INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Wednesday 5 July 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
Dr Sally Hemming	IIAC
Dr Sharon Stevelink	IIAC
Ms Patricia Quinn	Northern Ireland Department for Communities (NI DfC)
Mr Andrew Hay	NI DfC
Dr Charmian Moeller-Olsen	DWP IIDB medical policy
Ms Parisa Rezai-Tabrizi	DWP IIDB policy
Mr Garyth Hawkins	DWP IIDB policy
Mr Lewis Dixon	DWP IIDB policy
Mr Lee Pendleton	DWP IIDB operations
Ms Nicola Hobson	DWP IIDB operations
Mr Marc Dallamore	DWP IIDB operations
Ms Lisa Morris	DWP IIDB operations
Mr Mattew Saxton	DWP IIDB operations
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Steve Mitchell, Professor John Cherrie, Dr Richard Heron, Dr Anne Braidwood, Ms Lucy Darnton, Dr Rachel Atkinson

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. Dr Raymond Agius, through his involvement with the British Medical Association, indicated he was participating in writing up a paper on long-covid in doctors.

1.3. The Chair welcomed observers from the Northern Ireland Department for Communities who would be attending meetings from now on. The Chair also

welcomed observers from DWP IIDB operations, mainly decision makers, some of whom were involved in the recent IIAC induction events.

1.4. The Chair announced that the HAVS command paper had been laid before Parliament and the accompanying position paper had been deposited in the House libraries. The Chair asked why the command paper was only available in a limited format online – the secretariat indicated that the DWP digital publishing team needed more time to process the full version of the paper and this would be available in due course.

Minutes of the last meeting

1.5. The minutes of the March 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 albeit with some minor revisions and the secretariat would now send for publishing.

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

2. Occupational impact of COVID-19

2.1. The Chair introduced the topic by giving a brief overview of the changes to the report since the last version was shared and thanked members for their input into various sections. This paper has been updated to include education workers as well as those from transport.

2.2. The Chair noted that there had been a lot of papers published recently and notably the ONS and others have begun to evaluate inequalities in terms of occupation. These have explored how unequal occupation is related to age, deprivation etc. The Chair felt this was worthy of further consideration for the purposes of the paper. Some authors refer to an intersect which looks at the driver of poverty and inequalities being the occupation and the economics behind it. The discussion section of the paper will be expanded to include aspects of this.

2.3. The other addition to the paper is the section on outbreaks which requires further work. There has been discussions with the HSE and PROTECT (Partnership for Research in Occupational, Transport and Environmental COVID Transmission) study who are working on this and have had to integrate huge complex data-sets and consider other variables such as vaccination rates etc.

2.4. The Council has been given access to some of these data ahead of publication which will be useful for inclusion in the paper, subject to permissions being obtained. The data from outbreaks will need careful consideration but gives more insight into transmission/exposure.

2.5. Members were asked for their views on other industry sectors – there is a lot of information on transport and education, but less so for protective services, food processing, manufacturing etc.

2.6. The exposure section of the paper now includes the COVID job exposure matrix (JEM) which has been partially validated. Some studies are using the JEM in the absence of hard data, which may identify occupations which have higher risks. Putting this together with any epidemiological data will be

considered over the summer. A member drafted a paragraph explaining this in the draft paper.

2.7. The uncertainty around the risk estimates and probabilities using confidence intervals (CI) needs to be considered. Forest plots where CI included are a useful pictorial indication of the uncertainties around risk estimates.

2.8. A member thanked members for their hard work in putting the paper together, but they felt some reordering of the paragraphs was required so the JEM information was all in one place. They also felt that the exposure section should refer to aerosols rather than droplets. This member commented that perhaps the paper should be divided between occupations which could be considered for prescription and other issues which the Council are considering, such as outbreaks.

2.9. The Chair stated that the paper was a work in progress and if members felt there were gaps, then get in touch with their views.

2.10. A member raised the point of exposure in schools as children were not required to wear face masks. The Chair indicated that the paper contained information from other publications (Hargreaves) which showed the waves and schools infection survey, showing increases in infections. This member also asked if the use of the COVID JEM in this paper would set a precedence for other future investigations. The Chair stated that whilst the JEM had only been partially validated, it did give a way of estimating risks and what might happen.

