

## **Becoming an Effective Occupational Safety and Health Professional in the 21<sup>st</sup> Century**

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### **Introduction**

Effectiveness in any area of professional practice requires engagement with a range of audiences. Effective health and safety management is no different – it requires safety and health professionals to engage with senior managers, human resources and occupational health professionals and GPs, to name but a few. They need to get their messages heard and understood to effect change in the workplace. What could help them do this?

Knowing your subject inside out is important. Made up of three overlapping components – knowledge, skills and experience – competence is about being able to do something efficiently and effectively. But it's also about knowing one's limitations and recognising when it's time to call on others for support and advice. Competence should be proportionate to the safety and health professional's work and the type of organisation they work for.

Of equal importance, is the maintenance of competence, which can be achieved through a structured programme of continuing professional development (CPD). CPD must allow for the maintenance of technical and managerial skills. But knowing your subject isn't enough.

Developments in social, legal, scientific and technological areas impact on the work of the safety and health professional. As a result, they need to respond on a range of complex technical and ethical issues. In a changing world of work, developing a culture of using evidence to inform practice and working with an alongside other disciplines to develop solutions can help effect professional practice.

We start by considering the professional health and safety practitioner, before examining the challenges of competence, continuous professional development, ethical practice, evidence-based practice and multidisciplinary working.

## The Profession and Role of the Safety and Health Practitioner

So what defines a profession? Atherley and Hale (1975) and Hale et al. (1986) asked this in their examination of a potential professional occupation based on occupational health and safety at work. They found that characteristics then considered as leading to a strong profession were:

- A developed and complex world of work producing specialised problems requiring solutions
- Recognition by influential groups in society that these problems are important and that incompetent solutions are dangerous or undesirable
- A well-developed knowledge base and practical techniques for analysing and solving the problems
- A sufficient number of practitioners with a guaranteed and suitable level of training and competence and an accepted monopoly of the knowledge base and their employment (ie there shouldn't be different professional groups with different training and qualifications claiming the professional area).

Atherley and Hale (1975) concluded that the then recently introduced Health and Safety etc at Work Act 1974 provided a platform for the development of the profession of occupational safety and health. 11 years later, Hale et al. (1986) considered the profession had 'progressed significantly along the road to professionalisation' – there was recognition of the need for the expertise and of its knowledge base. In the early 1980s, the membership of IOSH stood at around 4,000 members.

Today, the Professional Associations Research Network (PARN) defines professions as occupations where there is:

- *an education and/or experience criteria for gaining membership into the profession and a system for maintaining standards and quality of service*
- *a code of conduct or ethical guidance for professional practice*
- *a commitment to continuing professional development*
- *an organisation that maintains a register of the members of the profession*

(Friedman, 2007: 25)

Membership of IOSH has cleared 37,000 members: Around 500 Chartered Fellows; 12,500 Chartered Members; nearly 5,500 Graduates: and nearly 11,000 Technicians.

The role of the practitioner has evolved considerably since the very early days of the 'profession' Although we have highlighted the development of the profession from the 1970s, the first 'safety officers' employed by industry can in fact be traced back to around the time during and after the First World War. Their focus was on ensuring the following of safety rules, use of personal protective equipment and maintaining the integrity of guarding. This technological focus remained dominant for many years as safety was considered a technical problem rather than an organisational or managerial issue and is still seen as an important area of work for the health and safety professional. Post Second World War saw the formation of associations of safety officers in a number of countries At this point the emphasis shifted to consideration of the design of jobs and man-machine interfaces – the human factor. This came to dominate thinking in the 1960s and 1970s. From the 1980s, the dominant concern was about safety management, shaped by in part the spate of major accidents at that time and the moves towards de-regulation, self regulation and certification (Hale et al., 1998).

Against this backdrop of health and safety management, Hale (1995) examined the complex relationship between health and safety professionals and managers. He questioned whether health and safety was the job of the manager or whether management was the job of the health and safety professional. Successful relationships between both groups are essential for effective health and safety management. This in turn raised the question about the type of safety and health professional needed, identifying roles for narrow 'technical' subject experts and broad policy and management-oriented advisors working closely with management.

But what do health and safety professionals do? This was the question addressed by a large survey study set up by the International Social Security Association (ISSA) and taken over by the European Network of Safety and Health Professional Organisations (ENSHPO), involving participants from Europe, including the UK, Australia and Singapore (Hale, 2005). Analysis of data from Finland, Germany, UK, Italy, Netherlands, Norway and Poland indicated that there is a clear core of tasks and hazards dealt with by health and safety professionals. This core focuses on the technical and mechanical aspects but also includes human factors and safety management for some countries, particularly for professionals with higher levels of education and training. UK participants reported involvement in the broadest range of tasks and hazards (IOSH, 2005), indicating the diversity and complexity of their role.

