Public health leadership in primary care practice in England: Everybody’s business?

ERIC A. WIRRMANN1 & CINDY L. CARLSON2

1GOAL Uganda, and 2HLSP London

Abstract
This article analyses the concept of leadership in relation to the UK Government’s current approach to ‘modernizing’ the NHS in England. Focusing on public health in primary care, the authors consider current developments in the public health workforce, in particular attempts to differentiate between public health ‘specialists’ and ‘practitioners’ by different levels of leadership function. It looks at leadership in policy, theory and practice, and draws attention to a number of key challenges along the leadership path. The concept of ‘leadership skills’ as a taught competence is questioned, and Shelton and Darling’s (2001) ‘quantum skills’ model of leadership is provided to suggest new ways in which public health leadership in a primary care context might be approached. Whilst this article focuses on public health and primary care in England, the complexity of primary care settings and public health delivery in other international contexts extends its relevance to non-UK settings.

Keywords: Public health, primary care practice, leadership theory, quantum skills

Introduction
It is increasingly recognized that primary care practitioners are key agents in the drive to strengthen the public health function in England. This is not a unique perspective, but rather draws on ideas propounded by the World Health Organization for many years (WHO, 1978). That health improvement, and the reduction of health inequalities, relies on the collaboration of individuals, organizations and communities, is well understood. However, ‘public health’ is a contested concept and its structure and form is difficult to pin down. The leading of its development within the uncertain, highly political and complex terrain of primary care is a massive challenge. The aim—to ‘improve the health of everyone and the health of the worst off in particular’ (DoH, 1999a, p. 1)—is clear. Extra resources are committed (DoH, 1999a, 2000, 2001a), the structure and culture of the government and the NHS are being ‘modernized’ (DoH, 1997, 2000, 2001b; DETR, 1998), and new powers and responsibilities are being introduced at the local level (DoH, 2001b; DETR, 2001a). But ‘public health’ needs direction. If practitioners are to make use of...
new power, skills and capacity, and tackle the public health agenda, they require leadership functions and skills that will focus resources and unleash new potential.

Leadership is a popular word in current political discourse, despite there being little clear understanding of what it means. Much research into leadership has focused on the determinants of leadership effectiveness (Yukl, 1981, p. 1). There have been many attempts to list the traits of a leader, which are often thought to include courage, honesty, judgement and humour (Adair, 1973). However, these lists are of limited use and, when compared, rarely agree. Stogdill (1948) made an early conclusion that ‘the qualities, characteristics, and skills required in a leader are determined to a large extent by the demands of the situation in which he [sic] is to function as a leader’ (quoted in Adair, 1973, p. 4). This is supported by writers on organizational development, such as Bennis (1989) and Senior (2002), who contend that different styles of leadership are necessary for different phases of the organizational life cycle.

Leadership, then, is a collective process; it is about leaders, followers and context. The amorphous nature of public health, and the complexity of the primary care setting, presents a particular challenge to public health leadership. Whilst this is the case internationally, this article focuses its arguments by analysing the concept of leadership in relation to the UK Government’s current approach to ‘modernizing’ the NHS. It draws on Shelton and Darling’s (2001) ‘quantum skills’ model to suggest new ways in which public health leadership in a primary care context might be approached.

The public health and primary care context

The British government, since the 1990s, has moved towards a ‘primary care-led NHS’ (NHSME, 1994; DoH, 1996). This move is not only about where priorities for healthcare are agreed, but also about who takes part in this process. It contains, then, a drive towards more effective partnership working and collaboration, and necessitates a shift in the balance of power from the centre to the local.

To this end, a number of important changes have taken place in the structure and organization of NHS primary care. The more recent of these changes include the creation of Primary Care Groups and Trusts in England, and their equivalents in Wales, Scotland and Northern Ireland; the launch of many new programmes including Health Action Zones, Healthy Living Centres and Sure Start; introduction of personal medical services (PMS) pilots, and, more recently, a new contract for general medical services. Political devolution of the four UK territories brings new and interesting variation.

