The Psychology of Leadership Incompetence

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Abstract

Theories and practices of leadership in celebrating competence and capability fail to engage with leadership incompetence. However, the high human costs of organizational failures increasingly encourage us to understand incompetent leaders. In *On the Psychology of Military Incompetence,* Dixon (1976) critically analysed military disasters throughout history highlighting the incompetency of particular generals. The leadership aspects of what happened at Stafford Hospital were analysed using twelve questions informed by Dixon's earlier research. In the discussion, the NHS leadership framework is compared and contrasted with Dixon's framework. Engaging with leadership incompetence is facilitated through asking awkward/provocative questions – lest we forget. Understanding leadership incompetence tends to be retrospective with leaders and institutions either conscious or unconscious of leadership incompetence. Consequently leadership development requires case studies of leadership incompetence which encourage critical self-questioning and reflective leadership development and practice.

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Introduction

We think, write about and understand leaders in terms of their capabilities and competencies, but what about the flipside of this coin understanding their incompetence? If we could acknowledge and better understand leadership incompetence, perhaps corporate failures similar to RBS, Enron and Lehman Brothers and public service failures such as the Child Support Agency, Haringey Children's Services and Stafford Hospital could be avoided and by association their tragic human consequences limited. However, even associating leadership and incompetence feels heretical and counter cultural. Our uncritical celebrations of leadership are grounded in broader social beliefs about the power of heroic individuals, changing the course of history, particularly common in North America (Alvesson et al, 2012). Many people still want to believe in the transformative capabilities of their leaders and focus upon their perceived competencies. However, Tourish (2013) and others have encouraged approaching leadership with a healthy feeling of scepticism; in escaping the seductions of leadership prescriptions, and beginning to understand the deceits, deceptions and failings characterising leadership. Instead, we need to think of leadership as morality magnified (Ciulla, 2006). Hogan and Hogan (2001) identified reasons for studying incompetence including; it may prove easier to identify an incompetent leader, rather than a competent leader, the prevalence of bad managers facilitates the study of incompetence and managerial incompetence has a moral dimension.

Military incompetence offers an extreme example of what happens when generalship (military leadership) goes wrong. In Dixon's (1976) account of the psychology of military incompetence we are offered explanations for why tragic military incompetence occurred. In the next section, Dixon's provocative thesis is revisited with literature relating to leadership competence subsequently reviewed and contrasted with literature beginning to explain leadership incompetence. Reports from the three inquiries into failings at Stafford Hospital were analysed in order to identify leadership incompetence and to test the applicability of Dixon's (1976) explanations in a different context. In the discussion section the NHS Leadership Framework is contrasted with Dixon's framework with conclusions answering four questions; what is leadership incompetence, when is leadership incompetence visible, are leaders conscious of incompetence and what are the implications for leadership development?

The psychology of military incompetence

In an early paper, applying psychoanalysis to organizations attention was drawn to Dixon's thesis demonstrating how organizations and their executives delude themselves 'in the face of imminent disasters, military, business and other leaders, like many "ordinary neurotics" have often displayed a remarkable ability to deceive themselves with wishful thinking'(Gabriel, 1992:350). *On the Psychology of Military Incompetence* is carefully prefaced as explaining '…how a minority of individuals come to inflict upon their fellow men depths of misery and pain virtually unknown in other walks of life' (Dixon, 1976:9).

Dixon after ten years' commission with the Royal Engineers left the army to study psychology becoming a professor at University College, London. Whilst, the title of his book was provocative he remained respectful of the military throughout the book believing that many of the arguments were equally applicable to politics, commerce and universities. The theme of generalship (military leadership) unifies the book.

> In short, there is nothing mysterious, romantic or necessarily laudable about leadership. Indeed, some of the most effective leaders have been those who, merely through having more than their fair share of psychopathic traits, were able to release antisocial behaviour in others. (Dixon, 1976: 215)

In revisiting Dixon's (1976) book there is something exceptionally prescient about his writing, pre-empting interest in leadership pathologies (Kets de Vries, 2006) and broader concerns with a darker side of leadership and the psychodynamics of leadership. In part one, Dixon devotes chapters to military disasters which include the Crimean War, the Boer War and the First World War. In part two/three, Dixon focuses upon the psychological processes of the generals as a means of explaining these disasters; chapter titles include "bullshit", "socialization and the anal character" and "authoritarianism".

