INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 29 February 2024

Present:

Dr Chris Stenton	Chair
Dr Lesley Rushton	IIAC
Professor John Cherrie	IIAC
Dr Ian Lawson	IIAC
Dr Jennifer Hoyle	IIAC
Mr Dan Shears	IIAC
Professor Damien McElvenny	IIAC
Dr Richard Heron	IIAC
Dr Anne Braidwood	MoD observer
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
Ms Molly Robinson	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: 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.

2. Minutes of the last meeting

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

2.2. All action points were cleared or in progress. It was again agreed the action points would be extracted and circulated to members in advance of the next meeting..

2.3. A member commented on the section in the minutes relating to thermotactile and vibrotactile threshold testing in hand-arm vibration syndrome and felt that a formal action point should have been included relating to referring the matter back to DWP. It was acknowledged that the concerns of members around testing had been recorded in the minutes and it was for DWP to bring the topic back to the Council for further advice if deemed appropriate.

2.4. An action was carried forward on obtaining data from the Surveillance of Work-related and Occupational Respiratory Disease (SWORD) relating to aspects of the commissioned review of respiratory diseases.

3. Occupational impact of COVID-19

3.1. At a meeting on 25 January 2024 members had agreed to recommend prescription for certain transport workers but not for education workers.
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3.2. A draft command paper which had been amended to take account of members' comments had been circulated with the meeting papers. Members were thanked for their input.

3.3. The section on long-covid has not been finalised, but has been drafted and commented on by some members.

3.4. A member felt that it would be difficult to accommodate long-covid generically within industrial injuries disablement benefit (IIDB) rules because its definition is relatively vague and dependent on subjective symptoms, because the language is often non-medical with terms such as 'brain fog', and because of the lack of a diagnostic test. They pointed out that some sequalae of infection were already covered by the recommendations contained in the health and social care workers' (H&SCWs) command paper.

3.5. Another member agreed but felt that the long-covid discussion should be more explicit, drawing attention to the lack of any recognised pathophysiological process in many cases, the associations with pre-existing medical conditions, the similarity of the symptoms with those following other viral infections, and the absence of a diagnostic test.

3.6. It was pointed out that whilst long-covid may not fit into the IIDB framework, there were also other conditions (e.g. some asbestos-related malignancies) that were also not appropriate for IIDB, and these had specific, separate schemes.

3.7. The meeting moved on to look at the discussion/conclusion sections.

3.8. Reference was made to a point raised in a previous meeting about the choice of reference populations which varied considerably between studies and potentially had a marked effect on relative risks. It was felt appropriate to reflect this issue in the command paper.

3.9. Discussions on the conclusion section included the need to reiterate the IIDB requirements and the evidence required to recommend prescription. A statement describing the difficulties faced by the Council was discussed along with the process leading to a consensus to recommend prescription. A

member felt this was essential to reflect how difficult it was for the Council to reach a decision.

3.10. A key element of the conclusion dealt with education workers who didn't meet the key criteria required to recommend prescription, as discussed at previous meetings.

3.11. There followed discussion about the use of the term 'worker' rather than 'driver' in the proposed prescription. The draft command paper suggests referring to public-facing transport workers whereas the evidence of doubled risk points to coach/bus/taxi/cab drivers based mortality data which used standard occupational classification (SOC) codes. The infection data is largely based on 'workers' but generally does not show doubled risks.

3.12. A member made the point that private hire drivers should be covered by the recommendations but they may not be captured by the terminology in the suggested prescription wording. Chauffeurs are mentioned and it was felt that that should include private hire drivers.

3.13. There was discussion about the appropriateness of extrapolating the evidence to other groups of transport workers such as train drivers, tram drivers, Docklands Light Railway workers, conductors, and air/sea transport workers. Whilst extrapolation from the evidence may be possible it was felt the use of the term 'driver' would be more appropriate based on the epidemiological evidence.

3.14. Members felt that this specific element of the command paper should be circulated to all IIAC members to seek their views.

3.15. It was noted that proximity to the general public at around the time of infection would be an additional requirement.

3.16. It was also noted that the accident provision of IIDB could be an option for those workers not covered by the proposed prescription.

3.17. The meeting moved on to discuss the prevention section of the command paper. It was pointed out that this would need to be revised as it is written from the pandemic perspective but this has now passed.

