INDUSTRIAL INJURIES ADVISORY COUNCIL
Minutes of the hybrid online meeting
Thursday 16 January 2025

Present:

Dr Lesley Rushton	Chair
Dr Chris Stenton	IIAC
Dr Ian Lawson	IIAC
Professor John Cherrie	IIAC
Professor Damien McElvenny	IIAC
Dr Jennifer Hoyle	IIAC
Dr Gareth Walters	IIAC
Ms Lesley Francois	IIAC
Dr Sharon Stevelink	IIAC
Mr Dan Shears	IIAC
Ms Lucy Darnton	HSE observer
Mr Lee Pendleton	IIDB observer
Dr Rachel Atkinson	Medical assessment observer
Dr Marian Mihalcea	Medical assessment observer
Dr Matt Gouldstone	DWP IIDB medical policy
Ms Parisa Rezai-Tabrizi	DWP IIDB policy
Ms Georgie Wood	DWP IIDB policy
Mr Stuart Whitney	IIAC Secretariat
Mr Ian Chetland	IIAC Secretariat
Ms Catherine Hegarty	IIAC Secretariat

Apologies: Professor Max Henderson, Mr Steve Mitchell

1. Announcements, conflicts of interest statements and sign-off of minutes

1.1. The Chair welcomed all participants and set out expectations for the call and how it should be conducted.

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

Minutes of the last meeting

1.3. The minutes of the October 2024 meeting and the action points had been circulated to members to comment on and agree. Action points were cleared or carried forward.

2. Neurodegenerative diseases (NDD) in professional sportspeople

2.1. The Chair indicated that this topic may generate further work and invited members who have been progressing this topic to give an update on amyotrophic lateral sclerosis (ALS) which was the first NDD to be investigated under the broader topic.

2.2. A member reminded the Council that discussions at previous meetings did not lead to a decision on whether or not to prescribe. Consequently, it was

decided that a meta-analysis would be carried out on the studies from which evidence had been obtained. This has been completed and the outcome discussed at the last RWG meeting.

2.3. Discussions at RWG, taking into account the meta-analysis, did not lead to any conclusions. At RWG, it was suggested that the ALS paper be redrafted to include a more detailed description of the methodologies used in the selected studies and to strip out some of the supporting information on extreme exercise.

2.4. Accordingly, the ALS paper has been redrafted and will be discussed at the RWG meeting in February.

2.5. Members who carried out the meta-analysis shared their views on the results. It was felt that, overall, there was an increase in the risks, swapping out each study demonstrated their contribution to the overall pooled estimate.

2.6. However, there were important issues with the studies which needed to be highlighted. There were differences in how cases of ALS were identified in the comparison/control populations in some studies compared to the exposed groups (sportspeople). One of the studies seemed to have a systematic reduction in cases identified in the comparison population across the NDD spectrum of health outcomes, including ALS. Some of the studies extensively searched for ALS cases amongst sportspeople including the use of social media. The same approach for the control groups was not consistently available and was also noted as a concern.

2.7. Other areas of concerns were the total populations of the exposed group were available but not for the control groups, making it difficult to replicate the studies methods. Also, in one study that had not been able to identify any cases of ALS in the control group, a case from the sportspeople was added to the control group to allow analysis.

2.8. Other members commented that they felt that the use of reference standardised mortality (population) rates for ALS was not applied uniformly across the different studies.

2.9. A suggestion was made to try to compare the mortality rates in the control groups with that found in the overall general population. It was felt this could be possible but would require a breakdown into age distribution and this was felt to not be necessary.

2.10. A member asked if the meta-analysis would be included in the ALS paper, but it was felt that this would not be appropriate due to the quality and quantity of the studies. It was concluded that the meta-analysis was an interesting exploration of the ALS data, but not to be published. A member pointed out that concerns about the studies still stand without the meta-analysis outcomes. It was suggested that the key message to put across in the ALS paper would be that the meta-analysis explored the heterogeneity between studies rather than calculating overall estimate of effect.

2.11. The next draft of the ALS paper will be reviewed at the February RWG and following discussions, will return to the main Council meeting for consideration.

2.12. A member asked if the studies for ALS evidence should be evaluated for quality, but it was felt that sufficient information was available (and published) to cover this point in the ALS paper.

2.13. There was some discussion around the next phases of this topic to take forward, namely Parkinson's disease and cognitive impairment (dementia). The majority of the work for these elements of the wider investigation will be outsourced and the secretariat is evaluating the best options to take this forward through commercial routes, ensuring adherence to procurement rules. An advert will be placed on the IIAC gov.uk website which should stay up for 14 days inviting interested parties to make contact, other portals will be considered.

