INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 23 May 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 Clair Leris	MoD observer
Ms Lucy Darnton	HSE observer
Dr Rachel Atkinson	Centre for Health and Disability Assessments
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Dr Matt Gouldstone	DWP IIDB Medical 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, Ms Lucy Darnton

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 February 2024 were cleared with minor edits required for publication.

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

2.3. It was noted that a general election had been called which would take place on 4 July 2024. Consequently, it would not be possible to lay or deposit any papers in Parliament. This date also corresponded with the next full Council meeting.

3. Occupational impact of COVID-19

3.1. At the last IIAC meeting, it was agreed that prescription should be recommended for certain sectors of transport workers along the same lines as previously recommended for health and social care workers (H&SCWs). It was also acknowledged that there was insufficient evidence to make recommendations for workers in education.

3.2. Although the evidence had been accepted and the terms and wording of the recommended prescription had been agreed, there were several sections which were not yet complete, so it was agreed that final clearance and sign-off of the paper could be done by correspondence with all members.
3.3. The most recent draft of the command paper was circulated in meeting papers, which included a revised long-covid section. All IIAC members had been provided with a copy and were invited to send comments to the IIAC Chair.
3.4. As a general election has been called, the command paper would not now be laid before Parliament until the autumn 2024 when a new government would be in place.
3.5. Members were asked to consider the long-covid section as this needed to be finally agreed and referenced accordingly.
3.6. A member stated they had contacted their colleagues to ask for any additional evidence to strengthen the summary/conclusions section, but this had not been forthcoming. It was agreed this would not matter as it would not materially alter the findings.
3.7. A member commented that a recent paper on masks and respirators[1] had been published and perhaps should be added to the references.
3.8. This member also commented that the mortality tables from the Office for National Statistics (ONS) may be missing some of the occupations and this may trigger questions from the education sector. Similarly, another table appears to be missing some of the other occupations in transport such as air/rail.
3.9. It was agreed that these results would be reconsidered and included if appropriate.
3.10. A member indicated that they had compiled a long-covid incidence rate table from the NHS Futures website. This would be explained by a footnote to the table and the website referenced.
3.11. There was some discussion around the long-covid section. A member was keen that this should make clear that the recommended prescription covers many of the symptoms of long-covid. Where objective evidence is missing, it is difficult to ascribe symptoms to the virus.
3.12. The issue of backdating claims was briefly discussed, and it was pointed out that many of the people who had been impacted by the conditions recommended for prescription may be ineligible to claim because the recommendations had not yet been accepted.
3.13. The Chair summarised the discussion and agreed the actions. Further work to the text of the command paper would be carried out and circulated to members for approval. The IIAC meeting on 4 July will feature this topic for final sign-off. The secretariat will seek a suitable date for laying the command paper and ensure its publication on the .gov website.

4. Firefighters and cancer

[1] Masks and respirators for prevention of respiratory infections: a state of the science review. Greenhalgh et al; Clinical Biology Reviews; May 2024

4.1. The member who had been working on this topic had not had time to progress this any further.
4.2. It was noted that Professor Stec had provided the Council with additional information about the methodology in the paper and it was agreed that a response would be issued.
4.3. It was felt that there was probably little else the Council could achieve with this topic, so it would likely be brought to a close.

5. Neurodegenerative diseases (NDD) in sportspeople

5.1. The Chair indicated that a copy of the latest iteration of the paper had been circulated in meeting papers with guidance notes. The Chair also stated that a decision would need to be taken whether to recommend prescription to the Council and that this was not an easy task.
5.2. The literature has been reviewed and there are about 20 papers relevant to the topic of amyotrophic lateral sclerosis (ALS) and professional sportspeople, but many are small studies with overlapping populations.
5.3. A member felt the evidence was not sufficient to recommend prescription, but it was close.
5.4. The Chair then asked if members had any views on the evidence included in the paper. A member responded they agreed that the studies identified contained small numbers as ALS is a rare disease, so few cases are apparent.
5.5. This member commented the issue is not just the risks identified, but also what might be included in a recommended prescription. Also, there is an issue of whether there is any mechanistic evidence to support prescription. They felt that it would be worthwhile asking an independent expert neurologist for their views as some of the studies are unusual as they have high risks for other neurodegenerative diseases.
5.6. A member involved in the investigation stated there were 2 main elements uncovered:
- Extreme physical exertion and associated inflammatory changes – likely linked to particular genetic profiles and linked to nerve damage;
- Head impact – quantification is difficult, not much evidence of the impacts within soccer, but more evidence is available on the effects of concussions.

