INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online RWG meeting
Thursday 28 November 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 Sharon Stevelink	IIAC
Dr Richard Heron	IIAC
Ms Lucy Darnton	HSE observer
Dr Clare Leris	MoD observer
Ms Parisa Rezia-Tabrizi	DWP IIDB Policy
Mr Lewis Dixon	DWP IIDB Policy
Dr Matt Gouldstone	DWP IIDB Medical Policy
Ms Georgie Wood	DWP IIDB Policy
Ms Vanessa Robbins	DWP IIDB Policy
Dr Marian Mihalcea	Medical assessment
Dr Sasa Markovic	Medical assessment
Mr Stuart Whitney	IIAC Secretary
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Dr Rachel Atkinson

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 September 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. The Chair noted that work on the risks faced by firefighters had not been finalised. This would be completed at some point. The Chair also noted that recent publications found less than doubled risks, consistent with IIAC's findings.

2.4. The IIAC Chair noted that a separate piece of work around organo-phosphate poisoning would be considered.

3. Neurodegenerative diseases (NDD) in sportspeople

3.1. The Chair indicated that several papers had been circulated including the draft paper summarising the evidence in relation to amyotrophic lateral sclerosis (ALS) in professional sportspeople. This version was unchanged from that previously shared with members. Also circulated were papers outlining the findings from the meta-analysis of the relevant studies.

3.2. The draft paper summarising the evidence did not make specific recommendations, but gave 2 options which were:

- to accept the evidence and recommend prescription or
- to reject the evidence.

3.3. The Chair also reminded members that an expert neurologist had reviewed this paper and shared his views at the July 2024 IIAC meeting.

3.4. Summarising, the Chair indicated that the evidence presented in the paper came from a small number of reviews in American football players, soccer players and rugby players. It was noted that all the studies had issues of some kind, including ascertainment and other potential biases.

3.5. The chair invited the members who had been involved in the meta-analysis of the ALS papers to discuss the outcomes.

3.6. A member expressed concern around the quality of the studies; how the cases were assessed; missing information; and the use social media to identify cases. However, the findings indicated that there might be something to consider.

3.7. Another member agreed with the summary, described the reasons for omitting one study from the meta-analysis, and reiterated disquiet around ascertainment of cases where a lot of effort was put into finding ALS cases in sportspeople but that wasn't reflected for the general/control population.

3.8. It was suggested that a forest-type plot might be used to demonstrate the variation between studies.

3.9. A member commented that if the American football study was omitted (as it has limited applicability to the UK) then the relative risks in the meta-analysis fell below 2. If it was included, the risks rose to just above 2.

3.10. It was noted that information relating to playing position was very limited. Generally, it was necessary to combine neurodegenerative diseases to obtain sufficient numbers for doing this, but the signal relating to ALS was dwarfed by the other neurodegenerative diseases, particularly dementia.

3.11. There was discussion around the quality of the studies. It was noted that the studies were variable in relation to the reliability of the diagnoses. There was a large variation in the risks found for broadly comparable studies e.g. a risk ratio (RR) of around 4 (Scottish study) compared with a RR or around 1.3 (Swedish study). The RRs for various NDDs were strikingly similar in the Scottish study but not in the Swedish study. Different experts' views about the similarity or otherwise of the pathology in the various NDDs were noted. Members reported difficulty in determining the actual numbers of cases in some studies, particularly in the control groups.

3.12. A member commented that social media could be a useful tool to identify former professional sports people for inclusion in studies. Another member added that the concerns around the use of social media were that the same process was not followed for control/comparison groups – this could potentially lead to over-estimation of the risks. A member felt that more needed to be said about the methodology in relation to ascertainment of the cases and controls – do these differ and what is the impact.

3.13. It was noted that the Swedish study had good linkage data whereas this is less robust for some of the other studies.

3.14. It was suggested the section on strenuous exercise be taken out of the draft paper as it helps little with the decision-making process. It could be summarised separately in an information note.

3.15. It was suggested that it might be possible to calculate standard mortality ratios to give an estimate of the expected numbers of ALS cases in the general population. This might help verify the risks.

3.16. It was agreed that the paper would be reviewed again at RWG before going to the main Council.

3.17. Overall, it was felt that there might be a link between ALS and sports but this could not be concluded for certain due to members not having confidence in the quality of the studies. Members' concerns about the quality of some of the studies were noted and it was felt that additional work would be required before they were confident enough to make a decision on whether or not to prescribe.

3.18. It was felt it was very important that the Council expressed its views very carefully as whatever the outcome, this topic will receive a great deal of attention.

3.19. There was then discussion around the next stages for this topic which would be to look at other NDDs potentially linked with professional sports. It had previously been suggested that it might be appropriate to outsource the majority of the work to a suitably qualified external supplier. A draft specification had been drawn up and was awaiting commercial input relating to sourcing potential suppliers.

