INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 24 November 2022

Present:

Dr Chris Stenton	Chair
Dr Lesley Rushton	IIAC
Professor John Cherrie	IIAC
Professor Damien McElvenny	IIAC
Mr Doug Russell	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Jennifer Hoyle	IIAC
Mr Dan Shears	IIAC
Dr Rachel Atkinson	Centre for Health and Disability Assessments
Dr Anne Braidwood	MOD
Ms Lucy Darnton	HSE
Dr Emily Pikett	DWP IIDB Medical Policy
Ms Sania Mushtaq	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Mr Garyth Hawkins	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: None

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. When members were reminded to declare any potential conflicts of interest, it was noted that declarations made at the previous meeting were still valid.

1.3. The Chair welcomed Dan Shears who has agreed to join RWG. Farewell and thanks were also given to Doug Russell who has stepped down from IIAC.

1.4. Dan Shears declared that GMB includes the Rugby League Players Association which has an interest in the topic of neurodegenerative diseases in sportspeople.

2. Minutes of the last meeting

2.1. The minutes of the meeting held in September 2022 were cleared with minor edits required.

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

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

3. Occupational impact of COVID-19

3.1. The Chair stated that the Council's command paper had been laid and published on 16 November. Several comments outlining its contents had been shared online; the secretariat indicated that no queries had been received to date. It was expected that the impact analysis to be carried out by DWP would take several months when further advice from policy officials would be given to Ministers. A modelling plan is in place and clinicians' views would be required at various stages.

3.2. At this point, Dr Pickett stated she would be stepping away from IIDB policy to take up a new role; a replacement would be sought and introduced to the Council. The IIAC Chair offered support to DWP for the modelling process.

3.3. A paper was circulated which summarised some of the important aspects for the Council to consider. There are multiple papers published every day which makes keeping up to date with the literature challenging.

3.4. The Chair stated there was nothing new to add on long-covid, very little on the other complications and nothing on the long-term consequences. It was noted that there are a couple of topics to monitor, for instance arterial thrombosis.

3.5. Commenting on the paper, a member felt that there was nothing omitted and stated the consensus was that rehabilitation outcomes were better than expected in relation to non-specific long-covid symptoms. This supports the Council's assertions in its command paper.

3.6. Frustration was expressed about the lack of occupational data. A member commented that poor mortality data from 2021-2022 is disappointing, however it was noted that Scottish data have been published with albeit crude occupational information. This indicated higher rates of death in the transport sector. The member commented that these workers should take priority for the next iteration of the Council's investigation, along with security workers, but data are again sparse for this sector.

3.7. It was suggested that in general terms, workers in the transport sector were likely to be older and overweight, which made them more susceptible to dying from COVID-19. Historical publications had indicated that bus drivers were more likely to develop heart disease.

3.8. Several publications had emerged recently, from America and Norway, which indicated transport workers had elevated (doubled) risks of death, but these were variable and not necessarily applicable to the UK.

3.9. A member felt the data were developing for taxi and bus drivers but was not sure the evidence is strong enough yet to recommend prescription.

3.10. Further data from outbreaks, which is another topic for consideration, were expected from the HSE, but nothing has been published yet, which was a source of frustration. A member pointed out nothing has emerged in the literature around outbreaks and they felt a useful definition, which would satisfy the requirements for IIDB, is unlikely to emerge.

3.11. A member offered to collate the evidence for transport workers for consideration at the next Council meeting.

3.12. The discussion moved onto accident claims related to COVID-19, but at this stage there was nothing to add to previous discussions. A member felt it

would be useful to understand the criteria used where accident claims had been accepted to help guide the Council.

4. Review of PD-D1, pneumoconiosis.

4.1. The Chair introduced the topic by stating that a draft command paper, recommending revisions to the prescription, had been agreed by the Council.

4.2. This command paper had been circulated to external respiratory disease (RD) experts for comments. A sub-group member meeting had been convened to discuss the external comments and a paper summarising this meeting was circulated in papers. Many of the external comments were supportive of the approach taken by the Council i.e. a simplified list and bringing the prescription into line with others. However, some comments referred to diagnosis or disability assessment, neither of which were proposed for change. Some of the comments were now no longer relevant, for instance the use of anti-fibrotic therapy is now more widely available.

4.3. The Chair stated the command paper had not been redrafted as further discussion at RWG would be useful to validate the approach being taken.

4.4. The first issue raised was the distinction between silicosis (disease which occurs following exposure to relatively pure silica) and mixed mineral dust pneumoconiosis which occurs when silica is a minor component. The 2 conditions have different pathological patterns. There was some suggestion that combining the 2 conditions (silica-containing dusts) for the purpose of prescription could help simplify an element of the prescription. The Chair asked members if they felt there were any reasons not to do this. There was discussion around the chest abnormalities associated with these conditions and how this proposal could be administered in IIDB.

