INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 25 May 2023

Present:

Dr Chris Stenton	Chair
Dr Lesley Rushton	IIAC Chair
Professor John Cherrie	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Dr Jennifer Hoyle	IIAC
Mr Dan Shears	IIAC
Professor Damien McElvenny	IIAC
Dr Rachel Atkinson	Centre for Health and Disability Assessments (CHDA)
Dr Anne Braidwood	MoD observer
Ms Lucy Darnton	HSE observer
Dr Charmian Moeller-Olsen	DWP IIDB Medical Policy
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Mr Garyth Hawkins	DWP IIDB Policy
Ms Penny Higgins	DWP ALB Partnership Team
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 set out expectations for the meeting and how it should be conducted. Members attending remotely 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, Professor Damien McElvenny stated he had been awarded additional funding for a study into mortality in footballers.

1.3. The Chair welcomed Georgie Wood, new to the IIDB policy team and Penny Higgins who has taken over responsibility for the IIAC secretariat.

2. Minutes of the last meeting

2.1. The minutes of the meeting held in May 2023 were cleared with minor edits required for publication.

2.2. All action points were cleared or in progress. It was agreed the action points would be extracted and circulated.

2.3. It was agreed to ask for feedback on noise-induced hearing loss which was discussed at the last RWG meeting.

3. Occupational impact of COVID-19

3.1. Several papers were shared with members:

- A revised paper about transport workers, which now includes a section on education and further data on outbreaks.
- Analysis from the PROTECT COVID-19 National Core Study.

3.2. The Chair commented that they felt members should discuss whether they are moving in the direction of recommending prescription. The Chair asked a member who had contributed to the paper to comment.

3.3. This member drew attention to a few points to note:

- The paper is still a 'work in progress'
- The section on exposure is being updated – it was noted that COVID job exposure matrices (JEM) were being increasingly used. The use of these had been extended to consider influenza A&B where similar results seen in COVID where risks were observed in workforce sectors. It was noted that the JEMs used had been validated and it was felt that these could be useful in drawing analogies between occupations to establish risks.
- It was noted that inequality in transport availability may impact access to healthcare services where lower income groups may have to rely on public transport.
- A member had contacted the PROTECT group and had a positive response from the researchers who had been looking at outbreaks and early access to their data may be available to the Council. It was felt further discussion with this group would be very useful.
- Outbreak data may influence the decision-making on whether to recommend prescription.

3.4. The data shared by PROTECT showed a large peak in education workers which coincided when the schools opened in 2021, but further interrogation of these data are needed.

3.5. It was noted that teachers have a similar JEM score to health & social care workers (H&SCWs). Further work will be carried out on education workers to include in the draft paper.

3.6. A member stated they were aware of a systematic review of outbreaks and offered to source a copy if it had been published.

3.7. It was noted that inequalities in terms of occupation are being considered in relation to age, deprivation, sex, ethnicity etc in the PROTECT studies and it was felt this was an important issue to discuss.

3.8. A member stated there was a lot more to include in the draft paper on the current sectors but also whether other occupational groups such as security, food processing/manufacture, retail or protective services should be included. Members were asked to give this consideration.

3.9. The Chair commented that there was a big difference whether the Council is heading towards recommending prescription, in which case a very detailed command paper would be required. If that was not the case and it was felt that the risks identified were not two-fold, then this could be an easier task. Their views were that there was not sufficient overall doubling of risks, however, other views were canvassed.