The world of work continues to evolve: workforce mobility, flexible patterns of work and the ageing workforce are a few examples of the changes we are witnessing. Related to this, has been an increased focus on health issues, as stress and mental health issues affect more workers than physical injuries. This in turn places further demands on the health and safety professional, who needs to broaden their skills set and engage with other disciplines and professionals to effect multidisciplinary solutions (Waterman, 2005).

## **Ensuring Effectiveness—Current Challenges**

We now discuss some of the key issues for ensuring individual effectiveness as a safety and health professional, including competence, continuing professional development, ethical practice and evidence-based practice. We provide illustrations of how IOSH is supporting its members on these key issues. We also draw on current thinking amongst UK professional bodies.

### Competence

The term 'competence' is popular throughout professional practice. Although widely used, there are varying definitions of the terms – competence, competency, competences and competencies – often used interchangeably.

Friedman (2007) provides an overview of these varying perspectives and argues there the three sources of confusion with the term competence: (i) it suggests adequacy rather than excellence; (ii) it can be interpreted as performance, rather than what underlies performance and (iii) the relation between competence and attitudes, skills and knowledge.

The conclusion of his examination is that the professional practitioner must acquire competency or competencies, which are made up of knowledge, skills and acquired attitudes, to be able to perform certain practices. These practice requirements and competencies may be quite narrowly defined. From performance experiences comes competence and the likelihood of being able to perform effectively in specific contexts in the future.

Professional competence is therefore more than being able to demonstrate a series of narrow competencies. Competency-based education can equip individuals with a set of competencies leading to competence. However, an understanding of the implications of applying competencies and understanding what alternative approaches, which may not be part of the knowledge, skills and behaviours included in the taught competency, is what makes professional competence.

Cheetham and Chivers (2005) point out that often competence gets stuck at 'functional competence', which focuses on the tasks to be performed, rather than attributes and behaviours. This, they argue, has arisen from the occupational standards approach to competence, which defines specific task-based competencies.

Turning specifically to occupational safety and health competence, legal guidance in Great Britain and elsewhere advocates 'competent advice' at an 'appropriate level.' According to Article 7 of the 1989 European Framework Directive, an employer shall designate one or more workers to carry out activities related to the protection and prevention of occupational risks:

- Designated workers must have the necessary capabilities and means
- External services or persons consulted must have the necessary aptitudes and the necessary personal and professional means
- Designated workers and the external services/persons consulted must be sufficient in number.

The Management of Health and Safety at Work Regulations 1992 introduced an explicit requirement for a 'competent person' to assist employers with health and safety matters. In the 1999 revision of the document, regulation 7 states: 'Every employer shall appoint one or more competent persons to assist him in undertaking the measures he needs to take to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions.'

The guidance supporting the Regulations and approved code of practice refers to the Qualifications and Curriculum Authority framework, which describes competence as: 'The ability to perform to the standards required in employment across a wide range of circumstances and to meet changing demands.'

In case law, *Gibson v Skibs A/S Marina and Orkla Grobe A/B and Smith Coggins Ltd* 1966 defines a competent person as: 'One who is a practical and reasonable man who knows what to look for and how to recognise it when he sees it.'

Current national competency standards for safety and health practitioners in the UK are generic and based on a safety management system. Occupational standards cover five main topics in 10 mandatory units (ENTO, 2008):

- Policy and culture
- Communication
- Risk identification and control
- Monitoring
- Audit and review

Despite the attempts to define competence in health and safety and the commonality of the term generally, employers and recruiters seem to struggle with knowing what qualifications and experience to look for when recruiting a health and safety adviser, or hiring a consultant.

Noted by the then Health and Safety Commission in 1983 (Hale et al.,1986), it's not a new problem.

Currently, absolutely anyone can operate as a health and safety 'adviser' or 'consultant', without any qualifications or experience. Even if they were successfully prosecuted, there's nothing preventing them from continuing to practice. It's not unusual to see recruitment advertising for the equivalent of 'A-levels' for senior strategic roles. Companies and employers, from the owner-managed business to the multinational, need to be clear about what type of advice they need.

IOSH has produced guidance for employers on competence and training good practice, which looks at the levels of competence needed by health and safety professionals and others – directors, managers and supervisors; health and safety representatives; non-supervisory staff and other professionals (IOSH, 2008).

#### Continuing Professional Development (CPD)

Achieving initial professional qualifications and competence is essential to being a professional practitioner; however, that's not the whole story. It's widely accepted amongst professional bodies that members need to refresh, maintain and update their professional knowledge, skills and attitudes. Although this is well understood amongst professionals, there is now increased formality in the way in which members are expected to carry out continuing professional development to meet requirements of their professional body's policy.