At this stage, it is necessary to offer caveats, firstly, the book was written over thirty five years ago (there were later editions, but the text remained unchanged), psychoanalytical theories that originally interested Dixon have evolved considerably. Secondly, Dixon's discussion of women and the language he employed are inappropriate in terms of today's social values. Thirdly, Dixon's framework has to be applied selectively, as some aspects were highly applicable to military environments of his day.

As a bridge between parts one and part two/three, Dixon includes a chapter entitled – Is there a case to answer? In this chapter, aspects of military incompetence are summarized (see Table 1) based upon his earlier narratives of military disasters. This chapter sets up his discussions in parts two and three, with his focus upon the commonality of these patterns of incompetence and explanations why they arise. Over 448 pages the book is very discursive and at times highly opinionated. Unfortunately the fourteen aspects contained in Table 1 were never rigorously tested within an inductive book, but what endures is the books provocation to rethink taken for granted assumptions about the competence of the generals and more broadly our leaders. In the final chapter, entitled *Retreat* Dixon is on the defensive and in his afterword he concedes that he would have made a 'grossly incompetent leader'.

Dixon's (1976, p152/3) Military incompetence	Leadership incompetence questions
1. A serious wastage of human resources and failure to observe one of the first principles of war – economy of force.	Did the leaders waste human resources, failing to apply economy of force?[1]
2. A fundamental conservatism and clinging to outworn tradition, an inability to profit from past experience (owing in part to a refusal to admit past mistakes).	1.Did the leaders cling to outworn tradition, failing to learn from past experiences/mistakes?
3. A tendency to reject or ignore information which is unpalatable or which conflicts with preconceptions.	2.Did leaders reject or ignore unpalatable information?
4. A tendency to underestimate the enemy and overestimate the capabilities of one's own side.	3.Did the leaders underestimate the problem (enemy) and overestimate their own capabilities?
5. Indecisiveness and a tendency to abdicate from the role of decision maker.	4.Were the leaders indecisive abdicating responsibility for decision making?
6. An obstinate persistence in a given task despite strong contrary evidence.	5.Were the leaders obstinate in their task, despite strong contrary evidence?
7. A failure to exploit a situation gained and a tendency to 'pull punches' rather than push home an attack.	6.Did the leaders fail to exploit the situation, 'pulling punches', rather than going on the offensive (attack)?
8. A failure to make adequate reconnaissance.	7.Did the leaders fail to make adequate reconnaissance?
9. A predilection for frontal assaults, often against the enemy's strongest point.	8.Did the leaders display a predilection for initiatives (frontal assaults)?
10. A belief in brute force rather than clever ruse.	9.Did the leaders believe in strength (brute force) over cunning (clever ruse)?
11. A failure to make use of surprise or deception.	10.Did the leaders fail to make use of surprise or deception?
12. An undue readiness to find scapegoats for military set-backs.	11.Did the leaders seek scapegoats for set-backs?
13. A suppression or distortion of news from the front, usually rationalized as necessary for morale or security.	12.Did the leaders suppress or distort performance information (news from the front)?
14. A belief in mystical forces – fate, bad, luck, etc.	Did the leaders believe in mystical forces?[1]

Table 1 – Leadership incompetence questions based upon Dixon (1976)

[1.] The first and fourteenth questions have not subsequently been adopted as they are specific to military contexts and difficult to apply generically.

The first column (Table 1), lists aspects of military incompetence which Dixon identified based upon his analysis of military disasters, using his own terminology. As Dixon (1976:214) writes 'whatever it's other causes, military incompetence implies a failure in leadership.' In the second column, Dixon's aspects of military incompetence are adapted into corresponding critical leadership incompetence questions grounded in the experiences of military disasters over the past century and as far as possible mirroring Dixon's own terminology. In the following discussion twelve of the aspects of military incompetence (featured in Table 1) are explained further and applied to organizations.

Conservatism within the military is a recurrent theme throughout Dixon's analysis, with a chapter devoted to 'bullshit' abbreviated in the following quotation to 'bull'.

> … It is no accident that 'bull' is so closely linked to conservatism, for its very nature is to prevent change, to impose a pattern upon material and upon behaviour, and to preserve the status quo whether it is that of shining brass or social structure. (Dixon, 1976:179)

Whilst, conservatism and preserving the status quo appear out of tune with today's change preoccupied organizations they may still exist (1). In undertaking his analysis, Dixon encountered a tendency of generals to reject or ignore unpalatable information (2); with defeat at Singapore in the face of evidence highlighted as a particularly striking example.