These changes in primary care present major challenges for the development of the public health function at local level. Since 1997, the Department of Health have outlined a clear vision for the ‘modern’ public health function in England, a vision that encompasses a wider understanding of the causality of ill health and that places the reduction of health inequalities firmly on the agenda. However, in many cases, primary care organizations do not cover a large enough population to make public health service delivery sensible. This is compounded by the dispersal of public health expertise across too many different organizations, so that public health professionals struggle to make their voices and concerns heard within their new organizations. A further complication comes from the continued lack of coterminosity between health and other organizations in many areas. This makes communication, coordination and the use and development of public health intelligence difficult. The emergence of new organizations and networks demands strong and flexible partnerships. The need for public health leadership in primary care has never been greater, and never more difficult.
Leadership in theory

Leadership is undoubtedly a complex and multifaceted phenomenon, and an abundance of leadership theories provide various perspectives. These perspectives often reflect the changing social and organizational climate. In their review of leadership theory, Bolden et al. (2003) describe the progression from early theories that tended to focus on the characteristics and behaviours of successful leaders, to later ones which began to consider the role of followers and the contextual nature of leadership. The concept of ‘transformational leadership’, described by Burns (1978), taps into the turbulence of a postindustrial, postmodern society in which our public services ‘must achieve greater diversity...so that [they] can meet the varying needs within our diverse society’ (Cabinet Office, 1999, p. 56). It is about change, innovation and entrepreneurship, encouraging the personal growth and empowerment of the leader and followers (Girvin, 1998, p. 59).

As Bolden et al. (2003) point out, though, leadership theories have tended to take a rather individualistic perspective of the leader. Rodgers et al. (2003) highlight a further tendency within most leadership theories to emphasize the leadership inputs (competences etc.) and outputs (standards etc.), at the expense of the processes in between. They challenge us to consider a more ‘relational’ notion of leadership. In this more modern vein, Rost (1994) proposes a ‘postindustrial’ paradigm of leadership, using the term ‘collaborator’ instead of ‘follower’ to convey the sense of involvement required in the leadership relationship.

But it is important to make a distinction between the notions of ‘leader’ and ‘leadership’. Where leadership is viewed as a process of sense-making and direction-giving within a group, the ‘leader’ can only be identified on the basis of his/her relationship with others in the group. The leader, then, may be seen as emergent rather than predefined.

‘Dispersed’, ‘emergent’ or ‘informal’ leadership is an alternative school of thought that is gaining increased recognition (Bolden et al., 2003). This approach views leadership as a process that is diffuse throughout an organization, rather than lying solely with the formally designated ‘leader’. ‘The emphasis thus shifts from developing “leaders” to developing “leaderful” organizations with a collective responsibility for leadership’ (Bolden et al., 2003, p. 6). This approach suggests a less formalized model of leadership where the leaders’ role is dissociated from the organizational hierarchy. It draws on concepts such as organizational culture and climate to highlight the contextual nature of leadership.

It is proposed that individuals at all levels in the organization and in all roles (not simply those with an overt management dimension) can exert leadership influence over their colleagues and thus influence the overall leadership of the organization. (Bolden et al., 2003, p. 17)

Within the primary care context, then, public health leadership must transcend organizational, professional, historical and political issues. It must look to both leaders and collaborators, and must focus on developing ‘leaderful’ organizations (Raelin, 2003). Central Government, Strategic Health Authorities and Primary Care Trusts will have a vital part to play in defining, maintaining and promoting the vision for public health but, for that vision to be realized, all collaborators need to develop confidence in their own ‘leadership skills’.

A new paradigm to enhance effective leadership, proposed by Shelton and Darling (2001), moves on from the individualistic focus highlighted in Bolden et al.’s review (2003), and thinks about leadership inputs and outputs in a new way, which highlights the processes in between. Although their article is focused on managerial leadership, they contribute some useful ideas which are particularly pertinent to complex settings. They argue for leadership skills ‘congruent with the perspective of organizations as
human-based systems that are fundamentally unpredictable, interactive, living systems, rather than stable, mechanistic-like operations’ (p. 264). By developing these skills across the organization, the emergent nature of leadership is highlighted within a more ‘leaderful’ organization. This perspective is discussed in more detail later in the paper.