5.7. A member felt they would like the opinion of a neurologist on the study of Scottish rugby players which showed unusual high risks across a number of different NDDs.
5.8. It was agreed that having the views of an expert neurologist would be beneficial – the secretariat had approached someone who declined, so alternatives will be sought.
5.9. Regarding the potential recommended prescription, a member commented on the timing of diagnosis after leaving the sport, especially with respect to late onset. Although much of the evidence relates to disease onset at a relatively young age, they felt the potential prescription shouldn't be too narrow to exclude those who were diagnosed late. It was stated that it would be unlikely that any prescription would include either an age range or a time limitation after leaving the sport.

5.10. The paper mentions ALS as well as motor neurone disease (MND) and a member felt if prescription was recommended both terms should be used to avoid confusion.
5.11. A member asked about what the causal exposures for ALS could be as it appears to be focused in elite sportspeople, with the requirement to have strenuous physical exercise and involvement of head impact or trauma. It was felt that concussion was not necessarily required. Much of the evidence comes from soccer where there are not many reported concussions. However, another member disagreed with the assertion that concussions weren't prevalent in soccer.
5.12. If concussion was a risk factor, then a member suggested the potential prescription could be extended to other sports where concussion was prevalent, but evidence was sparse. Exposure equivalence should be considered if the exposure could be defined.
5.13. A member felt that there appeared to be a synergistic effect with combined exposure to extreme exercise and head impacts being the causal effect. There are sports which require high degrees of fitness but no head impacts where ALS is not found. However, there doesn't appear to be any sport where head impacts are prevalent which doesn't require a high degree of fitness.
5.14. A member felt that if concussion isn't a prerequisite for ALS, then it could be a useful proxy for head impacts, so could be used to identify sports where there are risks.
5.15. It was not known if repeated head impacts or a single event are responsible for ALS development.
5.16. A member commented that some people may be genetically susceptible to concussion and repeated head impacts have a greater effect on these sportspeople, meaning less force is required to manifest the injury. These people may then retire early from their sport. There may also be an issue of the time taken for the brain to recover from concussion where sportspeople return too early – this may also be a risk factor. It was pointed out that genetic factors are not taken into account when IIAC makes recommendations for a prescription.
5.17. The Chair asked if members were minded to recommend prescription for at least some sports based on the evidence. It was felt that the picture may become clearer after speaking with a neurologist to better understand the pathology, so members reserved their judgement until then.
5.18. It was felt that the exposure-equivalence in other sports should be considered further, possibly where head impacts could be predicted and where there is a high degree of fitness required.
5.19. A member commented that they felt the draft paper was powerful and that the summary of the evidence led them to believe that recommending prescription was supported, but also agreed that views of a neurologist would be helpful.
5.20. A member then asked about chronic traumatic encephalopathy (CTE) as this topic has received a lot of attention. A member responded that diagnosis of CTE is given after post-mortem and the clinical correlates are poorly described in the literature. It was felt that this topic should be covered in greater detail in the draft paper. A neurologist may also be able to advise further on this topic.

5.21. There was discussion around which sports may need to be considered and it was felt advice from a sports scientist/medic would be helpful.
5.22. The Chair intimated that members may be heading towards recommending prescription, with reservations, and neurological input is required to check assertions are correct. Underlying mechanisms and CTE also need to be considered. If prescription were to be recommended, additional advice on which sports to cover would be required.

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. More recently:
- Silica and COPD
- Silica and lung cancer.

6.3. Further discussions would be needed on these topics as there wasn't agreement on the implications from the reports.
6.4. A member commented that IOM had done a good job, but felt there was a great deal more work to be done by the Council.
6.5. For the silica/lung cancer report, there are other considerations which need to be considered such as dose-response data, the key being what are the risks of lung cancer with/without silicosis. A member agreed and felt the data are there, just needs to be analysed. Another member commented that the dose-response is acknowledged to a certain degree by the acceptance of a doubling of risk of lung cancer if silicosis is present (current prescription PD D11). Practically speaking, it is difficult to assess if a high enough dose has occurred in the absence of silicosis.
6.6. With regard to COPD a member noted that the current prescription for miners is idiosyncratic.
6.7. Referring to the commissioned review as a whole, a member felt that the 6 reports received from IOM would require a great deal of work by the Council and pointed out funding was available to help take this forward. A further external tender could be considered to take the work through to completion for the whole commissioned review.
6.8. The reports received for discussion at the meeting were:
- COPD and cleaners
- COPD and agriculture