4. Work programme review/ Scoping review into women's health

4.1. IOM led this by giving an overview of the aims of the review and delivered an update on progress.

4.2. The aims were:

- To search for authoritative reviews and large-scale cohort or case-control studies to identify the industries, occupations and exposures associated with non-malignant occupational diseases that occur (a) only in women or (b) where women are potentially at greater risk than men, where both are similarly exposed.
- To give an approximate estimate, where feasible, of the range of the risks and the numbers/proportions likely to be affected.
- To assess the size of the literature base for outcomes/exposures to facilitate more detailed evaluation of the specific health outcomes and occupations.

4.3. Progress so far included:

- The identification of 306 potentially relevant high-level reviews, systematic reviews and meta-analyses
- The examination of definitions of mental health issues such as burnout and wellbeing;
- Screening for relevance of the full texts of just over 50% of the reviews identified. The remainder of the papers are being sourced apart from those that the abstract indicates do not fit the remit (e.g. not geographically relevant, or are related to occupations such as the military that are not included).
- The preliminary identification of (some) key findings.

4.4. IOM gave an overview of some of the discussions which had occurred at checkpoint meetings with selected IIAC members. Burnout was a topic which had been discussed as there are a number of definitions for this health outcome, but most are based on existing scales.

- Most commonly used is the Maslach Burnout Inventory (some reviews exclude studies using anything else);

- Others include: Hospital Anxiety and Depression Scale, Copenhagen Burnout Inventory, Perceived Stress Scale, Professional Quality of Life Scale;
- There was a decision to focus on defined mental health outcomes such as suicide, anxiety, depression etc and exclude papers dealing with burnout or emotional exhaustion. There should also be clear descriptions of how mental health outcomes were identified where possible.

4.5. All data have been made available to IIAC in a spreadsheet and an example of the study outputs document was discussed. An accompanying report providing a summary for each occupation or health outcome combination will be provided.

4.6. There was some discussion about reproductive health. Qualifying criteria for papers to be included need to be finally agreed as some studies concentrate on outcomes in children, which are not a focus for IIDB. Any accompanying impacts would need to be specific to the mother.

4.7. Premature ovarian failure (insufficiency) was briefly discussed as follow-on impacts such osteoporosis affect women in later life.

4.8. A member pointed out the HSE's Workplace Health Expert Committee (WHEC) has an interest in suicide and work, with reports already published, which may be a useful source of information.

4.9. It was also suggested that PTSD be included in the mental health outcomes.

4.10. IOM also agreed to review the search strategies to ensure that risks to women's health in wider studies which include men can be identified.

5. Commissioned review of respiratory diseases

5.1. The Chair commented that the review was essentially concluded and members had been provided with the final reports of the 6 disease/occupational exposure combinations which had been identified.

5.2. A final draft report which summarises the review had also been circulated in meeting papers. The Chair had identified possible future work for the Council and summarised this in an additional paper for consideration.

5.3. Members were invited to comment on any of the reports or papers provided.

5.4. There was some discussion around how this review would be publicised and it was suggested that the 6 individual reports be published as well as the final report which summarises the overall findings.

5.5. A member felt that IIAC should add its own comments to the final report, e.g., indicating the decline in some exposures over time.

5.6. It was pointed out that previous commissioned reviews (e.g. occupational health in firefighters) were accompanied by a separate IIAC commentary, however this was not required. It was suggested that the final summary report be published followed by the 6 individual reports – this would be put to the main Council at its meeting in January 2025. A short introductory narrative could be drafted to introduce the publication of the summary report.

5.7. Referring to additional work recommended in the 6 individual reports, a member asked for clarity whether IIAC should be taking these recommendations forward and if that was the case, then this should be made clear.

6. General review of the work programme

6.1. Before moving on to discuss the outcomes of the commissioned review and their potential inclusion in an ongoing work programme, the Chair felt that discussion on the prioritisation of topics would be useful. A document was circulated in meeting papers which set out the potential topics to consider.

6.2. The Chair stated they felt that a prioritisation structure would be useful and it was their view that the following points be considered:

- The amount of work required for an investigation;
- The likelihood of an investigation resulting in a change in prescription (or a new prescription);
- The potential number of people likely to be affected by a change in prescription

6.3. A member agreed this was a useful approach to take and suggested that the potential topics be scored against these criteria, which could indicate which of the topics are more important to take forward.

6.4. A number of other members supported the suggestion of ranking/scoring potential topics using a set of criteria. It was pointed out that where relatively simple changes to a prescription could have impacts, command papers would be required in each case.

6.5. Some members felt caution should be exercised when taking into account potential claimant numbers as rare diseases potentially linked to occupation could be disregarded, resulting in some people being disadvantaged. A balanced approach may be necessary.

6.6. There was some discussion around the reactive element to the Council's work and how stakeholders can influence the investigations which the Council carry out.

6.7. It was also felt that IIAC has an important role in highlighting issues associated with health and occupation across a spectrum of stakeholders.