**Leadership in policy**

For the first time in the UK, public health leadership in primary care, at least at national level, is becoming clearer. National health inequalities targets have been set, and the focus on health improvement is emphasized in planning guidance and new performance assessment processes (DoH, 1999b). A series of National Service Frameworks focused on particular fields, such as diabetes, further refine national standards and produce guidelines for service models. The quasi-independent Healthcare Commission (formerly Commission for Health Improvement) oversees this process and assesses local action to improve quality. The Modernisation Agency, meanwhile, has helped local clinicians and managers redesign local services around the needs and convenience of patients, and the Health Development Agency was established to ‘ensure that organizations and individual practitioners build their work on the highest standards and raise the quality of public health in England’ (DoH, 1999a).

All Primary Care Trusts in England are now expected to prepare Local Delivery Plans, in partnership with local authorities. These plans consist of local indicators and programmes for delivering health and social service targets defined by national and regional government (DoH, 2002). In addition, local authorities are not only obligated to participate in the preparation or review of the plans, they also have the additional duty to promote the economic, social and environmental well-being of their areas through Local Strategic Partnerships (Baggott, 2000; DETR, 2001b). In practice, coordination of these efforts at local level is problematic, and primary care organizations have found it difficult to prioritize health improvement among the multiplicity of national targets and priorities (Abbott et al., 2001, p. 3).

The Government has recognized the need for ‘first class leaders’ to deliver its comprehensive modernization programme. It announced a new Leadership Centre, in which to ‘develop a new generation of managerial and clinical leaders, including modern matrons with authority to get the basics right on the ward’ (DoH, 2000, p. 15). ‘Strengthening leadership’ was one of the priorities for action in the nursing strategy ‘Making a Difference’ (DoH, 1999c), and a proposed leadership programme for health visitors and community nurses promised to ‘provide them with the skills and expertise to work directly with representatives of local neighbourhood and housing estates to support communities to improve health’ (DoH, 2000, p. 112).

The concept of leadership espoused by the Government at policy level appears somewhat transformational: ‘We need visionary leadership ... to inspire and sustain the commitment of nurses, midwives and health visitors during a period of significant change’ (DoH, 1999c, p. 52). The nursing strategy also calls for a particular style of leadership: ‘We need nurse, midwife and health visitor leaders who can establish direction and purpose, inspire, motivate and empower teams around common goals and produce real improvements in clinical practice, quality and services’ (ibid.); and for particular qualities: ‘We need leaders who are motivated, self-aware, socially skilled, and able to work together with others across professional and organizational boundaries’ (ibid. 53).

Recent lists of leadership skills in the NHS (‘Workforce and Development’ Leadership Working Group, 2000; Burke et al., 2001), seem to confirm these transformational,
inspirational ideas (see Box 1). Similarities can be drawn between such lists of skills and Klakovich’s (1994) concept of ‘Connective leadership’, defined as ‘collaborative, contributory, mentoring, interactive in style, trusting, empowering, networking and persuasive’ (Girvin, 1998, p. 62). Clearly, leadership is about relationships: the ‘followers’ are just as important as the leaders. Such concepts of leadership appear to be moving on from being simply a competence checklist, and begin to take account of the more emotional factors of leadership.

Leadership in practice: Developing public health leaders in primary healthcare teams

It seems clear that the ‘public health function’ requires visionary leaders (see Box 2), working towards a number of different priorities including clinical, strategic and professional leadership (DoH, 2001b). Realizing these ideals in primary care and, in particular, within the public health function, is problematic given the complexity of both the organizational context and the public health workforce. There is an apparent unwillingness amongst many within the primary healthcare team to take on public health as their responsibility (Wirrmann, 2004). These complexities lie within a number of further tensions.

Whilst the NHS can be described as ‘a giant matrix organization’ (Pritchard et al., 1984, p. 221), primary care contains within it a range of organizational forms. The primary healthcare team is multidisciplinary and multi-professional, but driven by a predominantly medical agenda. Its organization is extremely complex, varies from team to team and changes frequently. Although most GPs have considerable freedom from hierarchical constraints, they have to work closely with people (nurses and others) who are themselves subject to those restraints (ibid., p. 221). Primary healthcare teams also work within their own, shifting, self-constructed boundaries. They operate as ‘network’ organizations,