2.11. The member postulated that if health & social care workers (H&SCW) showed an elevated score on the JEM, should other workers who showed the same score be treated the same as H&SCWs. This could be considered as exposure equivalence and this approach was taken with the HAVS review. Another commented that they felt the JEMs could be flawed and cautioned against too much emphasis being placed on them. The Chair felt there were some qualitative data to the JEM and would be useful to include.

2.12. The Chair asked members for their views on the results relating to education and transport workers, stating that the 2 occuptions were the opposite of each other – education showed increased risks of infection but lower risks of mortality, whereas transport is the other way around. Modifying factors such as comorbidities will influence the mortality rates.

2.13. When the Chair asked if there was an appetite to prescribe for these occupations, a member stated they felt the evidence was not strong enough. No other members disagreed. The Chair pointed out there were consistently high death rates for transport workers and infection rates in school were high.

2.14. A member commented that the coronavirus strains are changing and those which are prevalent now are not causing the same diseases as before and vaccination has had impacts.

2.15. Referring to the death data for transport workers, a member paraphrased David Spiegelhalter who stated the more risk you have of dying of any cause the more your risk of dying from COVID-19 – there appeared to be an almost linear relationship between death rates (adjusted) from any cause and the rate of death from COVID-19. This may be applicable to transport workers.

2.16. The Chair commented that they felt the risks were different for COVID as key workers, many of whom came from disadvantaged (social/ecomonic) sectors of society, were unable to work from home – 80% of transport workers had to go out to work.
2.17. The Chair felt this complicates the interpretation of the data – there are *a priori* probabilities which alter the probabilities obtained from occupations, but the Council is not able to quantify that.
2.18. Several members commented on the risk faced by transport workers and those in the education sector, stating they felt the risks were higher. A member felt, relating this back to the public COVID enquiry, that there were external expectations that education & transport workers would be recommended for prescription, but if the evidence was not strong enough, then this needs to be clearly spelled out in the paper.
2.19. The information on outbreaks indicated the importance of shared transport to work and breaks in contributing to spread of infections.
2.20. A member felt that 'workers' in education needs to be clearly defined as early years childcare continued through lock-downs etc and this sector is also heaviliy reliant on workers from ethnic backrounds and faced the same risks.
2.21. Another member pointed out that the draft paper acknowledges there are higher risks for transport and education workers.
2.22. A member felt that in order to assess the evidence for transport and education workers,the evidence obtained to support the recommendations for H&SCWs could be used as a benchmark for comparison. By adopting this method, if the evidence doesn't appear to support prescription for other occupations then there is a clear explanation why this would be the case.
2.23. This was considered to be a useful suggestion and would be put to RWG as an exercise to compare the data side-by-side from H&SCWs and transport/education.
2.24. A member wondered if the current evidence available for H&SCWs would be sufficient to recommend prescription and it was thought probably not, due to timelines, infection rates etc.
2.25. Regarding benchmarking, a member felt it would be important to define what would be meant by public facing and what that would entail to be comparable with H&SCWs. It was pointed out that this would probably be the case for education as there were data to show a high infection rate amongst children, who were more likely to be from key-worker families.
2.26. For transport workers, it was likely that whilst the infection may have been higher, the density would have been lower i.e. fewer people travelling.
2.27. The Chair commented on a point raised about the higher risks faced by early-years childcare workers and the inequalities related to this sector, that the data are not available in sufficient granularity. For transport workers, there are data relating to deaths, but little data on infection rates, the converse being for education workers, with a gap in information for early-years.
2.28. It was agreed that the benchmarking exercise would be carried out with data from education/transport.