> It is a feature of strongly held dogmas that they steadfastly resist not only unpalatable truths but even the faintest suggestion of the barest possibility of the most tangential reference to an unacceptable fact. Better that men should die and cities be overrun than the sacred teachings should be found wanting. (Dixon, 1976:136)

Closely aligned with ignoring unpalatable information was a tendency to underestimate the enemy and overestimate one's own capabilities (3). In a military context arrogance refers specifically to attitudes towards the 'enemy'. In an organizational context, notions of an 'enemy' are less applicable, but leaders may still act arrogantly when faced with significant problems. The procrastination/indecisiveness which Dixon repeatedly encountered within military settings may be equally evident within organizational contexts (4). Obstinacy of the generals was another recurrent pattern which Dixon detected, he was particularly critical of Commander in Chief of the British Armies (1915-1918) Douglas Haig disregarding warnings from his own intelligence staff, yet such criticism only made Haig more obstinate. In an organizational context this equates to the obstinacy of leaders (5). Dixon in reviewing military disasters identified a tendency to fail to exploit situations and push home the attack (6), in an organizational context this relates to leaders going on the offensive.

In military settings reconnaissance was a favoured precursor to engagement and Dixon cites the example of General Methuen in the Boer War failing to make sufficient reconnaissance. In an organizational context this similarly equates to leaders failing to make such reconnaissance (7). Military tactics were evolving over the timeframe Dixon was surveying. Originally frontal assaults on the enemy's strongest point were favoured, but as this tactic was being surpassed, the predilection for frontal assaults was regarded as military weakness.

The concept of frontal assaults in an organizational context equates to the preference of leaders to launch initiatives and high profile projects (8). Exercise of brute force reflects a historic, yet now outdated form of combat, in many ways similar to the frontal assault. In organizations power and politics are always at work (Buchanan and Badham, 2008), in this instance the characteristic relates to a leader's tangible use of strength (9). In terms of surprise or deception, Dixon cites the example of the Boers surprising the British at Modder River, surprise attacks were a favoured military tactic with resistance/failure to surprise regarded as incompetence. In an organizational setting this equates to leaders avoiding surprise or deception (10), although the implication that deception is a positive disposition is morally problematic. Apportioning blame and identifying scapegoats (11) feature prominently in military history, relating back to failure to learn from past experience (2). Dixon (1976) noted that it was a sad feature of authoritarian organizations that their nature militated against learning from experience through apportioning blame; denial, rationalization, making scapegoats or some mixture of the three equating in an organizational context to blaming others (11). In terms of suppression or distortion of news from the front, Dixon used an illustrative example of General Warren flying into a rage when a journalist attempted to relay dire events happening at Sion Kop. This equates in organizations to leaders suppressing or distorting bad news (12).

On the Psychology of Military Incompetence, is frequently cited and has provoked debates within the military, yet to date its application to leadership/organization studies has been very limited. In *Administrative Science Quarterly,* Penner (1981) a US Army War College Professor offered a comprehensive review of the book. His verdict was mixed, in that he questioned Dixon's emphasis upon authoritarianism and battlefield command, as well as, what he perceived as Dixon's selective version of military history. He saw merit in the questions the book raised and acknowledged that senior American army officers who read the book had indicated that it caused them to engage in some extensive and fruitful introspection. It is the spirit of provocative critical questioning and encouraging fruitful introspection which is developed here. Initially it is necessary to understand the prevalence of unquestioning and a-critical conceptions of leadership competence, how such conceptions are being challenged and then begin an uncomfortable process of engaging with leadership incompetence.

Understanding leadership competence and incompetence

In their comprehensive review of leadership competencies, Bolden and Gosling (2006) traced the origins of 'managerial competency' back to the work of McClelland (1973) and subsequently the work of the McBer consultancy group and Boyatzis's (1982) identification of 19 generic behavioural competencies. Competencies were institutionalized through initiatives such as the *Management Charter Initiative* resulting in organizations utilizing frameworks to recruit and promote their leaders. A bridge between managerial and leadership competencies was facilitated through distinctions made between management and leadership (Zaleznik, 1977 and Kotter, 1990) (see Bolden and Gosling, 2006 for a critique).