Increasingly, professional bodies provide support for their members CPD, such as, guidelines, mentoring schemes, standardised methods for recording CPD and advice. There is variation in the extent to which professional bodies impose CPD requirements on their members. According to a Professional Organisations Research Network (PARN) survey in 2006 (Friedman, 2007), 85 per cent of 110 responding UK professional bodies had a CPD policy. 21 per cent had a system of compulsory compliance, 44 per cent had a voluntary compliance system and 14 per cent had a mixed compliance system. In a compulsory compliance system, CPD is monitored and sanctions imposed if requirements are not met, whereas in voluntary system CPD may be monitored but no action taken if requirements are not met. A mixed system is where certain categories of membership may have compulsory CPD requirements. 70 per cent of the 91 organisations having a CPD policy had a system for monitoring whether CPD was being carried out.

But how can participation in CPD be evidenced? A simple and common way may be a list of activities carried out by a member. A more substantial approach involves gathering evidence of planning and reflection. The majority of UK professional associations surveyed gathered records of activity; while 47 per cent asked for evidence of planning and 39 per cent asked for evidence of reflection.

CPD monitoring has moved from a primarily input based approach, i.e. recording hours spent on CPD or 'points' based on the type of activity, to an output based one, i.e. reflecting on what has been achieved or gained from a particular activity. The real test, or evidence sought, should be how the activity has actually developed or improved practice. But this would be difficult to do without some form of peer review process. Evidence of planning and reflection are considered to correlate with improved practice. Reflecting on CPD activities is important for developing the habit of reflection, which in turn contributes to professional competencies and competence.

IOSH believes that continuing professional development (CPD) gives members the opportunity to create a structured career path and safeguard their professional status. By using a framework to identify skill gaps – technical or personal – and then creating an action plan to refresh or expand knowledge and experience, members can make a real difference to their professional effectiveness. For IOSH membership categories of Chartered Fellow, Chartered Member, Graduate or Technician Member, CPD is mandatory.

The categories of activity that members need to do are:

- planning development activities
- maintenance or core professional knowledge and skills
- developing professional skills
- developing transferable skills

### Ethical Practice

From a professional perspective, ethical practice is about carrying out the practice of an occupation in the way defined by the profession's Ethical Code of conduct produced and promoted by the professional body. Practically, this involves knowing what course of action is appropriate and what is not appropriate in certain circumstances, taking account of stakeholder needs and sensitivities.

Professionalism and ethical practice are inextricably linked. Professionals are expected to not only demonstrate technical competence but to exercise this competence in a responsible manner. It has been argued that ethical competence distinguishes a practitioner as a professional (Freidman, 2007). They are also expected to be trustworthy.

Standards of technical competence are embedded in the standards of professional qualifications awarded or accredited by professional bodies in conjunction with higher education institutions (HEIs) or other training providers. Standards of ethical competence are laid out in codes of ethics produced and promoted by professional bodies.

Ethical practice has become increasingly important for the standing of professionals and their professional bodies. Guidance on ethical and professional practice is commonplace amongst the professions. Friedman (2007) argues that professional practice (professionalism) is dominated by technical expertise with little concern for the ethical aspect. This, he argues, has led to decline in trust in professionals.

An alternate viewpoint is that while codes of ethics provide guidelines or rules for desired behaviour, at the same time they create an environment in which professionals shy away from certain activities for fear of 'breaking rules' (Neuberger, 2006).

What happens when practice falls below the standards set out in professional bodies' ethical codes? Unfortunately, there's a public perception that such instances are 'swept under the carpet' or where they are dealt with the punishment is insufficient. They perceive the professional body as protecting individuals and the reputation of the profession as a whole. Freidman (2007) argues that professional bodies need to do more to demonstrate they are driving up ethical practice, includes instilling codes and dealing with breeches of codes.

IOSH has established a code of ethical practice, containing guidance on a range of moral and ethical questions and professional conduct, which supports the professional and the good standing of the profession as a whole. The code covers a wide range of issues relevant to professional practice, including: professional independence; provision of objective and reliable

information, maintenance and development of competence, working within the limits of their competence, failure by recipients to adhere to their advice, behaviour and conflict of interest. The code also provides guidance for members with particular responsibilities, such as consultants, employers, researchers and education and training providers as well as information management and data protection issues and legal requirements. It also sets out the IOSH disciplinary procedure.

Collectively, the code points draw together many of the component elements of professionalism, i.e. ethical practice is professional practice.

### Evidence-Based Practice

Health and safety practice has historically been driven by laws, rules, customs and practice. As discussed earlier, legislation has been the foundation of the development of the profession. Although the goal-setting nature of British legislation allows scope for duty holders to develop ways of managing risks to safety and health, approved codes of practice and guidance have arguably done little to inspire innovative ways of delivering better protection. Against this legislative backdrop, education and training programmes for safety and health practitioners have previously tended to focus on the learning of facts and rules to be applied at the workplace.

