INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 19 October 2023

Present:

Dr Lesley Rushton	Chair
Dr Chris Stenton	IIAC
Dr Ian Lawson	IIAC
Professor Kim Burton	IIAC
Professor Max Henderson	IIAC
Professor John Cherrie	IIAC
Ms Lesley Francois	IIAC
Professor Damien McElvenny	IIAC
Dr Jennifer Hoyle	IIAC
Dr Gareth Walters	IIAC
Dr Sharon Stevelink	IIAC
Dr Richard Heron	IIAC
Ms Lesley Francois	IIAC
Ms Patricia Quinn	Northern Ireland Department for Communities (NI DfC)
Mr Andrew Hay	NI DfC
Dr Anne Braidwood	MoD observer
Dr Rachel Atkinson	Centre for Health and Disability Assessment (CHDA) observer
Ms Penny Higgins	DWP Arm's length bodies partnership team
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 Kieran McDermott	DWP IIDB senior operations manager
Mr Lee Pendleton	DWP IIDB operations
Ms Nicola Hobson	DWP IIDB operations
Ms Lisa Morris	DWP IIDB operations
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Mr Steve Mitchell, Professor Raymond Agius, Ms Lucy Darnton, Dr Sally Hemming, Mr Daniel Shears, Mr Stuart Whitney

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 welcomed Penny Higgins (DWP arm's length bodies partnership team) who would give an overview of the recent light-touch review of IIAC. Observers from DWP IIDB operations were also welcomed; the Chair commented that members who had attended Barnsley for the induction event

had found the exercise very useful and hoped a second event could be arranged soon for members who were not available previously.

1.4. The Chair announced the PD D1 command paper has been scheduled to be laid before Parliament and published on 16 November.

1.5. The Chair also announced that the secretariat had secured extra funding to provide scientific support for the Council and that discussions were being finalised to increase members' fees. The Chair thanked the secretariat and other members of DWP as the funding could help underpin the work of the Council.

Minutes of the last meeting

1.6. The minutes of the July 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.

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

2. Occupational impact of COVID-19

2.1. The Chair introduced the topic by stating a paper had been circulated which summarised the bench-marking exercise carried out to compare evidence from health and social care workers (H&SCWs) with that from other occupations.

2.2. This was felt to be a helpful way to assess evidence and this paper was the third iteration as the other versions were complex and difficult to follow.

2.3. The paper has Job Exposure Matrices (JEMs) at the beginning where attempts to link these to evidence on exposures have been attempted. The paper showed that many of the occupational groups have very similar risk scores and can distinguish between broad occupation groups but not individual jobs. Some validation of the JEMs of broad occupational groups has been established, but not for specific occupations.

2.4. The second section of the paper describes infection surveys, but as explained in previous published IIAC papers, the infection evidence may have problems such as unrepresentative samples from some occupations. There is a tendancy to have small numers of subjects in specific occupations.

2.5. Mortality data also have issues as there are several different measures of mortality risk used in different studies (same applied to infection) such as non-adjusted vs adjusted, porportional mortality, excess mortality etc. These data have provided good evidence and showed a doubling of risk for certain occupations, especially in 2020; however, death rates may be influenced by age, co-morbidities, gender, ethnicity etc. Some studies have adjusted for this but determining if COVID-19 was the causative factor can be problematical.

2.6. Having summarised the paper, the Chair felt that members needed to have a debate on where to go next with further occupations which could have been impacted by COVID-19. Transport and education workers have been considered so far but other occupations have much less data. It was also noted that long-covid will need to be discussed at some point and the Chair

observed that there was a useful article in the BMJ Evidence Based Medicine[1] which summarised the current issues around this topic.

2.7. A member asked about the eligibility criteria to claim under the accident provision. The recommendations in the previous command paper specified 5 health conditions in H&SCWs only, but other occupations may be able to claim under the accident provision. If a H&SCW developed a health condition not specified in the command paper (e.g. long-covid), they may be able to claim through the accident provision, which is currently the case. It was noted that the accident provision requires a specific event to be identified to claim, whereas if the command paper recommendations are accepted, presumption would apply.

2.8. A member asked if there was sufficient evidence for other occupations, including JEM scores, compared to H&SCWs as there appeared to be a difference in risks between waves, which also indicated that perhaps H&SCWs (in retrospect) should not have been recommended for prescription.

2.9. The Chair stated that, on the balance of probabilities, H&SCWs had much higher risks for developing disabling conditions as a consequence of having had COVID-19 in the course of their work and there was evidence to support this, taken from the sources described, albeit with some inconsistencies. This allowed an informed decision to be made.

