INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 7 September 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 Richard Heron	IIAC
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
Ms Georgie Wood	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Rachel Atkinson (Centre for Health and Disability Assessments)

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, Richard Heron mentioned that he is a senior research fellow at RAND Europe and has been involved in an advisory capacity with the Lloyds Register Foundation.

1.3. The Chair then formally welcomed Richard Heron, who has joined the RWG.

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.

3. Occupational impact of COVID-19

3.1. The Chair introduced the topic by reiterating that the Council had made a recommendation to prescribe for health & social care workers (H&SCWs) but members had raised concerns about the risks faced by other occupational groups. At the IIAC meeting in July, it was decided to carry out a benchmarking exercise to look at the evidence and how it stacks up for transport and education workers in relation to H&SCWs.

3.2. A member collated evidence from the literature and drafted a paper outlining various options for considering extending the H&SCWs recommendations to other sectors. Thich was shared with members ahead of the meeting. The Chair invited that member to discuss their findings.

3.3. The member outlined the process for gathering and assessing the evidence. They noted that H&SCWs were well-studied with a fairly rich dataset, but that is not necessarily the case for other sectors. This meant that it may be necessary to adopt similar approaches as used in the recent PD A11 review (hand-arm vibration syndrome) where epidemiological evidence is lacking, but there is information about exposures that allow parallels to be drawn.

3.4. There may be a case to recommend extension to other sectors – there is quite a lot of information available for education and transport workers. There may also be a case to consider including all essential key workers as this group all had to go out to work.

3.5. The proposed prescription for H&SCWs was restricted to those who had patient/client contact at the time of infection. Similar restrictions would need to apply for others, for example, for education workers they would have had to have been in school and not teaching from home. Similarly for transport workers they would be required to have had public contact.

3.6. H&SCWs were working with COVID-exposed patients. In other occupations, it might not be obvious who had the infection.

3.7. Another consideration applied to H&SCWs was peaks and troughs of the pandemic where risks changed and this will also be the same for other worker groups. Some occupational sectors could not work from home, as was the case for H&SCWs.

3.8. The member pointed out that if extension was not to be recommended, then the Council needs to explain the reasons. They made a number of additional observations:

3.9. Infection data was discussed and it was pointed out it was difficult to interpret this as the comparison groups were often different. A member felt the ONS, Virus Watch and REACT studies were the most useful sources of information.

This member pointed out that there were a lot of data from these sources, but very few doubled risks, including that for H&SCWs. It was noted that the confidence intervals were quite wide, which is due to sample sizes.

3.10. Another member took the view that pointed out that there were almost no exposure data in other occupations, and even in H&SCWs it was very limited, so this is not a good source of information for decision-making. They felt that if infection risks in other occupations, similar to that of H&SCWs, were evident, then this could be used as a basis for recommending prescription.

3.11. Equivalence of data between H&SCWs and other workers was discussed and it was noted that factors such as vaccination roll-out, timelines (waves/lockdowns) and lack of studies on other occupations in the early phases of the pandemic makes comparison very difficult. Whilst risks for H&SCWs were very high initially, as time progressed these fell and towards the end of the restrictions, risks were probably similar to that of other occupations.

3.12. Some discussion of ONS data from differing timelines followed with members indicating it was difficult to carry out a direct comparison of risks between H&SCWs and those of other workers. However, if the same patterns of infections, as seen for H&SCWs, are observed in other occupations, such as education or transport, then an argument could be made to recommend for prescription.

3.13. A member reiterated that direct comparison of evidence from H&SCWs with that of other occupations was very difficult due to some of the complexities already discussed.

3.14. Another member felt that the infection data showed that there very few doubled risks, mostly with around RRs of 1.5, and this should not be ignored.

3.15. It was pointed out that some transport workers showed excess risks for infection, had an excess risk of mortality and had a high JEM score – triangulation of these data could make the case for prescription. It was also stated that risk dilution occurs when broad categorisation is applied to jobs.

3.16. A member asked if there was any evidence taxi drivers would have been taking infected people to hospital which may be one of the reasons mortality is high in this group. A member commented they had no information on this but was aware that taxi-sharing was a common practice.
Infection

3.17. Job exposure matrices (JEMs) were covered in the last IIAC paper and these are now widely used applying to populations and have been validated in 1 publication. The scores are approximately the same for transport and

education workers same as for H&SCWs, however, it is difficult to meaningfully interpret this without examining the individual domains.

