INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 30 March 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
Mr Keith Corkan	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
Dr Anne Braidwood	MOD 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
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Ian Chetland (IIAC Secretariat/scientific adviser); Ms Louise Everett (IIDB policy)

1. Announcements, conflicts of interest statements and sign-off of minutes

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, or declare them as the meeting progressed.

1.3. The Chair noted this was Keith Corkan's last meeting having completed 10 years as a member of the Council and thanked him for his service, wishing

him well in the future.

Minutes of the last meeting

1.4. The minutes of the January meeting had been circulated to members to comment on and agree. The Chair asked if members were content to now sign those off, all agreed and the secretariat would now send for publishing.

1.5. All action points had been cleared or were in progress.

2. Occupational impact of COVID-19

2.1. Dr Sharon Stevelink advised she was an investigator on a project looking into occupations and long-covid.

2.2. The Chair provided an updated draft of the Council's report on other occupations but noted that it was still a work in progress. A member had provided additional paragraphs on transmission pathways for inclusion in the risks section and tables have been revised to include confidence intervals. Many factors remain the same for other occupations as in the initial command paper, in that there is a lot of mortality data but infection data reflecting occupation is extremely scarce. Many factors influence mortality that don't reflect risk of infection; therefore they are not confounders but modifiers of the risk of dying. These are also being seen in transport workers.

2.3. The Chair had discussions with the Chief Medical Officer at Transport for London (TfL) who had collected a lot of data on sickness absence. They had seen a spike in infection for bus drivers during the early stages of COVID-19; there had also been daily testing for TfL workers with a couple of cluster outbreaks as they had not taken into account worker to worker transmission.

2.4. Two papers, one from the UK, the other from the Netherlands, show transport workers have risks similar to Health and Social Care Workers (H&SCW) which should be explored. A presentation by the PROTECT Group, including Manchester University and HSE, illustrated this; data for other worker groups is more limited.

2.5. A member questioned the comments on the types of protection used and was assured more work on the papers would be included in this report. Another member also questioned the confusion over the relative protectiveness of the different types of face covering versus protection as a wearer or a customer.

2.6. There was also a query on whether IIAC were considering an extension of the recommended prescription for H&SCWs for transportation workers. Another member asked about the breadth of this review; would it only review COVID related outcomes for other occupations as in first report or is the Council considering including long-covid as broader than the H&SCW's recommendations?

2.7. The current review began as an extension of the occupations and a member is currently involved in monitoring what happens in the treatment of long-covid, diagnosing it etc. Much has been completed in terms of the data, so now the Council needs to focus what other occupations should be included in this review rather than have a series of smaller reviews for different occupations.

2.8. Concern was raised that IIAC was in danger of treating transport workers differently from H&SCWs regarding worker to worker contact, but was assured that is not the intention. This had already been mentioned in discussions with TfL which showed in a couple of clusters where outbreaks had been down to worker behaviours. Although a factor, as the Industrial Injuries Scheme (IIS) is a no fault scheme, this would not be considered in determining outcomes.

2.9. Deprivation also needs to be considered where there was a greater need for those in lower paid employment to have to go to work because they would lose wages or where the work meant contact with the public. A person's occupation defines their salary which in turn defines how they live their life.

2.10. Answering these questions and collecting data would become more difficult with less testing now taking place, so it would be expected a doctor or hospital diagnosis would be required.

2.11. Data from Scotland show a age-adjusted mortality ratio of 170% for transport workers compared with all workers for all causes of mortality. However, data from other large studies such as REACT, show points of difference when comparing infection and mortaliity data, indicating concerns if only using mortality data, which showed all UK mortality data related to death with COVID rather than death from COVID. It illustrated that if you were unwell in hospital there was a 10 – 20% chance of getting COVID as a result of being unwell rather than COVID being the cause of you being unwell. There doesn't appear to be any data where the underlying cause of mortality is COVID. Therefore lots of factors need to be taken into account in interpreting mortality data versus what the infection data says to ensure it's understood. The transport data seems quite in excess of other workers' outcomes.

2.12. Concern was also raised whether the use of different time periods should be considered. These were not used in the first report because it was too soon to do so, but three years on there is a question of the relative risks for various worker groups.