2.29. A member stated that for transport/education, they couldn't envisage what a prescription would look like given the the lack of information on disabling conditions. The Chair pointed out that for H&SCWs, there was no definitive occupational data which linked the 5 serious health conditions. These were prescribed because they are serious conditions which are known to have been caused by COVID-19, which H&SCWs were at greater risk of catching.
2.30. This would also apply to long-covid where there is risk of reporting bias and non-specific symptoms. So no robust data for long-covid by occupational groups ;it has also been observed that long-covid referrals are declining.
2.31. Referring to the granularity of data, it was pointed out that there is a hierarchy of risks for different occupations with H&SCWs, and there were a lot of data as this occupational group was unique due to its access to testing, but this was not the case for other occupations.
2.32. Paying devil's advocate, a member asked how the Council could justify not prescribing for occupations which are people-facing/essential workers. A member countered this by stating that rigorous scrutiny and definition is needed, and having a defined job category is important. The Chair added that when data from outbreaks are available and analysed, this may help inform decisions.
2.33. Commenting on outbreaks, a member thought this would not be applicable to education or transport – the Chair thought it best to wait until the outbreak reports are published. Transport for London indicated it had encountered outbreaks, but this were thought to be caused by workers congregating for breaks.
2.34. The Chair asked for any further views and a member commented they felt that the understanding around JEMs needed to be revisted, looking at their limitations and what value they add - this was agreed.
2.35. The Chair indicated work would continue on the paper and agreed that perhaps the outbreaks information may not be relevant for transport/education workers. The Chair commented that the benchmarking exercise will be a way forward for transport/education and then asked members again for their views on whether they thought other occupations should be considered.
2.36. A member felt that the use of the accident provision of IIDB could be reconsidered and perhaps the Council should consider a way to frame a form of words for other occupations where there may be elevated risks but not enough information/evidence to prescribe.
2.37. The Chair felt that, looking at the evidence it already has and the literature, it may be difficult to expand on what is in the command paper for other occupational sectors. Other members agreed.
2.38. Following on from some further discussion on outbreaks, it was felt that there could be some specific questions for RWG to deal with, which was welcomed by its Chair. The benchmarking exercise would be covered at the next RWG meeting in September.
2.39. A member asked if COVID-19 was now on the wane and not so relevant. Various members commented to say it was still very much prevalent, but testing was restricted. There were still deaths from COVID-19 being reported

and it was fortunate that a more harmful variant hadn't emerged. However, there were other viruses such as 'flu which were having an impact.

2.40. The Chair drew the discussion to a close and then asked DWP officials for an update on the progess of the recommendations the Council made in its COVID-19 command paper. A DWP official commented that impacting across a number of areas is continuing, considering factors such as deliverability. This is a complex topic with many aspects to consider. However, progress has been made. As part of this process, a small audit of IIDB accident claims related to COVID-19 has been carried out. This has considered occupations involved and some of the medical conditions referred to in the command paper.

2.41. IIDB officials asked for some further input from IIAC members to review high level findings from a review of accident claims, conducted as part of the impacting process.

3. Revision of PD D1

3.1. This topic was introduced by the Chair who stated this had been worked on for several years, had major input from the respiratory disease expert members and had been out for external review. Presumption had been raised in previous meetings and had now been addressed in this final version of the paper, subject to any further comments from members. The Chair felt this draft command paper was essentially complete and ready for sign-off.

3.2. The member who drafted the paper explained the presumption issue and commented that this would apply if a definitive diagnosis of pneumoconiosis had been given by an acknowledged expert.

3.3. Another commented that they felt the new proposed prescription should be in the main body of the report and not in an appendix.

3.4. The Chair felt that this command paper could address many of the questions which stakeholders have raised in the past and at public meetings.

3.5. The Chair asked if there were any further implications of this paper – it was raised that there were several potential legal implications and IIAC commented that some of the definitions in Social Security law, such as that for pneumoconiosis (alluding to dust reticulation), were outdated. A member of the secretariat commented that following the recommendations made by the Council, it would be for DWP to consider whether there is a consequential set of amendments which may need to be made if there is contradiction to existing legislation. IIDB policy will take this forward to review if the recommendations are accepted.

3.6. Members agreed that this paper could be signed-off – the Chair thanked the member who led this review for the enormous amount of work which had gone into it. The command paper will be prepared for laying in the autumn.

4. Respiratory diseases commissioned review

4.1. 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. This may result in recommendations to change current prescriptions or identify where new precriptions could be made.