Acknowledging Sparrow's (1997) distinction between management, behavioural and organizational competencies, Bolden and Gosling (2006:150) focused upon competency '…as an acceptable standard of practice and/or a behavioural predictor of improved performance'. They likened preoccupations with competency to a musical refrain with the repetitive 'hook' offering structure and consistency, yet discouraging further development. Whilst, competencies caught the imagination of many, Bolden and Gosling (2006) identified five weaknesses; they were reductionist, universalistic/generic, focussed upon current and past performance, emphasized measurable behaviours and offered a limited and mechanistic approach towards education.

In their textual analysis, Bolden and Gosling (2006) analysed two sets of texts; leadership competency and quality frameworks and feedback reports from reflective retreats for practising managers finding '… a disturbing gap between the attributes required of leaders as conveyed by practising managers and popular leadership competency frameworks.' They concluded that 'to escape from the repetitive refrain of competencies we believe more consideration should be placed on reflection, discussion and experience. Organizations should endeavour to develop opportunities for their members to articulate and explore their experience of leadership in all its richness' (Bolden and Gosling, 2006:160). Competence as an object of knowledge constructed by a discourse highlights why competence appeals and also it's major flaw as we cannot know in advance how someone will perform, we cannot distinguish between those who will perform in desirable ways and those who will not (Holmes, 1995). Similarly, Bolden et al (2006) found 'competence' being socially constructed, rather than a set of definable attributes and/or required behaviours.

What do we know about leadership incompetence? Diefenbach (2013) warns that very little attention has been paid to leadership incompetence in organizational studies. The most famous account of incompetence in an organizational setting according to Ott and Shafritz (1992) was Peter and Hull's, (1969) *The Peter Principle: Why things always go wrong* and Broadwell's (1969) useful differentiation between; conscious competence, unconscious competence, conscious incompetence, unconscious incompetence could also be added to this. These popular accounts whilst not empirically tested offered early warning signs about assuming the competence of our managers/leaders. Ott and Shafritz (1992:370) acknowledged that 'incompetence is a vitally important but minimally explored variable in organization theory', with three exceptions being military incompetence, medical-legal incompetence and professional incompetence. What do we know about conceptualizing incompetence?

Hogan and Hogan (2001) revisited earlier studies of failed managers, believing that incompetence was related to having undesirable qualities, rather than lacking the desirable ones. They regarded Bentz's (1985) interview study of failed Sears's executives as a pioneering study in this field with themes associated with failure identified including inability to delegate or prioritize, being reactive rather than proactive, having poor judgement, being a slow learner and having an overriding personality defect.

As well as this study they cited the research of McCall et al (1988) and Leslie and Van Velsor's (1996) summary of themes associated with failure; problems with interpersonal relationships, failure to meet business objectives, inability to build a team and inability to adapt to a transition. These studies formed the basis for their research (Hogan and Hogan, 1997) into personality disorders in line with DSM-IV (American Psychiatric Association, 1994). In applying the Hogan Development Survey they focused upon 11 derailment themes identified within the literature, their quantitative analysis of the survey findings lead them to draw conclusions which included; considerable agreement with the dysfunctional dispositions associated with managerial incompetence, summarized as tendencies to blow up, show off, or conform when under pressure and that these dispositions were invisible during interviews/assessment centres, but were typically first noticed by subordinates. People with these dysfunctional dispositions were unable to learn from past experience 'virtually every modern study of managerial performance identifies not being able to learn from experience as a major, if not the major factor in derailing careers' (Hogan and Hogan, 2001:51).

Inquiring into Stafford Hospital

The Mid Staffordshire Foundation Trust Public Inquiry (2013 a,b,c,d) reported on between 400 and 1200 patient deaths occurring between 2005 – 2009 at Stafford Hospital, run by Staffordshire NHS Hospital Trust which subsequently acquired foundation trust status. Prior to the Public Inquiry there had been an Independent Inquiry (2010 a, 2010b) and a Healthcare Commission Investigation (2009). These reports informed by qualitative and quantitative data gathering investigated the human tragedies at Stafford Hospital and why they had occurred. The evidence which was systematically gathered potentially informs our understanding through secondary analysis of the existence and nature of leadership incompetence and its implications for leadership development.