2.13. 70% of death certificates included a COVID code as a factor but only 30% where it was the main cause for transport workers, who carried on getting infected over a longer time period. However, because testing is no longer required there are concerns there won't be any more data coming through.

2.14. It was noted how different the transport sector is across Britain, therefore it was going to be difficult capturing variations and linking it across the categories of transport workers, e.g., cab drivers or taxi drivers and that it was not always someone's main job. It may be possible to get data from some organisations, but linking that to health data would be difficult.

2.15. A member asked what evidence could be used in the absence of epidemiology and was advised the Council needed to use other data such as case series and cluster information and any data from other companies such as TfL and the outbreak data that is held by UKHSA and HSE.

2.16. The Chair and some members had previously attended a number of meetings of the all party parliamentary group (APPG) on COVID-19 and long-covid. The APPG chair subsequently asked for data held by HSE to be shared with IIAC.

2.17. The lack of robust epidemiology was considered a difficulty not just for COVID-19 but also for other topics the Council are considering now and in the future. IIAC were therefore having to consider other mechanisms and find a balance for looking at the evidence in its totality. It was suggested that a papers on transport workers were seldom in the scientific literature, but they may appear in other data such as government testing data, or using sources such as employers like TfL; this would help to determine whether IIAC could recommend prescription for certain types of transport workers that regularly came into contact with lots of passengers and/or work colleagues. In terms of time frames, there would be an expectation that there'd be differences.

2.18. Concerns were noted that workers are no longer being tested in the way they were, therefore if they now go off sick they are unable to access sick pay.

2.19. There was a strong sense the education sector was also disproportionally affected. Most teachers in the first wave were working from home or teaching online. In contrast, teaching assistants and school support staff were generally in schools keeping them open for children of key workers. Therefore the picture was very different from one wave to the next when most teachers were back at school and where data should be available. It was agreed to go back to the PROTECT studies, but the results from mortality studies of the education sector showed reduced risk of mortality in contrast to those of the transport workers. The infection studies may show something different so IIAC will seek out that data.

2.20. The Council spent a lot of time discussing the waves during the H&SCWs review and it was felt from a practical viewpoint, it would be very difficult for claimants and administratively if IIAC had included the different waves for COVID. Also, a pragmatic decision was made at the time not to include an end date.

2.21. A point was made that it should make no difference whether a worker caught COVID-19 from a fellow worker in the canteen or the office, it's still the workplace and that there are no good data on worker to worker infection.

2.22. There was also a concern that unconsious bias could be a factor when considering data. If you know the data on mortality and dying with COVID rather than of COVID then there is a need to consider working age and risks. Certainly the first data showed a bias towards men, whereas in some sectors such as education, when there is a diagnosis of long-covid there is a signal that it is mainly women of a certain age that tend to report long-covid. Considering the mortality rate for education workers where 80% of the workforce are women, then there seems to be an unconsious gender and age bias which needs to be thought through.

2.23. However it was pointed out the Council have less data for women; for example only 60% of death certificates for women of working age had workable occupational codes, compared to over 80% of men. NHS data shows a peak towards women in their 40s and 50s, so there is a concern that these women are more likely to be diagnosed with long-covid but less likely to have died of it. It is therefore with thanks a member is monitoring the long-covid data.