3.18. There was some discussion on the JEMs and whether occupations with contact with individuals were separated from those which were not. The accuracies of the score obtained were questioned as a member felt it was too crude for the Council's purposes. It was pointed out that the JEMs were another piece of evidence and not to be used in isolation.

3.19. A member commented that they felt the JEMs were a more reliable indicator of risks of exposure for COVID than the other studies mentioned and felt there may be a case for other occupations, perhaps with a limited time window. The limitations of studies carried out on other workers may explain the discrepancies and different results.

3.20. Discussion moved onto mortality data, which was felt to have its own limitations, for example the accuracy of occupation recording or age-adjustment. Proportional mortality studies, which look at the odds of dying with a mention of COVID compared with other causes, showed significantly elevated risks in certain occupations, doubled in some transport-related jobs.

3.21. Excess mortality, which deals with deaths from all causes, was elevated during the pandemic with transport workers remaining high throughout. However, these data, whilst informative, are a poor substitute for direct epidemiological evidence relating to infection. Confounding factors such as ethnicity, age, comorbidities etc can skew mortality data.

3.22. The mortality data, taken as a whole, indicates excess risks but with a complex picture and is not a 'clean' measure of infection.

3.23. There was discussion around how the risks may have changed with the introduction of the vaccination programme and the use of protective equipment. H&SCWs were the first group to be vaccinated with other occupations falling in line with the general roll-out, so most occupational groups would have been vaccinated later. That is likely to have lowered the risks for H&SCWs making direct comparison with other working groups difficult. Social distancing was difficult for H&SCWs and those in education. Testing was also discussed where in education and H&SCWs this was mandated but in transport, this was much less stringent.

3.24. A member noted that with other prescriptions, the use of control measures, protective equipment etc is ignored, but not in all cases. Where control measures reduce the risks, this is taken into account.

3.25. Another member pointed out that in many occupations, the use of protective equipment is now being discouraged, along with the reduction of other mitigating factors.

3.26. A member commented that there had been plenty of discussion around the impact on risk of infection and the consequences of infection and vaccination, but not around the health conditions that were recommended for prescription for H&SCWs.

3.27. Another member questioned whether conflating the risk of infection with the risk of developing long-covid was the correct strategy as any potential prescription would focus on long-covid. Another member asked if workers, such as teachers, develop long-covid in the future, are they any more at risk than other members of the public? A member countered this by stating the Council was working on the assumption that the risk of complications is directly related to the risk of getting infected and that there was no occupational differential in the risk of having complications or long-covid having after COVID. It is possible that those with a higher infecting dose such as H&SCWs are more at risk but that is speculative.

3.28. A member noted that there were data indicating that vaccinations protect against the likelihood of developing long-covid, or the likelihood of complications. The difficulty of adequately defining long-covid for the purpose of prescription remains. If vaccination protects against these conditions, then a member felt this should be reflected in the recommended prescription.

3.29. There was some discussion about apply time limits to prescription for various occupations. A member felt that time-limiting any potential prescription could be a mistake as vaccination boosters are now limited to the over 65s (or those who are vulnerable) and the experience learned from the waves and vaccination is that vaccines offered protection from serious illness. There are still coronavirus strains circulating and if these develop into something dangerous, this could cause issues in occupations.

3.30. A member agreed, saying the tighter the time periods are defined for any group of workers, the easier it is to demonstrate that the risks were doubled. However, tightly defining time periods would make administering a prescription difficult. Widening the time periods for potential prescription dilutes the risks making it harder to demonstrate that these were doubled. The same applies to occupational subgroups.

3.31. A member asked what the views are of others on the discussion so far and in which direction to proceed.

3.32. A member felt there may be a case for recommending prescription for essential workers in the first year of the pandemic, which were public- or patient-facing or working in close proximity to others. They felt that there was probably a doubling of risk, but no direct evidence to substantiate this.

3.33. A member commented that they felt that all essential workers was too broad a categorisation as some workers didn't have direct contact with other people in the same way as H&SCWs for example. However, taxi drivers, bus drivers, transport assistance and some educational sectors did have this contact. They felt there was evidence, albeit not very strong, which supports their inclusion for prescription. Others, from protective services, may also be considered. The PROTECT data showed for some sectors such as education, there is a high risk of infection, but low mortality, but the converse for transport.

3.34. The Chair, and others, felt a narrative summary would be helpful in in determining a way forward. The Chair commented that they didn't feel the evidence was strong enough to allow prescription.