4.5. It was noted that silicosis is thought to be under-diagnosed, and it was this that initially prompted the review of ~~this~~ the prescription. It was felt the work-history question of the diagnosis was an important element to get across. It was also important to highlight some of the occupations to assist potential claimants. A member felt this was an issue around presentation and thought silicosis should be highlighted.

4.6. A RD member felt that silicosis and mixed mineral dust pneumoconiosis should be combined as this may assist clinicians where there is a relevant work history of exposure. The Chair felt this would need further discussion, so kept this open.

4.7. Non-fibrous silicates were then discussed, ie silicon dioxide with additional metals in the crystalline matrix.~~.~~ There was some discussion whether silicates are a causative agent or whether ~~the~~ contamination with silica is responsible. It was felt that a list of silicates would be unwieldy as all of them would have to be named, many of which if they cause disease do so only extraordinarily rarely. It was suggested that examples be given in context with the relevant occupation, which would be more useful for potential claimants. It was commented that this could be provided in guidance/explanatory notes rather than the prescription itself.

4.8. A member agreed it was likely (but not definite) to be contaminating substances (silica or asbestos) which are the causative agents so made the point that it needs to be presented in a manner which would not exclude claimants who had the disease but may not have been aware of what they were exposed to. Association with the exposure rather than caused by the exposure could resolve this issue.

4.9. It was also suggested that incorporating silicates into the mixed dusts may alleviate this concern. The Chair suggested that some of the issues could be put to the group of occupational lung disease specialists who would be well placed to comment.

4.10. The third point discussed was whether metal-induced pneumoconiosis should be included as part of PD D1 or have its own prescription. The member who drafted the command paper initially felt that hard-metal disease should be separate from PD D1, however, the majority of interested parties suggested the opposite and to expand PD D1 to include Beryllium, which is covered by PD C17.

4.11. One issue is other metals which may cause disease but have not yet been reported to do so in the UK, such as Indium or Cerium, It was suggested that a ‘wait and see’ approach be taken and to add these other metals if cases are reported. A member asked if the routeway for obtaining this information was robust enough. It was suggested that at the moment there was insufficient evidence to add these at the current time. It would also be necessary to exclude pneumoconiosis caused for example by iron ~~would all have to be listed~~ otherwise non-disabling conditions could be subject of claims for IIDB.

4.12. In the current PD D1, there is a ‘catch-all’ category and these was a difference of opinion whether this should form part of a revised PD D1. A member pointed out that the proposed prescription, which lists specific exposures, would be negated as they would all fall into a ‘catch-all’. The author felt that the exposures listed were the only currently recognised causes of pneumoconiosis in the UK. A member asked if there were any exposures/occupations in the proposed prescription would be excluded which are covered by the current PD D1. Grinding of mineral graphite and manufacture of carbon electrodes would not be covered, but these are very rare and no cases have been reported in the UK in at least the last decade. Boiler scaling would not be specifically covered but the dust generated would almost certainly be silica-related, so would be covered.

4.13. It was considered that where there were elements of doubt, specific information would be given in detailed guidance notes.

4.14. The Chair thanked members for their input into this topic.

5. Commissioned review into respiratory diseases

5.1. Professor Damien McElvenny who is leading this from the Institute of Occupation Medicine gave an overview of progress to date.

5.2. Following discussion with IIAC members, topics have been agreed for takeing forward. Partial tables of evidence for COPD have been compiled and work will continue to populate these.

5.3. Literature searches for lung cancer have been carried out and further tables of evidence will be compiled, hopefully for review by the next IIAC meeting.
5.4. A member asked if progress had been made for silica and lung cancer in the absence of silicosis. The papers which would be most useful would give an insight into whether there are increased risks of lung cancer with or without silicosis and whether there are any grey areas. IOM are aware of this and will be careful to scrutinise any evidence. A member pointed out that there may be other complicating confounders which need to be considered.
5.5. It was pointed out that WHEC produced a report which stated silicosis was not a precursor to lung cancer but was a measure of exposure. It was felt this was something for IIAC to bring out.
5.6. A member asked if IOM progress reports would be published. There are no plans to do this, although there are no restrictions, the Council would need to give close considerations to the outcomes of this review and publish its views, whether that be command papers where recommendations are made or position papers setting out IIAC's views. This would be a decision for the full Council.
5.7. Feedback was requested from members around the tables of evidence and some suggestions to additional columns such as impact of smoking within COPD.