3.10. A member commented that whatever the Council decides, it will attract criticisms, so however it is framed, the Council needs to be clear in its arguments.
3.11. Another member felt it would be useful for the Council to discuss what it requires in terms of sufficient evidence, especially in relation to outbreaks which might be covered by the accident provision of IIDB. Regarding the data, it was felt that confidence intervals (CI) need to be considered more closely as where these are wide, there is more uncertainty.
3.12. The IIAC Chair suggested putting together a working group to examine what might be considered acceptable evidence in the absence of epidemiological data, e.g., where there is a definitive occupational link to a disease, such as hand-arm vibration syndrome where the epidemiology information is sparse.
3.13. A member commented that the data are scarce for early in the pandemic when the risks were highest as subsequent phases would have been impacted by mitigations being in place and the roll-out of the vaccines. Also, COVID-19 infections are now less likely to be reported, employers are less likely to act, and testing is less widely available. All this makes current data gathering difficult with probable diminishing returns.
3.14. A member observed that there were very high numbers of teaching assistants, who were dealing with children of key workers, who went off sick due to COVID-19. Their risks would have been diluted as the wider education sector would have been at home.
3.15. A member commented that this appeared to replicate that seen for H&SCWs where the initial risks were very high but tapered off. It was suggested that rather than looking at the totality of evidence across the pandemic, perhaps to focus on the early part where risks were greatest.
3.16. The Chair suggested that whilst the epidemiology may not be strong, if information was available on implementation of mitigations, this may enable a determination that risks were higher before these measures were put in place, thereby making recommendation for prescription more feasible.
3.17. The Chair asked if information was available on the implementation of protective measures. It was felt that none was immediately accessible, but the COVID inquiry may yield information. The lack of official guidance on a sectoral basis was thought to be a contributory factor to risks arising from the pandemic. The success of mitigations were varied and different for individual sectors and, in some instances, guidance was ignored. A member is endeavouring to map out when guidance was issued, but this has proved difficult. The member stated they would make that available if helpful. They also had information on outbreaks from the Hazards campaign, but this may not meet the Council's requirements for inclusion in the paper. At the last IIAC meeting, a member suggested looking at employer records.
3.18. A member commented that the roll-out of the vaccines was a mitigating factor which impacted on reduction of virus transmission and on the development of long-covid symptoms. A member commented that the effects of the vaccination programme were complex as whilst workers may have been vaccinated, children would likely not have been, impacting on transmission

risks. A member noted that PROTECT were coordinating data on the vaccine roll-out which will be included in their analysis.

3.19. It was suggested again that the doubling of risk criterion be reviewed to determine what other factors, if any, could be considered when establishing what is acceptable risk which would fulfil the required 'more likely than not' criterion for IIDB. A member felt a generic paper which explored alternatives to doubling of risk was required.

3.20. It was noted that there are still significant numbers of hospital admissions due to COVID-19, so it's still relevant and not going away.

3.21. A member asked what the requirements were for the current prescriptions which cover infectious diseases – the eligibility criteria did not seem stringent, e.g., contact with blood, but many of prescriptions were old and some were obscure. It was commented that the infectious disease prescriptions require review.

3.22. A member pointed out that mitigations were not considered when the Council recommended prescription for H&SCWs, so including that in this investigation would be inconsistent. However, it was noted that H&SCWs investigation focussed on the early part of the pandemic when mitigations were not in place and subsequently risks will now have been diluted when looking at current data.

3.23. A member asked how the current paper should proceed given there are data available on protective services, transport and education but little on retail workers. It was suggested that the JEM scores for different occupations could provide a systematic approach. It was felt that those with scores similar to H&SCWs should be included because if it is decided to not prescribe, it is important to ensure these sectors are shown to have been considered.

3.24. Evidence available includes, exposure information, JEM scores (application and validation), epidemiological information, and outbreak data. There was concern that evidence of high occupational risks early in the epidemic is being diluted over time, so perhaps consideration should be given to data from early stages of the pandemic when risks were likely to be highest. However, it was noted that the studies often don't correlate with that. It was noted that England and Wales mortality data by occupation after 2020 is not yet available, so a member offered to contact ONS and other bodies to establish when it may be available.

3.25. It was agreed to proceed with the draft paper in its current form with further input when discussions with the PROTECT researchers are complete. It was also felt important to cover timelines, but acknowledged this may be complex.

4. Review and revision of the pneumoconiosis prescription, PD D1.

4.1. The Chair stated this had been under review for quite some time but significant progress had been made and was now close to a command paper. A revised draft version had been circulated in meeting papers.