3. **Commissioned review on respiratory diseases (RD)**

3.1. The Institute of Occupational Medicine (IOM) which carried out the review stated that it is now essentially complete. The 6 papers on the exposure/health outcomes are undergoing final proofing with minor comments to address. The final overview report was circulated to members in meeting papers.

3.2. The Chair asked about publication of the reports, and it was suggested that the overview report be published as the main item with the 6 individual reports published as a bundle so they are available to anyone who requires the finer details.

3.3. The secretariat indicated that whilst the Council is entitled to add a commentary narrative, it is not obligated to do so. Every paper published on the IIAC.gov website has space for an introductory paragraph to be added, which should be sufficient.

3.4. It was noted that any suggested recommendations contained within the reports would sit alongside other topics the Council may wish to consider, which will be prioritised according to an agreed framework.

3.5. The final overview paper was discussed, and it was felt this was an excellent summary of the RD commissioned review. Members were invited to comment on the report. A member had a few queries which they felt could be covered outside of the meeting. It was agreed that when these minor issues were addressed, the paper could be published. In addition, a member felt that the methods section could be made clearer that the initial phase that looked at systematic reviews was not the same as the studies which were included in the review itself.

4. **Work programme update**

Scoping review into women's occupational health

4.1. The Chair invited IOM to give a progress report on the work carried out so far.

4.2. IOM introduced the topic by reiterating the aims of the review:

4.2.1. 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.

4.2.2. To give an approximate estimate, where feasible, of the range of the magnitude of the risks and the numbers/proportions likely to be affected.

4.2.3. To assess the size of the literature base for outcomes/exposures for more detailed evaluation of the specific health outcomes and occupations .

4.3. IOM then detailed the work undertaken so far:

- 306 papers identified
- Topics identified
- Spreadsheet created:
- Title, authors, reference details, abstract;
    - Detailed and grouped categories for health outcome and occupations studied;
    - Inclusion/exclusion in more detailed analysis, with reasons for exclusions and key findings for inclusions;
    - Accompanying report providing summary of findings for each occupation/health outcome combination, including strengths and limitations of findings.
- It was decided to not focus on papers which listed 'burnout' as an outcome, but to focus on defined mental health outcomes: suicide, anxiety, depression, emotional exhaustion/burnout etc.

4.4. There was some discussion around reproductive health, and it was acknowledged that this is a sensitive topic as any occupational impacts on a child would not be covered by IIDB. However, both physical and emotional or mental health impacts on the mother could be considered.

4.5. Preliminary findings on reproductive health include:

- Hairdressers: weak evidence of effect on time to pregnancy, may be due to chemicals exposure, but could also be due to other confounding variables e.g. prolonged standing;
- Healthcare workers: some evidence of an association with miscarriage/spontaneous abortion, may be due to exposure to anaesthetic gases/sterilising fluids (surgeons) and/or prolonged working hours;
- Shiftwork: weak evidence of an association between night shift work and miscarriage (also gestational hypertension and pre-eclampsia). Some inconsistency between studies and noted difficulties defining night work.

4.6. Other exposures/occupations are being considered:

- Long hours/shiftwork - pre-term birth;
- Sleep disruption (shift work) – polycystic ovary syndrome;
- Ionising radiation - miscarriage and still birth;
- Cadmium - pre-eclampsia;
- Pesticide exposure/high job strain/repetitive work – severity of menopausal symptoms;
- Pesticide exposure – decreased fertility, time to pregnancy, endometriosis;
- Lifting heavy loads – spontaneous abortion, pre-term delivery;

- Semi-conductor (Fabrication) work – spontaneous abortion.

4.7. Timescales on the delivery of the final report were also discussed.

4.8. The final report may identify additional work for the Council to consider taking forward, which may form part of the work programme.

4.9. A member commented they felt whole-body vibration should be considered. It was noted that consideration would need to be given to how to prescribe for some of the health outcomes as some may be physical, but others may involve mental health impacts. The chair noted that prescriptions must also be practical to administer and that IIDB may not be suitable for some conditions.

4.10. IOM was asked if they have any views on the scale of any subsequent work for IIAC to undertake. It was felt this would be dependent on the health outcomes selected, for example shift-work, as topics such as this will involve a lot of literature to scrutinise. Others may be discreet, succinct pieces of work to complete.

4.11. A member commented that issues such as miscarriages may be difficult to ascribe to an occupation due to its occurrence in the general population, some of which may not be reported.

4.12. Commenting on the mental health aspects, a member suggested there may be lessons to be learned from the armed forces compensation scheme where mental health issues are covered, and a report has been recently published which discusses this topic.

