INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 5 September 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
Ms Lucy Darnton	HSE observer
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Dr Matt Gouldstone	DWP IIDB Medical Policy
Ms Georgie Wood	DWP IIDB Policy
Ms Vanessa Robbins	DWP IIDB Policy
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Clair Leris

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 May 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.

3. Neurodegenerative diseases (NDD) in sportspeople

3.1. The draft report was not recirculated as there have been no changes since the previous meeting at which it was decided that several members would carry out a meta-analysis of the sports studies.

3.2. Members have held discussions around data extraction for the meta-analysis and it is hoped that there will be more to report at the next RWG meeting in November.

3.3. A member raised the issue of former and current IIAC members being criticised in the press for not declaring IIAC membership when publishing the outcomes of a study online. The sponsor of that study was disappointed with the outcomes and inferred that membership of IIAC was a conflict of interest, which is not the case. The former members and current member had declared at IIAC meetings that they were involved in a relevant study, and this was considered appropriate. Rebuttals were issued by the secretariat on behalf of the Council. Members noted that the criticisms were wholly inappropriate.

3.4. The Chair indicated that the PFA had requested a meeting, but it was felt that this was not necessary at this stage and would be considered when the investigation was nearing its conclusion.

3.5. The Chair had looked through the latest publications and whilst there was little new on motor neurone disease (amyotrophic lateral sclerosis/ALS), there were several papers on cognitive function. Two reported that cognitive abnormalities after sports-related injury were less severe than following other causes of injury.

3.6. A member asked if the Council would need to have a position on the other NDDs as ALS was considered the most likely to be linked to professional sports. It was suggested that discussions around this be taken forward to the work programme agenda item.

4. Commissioned review of respiratory diseases

4.1. The Chair felt that there were 2 main issues that required discussion namely the new reports received from the Institute of Occupational Medicine (IOM) and what members felt should be the next steps in taking forward the outcomes from the review.

4.2. IOM presented the outcomes of the reports into:

- Chromium VI and lung cancer;
- Asbestos and lung cancer.

4.3. With regard to chromium VI and lung cancer the Chair noted that this is already a prescribed disease (PD D10). The prescription is based on chrome smelters but acknowledges that there might have been equivalent exposures in other industries. The chrome salts included in the prescription are different to those highlighted in the International Agency for Research on Cancer (IARC) reports.

4.4. The later prescription for nasopharyngeal cancer and chrome (PD C32) specifies the occupation rather than the exposure. It is unclear if any differences exist in the range of chrome exposures associated with

nasopharyngeal cancer compared with lung cancer. This may indicate inconsistencies in the prescriptions. It was observed that these prescriptions receive few claims.

4.5. IOM used the latest IARC monograph as the starting point for the report on chromium and lung cancer and the evidence was categorised accordingly. Chromate production, paints and pigments, electroplating, other industries, and population-based studies were examined.

4.6. The risks around chrome smelting were discussed. The IOM report concluded that there was evidence for doubled risks for chromate production – the current prescription may not adequately cover workers in this industry.

4.7. Reference was made to a possible change in process in around the 1980s which might have reduced exposures in chromate production. If IIAC were to consider specifying chromate production for prescription, it may need to be time limited. Doubt was expressed at whether chrome smelting is carried out in the UK anymore. The low numbers of IIDB claims may be indicative of this.

1.1. With regard to paint/pigment production IOM found studies where elevated risks were apparent, but it was not clear if these risks were doubled.

1.2. IOM referred to an IIAC publication from 2013 on lung cancer and welding which found limited studies that had elevated risks, but a further five reports on chromium VI were identified. However, the risks were not doubled for the exposure under consideration.

1.3. A member asked where workers in the UK would currently be exposed to chromium, but IOM had not looked into this. As noted, chrome smelting has diminished significantly. Chrome electroplating is common so would be a source of exposure along with stainless-steel welding, cement production and paint production.

1.4. The conclusions from the IOM report included:

- Chromate production workers have/ had elevated (doubled) risks of lung cancer;
- Chrome plating and welding may need to be revisited;
- Painting/painters may also need to be examined further, but it may be difficult to identify studies which distinguish between different types of paint or where chromium was present;
- Smoking data were not always quoted and were often variable when present. However, even with adjustment for smoking, there remained elevated risks for lung cancer due to chromium VI exposure.