4.2. The aim of the proposal is to simplify the prescription to 4 categories:

- Asbestos
- Coal or coal mine dust

- Silica-containing dusts
- Metal dusts

4.3. The Chair felt that most of the areas where members had differing views had been resolved.

4.4. The issue of whether or not to include lists of at-risk occupations or exposures required further discussion. There is an authoritative paper which provides a list of silica exposures, but this is not so easy for asbestos and other exposures.

4.5. The Chair invited discussion on the draft command paper which had been circulated to members.

4.6. A member suggested the use of the term 'non-exhaustive list' to defer any criticism. Another member commented that they were not in favour of having lists of exposures as inevitably something could be missed. It was suggested that a small table be drafted for each of the sections giving examples of exposures. The IIAC Chair responded that it was felt that for silica, it was important to illustrate the different types of exposures, similarly for hard-metal exposures which can be under-diagnosed.

4.7. A member stated that the GORDS (group of occupation respiratory disease specialists) group had been working on a consensus statement on diagnosis that should help assessors. The member also stated that they were waiting for data from SWORD (surveillance of work-related and occupational respiratory disease) and would provide this when available.

4.8. A member raised the issue of presumption for 2 years aggregate exposure which is referred to in the command papers Cm 8880 and 9030. It was agreed to consider this and revise the draft command paper if necessary. The Chair made the suggestion that presumption would apply if a specialist diagnosis had been provided but presumption would not apply in the absence of a specialist diagnosis. It was felt this did not need to be spelled out in the command paper as it was clear a specialist diagnosis would be expected.

4.9. A member stated that the Social Security Act has a specific definition of pneumoconiosis which is now considered outdated. It was agreed the secretariat would discuss this with IIDB policy officials to determine if the SSA needs to be revised and establish a course of action.

4.10. There was some discussion around idiopathic lung fibrosis and how this could relate to the proposed prescription. It was considered that the proposals provided more clarity in relation to the diagnosis question.

4.11. If the advice from Council is accepted by the Minister, guidance for claimants and assessors would be updated as a matter of course. It was felt that subject to some editorial adjustments, the draft paper could be put to the main Council for discussion with a view to signing it off ready for laying in Parliament and publication.

5. Firefighters and cancer

5.1. The Chair gave an overview of the two papers that prompted this topic to be revisited. They indicated high risks of cancers in firefighters which are out of step with most studies.

5.2. Several members reviewed the papers and concluded, amongst other things, that there appeared to be a denominator issue where the number of retired firefighters may have been underestimated, thereby over exaggerating the risks.
5.3. When the figures from these papers are applied to published data of Scottish retired and active firefighters, slightly lower rates of cancers are observed which is consistent with a 'healthy worker' effect, which is as expected.
5.4. The corresponding author of the papers has replied to some queries IIAC members had, but to date answers have not been received on follow-up questions.
5.5. IIAC will await further correspondence from the paper's author but nothing further is planned for this topic.

6. Neurodegenerative diseases (NDD) in sportspeople

6.1. The Chair introduced the topic by stating that this had received a lot of press attention and IIAC had received correspondence about this from a number of sources.
6.2. IIAC reviewed the topic in 2005 and 2016, but subsequently there have been a number of papers published. The Scottish studies into footballers and rugby players showed high risks of developing NDDs. However, a recent Swedish study of footballers demonstrated less than doubling of risk.
6.3. The current investigation is focussing on breaking the issues down into relevant diseases. A lot has been written about chronic traumatic encephalopathy (CTE) but this is diagnosed post-mortem. Other studies have lumped all the diseases under NDD. Multiple sclerosis and possibly epilepsy may need to be reviewed but there doesn't appear to be much information on these.
6.4. Initially, the investigation focussed on reviews as it is a large topic area. The original idea was to focus on football and rugby, but as other sports experience the same effects, it was decided to look at the individual diseases across relevant sports. A paper was circulated to members which gave a summary to date.
6.5. The next phase will be to update the 2016 IIAC review and produce a paper.
6.6. A member commented that they felt the right approach was being taken by looking at individual diseases, but thought there was scant evidence for cognitive impairment and there appeared to be some signal for other NDDs which warranted further consideration. Motor neurone disease (MND) also known as amyotrophic lateral sclerosis (ALS) appeared to be the strongest, although which sports should be included needed to be discussed – American football appears to have a fairly consistent risk for developing Parkinson's disease (PD).
6.7. Importantly, consideration is also being given to whether physical impact or concussions are the main risk factors. It was noted that concussion is discussed widely in the literature, but can be difficult to diagnose.
6.8. The Chair commented that there is some evidence which suggests extreme physical exercise, so non-contact sport, is associated with increased risk of