2.24. Another member re-emphasised methodological issues in interpreting the data where different comparison populations have been used in different studies. Another concern is the different categorisation of occupations between studies and a danger of dilution of the data.
2.25. The problem IIAC have is interpreting all the disparate data to make informed decisions; there is a need to revisit some of the data from the PROTECT study and two papers using job exposure matrices (JEMs).
2.26. There is still some work to do on exposures, collating outbreak data and adding one or two more occupations, education, security and possibly retail work before the July meeting in order for some decisions to be made. Although it should be noted there is not much data on education and even less for the security sector.
2.27. There were large numbers of infection across all the waves in these groups, including food processing. There is also a high prevelance of black and Asian minority ethnic workers across these sectors so reporting may not be as strong as in other areas. Some information may be in HSE's outbreak information, particularly in the first year from March 2020 to Easter 2021 when we saw high numbers of incidents and exposures in the food processing sector.
2.28. A member stated that exposure scores in the JEM across H&SCW, education and bus and taxi drivers were similar. It also shows across the analysis that women are far more susceptible because of status, nature and employment which is often short term with temporary contracts and often with limited benefits for part-time and lower income workers.
2.29. Another member was concerned that the data from the PROTECT study showed unconsious bias towards the female workforce. Also, the data from the most deprived areas were not coming forward with long-covid, highlighting how people from certain ethnicities access healthcare provision.
2.30. A member on an occupational group had worked through the 1st and 2nd waves for a corporate real estate firm and considered the security field could be broadened to include estate management who were always required to be on site and rules wouldn't encourage to take time off if they were sick.
2.31. Another member advised the TUC had recently published a paper which covers a lot of sectors providing union members' experiences. The data covered may prove useful for the broader deliberations of the report for different sectors and will share the report with IIAC.
2.32. The TUC were going to share this paper with HSE's board to try and find out if the data it holds regarding clusters and outbreaks could be useful.
2.33. A member suggested the Council need to have a conversation about subsets of long-covid and would write a piece on this and what diagnostic tests can be done, but acknowledged there is a lot that is still very vague.
2.34. The Chair brought the discussion to a close and acknowledged that including more occupations in this review would save a lot of work and also encouraged everyone who had made suggestions for sources of data to consider and to undertake to provide the data and think how they would contribute to the paper.

2.35. It was also agreed that long-covid would not be included at this stage as there is still much work to be done and how it can be defined.
2.36. A subgroup could also be used to draw all the information together for the next full Council meeting in a revised draft.

3. Revision of PD D1

3.1. Recapping, a member has been leading on the revision of pneumoconiosis and along with other respiratory members attended the meeting of Group of Occupational Respiratory Disease Specialists (GORDS), a respiratory diseases group, some of whom had the opportunity to see the draft report and had commented. It has also been reviewed by several experts, most of whom had been members of IIAC at some point. Comments were not all the same and so it has taken some time to consolidate their responses.
3.2. The prescription for pneumoconiosis is the oldest of the compensatable diseases, dating back more than 100 years. It's complex and as it stands there are a lot of categories of the disease or exposure and almost as many subcategories, making it difficult to navigate.
3.3. The impetus for recommending changing it is twofold; one, an all party parliamentary group (APPG) met to discuss raising awareness of new exposures that are likely to to give rise to silicosis in particular; and secondly our own recognition that some of these may be missed if you weren't aware of how the prescription worked. These could range from dental assistants, those making composite kitchen tops, or concrete workers who can be exposed to a lot of silica and not obviously covered by the current prescrption.
3.4. The paper included in the meeting papers is the second major iteration of the proposed revised prescription taking into account comments from some of the reviewers who were generally very supportive of the principles although they may have disagreed on some of the detail.
3.5. Principally IIAC is trying to achieve a simplified list, suggest a process where someone will get a clinical diagnosis of one of the suggested conditions, and then applies for IIDB. It is also proposed the prescription is also brought into line with other prescribed diseases. Pneumoconiosis is unusual in that if you have a diagnosis for it, even if not disabled by it, you would be entitled to an automatic award when diagnosed even if the person is not disabled in any way. This goes back to the early days when coal miners who had early stage pneumoconiosis and were moved to other work were compensated for loss of earnings. This no longer happens.
3.6. The changes suggested include combining three categories which are rare exposures and account for around 1% of claims; have a separate category for hard metal diseases caused by tungsten carbide and could include beryllium, although this is currently a separate PD, and other hard metals for the sake of future proofing the prescription; and to remove the open category.
3.7. There are several occupational exposures which would not be specifically covered by PDD1 at the moment e.g. workers using composite stone for kitchen tops and sinks etc. As radiologically it's difficult to distinguish silicosis

from sarcoidosis we rely on a detailed work history of silica exposure to make the diagnosis of silicosis.

3.8. It would be expected a clinical assessment would be made in the vast majority of cases by respiratory specialists. The Council is not trying to change the amount of exposure required to to cause the disease, or the way it is assessed.

3.9. There was a discussion on what substantial meant as it appears seven times in the current prescription and to provide clarity it was suggested the term ‘substantial’ be removed.

3.10. There is also an issue about the definition of pneumoconiosis, which is unusual in that it is defined in the Social Security Act; this is now potentially misleading in its current terminology, so there is a question around how you change that legislation as opposed to the list of PDs to consider.

3.11. There is also a question of how you treat TB or COPD within the legislation. Silica exposures can cause TB and coal causes COPD. But it could be concluded that complications of the diseases can already be taken into account.