3.18. A member agreed to take this forward and provide a draft for inclusion in the command paper. I was not felt necessary to engage with the UK Health Security Agency at this point, but information from the HSE website would be relevant.

3.19. The Chair summarised the discussion and agreed the actions.

4. Firefighters and cancer

4.1. The Chair invited the member who had been most involved with this topic to give an update.

4.2. A freedom of information (FoI) request was submitted to the Scottish firefighters pension schemes requesting data for the numbers of transfers into other pension schemes and those which had deferred their pension. The response indicated that only a limited of information could be provided without exceeding the £600 cost limit. A data-set was provided for 5 years, which was difficult to interpret as it included transfer tasks carried out by administrators, both into and out of the schemes.

4.3. A further request for clarification has been submitted and the explanation is awaited. A member asked if the awaited data would be sufficient to identify problems in the recent Scottish firefighters paper[1]. The member responded that it may give an indication of where these might exist, but the picture is complex.

5. Neurodegenerative diseases (NDD) in sportspeople

5.1. The Chair reminded members that it was decided to break down the investigation of neurodegenerative disease into separate neurological conditions and amyotrophic lateral sclerosis (ALS) was initially selected (as the condition appearing to show the strongest evidence of a raised relative risk).

5.2. At least 100 papers have been reviewed. There appears to be good evidence that there are lifestyle/exogenous factors which put people at risk probably in combination with certain genetic traits.

5.3. Environmental factors that have been explored in detail include exercise and head injury (trauma). There is some evidence that both increase the risk of ALS and many professional athletes are exposed to both.

5.4. The investigation found ~20 papers which referred to professional sports people, with the main evidence being in:

- American football players
  Soccer players
- Rugby players

5.5. It was commented that both ALS and work as a professional sportsperson are rare and so many studies are inevitably small making it difficult to draw conclusions. It was suggested, if appropriate to conduct one, a meta-analysis might be helpful.

5.6. The evidence was summarised:

[1] Scottish Firefighters Occupational Cancer and Disease Mortality Rates: 2000-2020
A A Stec, A Robinson, T A M Wolffe, E Bagkeris. Occup Med 2023; 73(1): 42-48.

- American footballers – there is essentially one study by Daneshvar et al (2021) who examined ALS mortality amongst 19,423 US National Football League players who debuted between 1960 and 2019. A total of 28 athletes died during the study window with 24 of the deaths identified in the National Death Index, giving a mortality ratio of about 4.

- Soccer players - there are 9 studies reporting risks in professional soccer players. Four from Italy are likely to have overlapping subjects, and there are single papers from Spain, France and Sweden. Two papers from Scotland have identical subjects. The study by Pupillo et al subsumed the previous Italian studies and found relative risks of about 2, with 34 cases of ALS out of 23,568 Italian soccer players. The other studies from Scotland, Sweden and France were roughly the same size (about 6-8k subjects) and showed relative risks ranging from 1 to 4.

- Rugby – a small study (~400 subjects) which gave high relative risks, but with no cases in the comparison group.

5.7. There was limited evidence relating to the risk of ALS in other sports, with non-contact sports showing no markedly elevated (i.e., doubled) risks. It was remarked that there were some case studies (e.g., in boxers), which could be referred to in the draft paper which is being drawn up.

5.8. A member asked if it was possible to read-across sports in terms of exposure/cause, but it was felt that this was not straightforward. It was noted exposure data, e.g., for duration of career or playing position are very limited.

5.9. The Chair asked if members had any views and whether sufficient evidence is available to recommend prescription. A member commented that the review is comprehensive and felt it would be beneficial to have a summary in order to help members form opinions.

5.10. A number of members felt that the data fell just short of being adequate to recommend prescription, but an author felt that more scrutiny of the data is required. There was discussion around the Mackay et al (2019)[2] study which showed high relative risks across a number of individual neurogenerative diseases, which was considered unusual (as it implied that all the neurological disorders examined were equally affected by playing football).

5.11. A member asked that if prescription is to be recommended, would this be for:
- Having played a particular sport, or
- Played in a particular position, or
- Having had head trauma or contact.

[2] Neurodegenerative Disease Mortality among Former Professional Soccer Players, Mackay et al, N Engl J Med 2019 Nov 7;381(19):1801-1808

5.12. Also, confounding and other causal mechanisms need to be carefully considered. It was noted that ascertainment and other potential biases in studies need to be considered as these may have had an influence on the data and results.