4.2. Based on systematic reviews and meta-analyses and following consultation with IIAC, IOM came up with six exposure/disease combinations to look at in more detail. These are:
   - Silica and COPD
   - Silica and lung cancer
   - Cleaning products and COPD
   - Work as a farmer and COPD
   - Chromium 6 (hexavalent Chromium) and lung cancer and
   - Asbestos and lung cancer

4.3. IOM intend to provide reports for the next RWG meeting (September 2023) on:
   - Silica and COPD
   - Silica and lung cancer
   - Cleaning and COPD

4.4. IOM expect to have completed the screening and data extraction for farming/COPD soon. The literature searches have been completed for Chromium and asbestos – the intention is to have initial reports available by end of November/early December, with final reports by January/February 2024. For the next IIAC meeting, it is anticipated that there will be 3 or 4 disease/exposure combinations for the Council to consider.

4.5. The Chair commented that this would be a lot of work, which may impact on its ability to look at topics on the work-programme as each of the disease/exposure items would need to be treated as topics in their own right.

4.6. Initial findings may indicate that it is not strictly necessary for a patient to have silicosis before going on to develop lung cancer, which is important for the PD D11 prescription where this is a requirement. This will require further discussion.

4.7. The Chair commented that they surmised there was a lot of literature for some of these combinations and some of the literature may be complicated to interpret. The Chair indicated that IOM's reports would be important in contributing to IIAC's papers on these topics and IOM would be asked to advise on their views of the most important topics to tackle first.

4.8. A member asked if dose equivalence for asbestosis had been considered given the increase in asbestosis cases and the type of occupation involved, e.g. construction. IOM stated the work was not complete on asbestosis but it was aware asbestosis was used as a signal for higher asbestosis exposure, it would be for IIAC to decide whether to look in more detail at dose equivalence.

4.9. The Chair thanked IOM for its update and looked forward to the outcomes. IOM will be giving a brief overview of this at the public meeting the following day.

5. RWG update

a) Neurodegenerative diseases (NDD) in professional sportspeople

5.1. The Chair advised this was a topic that was being pressed on and IIAC had received further correspondence from the PFA who had also shared papers. A response will be drafted, thanking the correspondent.

5.2. The member leading the review indicated that following a discussion with other members, it was decided to focus on amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease) and motor neurone disease (MND) as these appear to have positive signals in the literature.

5.3. The secretariat was asked to conduct a literature search of the most recent papers using a search strategy provided. This is a very active area of research and new papers are being published all the time.

5.4. Further neurodegenerative diseases (NDD) will be considered in due course.It was noted that literature can be unhelpful where NDDs are lumped together as claimants would present with a specifc condition (e.g. Parkinson's). Also, the exposure which could have caused the condition is often poorly described.

5.5. The Chair indicated this was a big topic to investigate which is likely to take some time to conclude. As stated previously, this is fast moving area of research – there are case reports and cross-sectional studies, but not a great deal of high quality epidemiological studies. This is a topic which will probably need to be monitored. A member commented that return-to-play policies may need to considered in the future, especially around consussive vents.

5.6. Professor McElvenny declared that they were involved in studies in this area and had received funding from the Drake Foundation.

b) Firefighers and cancer.

5.7. The Chair started by stating that previously conflict of interests had been declared (Dr Rushton/Prof McElvenny), it was felt appropriate for Prof McElvenny to leave the room for the duration of this topic as they are an assistant editor at the journal, Occupational Medicine, which published the article by Prof Stec (Scottish Firefighters Occupational Cancer and Disease Mortality Rates: 2000-2020, A Stec and others, Occupational Medicine, Volume 73, Issue 1, January 2023) – Dr Rushton was an initial reviewer of this paper prior to publication.

5.8. In the absence of Prof McElvenny, the Chair stated they wanted IIAC and Occ. Med. to be separated for the purposes of conflicts of interest in this discussion. The Scottish firefighters paper and follow-up questions to the author, along with their response, was cirulated separately to members.

5.9. In March 2021, IIAC published a position paper on firefighters and cancer in response to recommendations from the environment audit committee around firefighting and IIDB. This review found that there are risks associated with firefighting but other than mesothelioma (covered by IIDB), none are doubled. Firefighters are generally healthy and subject to regular health-checks. The IARC monograph meta-analysis indicated less than doubled risks.