1.5. IOM asked members to consider the report and provide feedback.

1.6. A member suggested that breaking the evidence down into industries such as smelting, plating, paints or welding may yield more useful information rather that looking specifically at chromium exposure as co-exposures may also be important. A member commented that certain environments, such as foundries, might be considered to be carcinogenic, so mixtures of carcinogens are important. Silica has also been linked to foundry exposures.

1.7. It was felt that welding might be an important additional topic. It was last looked at by IARC in 2013, but there is evidence of carcinogenic effects, ocular melanoma being a good example.

1.8. A member asked that given the low number of claims, would the prescription for Chrome VI and lung cancer be worth pursuing? A member commented that there may be other considerations, and the prescription may warrant some attention to clarify the occupational elements and exposures. They felt the IOM report was useful.

1.9. Sino-nasal cancers, which are rare, were mentioned by a member who felt that knowing the number of reported cases and if there were geographical links then this may be indicative of industries/exposures. It was felt this was possible and some data was shared. However, it was suggested that sino-nasal cancers do not need to be considered specifically at this stage.

1.10. The discussion moved onto asbestos and lung cancer where the current prescription mentions lung carcinoma in the presence (PD D8) or absence (PD D8A) of asbestosis. Heavy occupational exposure to asbestos is considered to be a requirement.

1.11. In discussion with IIAC members, IOM carried out a more focussed search of the literature looking for studies with heavily exposed asbestos populations.

1.12. The search strategy focussed on IARC findings, relating to exposures in asbestos mining, insulation work, textile work, cement work and friction material handling. These gave indicative risks for certain levels of asbestos exposures. Most of the occupations examined are now defunct and exposures historical and difficulty was encountered in finding other occupations which are not historical. It was suggested that a way forward is to look at the exposure literature to identify occupations with relatively high asbestos exposures.

1.13. There was further discussion about the relevance of the literature to more contemporary exposures. A member commented that they felt confident that asbestos exposure had decreased over the decades, and they felt that since IIAC last looked at this in 2005, it would be unlikely (but not impossible) that workers would have been exposed to the levels of asbestos specified in PD D8a.

1.14. An observer commented that there are dose-response data by fibre-type which suggest high cumulative exposures are required for a doubled risk of developing lung cancer. Examples of the occupational circumstances where these exposures could occur were specified in the prescription and it was thought that post-1975 it would be difficult for other workers to accrue enough exposure to double the risks.

1.15. An unpublished case control study on lung cancer may be able to shed light on occupations which were at greater risk from asbestos exposure. It was suggested that the author be sought and contacted.

1.16. The issue of the relevance of cumulative asbestos exposure as the product of concentration x time was discussed. PD D8a specifies durations of exposure, and it is likely to include workers at greatest risk from exposure. It was felt that some workers may have been exposed to very high levels of asbestos over a shorter period of time, so these might not always be appropriate. A member felt that dose-response looking at number of years exposed should be considered and studies had been published to support this.

1.17. The relationship between asbestosis and lung cancer risk was also discussed. It was noted that although historically it was believed that asbestosis was a necessary precursor of asbestos-related lung cancer that is no longer the generally accepted view. A member commented that that view arose at a time when asbestosis was diagnosed using chest radiographs whereas now the diagnosis is generally based on CT scans which are much more sensitive.

1.18. A member felt that looking at dose-response for both asbestosis and lung cancer is an appropriate route to follow.

1.19. A member made the point that Surveillance of Work-related and Occupational Respiratory Disease (SWORD) reported on cases of asbestosis, with joiners, plumbers and electricians amongst the occupations impacted with a low dose exposure over a long period of time. The member was unsure if there would be a difference between high dose over a short period or low dose over a much longer period, but felt there was a dose-response.

1.20. The member felt there is a shift in the diagnosis of asbestosis for example amongst reporters to the SWORD survey towards CT scans. However, there is not an equivalence of that to do with the prescription. For electricians or plumbers who have had low doses of asbestos of a long period, say 30 years, who may have pleural plaques but not asbestosis, would these workers always have to have asbestosis to be considered to be at risk of lung cancer?

1.21. The issue of specifying causes of asbestosis in PD D8 was raised. A member commented that in the recent review of PD D1 (pneumoconiosis), no occupations were specified. This raises the issue of the appropriateness of

specifying particular causes of asbestosis in PD D8. If a worker has asbestosis and lung cancer, then it doesn't matter if they have worked in these jobs or not, it's the combination of the two that signals the high exposure. The possibility of revising and combining the prescriptions (PD 8 and 8a) was raised.

