INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 30 November 2023

Present:

Dr Chris Stenton	Chair
Dr Lesley Rushton	IIAC (Chair designate)
Professor John Cherrie	IIAC
Dr Ian Lawson	IIAC
Dr Jennifer Hoyle	IIAC
Mr Dan Shears	IIAC
Professor Damien McElvenny	IIAC
Dr Richard Heron	IIAC
Ms Lucy Darnton	HSE observer
Dr Rachel Atkinson	Centre for Health and Disability Assessments
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Ms Georgie Wood	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Anne Braidwood, Dr Charmian Moeller-Olsen

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. Members were reminded to declare any potential conflicts of interest. Dr Hoyle declared that she was working for Pfizer as an expert witness.

2. Minutes of the last meeting

2.1. The minutes of the meeting held in September 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. A member comment on the section of the minutes which referred to thermotactile and vibrotactile threshold testing in hand-arm vibration syndrome was no longer being carried out due to issues with the equipment. This member felt that whilst the minutes were correct, the lack of testing was sub-standard (IIAC recommended testing should continue) and it was the responsibility of DWP to refer back to IIAC to determine if alternative testing regimes were available. Quantitative or semi-quantitative testing should be carried out to determine sensory loss.

2.4. It was agreed that this would pass back to DWP for consideration.

2.5. This member also commented that they felt the action points should be reviewed and made available prior to the meeting to give members time to clear any actions assigned to them. Another member felt that a tracker would be useful as actions from RWG are often carried forward to full Council meetings. This could help members explain aspects of the minutes to other interested parties.
2.6. The Chair commented that the minutes were read by a number of stakeholders to follow progress of investigations.

3. Occupational impact of COVID-19

Long-covid

3.1. The Chair took this item first which related to a recent, widely publicised, letter (and circulated to members) from the British Medical Association/Royal College of Nursing to the Secretary of State for Work and Pensions. This letter acknowledges IIAC's work in a positive way.
3.2. The Chair asked DWP officials if they had any updates on the official response to the BMA/RCN letter and if there had been any progress on assessing the recommendations made by the Council in its 'occupational impacts of COVID-19' command paper. The Chair also asked if the Council could help further to progress the assessment.
3.3. An official commented that the Department was working on a response to the BMA/RCN letter. There was no update on progress of impacting/assessing the command paper recommendations and at this time, nothing further is required from IIAC.
3.4. For the current paper on other workers impacted by COVID-19, an update on long-covid will need to be covered so the Chair asked a member if they would be willing to address this. The member commented that this work was almost complete.
3.5. Broadening the scope, the Chair asked the member if long-covid could form part of the Council's ongoing investigation into COVID-19 as the next topic for discussion.
3.6. The member indicated they were currently reviewing the literature on long-covid, but not much had changed since this was covered in the command papers e.g., definition of long-covid, wide variation in symptoms, often self-reported, symptoms remaining after other causes have been ruled out (e.g., breathlessness with normal lung function).
3.7. Papers showing an excess of symptoms over and above those found in the general population are missing, but there are a number of meta-analyses which are useful. Based on the observations of this member, they felt at this time there may not be sufficient evidence to suggest long-covid should be recommended for prescription, but that would be a decision for IIAC.
3.8. A member commented that it has been suggested some symptoms of long-covid can resolve themselves within 3 years, so felt any recommendations from the Council on this topic may be too late for potential claimants.

COVID-19 and its potential occupational impact – transport and education workers.

3.9. At the last IIAC meeting, members were asked to comment on the evidence available for recommending prescription for transport and/or education workers. The Chair thanked everyone for their contributions and stated the comments had been collated and circulated – these have been incorporated into the main paper where possible and addressed. The draft paper was also circulated to members in meeting papers.

3.10. The draft paper has been restructured based on general principles so that work patterns, transmission, mitigation methods and use of the JEM in the general population are addressed first and then these issues are covered separately for transport and education in their respective sections. There are also some additional data on education workers which haven't yet been discussed.

3.11. The member noted that it was important to distinguish what happened in the past as opposed to what is happening now as many of the factors which were relevant during the pandemic are not relevant now.

3.12. A member commented that they felt it was important to explain why education and transport workers (E&TW) had been selected for further investigation and to help other stakeholders understand why their particular occupational sectors were not considered. They also felt that there were different issues at different times in the occupational sectors e.g. certain groups of workers within both education and transport could have experienced very high levels of exposure to the virus at the beginning of lockdown restrictions, which would unlikely be reflected in statistics or studies. This was also the case for other sectors such as transport.