5.13. Given the complexity of the topic, it was suggested that the Council ask for input from expert neurologists and a number of names were put forward. It was felt it would be useful to discuss the approach taken in the investigation and to get a handle on the overlap between the different neurodegenerative diseases.

5.14. A member commented they had found a paper which defined contact sports to feed into the draft paper.

6. Commissioned review of respiratory diseases

6.1. The Chair gave an overview of the review being conducted by the Institute of Occupational Medicine (IOM) where 6 disease/exposure combinations were selected as topics for further consideration.

6.2. Reports from 4 of the topics have been received to date and some discussions of these reports have taken place. The Chair indicated the discussion at this meeting would focus on:

- Silica and COPD
- Silica and lung cancer

6.3. Members were reminded that IOM did not carry out full systematic reviews and were specifically looking for evidence of doubling of relative risk in certain exposure sub-groups.

6.4. A member had circulated a paper setting out their views on the topics and what the Council could take forward.

6.5. Silica and COPD

- The literature and studies which were reviewed did not provide sufficient evidence to justify prescription in relation to silica exposures generically. However, there may be industries where the risks could be doubled: foundry workers and construction could be areas to further explore.

- It was pointed out that IOM only looked at evidence relating to silica and didn't necessarily focus on evidence by occupation or job title in situations where there might have been high exposures to silica.

- There was some discussion on the degree of silica exposure in various studies and the issue of whether the associations observed are with mineral dust rather than specifically with silica. There is a wide range of

silica content in the dust in the various studies, ranging from ~90% in gold mines to ~4% in coal mines.

- There may also be an issue with the diagnosis of COPD in some of the papers where silicosis or lung fibrosis could have been confounding factors.

- It was noted that IOM focussed on COPD and not on changes in lung function. A member commented in the current prescription for COPD (PD D12), whilst the occupation was very clear, the prescription required changes in lung function to be evident. Members wondered whether the studies/papers could be looked at again to establish if there were any which had lung function data particularly in relation to exposure-response relationships.

- There was discussion around a German paper[3] which appeared to have low relative risks, but showed a threshold for exposure. As this study was carried out on uranium miners and there are no uranium mines in the UK IOM did not include this in the data synthesis. This could be reconsidered.

- A member commented that in previous years, many UK pottery and mine workers (mainly men) in the Staffordshire area were diagnosed with COPD, so wondered if there was something missing.

- Members felt it would be appropriate to look at specific industries with respect to high silica exposures. A member noted that it would be difficult to prescribe for COPD related to silica dust generally rather than that related to specific occupations as otherwise it would be difficult to determine the exposure.

- IOM agreed to respond to the points raised; the Council could consider whether to publish this report. A member raised the point that COPD had been redefined to include emphysema, but it was agreed to stick with the definition originally used for PD D12. IOM agreed to check the definitions of COPD in the studies reviewed.

6.6. Silica and lung cancer

- The International Agency for Research on Cancer (IARC) monograph was used as the starting point and later studies were identified for this review.

[3] Estimation of an Exposure Threshold Value for Compensation of Silica-Induced COPD Based on Longitudinal Changes in Pulmonary Function. Möhner & Nowak. Int. J. Environ. Res. Public Health 2020, 17(23), 9040

- A Workplace Health Expert Committee (WHEC) report was referenced indicating that the evidence suggested that radiographic silicosis is not an essential precursor of an increased risk of lung cancer in those occupationally exposed to silica. A number of members expressed agreement with that.

- There was discussion about the evidence relating to lung cancer risk in the absence of silicosis. The evidence is limited but generally does not support a doubled risk. Issues with potential confounders such as smoking and radon exposure within the studies were identified. Rather than a specific effects of silica, there might be increased risks in some industries possibly related to co-exposures.

- A member noted that for lung cancer the response relationships are generally flat. Even with very high levels of silica exposure, there is no evidence of a doubling of risk, so it is unlikely there would be a doubling of risk for lung cancer before a silicosis risk.

- A member asked if there were any up-to-date modelling studies of the dose responses, as this was a 'hot topic' but IOM had not considered this as it was not in the remit.

- A member agreed the current prescription was correct for the disease state but felt the occupational element was wrong.