1.22. A member asked if, for prescription purposes, the different types of asbestos can be ignored as it would be difficult to administer a prescription if these had to be specified. It was suggested that amphibole was more hazardous for lung cancer but some studies appear to show high risks for chrysotile, so the position is not clear-cut. However, from a prevention perspective it is assumed the fibre type is unknown, so treat as worst-case scenario.

1.23. The issue of bystander exposure was brought up. Mesotheliomas are reported in demolition (and teachers) and those who work in building maintenance. A member commented it was important to distinguish between diseases caused by low-level asbestos exposure such as mesothelioma and high-level such as lung cancer.

1.24. There was some discussion around the time to development of asbestosis or lung cancer after last exposure and it was felt this was something to look into further. An observer commented that the type of fibre may be important for lung cancer development after last exposure as chrysotile appears to be cleared from the lungs quicker than amphibole.

1.25. A member commented that the IOM report was comprehensive and invited members to give feedback. However, this was likely to be a big topic to tackle to provide advice to revise PD D8 and suggested this could form part of the longer-term work programme which could be looked at in greater detail by an external supplier.

1.26. A member felt that for the carcinogens, including silica, that any further IIAC reports should summarise the toxicology and mechanisms as this adds to the body of evidence.

1.27. A member commented that several suggestions had been made to take forward and felt they should be addressed, but another member pointed out that IIAC is not obliged to take anything forward, only what it deems to be a priority.

1.28. IOM concluded their presentation with a request for feedback on the other reports which had been submitted. When received, the final report can be drafted in whichever form IIAC requires and the project can be finalised. A member offered to collate members' views and feedback to IOM. Lists of references will be provided as requested.

2. Work programme review
Scoping review into women's health

2.1. IOM reiterated the aims of the review which were to search for authoritative reviews or large-scale epidemiological studies to identify industry/occupational/exposure circumstances where the health problems only occurred in women or where women are at greater risk, focussing on non-malignant issues. The size of the literature base will be assessed for the outcomes/exposures which may indicate where a more detailed evaluation may be required.

2.2. To date, employment patterns for women have been identified

- Identification of relevant health endpoints:
  - musculoskeletal,
  - reproductive,
  - anxiety & depression,
  - burnout,
  - obesity.
- Identification of relevant occupations:
  - 14 identified including healthcare, hair and beauty, teaching, hospitality, administrative roles.
- Development of search strings and literature searches focusing on reviews from the past 20 years.
- Screening of titles and abstracts to identify papers for full text review.

2.3. This has resulted in 306 studies for potential inclusion in the review.

2.4. IOM showed a slide which indicated the number of reviews for health outcomes across a range of different occupations.

2.5. The healthcare occupational group had the most reviews and mental health as a health outcome was the most reported.

2.6. A member asked whether home-workers (e.g. those who take phone calls) or remote working are covered. It was thought that this worker-group may be covered by the occupational groups identified.

2.7. It was noted by a member that exposures were not included and asked that commonality of exposures be identified across health outcomes and occupation for further consideration.

2.8. IOM indicated that data-extraction is the next step.

2.9. The project was on-course for completion by the end of January.

General review of the work programme

2.10. The IIAC Chair indicated that neurodegenerative diseases (NDD) in professional sportspeople is an ongoing big project. There are still a number of key decisions to be made, and the project will likely continue for some time. The other NDDs to consider are Parkinson's disease (PD) and dementia/cognitive dysfunction, but another member thought that chronic traumatic encephalopathy (CTE) should also be considered.

2.11. PD may be relatively straightforward, but dementia could be a huge undertaking due to the wide range of potential health outcomes and a large literature base to consider.

2.12. A member felt CTE may be difficult to evaluate as there may not be a great deal of literature and it is mostly pathology-based. CTE may present clinically as dementia, so cognitive dysfunction may be a better topic to take forward.

2.13. The IIAC Chair also reminded members that the Council had committed to continue to monitor the COVID data as risks may change with time and long COVID is an emerging issue. A member who has periodically been keeping an eye on the literature felt that nothing has become apparent which was of concern to the Council. Literature searches every 3 months or so should cover the topic adequately.

2.14. The respiratory disease commissioned review also yielded 6 reports that need to be considered further, which the IIAC Chair indicated would be a large piece of work, which may result in decisions being taken on whether to make recommendations for changes.