Other work programme activities – future work

4.13. The Chair introduced the topic by reminding members that a link to the prescribed diseases (PDs) was shared when meeting papers were circulated. A document with a suggested scoring mechanism was also circulated for the outcomes of the respiratory disease commissioned review.

4.14. When a work programme has been agreed, this will be published on the IIAC website.

4.15. Before moving on to discuss the wider work programme, the Chair suggested that IIAC could embark upon a 'tidying up' exercise for some of the PDs where only minor tweaks to the wording of prescriptions (e.g. PD C34/B6 extrinsic allergic alveolitis where this term has been widely replaced by hypersensitivity pneumonitis) would be required. This could be in the form of a command paper, similar to the IIAC report 'Completion of the review of the scheduled list of prescribed diseases' (2007).

4.16. Any recommended changes should be flexible enough to allow for future developments, for instance where common medical terms can be interchangeable. Also, where PDs are updated, consideration should be given to any impacts on other PDs in terms of occupation etc. Other terms such as 'diffuse' should also be reviewed. An observer commented that for PD D9 (diffuse pleural thickening or DPT) it is sometimes difficult to determine when thickening becomes diffuse rather than localised. Diffuse mesothelioma can also prove challenging when diffuse is used interchangeably with malignant.

4.17. The Chair had concerns that a claimant may have a diagnosis of a certain condition, but the PD lists a different term for the same condition – this may result in the claimant not making a claim despite having the correct disease.

4.18. The Chair felt that amending some of the PDs could be beneficial and could be achieved by working with IIDB policy / medical policy.

4.19. Commenting on medical terminology, a member suggested exercising caution in replacing one term for another as clinical coding may not pick up the more commonly used term, so both may need to be referred to.

4.20. The discussions moved onto the wider work programme where the RWG Chair referred to a template, circulated in meeting papers, which was comprised of suggested future topics and a number of criteria which could be used to score each topic to aid prioritisation. The suggested future topics were drawn from the outputs of the RD commissioned review, correspondence from stakeholders and others arising from the previous work programme. The scoping review into women's health may also yield additional subjects to consider.

4.21. Given the numbers of potential topics to take forward, it was felt that some form of prioritisation is required. Some suggested ideas put forward on the template which could then be assigned a score included:

- Amount of work required
- Likelihood of altering a prescription
- Number of claimants likely to be affected
- Public/ political interest/ concern

4.22. This was presented as a basis for discussion and was not 'set in stone' so members were invited to give their views.

4.23. A member commented that they had completed the template but was unsure about claimant numbers in most cases. Most of the topics scored highly for the amount of work required, with a small number of exceptions. This experience was shared by another member who felt that 'guessing' in some cases played a role.

4.24. The Chair made a general comment that the way IIDB is structured, topics which are 'high risk' will generally be at the forefront of IIAC's work as legislation states that that a disease must be linked to an occupation/exposure with reasonable certainty. Some of the future topics may not fit with IIDB and it may be opportune to communicate this to Ministers.

4.25. Another member commented they had completed the template and found similar issues to those already reported. They suggested that an alternative approaches to prioritisation could be adopted, such as 'MoSCoW' (must do, should do, could do, won't do this time). Each category would need to be defined, and explanations given for 'won't do', such as IIDB being an unsuitable vehicle.

4.26. The Chair commented that IIAC needs to have space to accommodate urgent work which may arise, with the firefighters and cancer investigation given as an example which arose from a specific request from the Environmental Audit Committee.

4.27. Returning to the template, a member agreed that it was useful but cautioned against simply aggregating the scores from each individual, which was supported.
4.28. The Chair felt that some of the topics which may require a lot of work could be done over a longer period of time. A member commented that they felt noise-induced hearing loss could be added to the work programme as it was some time since the Council looked at this topic. Other additional topics mentioned were non-melanoma skin cancer and ovarian cancer & asbestos.
4.29. As an aside, there was some discussion around noise-induced hearing loss in musicians.
4.30. A member asked how topics arising as outputs from the women's health scoping review could be taken forward if IIDB is not the correct vehicle. There may be important topics relevant to women which may be difficult for IIAC to take forward. The Chair commented that IIAC had previously published theoretical command papers on presumption and presumption & rebuttal in assessment, which deal with general principles under the legislation. The Council could publish a position paper on what IIAC find relatively straightforward to fit into IIDB and what are the limitations of the legislation.
4.31. A member suggested adding UV exposure in ocular melanoma as they were involved in a study across a range of different occupations.
4.32. Mental health was brought up as there are no current requirements to report catastrophic mental health (MH) outcomes in the workplace via the RIDDOR scheme. A member asked if the HSE were looking at this and if it would be making any changes. Coroner's courts often take a view on whether that outcome was related to working conditions.
4.33. A member commented that HSE may be looking more closely at work-related stress (w-rs) and mental health, but they were not aware of any recommended changes to RIDDOR. There have been campaigns to make w-rs reportable.
4.34. A member quoted a recent HSE report which looked at work-related ill health where stress, depression & anxiety made up ~46% of all new reported diseases from 2023-24. Occupations included health professions, teaching, health & social care associates which had elevated risks.
4.35. An observer commented that MH claims can be challenging as the effects of an accident on the MH and the MH effects on the individual are multi-factorial. It may be difficult to identify a prescription for MH where assessments are fully relevant, which may miss the intent of the prescription. The Chair acknowledged the point but felt that shouldn't deter IIAC taking on board the issue and examining it.
4.36. The Chair commented that MH aspects are taken into account for claims in addition to any physical impacts. A member felt that there appeared to be more flexibility when MH is a secondary consequence of a disease rather than the primary cause.
4.37. A member raised the point that MH can be a fluctuating condition and, in some instances, complete recovery can occur when that job ceases. This is similar to occupational asthma.