3.12. Psychological complications as a consequence of exposures was also discussed, but this could also be taken account of a sequaelae of the disease.

3.13. Discussions took place on the use of “substantial” without explaining what is meant by it and whether it could be left out given that the diagnosis depends on various tests and asking about a work history. An operational colleague agreed that claimants ususally have a diagnosis, but there are a few who might claim off their own back, so it can be difficult to quantify “substantial” exposure. Generally there is a rule of thumb suggested for asbestosis, but not for other diseases. They err on the side of caution where a work history with one of the causative agents is accepted. Therefore if “substantial” is to be kept in the prescription, guidance would be helpful.

3.14. The Chair asked if it wasn’t included what would the Department do, to which they responded that a good occupational history would be taken and borderline cases where the work was intermittent or a couple of years work would be discussed. But PD D1 is mainly a specialist referral, therefore a decision should be clear. This would stop those individuals claiming themselves allowing more straightforward cases. If someone should in the future claim themselves they would be advise to see a specialist to get a diagnosis.

3.15. The main issue is when someone has idiopathic pulmonary fibrosis (IPF) and a specialist hasn’t provided a diagnosis one way or another, but with a good work occupational history, these cases are currently being accepted.

3.16. There were some concerns that in some instances a specialist diagnoses idopathic disease and the person thinks that diagnosis is wrong. This occurred previously with asbestosis where if IPF was diagnosed treatment was available but not if asbestosis was diagnosed. This is not now the case. There is also concern that not all respiratory specialists,will recognise occupational exposures and that not all will take a work history.

3.17. Asked if assessors would send claimants to see a specialist, they advised not. If someone presents with pleural plaques then on balance they consider a diagnosis and write to the GP advising an outcome for PD D1 and suggest the GP may want to investigate further. They considered a change to the way in which the prescription was being described would be helpful for assessors.

3.18. Members went to a presentation by an All Party Parliamentary Group (APPG) on silicosis who were concerned that there was a lack of knowledge about silicosis, both by those working with silica and those who should be able to diagnose silicosis. There is a high percentage of silica in construction industries such as making floor tiles or sinks. There is therefore a need to have some detail on the types of exposures possibly in an appendix with examples that may be helpful to DWP.

3.19. A member noted the occupational and environmental lung specialist advisory group of the BTS is developing a position statement about silicosis and emerging exposures with the aim of gaining wider acknowlegement of the problem.

3.20. Another member asked about the attribution for complications when someone also presents with tuberculosis (TB). A response from an observer stated claims are assessed on disability for pneumoconiosis and any additional disability is added on if they have contracted TB.

3.21. A member asked whether O-pre (a condition pre-dates a claim) developed or O-post (a condition post-dates a claim) would be considered for any sequalae of a disease. It was advised that it would not be directly relevant to the disease and so would not need to be considered for the purposes of the prescription, so long as a sequalae, whether O-pre or O-post, is included in the discussion in the command paper.

3.22. An assessor asked whether a different microbacterium which wasn't TB could be included in the assessment because they had agreed a diagnosis and were able to agree the claim. This would have been relevant to any loss of faculty so could be included.

3.23. Another member asked if it would be appropriate to include a non-exhaustive list of occupations with exposure to silica that are recognised and relevant to the 21st century which would be helpful to assessors. It was agreed a list woud be useful to include as long as it was recognised it wasn't definitive. A similar issue occurred with PD A11.

3.24. CHDA wanted to explain the foibles of COPD in respiratory diseases in which if a certain threshold in miners is reached it is accepted as PD D12. But they are seeing people who have got COPD as well as pneumoconiosis. If it's a new pneumoconiosis or asbestos for example and it's assessed at over 50% then COPD becomes fully relevant in the assessment for PD D1. However, assessed below 50% they may do an O-pre or O-post interaction in addition so they don't include the whole effects of COPD, only the the way it makes the disablement from pneumoconiosis worse. They don't include the scope in the silicosis at present unless it fulfils the 50% rule. Therefore, apart from coal mining, where a separate claim can be made, it is taken into account in disability assessments. If a coal miner gets more than the 50% threshold, they

don’t have to apply for PD D12 because their COPD is assessed as fully relevant.