---

**BOX 1: Nine leadership ‘themes’ proposed by the ‘Leadership Group’ of the NHS Executive London Region**

1. Articulating the vision: communicating a broad vision for the whole health community
2. Motivation: understanding the need to have a highly motivated organisation
3. Decision-taking: being dynamic and proactive in identifying decisions which need to be taken
4. Releasing talent: demonstrating the belief that the people within the organisation are individuals with many talents and potential
5. Responsiveness and flexibility: valuing flexibility and responsiveness in the organisation
6. Embodying values: having a clear sense of personal values
7. Innovation and creativity: demonstrating that innovation and creativity are highly valued in the organisation
8. Working across boundaries: demonstrating ability to work across professional, team and organisational boundaries
9. Personal resources: demonstrating resilience and the ability to call upon reserves of energy

(‘Workforce and Development’ Leadership Working Group, 2000)
which depend on informal ties, and link individuals and organizations together, thus crossing boundaries (ibid.). Moreover, a broad and inclusive definition of the primary healthcare team includes not only other non-NHS practitioners (for instance, social workers or community development workers), but also informal carers, the family and the patient him/herself. This collection of professionals and non-professionals will work in different ways, with very different internal and external influences on the way they work.

Leadership within such an ‘organization’ is inherently complex, since there will be multiple lines of accountability and cooperation, criss-crossing both vertically and horizontally within boundaries, as well as diagonally across boundaries.

A further tension for leadership is created by the conflict, within ‘modernization’, between standardization on the one hand, and local innovation on the other. Within the primary care team, there remains a tendency towards rule-driven, evidence-based practice, requiring bureaucracy and hierarchy (especially with the increasing amount of government targets and audits). This is in tension with the Government’s desire for local responsiveness, flexibility and innovation. Harrison (2002) argues that ‘modernization’ is forging a type of medicine—which he terms ‘scientific-bureaucratic medicine’—that embodies many of the specific characteristics of the Fordist labour processes. The ‘modernization’ agenda, then, seems to be pushing the NHS towards Fordism (with increasing specification, standardization and centralization of control) in a post-Fordist world (in which local decision-making, innovation and flexibility are celebrated). Within this context, transformational, inspirational leadership is likely to be stifled.

The Government is conforming to a ‘Fordist’ pattern in its systematic approach to clinical leadership, by building new career structures and new consultant posts. This approach shows a clear understanding that leadership is related to authority, seeking to clarify this through hierarchical structural positions. This tendency towards hierarchy and systematic approaches can be seen to be affecting the current reshaping of the public health workforce, and the ‘role’ of public health leadership within it.

The public health workforce

The public health workforce has been outlined by the Chief Medical Officer (DoH, 2001c) as comprising three categories: public health specialists, public health practitioners and the

---

**BOX 2: The ‘leadership cluster’ of skills**

In the Public Health Skills Audit, carried out on behalf of the Health Development Agency, skills are grouped into several ‘clusters’, one of which is the ‘leadership cluster’. This includes:

- Clarifying a direction and purpose
- Building a shared vision
- Building commitment
- Empowering others
- Creating a learning culture
- Influencing others
- Political sensitivity and awareness

(Burke, Meyrick and Speller, 2001: Appendix 6)
wider workforce. Each of these has been further divided into two: strategic and operational/technical (Burke et al., 2001). The distinctions between these categories, though, are often difficult to make when there is so little clarity around what constitutes the roles, or potential roles, of each of the three groups (Peckham & Wirrmann, 2003). While the above discussion indicates that all categories of the workforce could potentially play a leadership function, the heaviest burden of leadership will necessarily fall to public health specialists and practitioners, with those in strategic roles having the greatest influence. Public health strategy, for the time being, sits squarely within primary care and with Directors of Public Health, as well as designated public health practitioners, such as health visitors, who are employed primarily by PCTs in England.

The ‘Standards for Specialist Practice in Public Health’ (Healthwork UK, 2001) detail the leadership performance criteria expected of public health specialists. These criteria include: ‘identify clear goals and processes for health improvement and communicate these effectively to others’ (8.1.2.) and ‘overcome individual and organizational barriers to improving health and reducing inequalities including those within the senior management team’ (8.1.9). The knowledge and skills identified to help specialists achieve the related performance criteria include being able to: ‘Develop and frame statements of vision for improving health that are realistic and capable of winning the support of others’ (8.1.h) and ‘Demonstrate vision in designing the long-term strategy based on the assessment of research evidence of effectiveness’ (8.1.f).

