for 6 July with a full Council meeting the afternoon beforehand on 5 July. Members were asked if they had any preferences for a location to hold the public meeting by the end of January.

c) Correspondence

6.3. Correspondence from the NUM on Dupuytren's and timings of the disease were circulated to members. Case studies were supplied which the Council cannot comment on, but the prescription is clear that the onset of the disease has to occur, in some way, during work – this could be palmar thickening. If Dupuytren's is late-onset, that is acceptable provided there is some indication or signs the condition started whilst in employment. The reply will reiterate the requirement of the prescription.

6.4. The Council has confirmed that medical evidence is not required for Dupuytren's claims, so the information note, which the Council published to clarify its intentions, mentions medical evidence, will need to be corrected.

6.5. Another letter from the NUM around pneumoconiosis, which was tabled for the meeting, was mentioned and a reply will be drafted to answer the query when the letter has been considered fully.

6.6. The Chair stated that the Council had been made aware of recent papers on risks faced by firefighters and a letter had been received asking for the Council to reconsider its views on this topic. IIAC was asked to consider the risks faced by firefighters by the Environmental Audit committee following the Grenfell Fire. In response, the Council published a position paper which indicated there were some excess risks, but not doubled. The Chair declared an interest at this point as they were a reviewer for recent the paper and asked for more details on the methodology used prior to publication as this wasn't clear, but wasn't forthcoming. The Chair agreed to write to the authors asking for further details. Members were asked to review the papers and examine the methodology. Several stakeholders had been in contact, so responses will be sent.

6.7. The Chair thanked members for their input and drew the meeting to a close.

Date of next meetings:
IIAC – 30 March 2023
RWG – 23 February 2023