2.10. A member questioned the assertion, in the benchmarking paper, that the risks of infection were broadly similar across the occupations (H&SCWs, transport & education) as they felt that H&SCWs were dealing with infected patients whereas others were public facing, other than perhaps taxi drivers who may have transported infected patients to hospital. Also, H&SCWs were subjected to testing, which other occupations were not.

2.11. The Chair responded to say that other factors such as exposure transmission and mitigation factors also need to be considered as the data are limited for other occupations. However, there were papers which showed high rates of infection in the education sector when the schools reopened. It was pointed out that the prescription for H&SCWs is very precise and narrow and if members were considering recommending prescription for other occupations, consideration needs to be given to restrictions which might apply.

2.12. A member commented on the point made about H&SCWs and agreed that the risks now have declined significantly compared to the early stages of the pandemic, so the current position is different to that when the command paper was written. This member thought that the risks faced by the broad groups of transport and education workers were not high enough to warrant prescription, but specific jobs (e.g. taxi drivers) may have had higher risks but data are sparce and it then becomes a matter of opinion, not evidence-based. This could also be the case for the education or security sectors.

2.13. A member asked what other routes for compensation might be available if it is not going to be possible to recommend prescription for these other occupations. The accident provision of IIDB was suggested by another member, but this may not be practical.

[1] Høeg TB, Ladhani S, Prasad V. How methodological pitfalls have created widespread misunderstanding about long COVID. BMJ EvidenceBased Medicine Epub ahead of print

2.14. A member commented that if other members felt there was insufficient evidence to prescribe, then the Council should not be apologetic as the investigations carried out have been thorough, systematic and robust. They felt that the risks for H&SCWs had declined because:

- Better PPE available;
- less virulent virus and
- vaccination.

Other occupational groups had longer to produce data, but would suffer the same risk-dilution as H&SCWs and would not have been studied as widely. This member felt that the Council could only recommend prescription based on the available evidence and, given the factors already described, the evidence for non-H&SCWs was not sufficient.

2.15. The Chair agreed that members were fulfilling their remit to a high standard and asked if other members agreed with the dilution factors. The Chair stated that the data for other occupations were not straightforward and elements such as death-data persisted for transport workers. This made the benchmarking exercise difficult to compile and interpret.

2.16. A member asked if it could be possible to recommend prescription for transport workers for the initial stages of the pandemic when risks were high. Another member challenged this as they felt there was not sufficient evidence to back this up, which was not the case for H&SCWs where the body of evidence was strong.

2.17. This was echoed by another member who felt there was not sufficient evidence to recommend prescription for other occupations and whilst this assertion may not be popular outside of the Council, this should not influence the decision-making process.

2.18. Consequently, the Chair suggested that the data for other occupations be presented as they stand and not use the benchmarking comparisons. The discussion section of the paper could then reflect what the evidence was showing, which might include data quality and evolution over time, neither of which were under the control of the Council.

2.19. The Chair indicated that the draft paper produced for other occupations (transport and education sectors), before the benchmarking exercise, would be recirculated to members to look again at the evidence to formulate their views.

2.20. A member agreed and felt that the emphasis on the evidence from JEMs needed to be revisited as this presents theoretical evidence. A member commented that when epidemiological data are lacking, the JEMs can give an insight into potential infection risks and this can be used as a potential source of information, albeit with limitations. On their own, JEMs are not definitive.

2.21. A member pointed out that a recent paper outlining other countries' compensation schemes for COVID-19 could be used to criticise IIAC. The Chair responded that IIDB was the only focus for IIAC and other compensation schemes were not comparable as they may provide lump sums or are insurance-based. This paper is descriptive only and doesn't give the methodology on how the decisions are reached.

2.22. It was agreed to go back to the original draft paper on other occupations and a member felt that the outcome of discussions was members perhaps felt not inclined to recommend prescription. However, members were asked to revisit the data/evidence and to email their thoughts to the Chair. This may then influence the direction of the paper and assist with decision-making. It was also suggested that the command paper be reviewed at the same time.

2.23. A member asked it was possible to determine risks at certain time points and whether the impacts of PPE or other equipment should disregarded. It was pointed out that PPE etc in other prescriptions is not taken into account and there are no data which show the impacts of this. Regarding data at certain time points, the Chair indicated this has been attempted, but may not be immediately apparent.