3.35. There was discussion around the choices the Council faces when epidemiological evidence is not clear or is sparce. The IIAC Chair thought it would be appropriate to consider this in more detail and suggested setting up a small working group to consider options for the Council to discuss. It has been suggested that inviting representatives of the legal profession could be useful, to get their views on what could be considered as acceptable evidence (reasonable certainty) and how they reach their decisions.

3.36. An observer commented that they felt there is no overwhelming or very clear scientific or medical base upon which to actually base anything in terms of the requirements for a prescribed no-fault scheme. They felt the Council does not have robust enough data capable of being analysed in the appropriate way for a prescribed scheme to actually take this forward. Decision making in what would be a complicated prescription would be a challenge and which will almost certainly be amended as time passes .

3.37. A member responded by stating the Council was very precise about the disease entities which were recommended for prescription for H&SCWs, with long-covid not being included. This is likely to be quite restrictive in terms of the numbers of claims and adding other occupations might be seen to be fair but won't increase the claims significantly. A DWP official commented that if the prescription was accepted, they would have to have very specific definitions for decision makers to interpret. A member commented that it

would be administratively simpler to expand the proposed prescription by occupational category than by disease complication, such as long-covid.

3.38. A member pointed out long-covid had not been fully discussed by the Council to date and they felt this was something which should be dealt with.

3.39. Summarising, the Chair suggested the next step would be to draft a document for the next IIAC meeting – they surmised RWG felt there is scope to extend the H&SCWs prescription by job category, with some dissension, based on an accumulation of weak evidence pointing in the similar direction rather than any clear epidemiological evidence.

4. Firefighters and cancer

4.1. The Chair felt that everyone knew the background to this topic and stated that the Council has reviewed this several times and produced 3 reports, the most recent being in 2021. This was prompted by evidence given by Prof Stec to the Environmental Audit Committee.

4.2. Earlier this year, a team from the University of Central Lancashire (UCLan) led by Prof Stec published papers suggesting very high risks of cancers in firefighters, much higher than those in other publications. Several IIAC members reviewed one of the papers and formed the view that there was a probable underestimation of the numbers of retired firefighters with resulting overestimation of the cancer risks.

4.3. The Chair reminded members that the lead author had responded to initial questions put forward by members but had not responded to follow-up queries. The Chair felt that decisions needed to be taken on where to go next with this topic.

4.4. A member felt that the Council needs to be proactive and publish their views as the Fire Brigades Union have been critical of IIAC's inaction. They felt there may be some merit in asking the FBU to press the lead author for a response to their queries. Another member felt that IIAC should respond, but in a way which encapsulates all of the published evidence, including the most recent IARC (International Agency for Research on Cancer) review.

4.5. There was some discussion about whether the findings of the paper should be challenged publicly. A member suggested writing to the journal (Occupational Medicine) outlining the concerns of the Council and asking for clarification of the sources of information, but this was thought to be inappropriate at this time. It was believed that the journal was already aware of issues about the findings and it was suggested that members look out for an update from the journal. A member suggested that the views of a credible, independent scientist could carry a lot of weight which would not be influenced by IIAC's views.

4.6. It was agreed to recommend that the Council prepare an updated report taking into account the IARC monograph, the UCLan papers and any additional publications.

5. Neurodegenerative diseases (NDD) in sportspeople

5.1. The Chair started the discussion by indicating this topic was undertaken after communication with various stakeholders (Professional Footballers Association, PFA, amongst others) who had voiced their concerns about NDD developing in footballers.

5.2. Initial work focussed on breaking NDD into individual diseases such as Alzheimer's-type dementia, Parkinson's disease and motor neurone disease (amyotrophic lateral sclerosis, ALS). This indicated the literature appeared to be strongest for ALS and sport.

5.3. The association did not appear to be solely with trauma to the head or head movements, but with vigorous physical exercise of various sources. The published literature on this aspect is large and is being examined, but will take time to work through. Preliminary indications are that there may not yet be enough evidence to consider trauma in any meaningful way, but there does appear to be a consistent thread of evidence showing extreme physical exertion at work, whether in sport or other heavy manual work, could be a risk factor for ALS.

5.4. An issue may be the rationalisation of 'physical activity' and harmonising various definitions around this.

5.5. The next stage will be to look at the literature on trauma, either shaking of the head or direct trauma to the head. Other disease states will then be examined.

5.6. The member leading the investigation indicated they had met with a representative of the PFA and shared their initial thoughts.

5.7. An official indicated that a back-bench debate in Parliament had been scheduled to cover head injuries, NDDs and football.

