INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 18 April 2024

Present:

Dr Lesley Rushton	Chair
Dr Chris Stenton	IIAC
Dr Ian Lawson	IIAC
Professor Max Henderson	IIAC
Professor John Cherrie	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
Mr Steve Mitchell	IIAC
Professor Raymond Agius	IIAC
Dr Sally Hemming	IIAC
Mr Dan Shears	IIAC
Mr Andrew Hay	Northern Ireland Department for Communities (NI DfC)
Dr Claire Leris	MoD observer
Dr Rachel Atkinson	CHDA
Dr Charmian Moeller-Olsen	DWP IIDB medical policy
Ms Hazel Norton-Hale	DWP IIDB policy
Ms Georgie Wood	DWP IIDB policy
Ms Molly Robinson	DWP IIDB policy
Mr Lewis Dixon	DWP IIDB policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat

Apologies: Ms Catherine Hegarty, Ms Lucy Darnton

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. The Chair thanked Dan Shears for hosting the meeting at the GMB offices.

1.2. The Chair welcomed Dr Claire Leris who joined the meeting as the new observer from the Ministry of Defence.

1.3. Members online were asked to remain on mute and to use the in-meeting options to raise a point.

1.4. The Chair indicated that the DWP IIDB policy team would be giving a presentation on their work and how IIAC fits with this. The chair noted that for command papers to be laid before Parliament, there are a number of administrative steps which need to be completed.

1.5. The topic of AI was raised by the Chair who stated that it was a valuable tool which should be disclosed if used.

1.6. The Chair announced that this would be the last meeting for Professor Raymond Agius. The Chair thanked Prof Agius for his substantial input into the work of the Council and his contributions have been invaluable.

Minutes of the last meeting

1.7. The minutes of the January 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. There was some discussion around the placement of a comment which was made during the discussion of a different topic, but it was agreed to leave it where it was discussed.

1.8. Prof Agius indicated that in the previous meetings where he had declared potential conflicts of interested, he would like it to be known that he was not responsible for the letter sent by the BMA.

1.9. 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. There had been comments on social media around the publication of a study involving a previous IIAC member and their membership of the Council. Prof McElvenny and Prof Cherrie both reiterated their involvement in the HEADING study being carried out by the London School of Hygiene and Tropical Medicine. Prof Henderson also reiterated (previously declared) that he had received funding to look at the mental health aspects of COVID-19. Dr Stevelink also declared she had received funding for researching COVID and long-covid in healthcare workers.

1.10. The Chair stated that it is important that declarations of interest are made to ensure the Council is seen to be unbiased and independent. The secretariat can help when members receive queries on this.

1.11. The action points had been circulated ahead of the meeting and were cleared or were in progress.

2. Presentation from IIDB policy

2.1. Members of the IIDB policy team gave a presentation on their remit and what happens once IIAC has published a command paper recommending a new prescription or a change to an existing prescription.

2.2. Members asked follow up questions leading to further debate.

2.3. It was agreed that should members wish to use any of the information from the presentation, IIDB policy team may be able to provide bespoke, tailored material.

2.4. The Chair thanked the team for a useful and informative talk.

3. Occupational impact of COVID-19

3.1. The Chair introduced the topic by indicating members would have received a copy of the draft command paper in meeting papers and the aim of the meeting was to try to agree a final, signed off copy.

3.2. The paper now contains a summary and a revised version of the prevention section from a member and HSE colleagues.

3.3. The recommendations in the paper need to be agreed by members.
3.4. Several members have been working on the long-covid section and a final version of this section needs to be completed. This has been referred to in the discussion and summary to explain why the Council is unable to recommend prescription for this condition at this time.
3.5. The Chair drew attention to the recommendations in the paper and asked members for their views. The diseases covered by the draft command paper are the same as those recommended for prescription for health and social care workers (H&SCWs), but the occupational element reflects sectors within transport working in proximity to the general public. Some examples of jobs covered by the recommendation are given.
3.6. It was noted that 'instructors' are listed in the recommendations and there was some concern that this might include driving instructors, who wouldn't be covered – adding '…in these sectors' would clarify this.
3.7. There was also some discussion around the use of 'consistently' when referring to the mortality data as evidence could be found for the different groups, but not consistently, so it was agreed to reword that section.
3.8. A member commented on the use of the term 'direct contact' throughout the report and felt this needed to be changed to 'proximity' to be consistent with the recommendations – direct contact could be inferred to mean touching. Proximity was referred to in the H&SCWs command paper.
3.9. Referring to the summary, a member felt that the language around the availability or scarcity of data needed to be clearer, which was agreed. This member also felt that long-covid should be covered in more detail in a separate paper.
3.10. However, other members were reluctant to conduct a full review, at this point, on this topic as it is frequently changing. A member felt the long-covid section in the command paper should stay and pointed out that the National Institute for Health and Care Excellence (NICE) definition of long-covid includes post-intensive care syndrome and other diseases covered by the recommendations are also covered by the NICE definition.
3.11. It was also pointed out that it would be difficult, at this time, to correctly interpret data from studies as the definitions of long-covid vary and where available, not being correctly or consistently applied in studies.
3.12. In a clinical setting, a member commented there appeared to be 2 populations of those impacted by long-covid emerging:
- Those who had acute COVID symptoms resulting in end organ damage – there is some evidence that rehabilitation strategies may be having a positive impact.
- Those who may have had a milder case of COVID who have relapsing/remitting long-covid symptoms, which may align to myalgic encephalomyelitis (ME) or chronic fatigue syndrome but there is no evidence linking these to long-covid. It was also pointed out that the definitions for ME are different to those of long-covid.