The professionalization agenda dominating public health is concentrating the attention on public health specialists. Its focus is on defining core competences, and it emphasizes the exclusivity of roles. This creates a hierarchy of public health practice, which maintains an arbitrary split between public health specialists, practitioners and ‘the wider workforce’. Moreover, by carving out the leadership role and placing it within the domain of the public health specialist, the public health leadership potential of other members of the public health workforce is denied.

The arbitrary nature of the split between public health specialists and practitioners can be seen in the more recent work by Skills for Health (2003), who applied the same 10 key standard areas defined for specialists to practitioners. They lay out, too, the leadership qualities of public health practitioners. Not surprisingly, there is a great deal of convergence between the skills and competences defined for ‘specialists’ and ‘practitioners’.

In the real world, however, numerous skills audits point to a clear gap in the public health workforce’s leadership skills amongst primary care professionals (Harvey-Jordan, 1999; Billingham, 2000; Burke et al., 2001). Billingham’s work focused primarily on the public health skills of community nurses, in particular health visitors and school nurses, while the Health Development Agency and the Harvey-Jordan audits looked at a wider range of professionals in the workforce (public health consultants, communicable disease consultants, GPs, epidemiologists, community nurses, and so on). Nevertheless, the skills gaps picked up in these audits are remarkably consistent and make worrying reading for those concerned with promoting leadership in the public health and primary care workforce, as the gaps centre on those qualities needed for strong leaders:

- Management and leadership areas: This group of skills comes up repeatedly in skills audits and training needs assessments, whether applied to public health or to other professional areas. The HDA skills audit (Burke et al., 2001) highlights the great demand for organizational development skills to help teams better undertake partnership working and to manage the changes required to deliver the government’s public health agenda.
Information analysis: The HDA skills audit also uncovered an unexpressed gap in the need for IT skills and information analysis. This was reinforced during a half-day workshop on the public health capabilities needed to implement the National Service Framework for Coronary Heart Disease (Public Health Resource Unit, 2001). Furthermore, many respondents to the various audits felt that they needed further skills in appraising and using research evidence. Information analysis and applying evidence are two critical areas required by leaders to inform their decisions and persuade others of the strength of their arguments.

Collaboration/networking/partnership skills: In order to work across agency and professional boundaries there is a clear need for all categories of the workforce to be well versed in the importance of, and tools needed, to assist with greater collaboration (Billingham, 2000; Stoten et al., 2000; Burke et al., 2001).

Given the results of the different skills audits, it is not surprising that research into the content of curriculum, both in terms of professional training of primary care professionals and more specifically around public health, reveals a dearth of content in the above areas (Latcham, 2000; Speller, 2000; Carlson & Baker, 2001; Spencer & Jordan, 2001; University of Central England, 2001). While leadership theory is often covered, a significant obstacle to educating for leadership appears to be allowing opportunities to put leadership skills into action once in primary care settings. Influencing, networking, collaborating and visioning are all activities that need practice. Yet, in practice, they are often undermined by organizational boundaries, conflicting priorities and competing agendas. Perhaps a more fundamental concern, though, lies in the mismatch between the visionary sense in which leadership is perceived in policy, and the reliance on leadership skills being taught, rather than developed and practised.

Challenging the notion of ‘competence’

Within educational circles associated with primary care and public health, the notion of ‘competence’ abounds. Yet it is a concept that receives little critical analysis. Ashworth and Morrison (1991) define competence as ‘a wide concept which embodies the ability to transfer skills and knowledge to new situations within the occupational area’ (p. 257, cited in Beach, 2002, p. 83). However, they then question whether it is a capacity, bits of behaviour or a particular outcome. This leads us to ask, first, how knowledge and competence are linked; and, second, whether the latter always demonstrates the former.

Public health encompasses a wide variety of activities and issues. Its sphere of practice is large, and it is difficult to pin down. The construction of a list of ‘requirements’ in the form of competences, then, may amount to a reification of public health, restricting its scope, and leading professionals down a ‘potentially problematic route as...[they] somehow try to get all the required characteristics “right”’ (Beach, 2002, p. 80).