6. Commissioned review of respiratory diseases

6.1. A member gave a short update on progress made on the review.

- Silica & COPD almost complete, data synthesis awaiting review
- Silica & lung cancer data summary underway
- Cleaning products and COPD data summary underway
- Farming/pesticides & COPD screening of literature underway

- Literature searches for Chromium VI, asbestos and lung cancer literature searches have been completed.

6.2. Work had slipped slightly, but the contract with IOM has been extended at no cost to allow for completion, with a view to producing the final report in February 2024.

6.3. There was some discussion on diesel fume exposure and lung cancer, which is not part of the commissioned review. High risk estimates had been reported in a specialist study of underground mineworkers where exposures were very high. Whilst this is a source of additional evidence, it was not considered enough to include on the work programme, but worthy of ongoing monitoring.

7. Work programme review

7.1. 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 relating to non-malignant conditions had been shared with members for consideration.

7.2. The IIAC Chair felt this was a reasonable proposal and reminded members that this topic had generated interest amongst a number of groups at the public meeting held in July 2023, which will be followed up.

7.3. There was some discussion around what had been included in the scoping proposals which will be discussed at the next full Council meeting.

8. AOB

8.1. (A.) 20 year working rule in mineworkers and COPD. It has been suggested that because average working hours in mines increased in recent years the 20-year limit for IIDB claims for PD D12 should be reduced to take that into account. The topic was discussed at previous meetings.

8.2. It was noted that the average working hours of mineworkershad increased, on average, by 8%, but for some up to 30% At the same time average exposures to dust have decreased. When the prescription was introduced, it was based on exposures of 3.0 - 6.0 mg/m3 for a 20 year period. Current exposures are thought to be ~2.0 – 3.0 mg/m3.

8.3. More up to date information may be available from HSE or chief of mines inspector, but any data may be limited. It was agreed to reply to the stakeholder in general terms.

8.4. (B.) Correspondence relating to PD D9 and occupations. A letter from the National Union of Mineworkers (NUM) indicated concerns about asbestos

exposure in mines and occupations. The letter also referred to the Coal Industry Pneumoconiosis Scheme.

8.5. Members were unclear why occupations would need to be described as there is no occupational requirement within the prescription – exposure to asbestos in the course of work and having unilateral/bilateral diffuse pleural thickening should allow qualification for the prescription.

8.6. The Coal Industry Pneumoconiosis Scheme is administered by the Department for Energy Security & Net Zero and IIAC is unable to advise on this scheme. A member pointed out that this scheme may not have been updated to reflect the changes which took place to the PD D9 prescription which were recommended by IIAC in 2016, which removed the requirement for costophrenic angle obliteration on chest radiograph.

8.7. It was recommended that the occupational coverage for PD D9 remain unchanged

8.8. (C.) The IIAC Chair referred to discussions relating to the decision-making process for the Council when there is an absence of good epidemiological evidence and felt that a small working group to look at this would be beneficial. How this could be taken forward will be discussed.

8.9. (D.) A DWP official asked for advice on the imaging requested as part of the PD D9 prescription. As assessment is based on functional symptoms, if there were other medical evidence supporting the claim, then requesting imaging should not always be necessary. A member commented that if a claimant had been to see a specialist and a diagnosis confirmed, this should be adequate for the diagnosis.

8.10. (E.) An official asked if not conducting 3 kHz bone conduction tests, for noise induced hearing loss (NIHL), would be detrimental. A member commented that this should be ok if the assessment process wasn't being compromised.

8.11. (F.) Another question from an official related to NIHL where hearing can deteriorate further but may not be related to the claimant's original occupation. It was queried whether this could be taken into account when assessing disability as some conditions can be excluded if not occupationally related, however this is difficult to do in practice. A member felt that if a claimant had qualified for the prescription but subsequently suffered further hearing decline, it would be difficult to determine what was occupational, so felt the claimant should be given the benefit of the doubt.

8.12. (G.) It was also noted that the equipment used to carry out thermotactile and vibrotactile thresholds in hand-arm vibration syndrome had not been used for some time and a request had been submitted to decommission the equipment as it was no longer functional. A member commented that when IIAC was

asked to look at this prior to the pandemic, its recommendation was that testing should continue.

8.13. (H.) A member of the secretariat indicated that the annual report for 2022-23 should be deposited in the House libraries on 14 September.

Date of next meetings:
IIAC – 19 October 2023
RWG – 30 November 2023