3.13. This member felt that the recommendations in the command paper cover all the conditions listed by the NICE definition, so the Council has addressed long-covid sufficiently.
3.14. The Chair made the point that IIDB has specific requirements (and limitations) and there are some conditions which may not fit, especially, like long-covid, which are mainly self-reported and have no clear diagnostic criteria.
3.15. There was some discussion around how the draft command paper may be received and, as a consequence, how the Council could attract criticism. However, the Chair pointed out that members had made a decision on their best understanding of the science and potential criticism shouldn't detract from that.
3.16. A member asked about the time frame if this command paper (and that of H&SCWs were accepted), given that IIDB can only be backdated for 3 months. As many of the potential claimants may not be eligible to claim if their symptoms had resolved, would there be any flexibility in relaxing the rules around backdating or posthumous claims. The Chair indicated that this is not within IIAC's control. An IIDB policy official confirmed that there was nothing IIAC could achieve in this area and stated that discussions around the IIAC command papers were ongoing, which were multi-faceted. They agreed to take the question away for further consideration. The Chair stated they had made representations at Ministerial level about the situation with COVID command papers.
3.17. There was some discussion around the requirements for IIDB and the wording in the draft command paper on long-covid where reference was made to objective signs of a condition. There was also discussion around the statement in the command paper that no condition had been prescribed on the basis of self-reported symptoms in the absence of additional evidence. It was felt that this narrative should probably be removed as some older prescriptions may not have been derived according to modern standards.
3.18. A member reiterated the point that long-covid symptoms, as described by NICE, are covered by the command paper recommendations. It was agreed to ensure the long-covid section would be bolstered to include the points raised. It was suggested that the long-covid section be rewritten and that section or the whole report be recirculated by email for review.
3.19. The Chair asked members if they were happy with the recommendations in the command paper and there were no dissenters.
3.20. A member agreed that the long-covid section should be strengthened and having a separate paper at a later stage wouldn't detract from criticism which may be aimed at IIAC. It was suggested that IIAC members could help draft lines to take to assist in dealing with enquires from stakeholders or the media.
3.21. The Chair drew the discussion to a close and thanked everyone for their input.

4. Firefighters and cancer

4.1. The Chair indicated that obtaining data from the Scottish firefighters' pension schemes had been partially successful. Prof Stec had replied to the further questions posed by members, but this has not been evaluated yet.

4.2. Correspondence had been received from a firefighter around bladder cancer and whilst there appears to be an association with this cancer and firefighting, the International Agency for Research on Cancer (IARC) indicated that risks were under 1.5, so would be difficult to prescribe for.
4.3. Due to time constraints, the Chair stated they would summarise the findings from the pension scheme data and circulate this to members.

5. Neurodegenerative diseases (NDD) in professional sportspeople

5.1. The Chair introduced the topic and signalled that several members had spent a great deal of time on this investigation and a draft paper had been circulated.
5.2. These members gave a verbal update on progress to date.
5.3. Following a trawl of the literature, the evidence has been separated out into categories:
- Exercise and ALS (amyotrophic lateral sclerosis)
- Sports and ALS
- Contact sport and ALS.

5.4. For exercise and ALS, the evidence initially appeared to be strong body of evidence, but subsequent scrutiny of the data suggested this may not be the case.
5.5. The evidence for sport and ALS is mixed and there are certain sports such as American football, soccer and rugby which show some evidence of an association, which focussed the work to look at contact sports.
5.6. The evidence for contact sports, from a number of papers on American footballers and soccer players, does appear to show some evidence of a more than doubling of relative risk. At this point, it's unclear what the exposure may be, whether its concussion or contact sport.
5.7. There may be sufficient evidence to recommend prescription, but there are some doubts over the quality or robustness of this evidence.
5.8. A draft paper will be provided to RWG meeting in May with a view to bring back to full Council for its July meeting where options could be provided.
5.9. The Chair asked the members if they were to recommend this for prescription, what the occupation might be. The member felt if could be work as a professional sports person in a number of sports, such as where there is a risk of head contact.
5.10. A member asked about the other neurodegenerative diseases which are thought to be associated with this field. In the early stage of this investigation, the evidence was assessed as a whole, and ALS was selected as this looked the strongest. There is a plan to look at the other diseases such a dementia, Parkinson's, multiple sclerosis etc but there is some indication the evidence may not be as clear.
5.11. The members who are looking at this topic felt it was important to separate out the diseases as a patient won't present with NDD, they will have a specific diagnosis. Parkinson's disease will be considered next and dementia after that, but dementia is a hugely complicated topic and less specific.