2.24. Another member commented that they felt there was consensus for other essential workers, such as retail, there was not sufficient evidence, so the focus should be on education and transport. However, another member commented that where small groups were at risk, such as prison officers, there would unlikely ever be any epidemiological evidence, so for now would like to review the data as a whole and keep an open mind. The Chair stated that exposure equivalence could be considered in this instance, as referred to in the rcent command paper on hand-arm vibration syndrome. Commenting on this, a member pointed out that if occupation is sub-divided, the time-period would also have to sub-divided as risks varied with time, which could be difficult to reconcile.

2.25. A member suggested that perhaps the paper should include an explanation of the gap in what would be an ideal data-set and what evidence the Council actually has to decide if prescription was appropriate, which may help the reader understand the Council's reasonings.

2.26. Referring to smaller groups of workers, a member felt this could be covered by an 'outbreak' and asked if there was any further update on the work being carried out by the HSE/REACT study. The Chair stated they would make contact with the relevant researchers seeking further information. A member pointed out that a definition of an outbreak would be required which suited the purpose of the Council.

2.27. A member felt the JEM information would require more clarification in the paper as the theroetical risks were high across a number of other employment sectors, so needs to explain why transport and education sectors were selected for further scrutiny. It was pointed out that there were more data for these sectors and also the theroetical JEM risks did not distinguish between those who were actually working or those who were furloughed or had lost their jobs.

2.28. The Chair summarised the actions - members to review and comment within 2 weeks of the next RWG meeting on 30 November:

- The paper on transport and education and
- the benchmarking paper.

2.29. A member asked if dental workers would be covered by the recommendations for H&SCWs as the JEM scores were high. A member commented that this would need to be made clear in guidance if the recommendations were

accepted as this worker group wasn't specifically mentioned in the command paper.

2.30. Long-covid was briefly discussed and it was agreed a paper would be drafted for further discussion at the forthcoming RWG meeting.

3. Commissioned Review - update

3.1. This topic was introduced by the member leading on this from the Institute of Occupational Medicine (IOM).

3.2. Reports have been prepared which will be cirulated prior to the RWG meeting.

- Silica and COPD has been completed, under peer review at IOM
  - Small number of reviews from disparate occupational sectors, but 2 occupational circumstances worthy of consideration are work in the construction industry or work in a foundry.
- Asbestos and lung cancer report has not had literature screening completed and there were concerns this could be large.

3.3. It was noted that the occupational requirements for PD D8a were being reconsidered.

3.4. There were outstanding questions for silica/lung cancer and asbestos/lung cancer on the roles of silicosis and asbestosis. Where it allows, the literature will be separated out for these questions.

3.5. It was agreed that reports would be circulated as soon as they are complete.

4. RWG update

a) Neurodegenerative diseases (NDD) in professional sportspeople

4.1. The member leading on this topic referred to their paper which had been circulated to members which detailed the literature review for amyotrophic lateral sclerosis (ALS) and sportspeople. This has not specifically focussed on head injuries or sub-concussive head impacts but on sportspersons in general.

4.2. There have been a number of studies which have found an association between ALS and extreme physical exercise, which included sports or other occupations which require physical fitness.

4.3. From the 50 or so papers identified, a table of evidence will be constructed which will allow a synthesis to be carried out.

4.4. There are a number of issues relating to 'exercise' as studies have looked at this in different ways and some have allowed self-reporting. The paper will be updated and circulated to RWG members for discussion.

4.5. A similar exercise may be considered for Parkinson's disease (PD) and dementia.

4.6. A member asked if the evidence for ALS is sufficient to warrant prescription – the response was that the synthesis has to be done, but is looking more likely for extreme exercise than head trauma. The member stated they had some concerns around how physical activity could be measured. The evidence suggests sportspeople are most likely to be impacted, so from an exposure perspective, that would be the place to start. From the perspective of potential prescription, this would almost certainly be related to job title, but this is too early to say.

4.7. A member asked if the link between extreme exercise and ALS is related to gender, potentially having more of an impact on men. The member leading on the topic stated they would consider the gender issue in more detail, but they suspected that many of the studies would have been carried out on men.
4.8. Another pointed out that genetic links appear to be an important factor for ALS, interacting with physical exercise and testosterone has been implicated. It was acknowledged this is a complicated topic and genetic factors may need to be considered.
4.9. The Chair felt that there needed to be a description of the risk factors, including genetics, along with the number of cases, in the draft paper circulated to members.
4.10. A member pointed out that there is a form of ALS which is associated with dementia – this is also the case for PD.
4.11. The Chair mentioned that there had been a back-bench debate in the House of Commons on NDD in footballers and a number of MPs have asked to meet with the Council to discuss the topic.
4.12. An updated paper will be produced for the RWG meeting in November.

b) Firefighers and cancer.