‘Competency based education...rests upon the premise that occupationally derived tasks can be isolated and converted into identifiable outcomes capable of assessment’ (Webb, 1992, p. 227). However, the practice of public health is an ‘art’ as well as a science (Acheson, 1988). ‘Art’ can be defined as ‘skill in doing anything as the result of knowledge and practice’ (<I>Oxford English Dictionary</I>, 1989). This linking of skill, knowledge and practice reminds us of the importance of experience in the process of learning and doing. The Merriam-Webster dictionary (2004) considers art to be ‘the conscious use of skill and creative imagination’. As we can see from these definitions, artistry ‘is not reducible to the exercise of describable routines’ (Schön, 1992, p. 51).
Assessing the knowledge base behind the practical ‘art’ of public health is arguably problematic, if not impossible. This leads to a concern that the notion of ‘competence’ in public health is associated with the reduction of it as a broad concept to its more scientific aspect.

Competences can be linked to the professionalization agenda: ‘the systematic knowledge base of the professions is thought to have four essential properties. It is specialized, firmly bounded, scientific and standardized’ (Schön, 1987, cited in Beach, 2002, p. 80). Where science is emphasized over art, and bureaucracy over adhocracy, an anti-innovatory culture may develop in which individual innovation and novelty are only tolerated within limits. ‘It is in the specifying of occupational competencies that a skills based outcome training rather than a process oriented professional education has been gradually established’ (Webb, 1992, p. 227, emphasis in the original). The muddle that has been created by trying to delineate boundaries between public health specialists and practitioners creates further problems for promoting public health leadership both in primary care and within wider circles of local strategic partnerships, where practitioners may be employed by local government bodies as well. Perhaps public health needs to work more from broad principles than prescribed rules.

A final consideration of competences stems from the belief that they ‘involve a surreptitious subordination of the individual to the alleged needs of the organization’ (Performance and Innovation Unit, 2001, p. 79). Webb (1992), going even further, suggests that new ‘competence’ driven initiatives in professional education are ‘a mask for the superintendence of expert labour by the state’, and ‘a vehicle for endorsing the increasingly market oriented context within which employers now operate’ (p. 224). Whilst this view might be dismissed as mere cynicism, it does point to the possible commodification of public health, where the focus on competences forms part of the increased control by the centre, ‘enforcing’ new training practices, with the aim of greater consistency and reliable transportability of the qualified worker.

This discussion highlights, though, the tension between the ‘art’ and ‘science’ of public health. The Faculty of Public Health, speaking from a predominantly ‘scientific’ public health perspective, argues that defined professional competences are required to ensure public safety and accountability. This is a legitimate argument within an area that is still medically driven, but is much more difficult to argue within the more ‘artistic’ elements of and approaches to public health.

Thus, a critique of the focus on competences in public health points to two possible areas of concern: first, a competence-based education—like that promoted in ‘Making a Difference’ (DoH, 2001d)—does not appear to offer any certainty that practitioners will be more knowledgeable. It may even be a restrictive way forward (Beach, 2002, pp. 54–55). However, the move to having to demonstrate skills and competence by portfolio assessment may obviate some of this problem. Second, the broad vision of public health is in danger of being reified, reduced and commodified by the very process of establishing the ‘competences’ required to engage in it.

**Thinking about leadership in new ways**

Shelton and Darling (2001), in their new paradigm to enhance effective leadership, use the basic principles of quantum mechanics to ‘provide meaningful insights into an organizational world that is both objective and subjective, logical and irrational, linear and non-linear, orderly and chaotic’ (ibid., p. 265). Their theory develops from an
interest in the actions and interactions of individuals throughout what they call ‘quantum’ organizations, where leadership is distributed, communication is multi-directional, trust is high and the whole is greater than the sum of the parts. Their paradigm of thinking and model of seven skills (see Box 3) would seem consonant with the often chaotic, paradoxical realms of public health and primary care both in the UK and elsewhere.

The first three quantum skills—seeing, thinking and feeling—are primarily psychological in nature, enabling leaders to create more intentionally and more imaginatively. The next three—knowing, acting and trusting—are ‘spiritual’ skills, which give leaders a sense of meaning and fulfilment. The final quantum skill—quantum being—is intricately connected to each of the other six.