6. Neurodegenerative diseases (NDD) in sportspeople

6.1. The Chair introduced the topic stating they felt this was going to be challenging. The all-party Parliamentary group (APPG) investigating this topic met recently and selected IIAC members attended. A presentation was given by the professional footballer's association and discussions followed which questioned why IIAC isn't active enough in this area. At this meeting, it was felt NDD should be a prescribed disease.
6.2. A review of the literature is clearly required where the various conditions associated with this topic may need to be separated out. Determining if head injuries cause all of the neurodegenerative diseases may be challenging as might the question of whether there is a specific issue in football.
6.3. Determining if the exposure occurred when playing professionally or as amateurs will be important in relation to attribution to paid employment. Duration and timing of exposure will also be an important factor to consider – might for example the developing brain of children and adolescents be more susceptible to injury?
6.4. Literature searches will be carried out and further refined to bring out papers related to the epidemiology. Consideration will be given to investigate if chronic traumatic encephalopathy (CTE) may be a precursor to dementia. Further, independent expert advice may also be needed during this investigation.
6.5. The quality of data and analysis in publications will need to be scrutinised to ensure risks are accurately assessed.
6.6. A member pointed out that American Football was played professionally in the UK, so this sport would need to be included. There may also be further

complications where different sports would have been played professionally. It was also pointed out that there is an ongoing legal dispute in France between rugby players and clubs around safeguarding, which may be relevant.

6.7. It was noted that Dr White from the PFA had written to the Council and a response will be drafted by the secretariat.

7. Work programme prioritisation

7.1. The IIAC Chair circulated a short discussion paper outlining the potential for a scoping review into women's occupational health which could be outsourced.

7.2. This document showed published statistics by gender show only a small proportion of new claims each quarter are by women (<10%).

7.3. Patterns of employment differ between males and females: fewer women are employed in manufacturing (5%F, 12% M), construction (2%F,11% M) and transport (2%F, 7%M); approximate equal proportions in wholesale and retail (11%F, 12%M) and professional, scientific and technical (8%F, 9%M); more women in education (17%F, 6%M) and Human health (23%F, 6%M).

7.4. Non-malignant vs malignant conditions were looked at and it was suggested the most relevant malignant conditions might be ovarian and breast cancers. However, these need not form part of the scoping review as there are good reviews available.

7.5. Non-malignant disease may include reproductive outcomes, which could be related to heavy lifting, manual work etc.

7.6. A member asked if the HSE publication by McDowell on reproductive effects and occupation is still available as this may help inform a scoping review.

7.7. It was suggested that mental health or musculoskeletal (MSK) issues could be considered, but some of these may be difficult to prescribe for.

7.8. Ovarian cancer is relatively rare, so this could be something to consider. Other reproductive health issues may be difficult to prescribe for e.g. the mental health impact for miscarriage. For potential teratogens (solvents?), the child would be impacted but this is not covered by IIDB.

7.9. It was agreed that a further information-gathering exercise would be carried out with a view to discussing this at the next full Council meeting.

8. PD A15 Dupuytren's Contracture

8.1. Following the audit of claims for PD A15 by DWP officials, a question was raised around the timescales and daily duration of exposure required to qualify for the prescription.

8.2. Members with MSK expertise reviewed this requirement and circulated a paper for discussion. The original command paper was revisited and more recent meta-analyses papers reviewed to check this requirement.

8.3. It was felt that the 10 year requirement was a threshold and should be retained, but perhaps if the daily exposure was less but encountered over longer times, discretion could be afforded to allow those claims. However, this was not considered to be practical as other prescriptions have a definitive cut-off where there is no discretion.

8.4. Following further discussions with officials, it was decided that the qualifying conditions of the prescription would remain.

9. AOB

Correspondence

9.1. Correspondence had been received from the National Union of Mineworkers (NUM) outlining their concerns about onset of Dupuytren's Disease (DD) during employment but where no medical evidence was documented at that time.

9.2. There were examples given in the correspondence, however, it was noted that the Council does not comment on individual cases.

9.3. A member stated their understanding of the prescription was that it would be difficult to obtain medical evidence so if the claimant's work history satisfies the requirements and they state DD started whilst in employment then that would be accepted. The onset of DD would have to be during employment in the relevant occupation. This was confirmed by officials.

9.4. The information note published by the Council to clarify its amendment of the original prescription appeared to be incorrect and will be checked.

9.5. It was confirmed by officials that documentary medical evidence is not always available, so the claims would be accepted based on work history. It was noted that if claimants were assessed for other conditions (e.g. hand-arm vibration PD A11) and there is evidence of DD, this would also be accepted and generally documented.

9.6. Comments were made on the language used in the correspondence which was deemed to be wholly unacceptable and inappropriate. This matter will be taken up with the stakeholder by the secretariat. It was also noted that matters are referred to the Council which should be taken up with the DWP and it was reiterated that individual cases would not be discussed.

Outbreak data

9.7. A HSE observer updated members on progress for publication and analysis of the data from outbreaks. There are a number of strands to this work and further funding has been sought to enable completion. Publication is expected in spring 2023.

Other business

9.8. The secretariat asked members to give advance notice, if possible, if hotels are required to attend meetings in person. A note will be circulated in preparation for the January meeting.

9.9. The recommendations for appointment of new members to the Council following the recent recruitment exercise is with Ministers and decisions are expected soon.

Date of next meetings:
IIAC – 12 January 2023
RWG – 23 February 2023