2.15. It was suggested that the work carried out by IOM on lung cancer/silica exposure be extended to look at:

- Further literature searches for specific industries e.g. stone masons;
- Silicotics and dose responses;
- Cross-sectional population studies;
- More detailed evaluations of narrative reviews and meta-analyses;
- Review of the available dose-response – this was regarded as being 'key'.
- A concise summary of the toxicological and mechanistic work which underpins the classification of silica as a human carcinogen.

2.16. It was suggested that the silica project could be the first topic to consider using the funding to appoint an external organisation to carry out much of the work. An initial draft of the overview of this has been drawn up as a starting point.

2.17. Advice on the identification and procurement of external organisations was given by a DWP staff member with significant commercial expertise – public

sector commercial rules would have to be adhered to. A member felt that suitable organisations would probably need to have mathematical expertise to review the dose-response modelling studies and be able to review the toxicological aspects for silica exposure. It was noted that organisations outside of the UK could be considered which could increase the choice of available resources.

2.18. Other government-sponsored committees also use external organisations for scientific support, so it was suggested that it be established how this is done and which organisations the other committees use.

2.19. The point was made that IIAC needs to be very clear on the outcomes it requires. It was also pointed out that IIAC still needs to be responsive to the reactive nature of some of its work and having some funds available to support this may be required.

2.20. A member felt that prioritisation should be discussed as NDDs was a complex topic which has taken a great deal of members' time. Some of the proposed work such as the scoping review into women's health could be a longer-term project as could the respiratory disease elements as these may take some time to complete.

2.21. A member felt that less complex tasks would be easier and quicker to complete, so this could approach be considered for shorter-term requirements. NDD was raised and it was felt that it might be possible to progress this topic. Members agreed to give this some thought, possibly cognitive dysfunction.

Assessment of disability for PD D1 (pneumoconiosis)

2.22. Correspondence had been received outlining an alternative approach to assessment of disability using a gas-transfer technique. Members were asked for their views. It was felt that this technique might have benefits for some individuals but did not have any great advantage overall. The administration of the IIDB scheme should be straightforward and this technique would add costs. Overall, the technique may not be better than the testing regime currently used, e.g. studies of pharmacology in lung fibrosis use spirometry rather than gas transfer. Members agreed to help draft a response to the correspondent.

PD D14 (osteoarthritis of the knee)

2.23. A stakeholder has argued that other jobs in mining should be considered in addition to those specified in the prescription. It was agreed that the secretariat would continue to look into the original engagement with

stakeholders to establish how the initial list of underground jobs were prescribed for.

PD D9 (diffuse pleural thickening)

2.24. The criteria for the prescription mirrors that of PD D8 (lung cancer/asbestos) where asbestos exposures were high. This topic will remain an agenda item.

PD D11 (lung cancer with silicosis)

2.25. This will form part of the additional work to come out of the commissioned review into respiratory diseases.

3. COVID-19

3.1. This will remain an agenda item, nothing additional was discussed.

4. IIDB benefits analysis

4.1. A paper was circulated which looked at the online stats for IIDB and pulled together the analysis covering March 2017 up to June 2023. A number of members felt this was very useful and informative.

4.2. A member observed that claims for PD B6 and PD C34 (extrinsic allergic alveolitis) might have been impacted by a change in terminology to hypersensitivity pneumonitis.

4.3. The range of disabilities awarded was also discussed.

4.4. A member felt that information such as this could be used to help inform the Council when prioritising its work as where there are no claims for a PD or where studies indicate no claims could be expected, there may be little value in recommending changes to them. This could also apply to topics the Council takes on where diseases may be very rare. However, this view was not shared by all members, with opinions that if a rare disease has a strong association with an occupation, there should not be barriers placed to recommending prescription.

4.5. A member felt that where no claims or few claims had been recorded for a PD, this may be due to lack of awareness of IIDB. It was also commented that a claimant may be diagnosed at assessment with a different disease.

4.6. It was also noted that there were significant claims for the accident provision. Focal dystonia was also discussed where a member speculated which occupations were involved.

5. AOB

5.1. The transport and education workers command paper is likely to be laid before Parliament when the conference season is over.

5.2. IIDB policy officials indicated the COVID command paper for health and social care workers is still being impacted amongst other Departmental priorities. Deliverability of the recommendations and legal implications are being considered.

5.3. It was noted that the IIAC annual report had been scheduled for deposit in the House libraries.

Date of next meetings:
IIAC – 17 October 2024
RWG – 28 November 2024