6.9. It was noted that studies in cleaners tend to focus on asthma but many studies also look at COPD.
6.10. A member felt that the exposure element needs to be considered as cleaning takes place in a large number of occupations and there are a number of papers which may cover this. Another member commented that domestic and industrial cleaners are exposed to different products, but the risk may there for both. If prescription were to be recommended, it would likely to be for the occupation of cleaning in certain environments rather than the chemicals cleaners are exposed to. It was noted that what constitutes a 'cleaner' can be

uncertain and certain occupations such as healthcare workers have a large element of cleaning. That would need to be taken into consideration.

6.11. A member commented that a previous IIAC information note[2] on asthma in cleaners mentioned irritant-induced asthma (reactive airways dysfunction syndrome / RADS) and wondered if this needs to be revisited and considered for prescription. Currently IIDB claims for asthma are only accepted when there is exposure to a sensitizing agent (PD D7).

6.12. A member noted that there been developments in understanding the mechanisms of various types of asthma which is important in relation to new treatments.

6.13. Another member asked if asthma could develop into COPD? A member responded that chronic asthma can produce a condition very much like COPD. So, for cleaners, it may be asthma which needs to be looked at again. It was noted that the commissioned review specification excluded asthma.

6.14. There was discussion about diagnostic criteria for COPD. This is potentially a difficulty as not all studies define the condition in the same way. For any future prescription COPD could be easily defined in standard terms based on lung function measurements so this was not thought to be an issue.

6.15. It was felt that it was time to update IIAC's views on cleaners and asthma as it is an important topic, and the current information note is out of date.

6.16. A member asked if cleaning agents which could cause asthma could be a route to investigate COPD? Smoking is also a huge issue which complicates occupational exposures.

6.17. A member suggested that COPD/cleaners not be pursued at this point as the risks were not approaching doubled, but a more general approach to look at cleaning to include asthma which could involve COPD at some point.

6.18. The discussion moved onto agriculture/COPD. The IOM report identified 8 studies which were not without issues. The report suggested there was insufficient evidence to recommend prescription for this disease/occupation combination. Some population studies indicate less than doubled risks, but some lung-function studies show a varied pattern with some showing a large effect.

6.19. The Chair asked for comments and for views on how to proceed with this topic. A member stated they had found a systematic review which touched on some of the issues raised, such as the definitions used for COPD. The exposures encountered (e.g. pesticides) and the different types of farming which can result in mixed exposures.

6.20. It was felt that exposures in farming were changing as more work is now being carried out indoors. A member felt the clarification of the different types of farming and what they contribute to the relative risks (RR) was important as dilution of RR can occur in combination with other types of farming. Pesticides were considered to potentially be a difficult topic to undertake.

6.21. Prioritisation of the work programme was discussed with a view that perhaps IIDB statistics could be used to identify topics which would be beneficial to a large number of claimants. The changing nature of work also needs to be

[2] Asthma in cleaners: IIAC information note (2015)

considered, especially in relation to smaller employers who may not be able to effectively control the risks.

6.22. Returning to the commissioned review as a whole, the IOM gave an overview of the progress to date and when all the reports were likely to be completed. Chromium/lung cancer report will be completed very soon, as will asbestos/lung cancer.

6.23. The question of publication of the commissioned review was raised and it was felt that that an overall summary from the Council would be appropriate to accompany the reports potentially as appendices.

6.24. The final two outstanding reports will be discussed at the next RWG with a view to decide how to take forward the results from all six of the reports. IOM will be drafting a summary of their findings to be ready for the next RWG meeting in September.

7. Work programme review

7.1. The terms for the scoping review had been agreed with IOM, the contract has been signed and some initial work completed. IOM gave an overview of the specification of the review:

- To identify the industries, occupations and exposures associated with non-malignant occupational diseases which occur;
  (a) only in women or
  (b) where women are potentially at greater risk than men, where both are similarly exposed.
- Give an approximate estimate, where feasible, of the range of the magnitude of the risks and the numbers/proportions likely to be affected.
- Assess the size of the literature base for outcomes/exposures for more detailed evaluation of specific health outcomes and occupations.

7.2. There was discussion around how health outcomes related to women could be identified as historically the bulk of occupational data relates to men.