developing a NDD. A member asked if there was a link to trauma (non-sport related), such as a fall, and developing MND. It was thought there may be some reverse causality as someone who falls may be more likely to be diagnosed with a neurological disorder.

6.9. An observer commented that there is substantial literature on traumatic brain injuries over the spectrum from mild to medium to severe. They have reviewed this and offered to share the findings with IIAC.

6.10. This observer also pointed out that there may be a genetic propensity to NDDs as in PD and other disorders, a genetic change is associated with developing the conditions. The Chair commented that they were aware of literature on MND which hypothesises the genes that allows individuals to run fast are the same genes which predispose MND, so possibly not a causal relationship.

6.11. There was some discussion around genetic susceptibility and occupational diseases and whether there was a causal relationship. In general terms, if someone has an occupational exposure and develops a disease, genetic elements would not generally be considered for compensation.

6.12. It was felt that MND would be the first disease to focus on across a variety of sports and build upon the 2016 IIAC review.

6.13. A member commented that studies on MND by occupation indicate that agricultural, horticultural workers and growers show excess risks, possibly linked to pesticides. Also, they believed frontal temporal dementia and MND have genetic links.

6.14. A member commented it was important to look at the exposure within each of the sports.

7. Commissioned review of respiratory diseases

7.1. A member gave an update on progress made on the review.

- Final draft reports of silica/COPD and silica/lung cancer are nearing completion.
- In the process of data-extraction for cleaning/COPD.

7.2. Based on the findings to date, the member stated they could pull out topics for further consideration but felt this would be a decision for the Council.

8. Work programme review

8.1. Topics relevant to women's occupational health such as ovarian cancer will be looked at. The Institute of Occupational Medicine (IOM) were approached to discuss a scoping review into women's health in the workplace and a proposal for a scoping review of non-malignant conditions is awaited.

8.2. The IIAC Chair stated they were pressing for more funding for scientific support to look at other topics, for instance a commissioned review of infectious diseases or sub-topics of that.

8.3. It was felt a prioritisation of topics to take forward should be considered and a work-plan drawn up.

8.4. A member commented they were involved in establishing a global network for evidence synthesis in occupational safety and health. This could look at

reviews of causality, exposures etc. There may be an opportunity for IIAC to become involved, so will be added to a mailing list.

9. AOB

9.1. 20 year working rule in mineworkers and COPD

- This topic was discussed at previous meetings. It was felt that further information about the levels of dust (exposure) in modernised coal mines would be helpful. Whilst working hours may have been increased, this may have been off-set by reductions in dust levels.
- An HSE observer was asked if there were any newer data available on dust exposures in mines.
- Due to the reduction in the size of the industry, work patterns will differ and further information may be limited, but intervention data may be available since 2014, so this will be followed up.
- It was noted that IOM may have some information which may be relevant.

9.2. The IIAC public meeting

- The meeting will be also be online, so members with other responsibilities, which makes travel challenging, can join remotely.
- The proposed agenda was discussed and it was felt NDD needed to be included.
- It is anticipated questions will be submitted in advance, along with those online and in the audience. Practicalities for dealing with this will be considered.
- Members were asked to promote the meeting through whatever channels are available.

Date of next meetings:
IIAC – 5 July 2023 (pm)
RWG – 7 September 2023