4.38. The Chair drew the discussion to a close, encouraging members to complete the prioritisation template if they were able to.

5. **Decision making - which diseases should be prescribed for IIDB**

5.1. The Chair indicated that the guidance on the website Deciding which diseases should be covered by Industrial Injuries Disablement Benefit (IIDB): Some frequently asked questions required updating and an amended version was circulated in meeting papers. However, the Chair acknowledged that confidence intervals was not adequately covered in the proposed revision, so it will require further work. Exposure equivalence will also be covered.

5.2. The current version focuses on doubling of risk and as the Council has now expanded its ways of assessing risks, changes were required.

5.3. Members were invited to comment, and it was pointed out that the document should reference 'more than doubling of risk', this will be covered under the confidence interval explanation.

5.4. A member felt that having input from a 'lived experience' might benefit but it was pointed out that IIAC doesn't consult as this would not form part of the evaluation of evidence. 'Lived experience' when conveyed in correspondence may generate interest in a topic.

5.5. Related to this, a member commented that some advisory boards/committees have a lay representative who may have some experience of the topic under investigation. This has been considered for IIAC, but it was felt that the employer/employee representatives cover this for the Council. This could be revisited when a new Chair is appointed.

5.6. A member felt that bias and confounders could be covered in more detail.

6. **AOB**

Questions for the Council

6.1. An observer asked if the Council could advise on a number of topics:

Non-Specific Interstitial Pneumonia Vs asbestosis

6.2. It was agreed that it is reasonable to accept NSIP as asbestosis if significant occupational exposure to asbestos is evident.

"Mesothelioma in situ"

6.3. This appears to be a relatively recent concept which is part of research and arguably a pre-malignant or malignant state. The question posed was do members consider this to be eligible for PD D3 (mesothelioma). The general consensus was that if a claimant presented with evidence of mesothelioma in situ, then this should be allowed. Concern was raised that the wording of the D3 prescription was outdated as the term 'diffuse' is no longer considered useful. This should be addressed when the Council considers reviewing some of the prescriptions which have outdated terminology in the wording.

Latency period for PD D3

6.4. There doesn't appear to be a consensus in the literature around what the latency period can be for mesothelioma to develop, ranging from 5-20 years or more.

6.5. Members discussed the options and felt that 10 years would be a good cut-off, but caution was urged as recall bias from when a claimant may have been exposed.

6.6. A member asked if there were any links to heavy asbestos exposure of a short period of time in someone who was younger. It was not thought that mesothelioma develops any more quickly in that scenario.

6.7. A member pointed out that according to an HSE report, mesothelioma cases were declining but cases were appearing in 'white collar' industries. There was also some concern that children could be at risk from asbestos in schools.

2025 IIAC public meeting

6.8. Scotland was suggested, but IIDB has been devolved and the last meeting held there was not well attended.

6.9. Birmingham was also suggested.

April IIAC meeting

6.10. The secretariat indicated that an external venue would be provided and members encouraged to attend in person if possible. The interviews for the next IIAC chair have been held and it is likely a new Chair will be in place for the April meeting. Dr Rushton agreed to extend her term for a month to accommodate a hand-over to the new Chair.

Head injury cases in professional rugby class action

6.11. Rugby cases have grown to around 800 and another separate set of cases involving professional footballers is proceeding.

6.12. Case management hearings are due to be held for both late January/early February.

6.13. A member agreed to keep members updated.

Date of next meetings:
RWG – 20 February 2025
IIAC – 10 April 2025