5.12. A member asked if it might be better to produce a command paper (if the evidence is suffice) covering the whole of the NDD rather than individual papers. The Chair responded that the investigation started by looking at the topic as a whole and they felt there was sufficient information already written to produce an initial introductory information note.

5.13. A member stated that the first case of chronic traumatic encephalopathy (CTE) in rugby union was confirmed recently which has caused concerns in that sport. They felt that this topic needs to be covered in any IIAC paper, explaining why it's not being included. It was explained that this is a complicated condition which has traditionally been diagnosed at post-mortem. There are also examples where the pathophysiology is present but there are no symptoms. This would be difficult to prescribe for given the requirements of IIDB.

5.14. The Chair asked if it could be possible to draw together a short information note with what's already been done.

5.15. A member reported on progress with the group litigation made against the rugby bodies, this included early-onset dementia, epilepsy, ALS etc. Repeated head injury was also being considered. There is a likely to be a hearing soon which will consider whether this can be a group litigation order (GLO). Law firms were representing amateur as well as professional players and other sports (with contact) could be considered. This will be monitored as the number of claims has now reached over 350.

5.16. A member pointed out that ALS is a relatively rare disease, and the numbers of professional sportspeople are also small, so if prescription was made and accepted, there would be very few claims. The Chair replied that the condition was selected because it was of concern and there was some available evidence to evaluate. Rare diseases are looked at based on their merit and this has been brought to the Council's attention by several individuals and organisations. There is also a public health impact of the Council's work in raising awareness. Civil courts also take note of IIAC's work.

5.17. It was suggested that an expert neurologist should be consulted, so it was agreed to discuss this further off-line.

5.18. A member agreed with the point about rare diseases and felt they should be pursued, especially if they are high profile.

5.19. The Chair thanked all concerned.

6. Commissioned review on respiratory diseases

6.1. The Institute of Occupational Medicine (IOM) gave a short presentation on progress made to date and outcomes so far. 6 disease/exposure combinations were selected for further work:

- Silica + COPD
- Silica + Lung Cancer
- Cleaning products + COPD
- Farming/ pesticides + COPD
- Chromium VI + lung cancer
- Asbestos + lung cancer

6.2. Reports on the topics will be completed and discussed at RWG - a full update will be given to members at the July meeting. All the search strategies and database of papers will be made available to the Council. There was some discussion around the use of AI, but this was not employed for the commissioned review. However, the use of AI will be considered in the future and will be declared. The Chair thanked IOM and stated there would be a great deal of work for the Council to take forward.

7. Work programme update

7.1. The Chair explained that the secretariat and a DWP colleague had been exploring how the Council could use the additional funding to provide scientific support. To support this, the Chair was asked to draft a broad specification of the overarching requirements, circulated to members for information.

7.2. The next stage would be to decide on a list of priorities for the Council. A member felt that mental health or disorders should be included as well as social determinants of health.

7.3. A member had provided a breakdown of claims for various prescriptions and another member suggested that IIDB B diseases should be looked at as the last review was over 20 years ago. A member commented that there were some prescriptions where no claims had been submitted which could be because there is no one eligible to claim or there is a lack of awareness about being able to claim.

7.4. Another member felt that the jobs which caused these diseases no longer exist, but also the occupational element may have changed, so claimants may not be eligible - hand-arm vibration syndrome was used as an example of this. A member asked then how the Council could use data/information like this to help prioritise its work programme. This member also commented that some stakeholders see IIAC as a route to prescription, but where a topic doesn't fit within IIDB, it may be that publishing a paper to that extent raises awareness of that topic to be dealt with by other means. Perhaps the work programme could create packets of work, changing the narrative and perception, which add to the body of knowledge around occupational health.

7.5. Referring to the IIDB statistics, several members felt that where no claims had been recorded, this may not be accurate, so caution needs to be exercised. Other members felt that the HSE guidelines may have had an influence by reducing exposure.

7.6. The Chair stated there was quite a lot of work still ongoing such as NDD and respiratory diseases review and the reactive nature of the Council's work also needs to be factored in. A member asked if an annual review of the IIDB statistics could be produced to help guide the Council.

7.7. Members were asked to consider approaches for further discussion at the July meeting.

8. AOB

a) Promotion of IIAC's work

The Chair thanked members for their suggestions on how to promote IIAC's work and apologised that due to time constraints this topic was unable to be discussed. The Chair indicated they were giving a number of talks to different audiences.

b) The Chair was aware that IIDB policy officials had approached the Council for advice on progressive massive fibrosis (PMF) and pneumoconiosis – it was agreed that the respiratory disease experts would provide responses by email.
c) The Chair drew the meeting to a close and apologised for it running over.

Date of next meetings:
RWG – 21 May 2024
IIAC – 4 July 2024