3.13. The Chair commented this has been briefly covered in the paper and it is possible to extend this further when sectors are discussed. It was difficult to get a good handle of the data due to the waves, but there were data from schools showing increases in infections which correlated with the waves.

3.14. Another commented that they felt that timelines may need to be revisited as there is currently a background level of circulating COVID, so may not see peaks/troughs as before. In the initial phases of the pandemic, there were no mitigations in place, so the picture looked different then than today i.e. the relative risks have changed. As time progresses, it is much more difficult to ascribe impacts of COVID-19 to occupations as data will be harder to acquire. There was anecdotal evidence to suggest that referrals to long-covid clinics was declining. As the virus is now circulating in the general population, it will become more difficult to determine if someone had become ill as a consequence of work.

3.15. The Chair commented that the recommendations in the command paper focus on 5 serious conditions and wondered if those conditions would still continue to be prevalent.

3.16. A member commented referencing the conditions education workers experienced in schools during the early pandemic and when lockdown

restrictions were lifted where there were large numbers of infections. They also referred to long-covid where less well-paid workers were unable to take time away from work (with long-covid type symptoms) due to sick-pay restrictions, so were/are unable to access support from long-covid clinics.

3.17. A member commented that when lockdown restrictions were lifted, due to circulating levels of the virus it would be difficult to say for certain, with H&SCWs and possible transport workers, being the exception, that any infections were due to work. They felt that there had to be a cut-off point before restrictions ended, they were unaware of any occupations which would be impacted other than H&SCWs who were dealing with sick people. Transport workers may also be impacted, as they may take sick people to hospital.

3.18. The Chair felt that it might be necessary to update the information, possibly using death data, from when restrictions ended which saw a large spike in cases.

3.19. It was commented that the structure of the draft paper is good.

3.20. Responding to points made, a member felt that doubled risks for any occupation can't be demonstrated after March 2022 to date. In their view, the evidence isn't there. Others disagree, so this needs to be resolved. They felt that specifying time periods may need to be considered if the recommendations in the command paper are to be extended to E&TWs. The epidemiology data up to 2022 suggests risks are not doubled.

3.21. A member drew comparisons with other prescriptions where an exposure could be accumulated over a long period of time versus a high exposure in a single event. Both have a beginning and an end, so comparable exposures between work and that in general circulation could be defined when lockdown restrictions ended. In this instance, defining timelines could be important to determine when the risks were greatest.

3.22. Another member felt that certain occupations at certain times (e.g., E&TWs) probably had more than doubled risks, but the epidemiological evidence was weak to support this, so to what extent can IIAC extrapolate and use professional judgement to make recommendations. A member agreed and felt that other methods of informing decisions such as the JEMs could help provide a solution.

3.23. The Chair pointed out that there are data for E&TWs and if the Council were to recommend prescription, it needs to be considered what this would look like and who it would apply to. There is an issue with data quality, the various study designs have advantages/disadvantages and some of the studies of specific occupational groups are based on small numbers. As with H&SCWs, analogies can be drawn with the different sectors within E&TWs where risks can be assumed but where data are lacking. However, it can be presumed that any prescription would have to include direct proximity to people who were at higher risk of infection.

3.24. A member expressed their concerns that the JEMs are too theoretical to use as tools for decision-making. They felt that it was not relevant to associate

risks at the beginning of the pandemic with later timelines – they felt that even H&SCWs no longer have doubled risks.

3.25. The Chair felt that the JEM is a hypothetical tool which gives a score, it doesn't discriminate well between jobs, but indicates where exposure could be expected. A member commented that analogies had been drawn between the paper published on HAVS which recommended changes to the PD A11 prescription based on assumptions risks were the same for some tools where epidemiology data were missing. However, this was based on actual risks for certain tools. In the case of E&TWs, that doesn't appear to be the case.

3.26. A member agreed that they felt that risks were no longer doubled and due to circulating viral levels in the general population, it would now be difficult to determine if exposure occurred during work. However, mitigating factors and the vaccination programme had contributed positively and some sectors such as transport appeared to be adequately covered, but education workers were still at greater risk and the future needs to be considered. They agreed with the earlier comments about risks/exposures and that in the early stages of the pandemic, some work sectors had similar risks to H&SCWs, so this should be taken into account when considering prescription.

3.27. The Chair commented that agreement needed to be reached about the draft paper and noted that members were content with the proposed structure. The Chair noted that selected members had spent a great deal of their time working on the document.