In Dixon's (1976) review of military disasters there were historic and critical parallels with what happened at Stafford Hospital; patterns of behaviour kept repeating themselves with tragic human consequences, yet no apparent learning. The leadership incompetence questions (see Table 1) offer a critical framework to investigate what happened at Stafford Hospital. The research design was deliberately exploratory in seeking to investigate the little understood and emerging phenomenon of leadership incompetence. The three inquiries generated a large amount of qualitative data (six volumes and 2768 pages) with NVivo10 used to undertake the analysis reported here. In the next sub-section the language of leadership and competence within the reports is highlighted, followed by analysis informed by the leadership incompetence questions (Table 1).

The language of leadership and competence The reports contained 951 references to either 'leader' or 'leaders' or 'leadership', whilst part of the explanation of what went wrong at Stafford Hospital was attributed to organization culture, the inquiries also emphasised failures of leadership. Inquiries focussed upon leadership at all levels, frequently employing a mantra 'from Board to Ward', leadership failings were located not just within Stafford Hospital, but at local, regional and national/governmental level. The inquiries focused upon significant events over many years, missed opportunities to spot warning signs and failures to act upon them earlier. 'Development' was referred to 106 times in the context of leadership, understandable given that these inquiries were seeking to inform future NHS leadership development. The next most frequently referred leadership coding was 'lack of leadership' (54 references) with an equal number of references to 'monitoring'. There were 48 references coded as 'weak/failing leadership', 42 references coded as 'leadership responsibility', 34 coded as 'appropriate leadership', and 24 coded as 'leadership by example'. Also, personal constructs (Almo-Metcalfe, 1995) were evident within the inquiry evaluations of leadership with the most common being lack/presence of leadership and strong/weak leadership.

Coding of specific references to 'incompetence', 'incompetent','incompetencies' or 'incompetency' revealed only 15 references across all the reports referring to generalised incompetence, managerial incompetence or professional incompetence, rather than specific leadership incompetence. By comparison coding of 'competence', 'competent', 'competencies' or 'competency' revealed 131 references across the reports, nine times as many references as incompetence. The references to competencies were informative in terms of the scope of the competence label being applied to roles including; nurse, trade unionist, doctor, leader, manager, board member and Chief Executive. Competence was also applied to many different functions including; commissioning, financial, technical, general, clinical, surgical and professional. Also, there were indications of competence being institutionalised/formalized within healthcare; *The Code: Standards of Conduct and Performance and Ethics for Nurses and Midwives*, *the Clinical Leadership Competency Framework*, the NHS Commissioning Boards *Joint Report on Compassion* and the General Medical Council's – *Good Medical Practice*.

Leadership incompetence questions Incompetence as identified by Dixon (1976) (see Table 1) offered another perspective on what went wrong at Stafford Hospital - the twelve leadership incompetence questions are signposted through underlining. Chapter one of the first volume of the Public Inquiry entitled *Warning Signs* opened with the following sentence:

> During the course of both the previous inquiry and this inquiry there has been a constant refrain from those charged with managing, leading, overseeing or regulating the Trust's provision of services that no cause for concern was drawn to their attention, or that no one spoke up about concerns. (Francis, 2013b:47)

Chapter One then effectively demonstrated chronologically a timeline of key warning signs commencing in August 2001 through to March 2009 of serious concerns repeatedly expressed by very different groups, yet never addressed, reflecting a failure to learn from past experiences and rejecting/ignoring unpalatable information. In 2004, the Trust went from being a three-star trust to a zero-star trust; in response, the Trust produced a *Stars Recovery Plan*.

> When the news from the rating system was positive, either by way of a good star rating, or good scores on the balanced score card, this was taken to be reassuring with regard to quality, whereas negative results were discounted. Therefore, there was an element of false assurance being taken and a lack of association of concerns about the competence of management with the potential and current effects on patients. (Francis, 2013c:739)

Whilst the supporting narrative suggested that within the Trust there was a belief that the loss of stars was due to poor record keeping and within the health authority the star system was regarded as 'crude' and 'mechanistic', these actions illustrated rejecting or ignoring unpalatable information and leaders suppressing or distorting information.