However, our knowledge of the nature and scale of risks and the effectiveness of interventions is only provisional and requires refreshing as technology and society evolve. A rule-based approach cannot support this. Crucially, best practice can only be based on the best available knowledge. As this is evolving, a dynamic approach to controlling health and safety risks is required with recourse to best available data – an evidence based approach.

Grounded in the use of rational data-gathering, appraisal and interpretation approaches, evidence-based practice offers the opportunity for improved quality in risk control and the provision of quality assured information. It also strengthens the role /standing of the health and safety professional as person who is providing advice and contributing to better protection in a cost-effective way rather than merely following the rules. This of course requires a transition within the profession to a culture of evidence driven development.

In other areas of professional practice, particularly healthcare, there has been a transition to evidence based practice. This has been driven by the need to develop address quality assurance requirements, make professional decisions transparent to stakeholders and critically ensure that treatments work and are cost-effective.

Growing recognition of the importance of evidence-based practice has led IOSH to set up its Research and Development fund. The fund supports and explores new thinking. We commission individual projects to establish evidence for health and safety policies and practice. Full and summary reports are used to disseminate the findings of this work to as wide an audience as possible. In particular, summary reports identify the problem, the approach taken by the researchers, the findings and crucially what does the research mean for health and safety practice. However, there is much work to be done in encouraging the culture of evidence driven development.

### Multidisciplinary Work

We have already highlighted the changing nature of the world of work and the implications this brings for the work of the health and safety professional, in particular health issues (Waterman, 2005). From a UK perspective, IOSH believe that in order to better tackle work-related illness in the UK, and to support those seeking to move back into employment following long-term illness,

a change of approach is needed. We believe a multidisciplinary approach is required, involving managers, HR professionals, occupational health professionals, GPs and safety and health practitioners.

Occupational health (OH) services in Sweden, Denmark and Netherlands employ multidisciplinary teams of, for example, physicians, nurses, hygienists, ergonomists and safety engineers and safety management practitioners (Westerholm et al., 2000) However, in UK there are three uncoordinated ways in which OH services are provided in the UK: (i) state provision through the National Health Service (NHS); (ii) employer provision through in-house occupational physicians, nurses and other OH professionals and (iii) private provision through contracting services. However, there is not a single coherent approach to the provision of occupational health services or access to those services that do exist (Waterman, 2007).

To maximise the impact and efficacy of qualified occupational health practitioners, and to prevent conditions becoming chronic, we suggest better use be made of safety and health practitioners. These individuals exist in large numbers; already have a degree of OH knowledge; are well-established in the workplace; and are able to provide a support function in terms of noticing when things may be going wrong, raising awareness, communicating policies and services, and promoting the health message.

The role of the safety and health practitioner is absolutely not one of clinical diagnosis, but they may be able to act as an effective advocate and signpost, play a role in educating managers; and help spot the early indications of possible occupational illness, ensuring earlier interventions and referrals. Many issues that prevent a return to work are not clinical, but are organisational; hence the safety and health practitioner could play a vital role.

With this in mind IOSH has developed resources to help health and safety practitioners in a supporting role. The IOSH Occupational Health Toolkit ([www.ohtoolkit.co.uk](http://www.ohtoolkit.co.uk)) provides a 'one-stop shop' for health and safety professionals and others. While there are already plenty of good resources available, they are often distributed across several websites and non-electronic media. The toolkit brings them together in a coherent structure, covering the spectrum from prevention to rehabilitation. The Toolkit also offers supplementary resources, including presentations, to use in tackling health problems at work.

Provision of a small amount of additional training could mobilise several thousand health and safety practitioners to play an increased and vital role in facilitating and supporting safe returns to work and long-term retention. Building on their core competence training and experience, we believe a focussed one- or two-day training course would help establish a national 'critical mass' of practitioners in the workplace. Ideally positioned and sufficient in number, once trained – they could help make a real difference. IOSH is currently working with the UK government to develop and pilot a training programme for health and safety practitioners.

IOSH has also produced guidance on rehabilitation and return to work and wellbeing ([www.iosh.uk/guidance](http://www.iosh.uk/guidance)).

## **Summary**

This paper has:

- Highlighted the changing nature of the role of the health and safety professional in response to changing in the world of work
- Briefly discussed key inter-related issues for effectiveness: competence, continuing professional development, ethical practice and evidence-based practice



- Highlighted how IOSH is supporting members in these aspects
- Outlined a role for health and safety professionals in multidisciplinary teams tackling work-related health issues.

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