3.28. The Chair felt that the data-gathering for E&TWs sectors was probably complete, with sufficient to warrant discussion for prescription and little else needed to be added. The discussion section of the paper has been started which indicate the issues faced with the data. A question which needs to be addressed:

- Is the Council correct to focus on E&TWs or should the benchmarking exercise be revisited to include key-workers as a whole?

3.29. A member felt the answer to that question would be dependent on prescription for E&TWs not being recommended, as there was insufficient evidence/data for other occupational sectors. If the decision is to recommend prescription, then the member felt, agreeing with others, there were pockets of workers which could also then be considered outside of E&TWs – these may have similar exposures but little data to evidence this.

3.30. The Chair noted that the data on workplace outbreaks were not yet published and this may be more relevant to the other smaller sectors.

3.31. Referring to the JEMs, a member expressed some support for their use in the early stage of the pandemic before data were being collected. Where there are no good data later in the pandemic, there were other occupations with similar JEM scores to E&TWs, so there would have to be reasons to not include these groups if prescription is recommended.

3.32. It was commented that a way forward for this paper needs to be agreed, so pointers were requested from members on how to proceed. A member stated they felt the contributors to the paper had done a great job, but hadn't been able to agree on conclusions. Another member suggested to revisit the criteria

which were reason enough to make recommendations for H&SCWs and determine if E&TWs meet these, i.e. can extrapolation be carried out for E&TWs to meet the requirements for prescription.

3.33. The Chair pointed out that the totality of the evidence, not just the magnitude of relative risks, was considered for H&SCWs given the limitation of the data. However, there were a lot more studies carried out on healthcare workers, which is not the case for E&TWs.

3.34. A member stated that the data for workplace outbreaks would be key as there were a number of occupations, such as food production/manufacture, who were not public-facing, but were greatly impacted. It was not known when the HSE would be in a position to make these data available.

3.35. The Chair noted that there did not appear to be a consensus amongst members about recommending prescription – a member summarised their thinking by stating they didn't feel members were confident enough about the data and some were unsure about the weighting given to the JEMs and the anecdotal style of the some of the evidence.

3.36. The Chair asked if the data from H&SCWs was any more convincing and a member responded by stating that infection data were very convincing early in the pandemic but did fall off later. The issue is that early infection data are not available for E&TWs due to lack of testing and not being picked up in population studies. Mortality data are available for E&TWs and is high for transport and sub-sectors, where excess high mortality was apparent for longer.

3.37. There was some debate amongst members around the pros and cons of recommending prescription for E&TWs with a division apparent. One member couldn't see a route to prescription without direct comparison to the decision-making and data from the H&SCWs command paper. They felt it would be difficult to come to the same conclusion for E&TWs, but a timeline might be useful as after a certain point, risks diminished.

3.38. It was pointed out that the greatest risks were for workers who were exposed to the general public, the number of contacts and/or their duration being important; e.g., teachers would have been in close proximity to children for long periods so may have been at higher risk, i.e., cumulative or intermittent exposure. This was not apparent for certain sub-sectors, such as van delivery drivers, who did not have the same degree of contact with the public.

3.39. A member pointed out relevant paragraphs in the command paper which indicated the rationale used and mentions other occupational sectors, so perhaps these should be revisited and considered for this paper. In the early stage of the pandemic, there were a number of occupations which faced similar risks to H&SCWs, so the Council need to be mindful how this is covered.

3.40. Going back to the JEMs, a member felt the evidence from these were not sufficiently robust as scores could be adjusted if different relative risk estimates were used, which may have been apparent at different times.

3.41. Bringing this topic to a close, the Chair asked if there was a way forward. A member felt there may be a case for prescription for certain specific sub-

groups (with caveats) at certain times. However, the IIDB rules mean that only those with ongoing disabling conditions might be eligible for benefit.

3.42. It was agreed that discussions would be held outside of the meeting and an extra-ordinary members meeting be called to focus entirely on the topic.

4. Firefighters and cancer

4.1. The Chair gave an update on subsequent action taken to help understand the use of data in the Stec papers which indicated much higher risks of cancer in firefighters, above those reports previously published.

4.2. The Chair and Council members postulated that the figures for firefighters obtained from a freedom of information (FoI) request made to the various pension schemes underestimated the numbers. To clarify the position, the Chair submitted a request to the Scottish pension schemes to ask if the data supplied to Prof Stec contained firefighters who:

- Deferred their pension,
- Transferred to another scheme,
- Cashed in their pensions.

4.3. It was confirmed that the data supplied to Stec did not include any of the above three categories. Therefore, the data used by Stec only relates to firefighters currently being paid.