3.25. A member suggested that those on the Council who were part of (GORDS) group could contact the group to suggest that the British Thoracic Society (BTS) or GORDS do consensus statements about asbestosis and the types of exposures IIAC would expect and have a consensensus view.

3.26. It was felt the Council were nearing a final version of this report and having dealt with all the comments on the report would bring it to the RWG with a final draft brought to the next Council meeting.

4. Firefighters and cancer risks

4.1. The Council had previously discussed a recent paper by Anna Stec in which very high levels of risk for may cancers were found. The Council were concerned about the methodology of the paper and had written to Anna Stec with a list of questions from members. Professor Stec had replied with some additional details. However, this raised a further major issue of concern and Professor Stec was contacted again with another query. To date no response has been received and a reminder had been sent.

4.2. There is a lot of interest in the report and in particular from the Fire Brigades Union (FBU) who want to meet with IIAC about the report.

4.3. It should also be noted that IARC classified firefighting as a Group 1 cacinogen, and a summary was published in The Lancet oncology in August 2022. It is based on sufficient evidence for cancer in humans, particularly for mesothelioma and bladder cancer, with limited evidence for colon, prostrate to testicular cancers and for melanoma and non Hodgkin’s lymphoma and evidence for certain metatastic cancers. Being in Group 1 doesn’t necessarily mean the estimates are anywhere near a doubling of risk and that is the issue with Anna Stec’s paper where everything is high, including acute heart disease with no healthy worker effect.

5. Respiratory diseases commissioned review

5.1. A member outlined briefly the history of the project for the benefit of new members. IIAC commissioned the Institute of Occupational Medicine (IOM) to look at the epidemiological associations between risk agents that cause respiratory cancers or COPD. Based on reviews considered over the laast 10 years or so, and following consultation with IIAC, IOM came up with six exposure disease combinations. The most developed one silica and COPD where the literature search is complete, and produced a summary of the findings and had comments back on how the data should be synthesised. IOM are in the process of doing this. They are currently doing the same exercise for silica and lung cancer. For both silica associations they intend going back to apply a simple assessment of the study quality.

5.2. IOM’s intention is to have completed this process for the other exposure combinations by the end of the calendar year: cleaning products and COPD; farming and pesticides, and lung cancer and COPD; hexavelant chromium and lung cancer; and asbestos and lung cancer.

5.3. A member asked if it was the intention to release reports for each disease exposure sets as IOM produce them, or is it intended to wait until they are all complete. IOM stated their intention would be to produce one report at the end, however the Council acknowledged it would be a lot to get through in one report so may be useful to have an idea of the data synthesis and summary for silica and COPD to understand how that might inform the other exposure sets moving forward.

6. RWG update

a) Neurodegenerative diseases (NDD) in professional sportspeople

6.1. The Chair advised this was a topic that was being pressed on and IIAC had received further correspondence from the PFA having met them previously and IIAC will respond in due course.

6.2. The secretariat had provided a large literature search and a small group of members came together to discuss a way forward. Members have been considering some of the systematic reviews and also looked at the research by sport.

6.3. It was agreed the focus should be on three specific diagnosis and look at these for all different sports:

- Motor neurone disease seemed to show the strongest indication there may be an association;
- Parkinson's disease; and
- Dementia.

6.4. Chronic traumatic encephalopathy (CTE) and declined cognitive function were also of concern.

6.5. There is a mixture of mortality and morbidity studies across a range of sports, such as football, rugby, american football etc.

6.6. It was noted that it was important ot look at the pathology data of which there is a lot and the mechanisms as to why it happens and what the causes are. There is also a large variation on the types of exposures that are measured in the papers.

6.7. One member considered it may be worth considering early onset disease rather than just the increased risk of disease. That would be difficult to entangle as most papers do not consider this.

6.8. It was noted that early Alzheimer's was still relatively rare and that there are relatively few studies addressing the issues of early diagnosis, the involvement of medical practitioners and use of cognitive testing.

6.9. Some of the retrospective studies had the potential to link up death certificate data with NHS in-patient and out-patient data, potentially also using GP data, e.g. the Swedish soccer study that has just been published may have sufficient/potential power to look at early onset disease.