5.10. In the paper by Prof Stec, there doesn't appear to be a healthy worker effect, as you might expect for a group of heathy workers such as firefighters. The risk estimates for cancer in this paper are also much higher than reported in the rest of the literature, prompting questions on how this was derived.
5.11. Several IIAC members had reviewed the paper and formulated a number of detailed queries for the authors as to how they got the data and the methods used. The response was useful but what was apparent that pension records (via freedom of information request) had been used which only seem to include 'paid-pensioners'. A further query to the author was submitted which asked about this pension data (no response received at the time of the IIAC meeting).
5.12. The issue with using data from the pension scheme is that the numbers reduce sigificantly from ~ 2007. This could be for a number of reasons, including transfer into other schemes. This was included in the follow-up query to the author.
5.13. A member commented they thought it was a denominator issue as the paper didn't find sufficient retired pensioners to ensure the denominator was correct for the risk ratios. They also agreed that a healthy worker effect would be expected.
5.14. A member questioned how this paper got though to the publishing stage if there are issues as described – this was thought to be an editorial decision at Occupational Medicine.
5.15. The Chair stated that they had looked at the paper, along with other members, and scrutinised its findings, but asked that someone else take a look to give their views.
5.16. The secretariat stated the Home Office, who own the policy for firefighter safety, had been in touch asking for IIAC's views and would be kept informed of progress.
5.17. Another member commented that they agreed that the population numbers don't look right in the paper i.e. an excess of numerators.
5.18. Prof Agius declared, for the purposes of conflict of interest, that the FBU had been in touch with the BMA and Prof Agius was dealing with the correspondence.
5.19. It was noted that representatives of the Fire Brigade Union (FBU) would be present at the public meeting the following day, so a response to their queries would be drafted, including why the numbers of pensioners quoted may be incorrect.
5.20. The Chair discussed briefly how Prof Stec had rightly highlighted the elevated risks faced by firefighters from inadequate cleaning of uniforms etc. but the Chair indicated this data wase inadequate to indicatethat exposures were sufficient to cause diseases.
5.21. The Chair suggested it may be appropriate to respond officially when the author has had the opportunity to clarify the additional queries put to them. This could be an information note, published on the IIAC.gov site.

c) Work programme update

5.22. The Chair asked that Prof McElvenny rejoin the meeting.

5.23. The Chair started the discussion by stating that the Council already has a number of big projects with more expected when the commissioned review has concluded. It had already been decided that women's health needed to be explored, with the Chair focussing on ovarian cancer – IOM had been asked to provide a proposal to scope out other issues relating to women's health.

5.24. Members had been provided with a list of topics (drawn from a variety of sources) which could be looked at and as an out-of-date version of this was on the website, it was time to update this. It was noted that rather than stating 'not started' to use the term 'remains under consideration'.

5.25. It was felt that the IIDB 'B' diseases need to looked at and others could be taken off, but welders should remain, especially around ocular melanoma. Cleaners are on this list, but would be covered by the commissioned review.

5.26. Fibreglass and styrene were thought to be worthwhile exploring given a number of cases related to bronchiolitis had emerged – several members volunteered to look at this.

5.27. Osteoarthritis (OA) of the knee in other occupations was also suggested. It was noted that there was a question relating to occupations in mining for OA knee for the public meeting the following day.

5.28. The secretariat agreed to update the list and share with RWG for discussion at next meeting.

6. **AOB**

6.2. Correspondence had been received on laryngeal cancer and asbestos which will require a follow up response. This will be drafted by the secretariat.

7. **Public meeting**

7.2. The Chair thanked all members for the work they had put into the presentations and for the member who had agreed to lead the public forum.

7.3. As this is the first hybrid/in-person meeting, a member volunteered to keep an eye on questions which may appear in the chat.

7.4. Written questions which had been submitted ahead of time could be dealt with by a written response or addressed at the meeting. Some questions may be resolved by the content of the presentations. Questions which are outside of IIAC's remit will be referred back to DWP to respond.

Date of next meetings:

RWG – 7 September 2023
IIAC – 19 October 2023