4.4. The Chair proposed to submit a further FoI request to obtain the missing data – this was agreed.

4.5. A member indicated that at a recent British Thoracic Society meeting, a review of firefighters was presented which independently aligned with the findings from IIAC's position paper on firefighters carried out in 2021.

4.6. Further action will be determined when the data from the FoI request has been returned.

5. Neurodegenerative diseases (NDD) in sportspeople

5.1. Members who have been working on this topic gave an outline of the investigation progress to date. This initial phase has focussed on amyotrophic lateral sclerosis (ALS) also known as motor neurone disease, which is a complex topic with a mixture of genetic and environmental causes.

5.2. Rather than focussing on rugby or footballers specifically, links to physical exercise or head injury were investigated as these were the relevant exposures. A paper was circulated to members which includes sections on the evidence for 'exercise and ALS', 'head trauma and ALS' and 'sport and ALS'.

5.3. An initial view of the evidence is 'suggestive' for a link between extreme physical exercise and ALS. A difficulty in interpreting the evidence is the variable way in which physical activity has been described in studies. There is an argument to consider within the set of professional sportspeople, those who experience head trauma.

5.4. There may also be a side issue where other occupational groups which require physical exertion may need to be considered, but probably not at this time.

5.5. It was commented that it would be very difficult to prescribe for extreme physical activity and drew analogies with carpel tunnel syndrome where evidence about force of gripping was available but wasn't prescribed for because this couldn't be measured. It was considered that describing an activity which required extreme physical exercise should be sufficient if prescription was proposed.

5.6. Work has begun to synthesis the evidence relating to sport, breaking this down into subsets relating to subconcussive exposures, and it is hoped to decide on a recommended way forward for the full IIAC meeting in January.

5.7. The Chair stated that decisions would need to be taken how to define the exposure and where this exposure occurred for the purposes of prescription.

5.8. As an aside, a member recalled a paper which linked cross-country skiers to ALS where head injury/trauma would be unlikely.

5.9. Another member commented that the genetic component of this condition needs to be carefully considered as genetic mutations which produce high physical ability which also increased the risk of ALS, so this interconnectivity may be important. However, for the purposes of IIDB, this shouldn't matter.

5.10. A member asked if evidence had been uncovered linking pilots to ALS as hypoxia/oxidative stress (as seen in extreme physical exercise) can affect the motor neurones and may also have a genetic link.

5.11. The authors of the paper feel this may be a position paper as the picture is complex but will wait until the data synthesis are complete.

6. Commissioned review of respiratory diseases

6.1. To remind members of the priorities for disease/exposure combinations agreed by the Council to focus on, and the lead on this from the Institute of Occupational Medicine (IOM), gave a short presentation which showed progress to date.

- Silica + COPD – currently prescribed, evidence of exposure-response – patchy evidence of a doubled relative risk in some industries. Recommend reviews of industrial settings with high silica exposure (foundries, construction etc).
- Silica + Lung Cancer – currently prescribed when accompanied by silicosis. When broken down into industry categories, work in quarries with sand/gravel showed a more than doubling of risk. Foundry workers could be looked at in greater detail.
- Cleaning products + COPD – no current prescription, overall evidence limited, but some consistent evidence of increased relative risk (< 2).
- Farming/Pesticides + COPD
- Chromium VI+ Lung Cancer
- Asbestos + Lung Cancer

6.2. A member commented that the report didn't contain the dose response between silica and cancer, which the Council would expect to see and would need to know at what exposure lung cancer risk was doubled where there

would likely to also be silicosis. This would also help understand which occupations would be at greatest risk.

6.3. It was stated that further reports would follow. It was suggested that a specific meeting of a sub-group of members be set up to review the reports and determine next steps.

6.4. The Chair stated that some of the reports would be published by the Council.

6.5. There was some discussion around lung cancer and asbestos where the current prescription is fairly specific for the type of job carried out.

6.6. A member asked if there was enough evidence for equivalence of risk of lung cancer for those exposed to asbestos but in the absence of asbestosis – such as may be seen in construction industry.

7. Work programme review

7.1. The Chair stated that funding had been secured to allow the provision of additional scientific support for the Council. Details are being worked through with the secretariat before being brought back to the Council.

8. AOB

8.1. A member of the secretariat stated they had been approached by a stakeholder who raised concerns that some claims for PD D1 (pneumoconiosis) had been turned down if a subsequent diagnosis of progressive massive fibrosis (PMF) was given. It was agreed to get further details to look into this.

Date of next meetings:

IIAC – 11 January 2023
RWG – 29 February 2023