In the case of quantum seeing, Shelton and Darling suggest that clear intention serves as a magnifying glass, providing ‘a new lens through which managers can make new perceptual choices—choices that otherwise would have been missed, thus creating lost opportunities’ (2001, p. 266). In primary healthcare, all practitioners should be clear about their public health intention to help them make the choices they face in everyday practice, without missing opportunities. At the organizational level, this skill also acts as a reminder that all collaborators should be involved in visioning and planning processes, riding above organizational and professional boundaries. ‘If employees are not involved, they are likely to be perceptually incapable of seeing and, hence, of creating new possibilities. Instead, they remain committed to their current mindsets, unable to make the perceptual choices required for successful execution’ (ibid., p. 266).

Paradoxical thinking is a valuable skill in public health delivery: ‘the skill of quantum thinking provides an ongoing stream of highly innovative, often illogical ideas that help the … leader transcend the box of binary thinking’ (Shelton & Darling, 2001, p. 267). Quantum feeling stresses positive emotions and enables the person to feel good internally, regardless of what happens externally. A coherent state of mind is more open to opportunities than one in a state of negativity (ibid., p. 268). In the context of constant change and ever increasing demands, from both patients and the government, quantum feeling might help ensure that the public health agenda retains a vision that rides over competing demands.

The three spiritual skills encourage the view of leadership as a personal and continuous learning process. In true learning organizations, all the stakeholders value learning from the inside out, thereby recognizing the importance of intuitive ideas (Shelton & Darling, 2001, p. 269). In the public health field, often dominated by medical and technical rationality, a focus on ‘staying aware’, or quantum knowing, would keep individuals attentive to both external conditions, and to internal intuitions. This is a skill that all

**BOX 3: Seven ‘Quantum Skills’ for leadership**

1. *quantum seeing*: the ability to see intentionally;
2. *quantum thinking*: the ability to think paradoxically;
3. *quantum feeling*: the ability to feel vitally alive;
4. *quantum knowing*: the ability to know intuitively;
5. *quantum acting*: the ability to act responsibly;
6. *quantum trusting*: the ability to trust life’s process; and
7. *quantum being*: the ability to be in relationship.

(Shelton and Darling, 2001)
specialists and practitioners should possess—through their day-to-day experience—but which managers or strategic leaders may easily overlook.

The ability to act responsibly, with concern for the whole, is vital in public health, where individual, family and community health status are interrelated, and where everyone contributes to the improvement of each. Quantum being values relationships as extraordinary learning processes, and stresses the need to create time and space for dialogue, trusting that improved relationships will generate improved results. Where public health activity is truly collaborative and participative, each person will influence others; rather, if public health activity is to be truly collaborative and participative, everyone must have the opportunity to lead.

Much can be learned from leadership theories. Many of the qualities necessary to progress a stronger and more extensive public health function in primary care are reflected in contemporary theory as ‘leadership skills’. However, a focus on leaders should not be at the expense of followers. By treating all primary care practitioners as collaborators, with the potential to lead in public health, there is an opportunity to allow public health leadership to flourish from the bottom up. This leadership would be in a stronger position to transcend the organizational hierarchy and professional differences inherent in many primary care teams. Both specialists and practitioners, though, need confidence and encouragement to act as leaders in public health.

In England, this might mean that primary healthcare teams regularly make time to share and discuss issues related to the health of their local populations. This would need to be within a forum that breaks down existing barriers between different disciplines and different levels of hierarchy, and that draws on and utilizes the insights, experiences and skills of all members of the team. Such a team would know where to go to access help and advice from public health specialists, but would not necessarily be ‘led’ by them. In this way, members of the team might develop common ground based on shared public health values that will guide practice and innovation and allow practitioners to look outside their established routines. Good ‘leaders’ will emerge through the process of individuals being encouraged and supported to discuss, engage with and tackle issues that they identify as being important to them and to their local communities. Such practice might be developed through the use of ‘learning sets’, for example, which the Public Health Resource Unit in England has shown to be successful in helping practitioners to improve their capacity and capability to problem solve, and share and enhance good practice (PHRU, 2004).

This article highlights that the current focus on drawing up and testing lists of public health competences is in danger of reifying, reducing and commodifying the art of public health, and may serve to dampen the innovatory spirit of practitioners. Shared leadership in public health needs to be supported through a learning culture that encourages practitioners to think and act in new ways. Whilst the science of public health inevitably entails the learning of practical skills, the art of public health leadership requires the possession of what have been described in this article as ‘quantum’ skills.

References