6.8. The recent command papers which had yet to be considered by the DWP were noted. It was suggested that the recommendations contained within these could have a positive impact for both claimants and the operation of the IIDB scheme.

6.9. The Chair suggested that potential topics for the work programme could be scored according to an agreed set of criteria

6.10. The Chair summarised that additional criteria had been identified that might help rank/score topics:

- Public or political concern about a topic;
- Wider public information and benefit in alerting potential claimants.

6.11. It was suggested that a matrix be drawn up of potential new topics, including those which may emerge as recommendations from the commissioned review. This could then be presented to the wider Council for consideration with a view to outsourcing some of the scientific support, probably on a rolling annual basis.

6.12. Silica and asbestos were then discussed. These will continue to be important topics for the Council due to the changing nature of work that may involve exposures. They were considered in the commissioned review and it was suggested that the work programme could be rationalised with overlaps and considered, having wider applications to IIDB.

6.13. The work done to review the PD D1 (pneumoconiosis) prescription was highlighted, in particular the move from describing specific occupational circumstances to a focus on the exposure. In relation to silicosis and lung cancer a similar approach could be taken, i.e., the occupational element may not be required in the prescription so long as the diagnosis of silicosis is established. It was noted that it is a lot more difficult to prove a causative link between an individual's silica exposure and lung cancer in the absence of silicosis. A member pointed out that the HSE Workplace Health Expert Committee (WHEC) and the International Agency for Research on Cancer (IARC) concluded that silica is a cause of lung cancer.

6.14. Potential methods for estimating dose responses for silica were discussed including meta-analysis across classifications and combining dose responses from different studies possibly on a log-linear scale or log-log scale. Years

worked would likely serve as a better measure of exposure for IIAC's purposes rather than estimates of cumulative exposure.

6.15. A member asked if there was an interaction between smoking, silica exposure and lung cancer. A member responded that they felt that this was less well established compared with the smoking/ asbestos interaction, but could be a multiplicative risk.

6.16. Presently, the future work of the Council is detailed on the gov.uk website. It was agreed that this will be taken down and revised, to be replaced with an updated version. It was pointed out that as IIAC is an independent scientific advisory council, it can decide which topics it wants to pursue. The work of the Council will change over the course of time due to the reactive nature of stakeholder engagement. Members were invited to submit any ideas for future topics.

PD D14 (osteoarthritis of the knee)

6.17. 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 list of underground jobs included in the prescription was established.

PD D9 (diffuse pleural thickening, DPT)

6.18. Following stakeholder concerns around the presence of asbestos in mines, a member noted at a previous meeting that the criteria for D9 (diffuse pleural thickening) mirrored those for D8 (lung cancer). However, the amount of asbestos required to cause diffuse pleural thickening is probably lower than that needed to double the risk of lung cancer or cause asbestosis.

6.19. It was pointed out that in the case of D8 there was an additional requirement for asbestosis to be present which is likely to indicate heavier exposures and so two prescriptions (D8 and D9) are not equivalent in their exposure requirements.

6.20. It was noted that there are other causes of diffuse pleural thickening including trauma with bleeding into the pleural space or severe pneumonia with infection in the pleural space (empyema). If alternative causes could be eliminated, and if asbestos exposure at work could be established, then there may be an argument for a change to the prescription.

6.21. There was some discussion about levels of asbestos exposure required to cause diffuse pleural thickening particularly in relation to the use of the term 'substantial exposure'. There was noted to be uncertainty about the matter.

6.22. In relation to mining, it was considered that overall asbestos exposures are likely to have been low but there might have been specific circumstances in which they were sufficient to cause diffuse pleural thickening. It was noted that these circumstances should be covered by the phrase ‘substantial exposure to dust arising from ...’ at D9d.

6.23. It was felt that the current wording of the prescription should be adequate to accommodate asbestos exposure in mines.

6.24. Mesothelioma was briefly discussed and it was pointed out that miners have a low number of cases. However, the occurrence of mesothelioma cases in miners does provide some evidence of asbestos exposure in mines.

6.25. The meeting went on to discuss other circumstances involving low level asbestos exposures including schoolteachers and those working in public buildings where asbestos might be deteriorating. There was discussion about the likely levels of exposure in these circumstances and the associated risks of mesothelioma. A member commented that any potential revision to this prescription (D3) should take these sources of exposure into account. This could have wider implications for IIAC.

6.26. It was decided that the stakeholder be approached for more information on which jobs miners were doing underground where diffuse pleural thickening was identified.

PD D11 (lung cancer with silicosis)

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

7. AOB

7.1. DWP IIDB policy gave an update on the COVID-19 command papers.

7.2. COVID-19 was briefly discussed with nothing new to report. A member commented that pressure was continuing to be exerted to classify COVID-19 as an occupational disease.

Date of next meetings:
IIAC – 16 January 2025
RWG – 10 April 2025