- The discussion moved on to the current prescription for lung cancer with accompanying silicosis (PD D11) which is restricted to certain occupations. A member considered this to now be potentially discriminatory against workers who have silicosis and lung cancer but are not in the occupations listed. It was pointed out that it would be unlikely that studies would be published for occupations not covered by the current prescription as the numbers would likely be small. Non-occupational silica exposure at high enough levels to cause silicosis/ lung cancer would be extremely rare and removing the job restriction is not likely to lead to any unfairness.

- A member felt that when considering lung cancer and silicosis, discussion of the mechanism of action would be required. The meta-analyses of the studies identified should be looked at carefully because of the issues identified with the studies. A member agreed to do this and to discuss toxicology with an expert.

- Summarising the discussion, the Chair concluded there was little evidence to support prescription for lung cancer in the absence of silicosis but that the PD D11 prescription should be revised to include lung cancer associated with silicosis whatever the cause. A command paper highlighting the issue would help draw attention to silicosis which is

believed to be underdiagnosed. The IOM report contains up to date information, so would be helpful for a potential command paper.

6.7. The other reports yet to be discussed would be handed over to the Council as soon as possible and the reports already discussed would be amended to incorporate views of the Council.

7. Work programme review

7.1. The Chair stated there were 3 elements for consideration:

- Scoping review into women's occupational health;
- How the funding could be used to support the Council's work;
- Prioritisation of the work programme.

7.2. It was noted that the terms for the scoping review had been agreed with IOM and this was now going through due process within DWP.

7.3. Discussions have been ongoing on how the Council could use the funding. Members were asked to consider what skills potential suppliers would require as these would need to be matched with approved suppliers which are listed on the Crown Commercial framework. It is anticipated that an overarching requirement would be drafted and approved suppliers could be invited to carry out work on behalf of the Council if they meet the criteria. The overarching requirement would require a number of broad skills with individual topics requiring a more detailed specification. Critical evaluation of evidence by suppliers was thought be vital.

7.4. Prioritisation of the work programme was discussed and with a number of ongoing topics which need to be considered:

- Women's occupational health;
- Other neurological diseases related to professional sportspeople (e.g. dementia, Parkinson's etc)

7.5. It was felt that the prioritisation of the work programme should be discussed at a full Council meeting, but suggestions could be discussed by email.

7.6. The point was made that there needs to be flexibility to allow for the reactive nature of the Council's work which can be unpredictable.

8. AOB

8.1. Stakeholders had expressed concern that claims for PD D1 (pneumoconiosis) have been declined where progressive massive fibrosis (PMF) had been diagnosed. A DWP official noted that action would be taken to ensure guidance was up to date and that PMF would be recognised as being covered by the PD D1 prescription. It was felt that there was no requirement for IIAC to publish an information note as the issue related to the guidance for assessors.

It was noted that the Council would be happy to answer queries from DWP and the secretariat could facilitate this.

8.2. A member commented that there must be other cases of diseases where synonyms are used and it was felt this should be covered in guidance notes. A member felt that the training and guidance may need to be revisited. The IIAC Chair suggested that an occasional online meeting could be held with DWP operational staff and Council members where these types of queries could be discussed.

8.3. DWP officials asked for clarification from the Council about cases where asbestosis had been ruled out at a post-mortem due to issues with fibre counts. The Chair noted that the Council's position is clear on this as set out in the 2005 command paper Asbestos-related diseases which states post-mortem fibre counts cannot be used to rule out a diagnosis of asbestos. This would also be the case for PD D8 (lung cancer with asbestosis) where, in the absence of a post-mortem report, asbestosis would have been accepted.

Other business

8.4. A member stated that an abstract will submitted to the Faculty of Occupational Medicine/Society of Occupational Medicine for their June meeting where a number of members will be present. Members were thanked for their work in this area which will raise the profile of the Council. It was noted that the IIAC Chair will be addressing a number of TUC meetings in the near future.

8.5. A member asked about the criteria for receipt of a lump sum payment (e.g., for asbestos) where the employer is currently trading. An official confirmed that the 1979 Act, where a relevant employer is trading and thus can be traced, a lump sum payment would not be allowed. This would not apply to IIDB where, if the prescription conditions were met, a claim would be allowed.

Date of next meetings:
IIAC – 18 April 2024
RWG – 23 May 2024