7.3. IOM outlined progress to date:

- Development of a search strategy (completion date 10th June 2024): identify occupations where workforce is predominantly women e.g. healthcare, education, office work, hair and beauty, hospitality.
- Review of selected literature for these occupations to identify key health outcomes: e.g. reproductive outcomes, musculoskeletal, anxiety/depression.
- The next steps are to integrate these findings into search strings and carry out trial searches and agree a search strategy with IIAC.

7.4. Members were shown a slide which detailed some of the occupations which predominantly employ women (e.g. healthcare, teaching) and the health endpoints (e.g. musculoskeletal, reproductive) which could be investigated.

7.5. Other areas which members suggested to look at included manufacturing and laboratory work. A member pointed out that whole-body vibration has risks in pregnancy.

7.6. A member commented that it would be relevant to look at why women might be at greater risk if they have similar exposure to men and discuss any biological basis for this.

8. AOB

8.1. The Chair reported that a meeting had been held with the National Union of Mineworkers (NUM) where various topics were discussed. The main concerns were osteoarthritis (OA) of the knee (PD A14) and pleural thickening (PD D9).

8.2. Regarding PD A14 there are certain job categories which are specified in the prescription, but there are other workers with jobs that are said to have similar exposures (squatting, kneeling etc) which are not covered. The NUM have requested that the prescription could be extended to cover these workers.

8.3. A member suggested that given the basis on which the original command paper was written, the topic could be looked at again and determine which underground workers could be impacted. A member commented that finding objective evidence to support extending the prescription, at this point, may be challenging.

8.4. It was noted that different areas of the country may have different titles for the same job and that restructuring of the industry may have changed the roles undertaken. It was felt that the original consultation with the unions be revisited to try to understand how the list of job roles was incorporated into the PD A14 prescription.

8.5. A member pointed out that more literature had been published over the years, including some systematic reviews. IIAC should perhaps consider looking at the prescription as a whole to establish if other occupations are impacted by OA. It was noted that occupations which predominantly employ women, (e.g. cleaners) which involve kneeling, could be impacted.

8.6. It was agreed that this topic could be taken forward but would depend on Council priorities. A suggestion was made that this could be a future commissioned review.

8.7. The IIAC Chair picked up on this point and updated members on the progress being made with DWP/IIAC secretariat on setting up the commercial element to allow IIAC to use the additional funding provided for additional scientific support. To move this forward, the Council would need to decide on which topics it wanted to look at in detail i.e. prioritisation would be required and decisions taken.

8.8. It was suggested that topics prioritised could be shared with external experts to validate the approach being taken.

8.9. This topic will be discussed further, along with communication/IIAC promotion at the next IIAC full members meeting in July. A member mentioned resources which may be of use to the Council and agreed to send it onto members for consideration.

Unilateral or bilateral diffuse pleural thickening (PT) (PD D9)

8.10. With regard to PD D9 (diffuse pleural thickening) the Chair relayed NUM concerns about the presence of asbestos underground (e.g. dust from brake-linings). It was agreed that the incidence of other asbestos-related diseases (e.g. mesothelioma, pleural plaques) could be investigated as a surrogate for

asbestos exposure. The NUM were asked to share any evidence they may have, and some work has been undertaken to look at IIDB statistics. Some cases of mesothelioma have been uncovered. A member suggested looking at the HSE register and filter it by occupation.

8.11. It would also appear that claims for PD D1 (pneumoconiosis) in mining and quarrying also include significant numbers were asbestos was the reported causative exposure which is puzzling. A member pointed out that there were some instances where asbestos was used as fireproofing in mines and this process may have caused high levels of exposure.

8.12. Another issue discussed was whether PD D9 is too restrictive as it suggests circumstances of very high levels of asbestos exposure and the levels required to cause diffuse pleural thickening are not particularly high. It was pointed out that the occupational criteria for D9 are the same as D8 which in general requires substantially heavier exposures. There are other causes of PT which might have influenced the original prescription. It was agreed that there was a case for PD D9 to be looked at again at some point.

8.13. Anecdotally (and this needs to be checked) it would appear from IIDB statistics that the majority of all claims for prescribed diseases between 2017 and 2023 route involve asbestos.

Other business

8.14. There was discussion around the date of the next IIAC meeting as this now falls on the date of the general election on 4 July. It was suggested that the meeting go ahead but to hold it in London rather than Leeds as had been proposed. It was requested that papers for the July meeting be sent out as early as possible as some members may have other commitments relating to the election.

Date of next meetings:
IIAC – 4 July 2024
RWG – 5 September 2024