6.10. Another member suggested that other newer studies including the one on Italian footballers and motor neurone disease may address early onset. It was acknowledged that the literature is complex and a lot of it is only tangentially relevant to what the Council wants to do e.g. CTE is a pathological diagnosis

and a lot has to do with post concussion and changes post concussion whereas for prescription the Council would focus on specific diseases.

6.11. One of the other difficulties noted was that a lot of data relates to NDD generally without specifying any particular disease.

6.12. An observer noted it it would come into the mild category and therefore attract 14%, but that cognitive disorders such as anxiety and flat mood would not be included. The individual may function well in an environment tailored to limit stress, but may have difficulty with attendance at work. The medical assessment framework is outdated for this purpose.

6.13. It would be easier for IIAC to move forward with three diseases rather than use something that can't be quantified, so allow the data to inform the review. If there is not much data on neurocognitive impairment the Council can't comment.

6.14. Another member asked if there was a precedent or any similarities that could be drawn from some of the chemical causes that are prescribable and cause neurological dysfunction. There won't be many prescriptions, but manganese may be one and someone would need very high doses.

6.15. The Chair considered someone with dementia expertise that is not directly involved in any of the reviews either recently undertaken or underway would be needed to ensure there would be no conflict and be able to consider the evidence objectively. A member suggested a professor of neurological disease at Kings' and was asked to contact them.

6.16. One member considered it may be best to avoid mild neurocognitive dysfunction even if there is a lot of literature because it is comparative to long-covid where it would be difficult to say what the disability might be.

b) Work programme update

6.17. The Chair advised the Council had never specifically considered women and occupational health as a stand-alone topic.

6.18. Having had initial discussions with IOM to provide a scoping review, IIAC provided a short briefing to take an initial look at non-malignant diseases in women and reproductive conditions.

6.19. The Council awaits a response as to whether IOM can undertake an overview of what the literature points towards in terms of both non-malignant diseases and occupations that might be worthy of further investigations.

6.20. The Chair is going to look specifically at ovarian cancers.

c) Other updates

6.21. There were some practical issues discussed about noise and hearing loss and also a discussion around the 20 year rule which has been brought up again.

6.22. The Council is waiting for some information from HSE, so will discuss at a later time.

7. **AOB**

a) Update from DWP IIDB policy

7.2. The Chair asked if there was anything that DWP colleagues would like to ask or bring to the Council's attention.

7.3. DWP asked whether the Council had any thoughts or objections on the use of alternative practitioners in assessments (e.g. physiotherapists), where these assessors are trained and put through the same approval process as any other health practitioner or doctor.

7.4. Members didn't have objections to physios being used for IIDB assessments as long the correct training process had been followed, and considered that they may already have had extensive training in MSK type assessments. It was pointed out other alternative practitioners already sign fit notes. However, in general, as long as they were trained appropriately there would be no objections.

7.5. DWP colleagues agreed to consider this further.

7.6. DWP colleagues also asked a question about the potential to outsource spirometry testing to an external provider. This could enable a customer to bring this with them to the assessment in some circumstances.

7.7. IIAC noted that there has also been a recognition over the past five or ten years that quality control is very important in doing spirometry properly. Therefore using external providers who regularly do the testing and have good quality controls in place could be preferable to those doing them more intermittently.

7.8. DWP thanked IIAC for its advice and agreed to conisder this further.

b) Updated Dupuytren's contracture information note

7.9. A copy of the updated note was circulated in the papers for agreement and this now requires final sign-off by the full Council. The Chair thanked a member in particular for the work they put in to ensure it provided clarity. It was formally signed-off and the secretariat would now send it through for publication.

c) Public meeting

7.10. The secretatiat advised that Cardiff was the location of the public meeting on 6 July. The IIAC meeting will be held on the afternoon of 5 July. The secretariat will confirm with the providers by the end of the week and let members have details so they can make arrangements for travel.

7.11. It will be a hybrid meeting, so there is also scope for participants to attend without travelling to the venue as that has proved difficult for some in the past.

7.12. Details will be circulated soon.

d) Induction visits to Barnsley

7.13. The meetings start a 11am and the secretariat will forward details including the agenda and will forward to all members attending both days along with some advanced reading material.

7.14. The secretariat has asked for questions ahead of the meeting in order that members can respond on the day rather than have to take queries away to respond at a later date.

Date of next meetings:
RWG – 25 May 2023
IIAC – 5 July 2023, pm
Public Meeting – 6 July