4.13. The Chair reminded members of the background to this topic and had circulated a short paper ahead of the meeting. Prof Stec published a paper on Scottish firefighters which indicated high risks for malignant and non-malignant diseases that were much higher than other reviews. The data used to inform this paper came from a freedom of information (FoI) request to the firefighters pension schemes.
4.14. There appeared to be an anomaly in the data where, potentially, the number of firefighters receiving a pension was lower than expected and no account had been taken for firefighters who had chosen not to take their pension or had moved it to other schemes.
4.15. The International Agency for Research on Cancer (IARC) subsequently published a mongraph[2] on occupational exposure as a firefighter, which classfied firefighting as a class 1 carcinogen, with sufficient evidence for mesothelioma and bladder cancer. Graphs and other information were shown to members which demonstrated the extent to which Prof Stec's data differed from that of IARC, which had been compiled from a meta-analysis of more than 20 non-overlapping cohort studies. This illustrated the discrepancy between Prof Stec's data and that from other sudies, including IARC.
4.16. Had Prof Stec's paper been included in a meta-analysis, this may not have affected the risk results as papers are weighted in terms of the size of the study and therefore variability.
4.17. The Chair stated that in order to check the methodology of the Stec papers, another FoI request should be made asking for additional information on pensioners (firefighters) who may not have taken their pensions (e.g. defered) or had moved out of the schemes. This draft FoI was shared with members for comment.

[2] IARC Monographs Volume 132: Occupational exposure as a firefighter

4.18. It was suggested that the Chair engage with the Scottish Public Pensions Agency to check how to obtain the required information as there are a number of different pension schemes for firefighters in existence.
4.19. A member commented that the findings from the Stec paper indicated that Scottish firefighters were at increased risk of cancer compared to firefighters everywhere else in the world, which doesn't necessarily make sense. This may indicate the Stec data are out of step with that of everyone else, including IARC.
4.20. The Chair indicated that having the relevant data from a FoI request would enable the Council to make an informed view based on fact rather than opinion. The Fire Brigades Union (FBU) has been critical of IIAC for not amending its position on firefighters, so this exercise may help to explain the obvious discrepancies.
4.21. A member asked what action should be taken to address the issue. The Chair felt a decision on how to respond should be taken after obtaining the data and analysing it.

c) Work programme update

4.22. The Chair introduced the topic by stating that IOM had been asked to produce a proposal to carry out a scoping review into women's occupational health e.g. where women are the only subjects of studies or where women are potentially at greater risk where they are similarly exposed to men. This was circulated to members who were asked for their views.
4.23. Members were content with the proposal, so IOM would be contracted to carry out the scoping review.

5. **AOB**

5.2. The Chair invited a DWP official to give an overview of the recent light-touch review carried out on IIAC for the Cabinet Office and to outline the recommendations. The official gave an overview of the review process and outlined the recommendations to members.
5.3. The Chair asked when the recommdendations would be available. Ministerial approval is required, so the review team are working through that process.

Update from DWP officials

5.4. Officials indicated that there were no significant updates, work is still ongoing on the COVID command paper.
5.5. The CHDA observer stated they found IIAC meetings useful.

Statistics

5.6. The IIDB publically available claim statistics were shared for information. They are now hosted on a different website.
5.7. The Chair commented that several prescribed diseases had no claims for several years. They felt that wider promotion of IIAC's work could help claimants navigate the system by raising awareness. This could be done in a number of ways e.g. the TUC or conferences. Publishing an overview of IIAC's work annually in a journal could also be considered.

5.8. A member asked if there is any benefit in removing prescriptions and this may be something to consider.

5.9. Another member noted that there was a heading for ‘cause’ and asked if COVID-19 could be included as this would help with tracking of accident claims for this disease.

5.10. A member challenged the suggestion that some prescriptions could be removed as employees of smaller companies could miss out and felt the lesser used prescriptions could be left dormant. Another member felt that having a long list of unused prescriptions could make it more challenging for a claimant to navigate.

5.11. As the meeting was drawing to a close, the Chair asked if members, wherever possible, could attend the January meeting in person, which could be at a different venue.

Date of next meetings:
RWG – 30 November 2023
IIAC – 11 January 2024