> Staff had little confidence in the system for reporting incidents. Serious incidents were not discussed by clinical staff as part of a systematic process to learn lessons. (Healthcare Commission, 2009:53)

> Such broad categories restricted the usefulness of complaints as a means to learn about possible shortfalls in services. (Healthcare Commission, 2009:96)

> In any event he (Mr Yeates, Chief Executive Officer) did not evidence any real appreciation of the implications of the mortality figures, or of the fact that the HCC had decided on a formal investigation, or of the many complaints considered by both this and the first inquiry where he signed off letters of apology and undertakings to learn lessons. (Francis, 2013c:149/150)

These three quotations are illustrative of a failure to learn from past experiences. There appears to have been systemic failures at Stafford Hospital and within the wider health service tasked with regulating/overseeing Stafford Hospital, consequently critically highlighting individual leadership dispositions may misrepresent what happened. Although, Sir Stephen Moss in his testimony highlighted a local leadership mind-set which can arise out of granting Foundation Trust status:

> This is dangerous for the mind-set of the board who will often react by, at best, resting on its laurels and, at worst, becoming arrogant and complacent. What many new Foundation Trusts do is to build a fortress around themselves, reluctant to pass information on to commissioners and regulators, thinking that they are no longer answerable to anyone. (Francis, 2013b:183)

A key theme of the Public Inquiry related to a need for Openness, Transparency and Candour.

> Frank and accurate information about the cause of death of patients was not universally conveyed to relatives. Exaggerated claims of success were made to the public. (Francis, 2013d:1441)

These quotations illustrated, leaders overestimating their own capabilities. There were certainly changes in leaders, systems and structures between 2001 and 2009. However, clinging to out worn tradition and the obstinacy of leaders relates to a pattern of preventing decisive actions and preserving the status quo. The Chief Executive between January 2005 and March 2009 was not medically fit to attend the inquiry. But based upon his earlier documentary evidence, he was aware of complacency and poor standards 'acknowledging that there was work to do, he described the Trust's culture as being inwardly focused and complacent, resistant to change and accepting of poor standards' (Francis, 2010a:22).

The leaders as obstinate in their task despite strong contrary evidence was revealed by all three inquiries and was primarily related to leadership failures to act upon many warning signs, over many years. More specifically complaints which leaders could have utilised to inform their learning and development were ignored/downplayed.

> In short, a defective complaints process in the health service has far more serious consequences than bad customer service in the retail industry. It can harm the very people it is designed to assist. (Francis, 2010a:270)

> The Board of the time collectively must bear responsibility for allowing the mismatch between the resources allocated and the needs of the services to be delivered to persist without protest or warning of the consequences. It was or should have been the directors' primary responsibility to ensure either that they did deliver an acceptable standard of service or, if this was not possible, to say so loudly and clearly, and take whatever steps were necessary to protect their patients. (Francis, 2010a:211)

Each of the inquiries highlighted leaders being indecisive and abdicating responsibility for decision making, in that despite many and varied warning signs leaders failed to act. The trust's response to Stafford Borough Council Health Scrutiny Committee was analysed through a review of the minutes.

> The Trust's slides for the presentation were attached to the minutes. They give an impression of an unrelentingly positive picture being portrayed, with the focus being on issues such as the precise make up of the FT governors and membership, as opposed to a consideration of any performance issues. (Francis, 2013b:343)

At a national level the Department of Health's (DH) positive expectations were questioned.

> Whilst this language emphasised that good financial management underpinned good care, it is worth asking whether the DH was demanding the impossible by suggesting such cuts could be made without impacting on services. In practice, there is little evidence to suggest the DH had any means of knowing whether or not this was the case. (Francis, 2013c:1277)

All three inquiries highlighted the strategic significance placed upon achieving Foundation Trust status.

> As with some of his (Mr Yeates) Board colleagues there is a suggestion that the application for FT status was a driver for improvement, rather than a benchmark to be obtained once improvements were in place and working. (Francis, 2010a:341)

These quotations illustrate the leader's predilection for initiatives (in this case Foundation Trust status). Dixon (1976) highlighted apportioning blame and identifying scapegoats as characteristics of incompetence, whereas the authors of the inquiries analysed here largely resisted scapegoating individuals.

> When examining what went wrong in the case of a systems failure as complex as that surrounding the events in Stafford, the temptation of offering up scapegoats is a dangerous one which must be resisted...There was a combination of factors, of deficiencies throughout the complexity that is the NHS, which produced the vacuum in which the running of the Trust was allowed to deteriorate. (Francis, 2010a:42)

That said there were systemic failures and the first volume of the Public Inquiry highlighted these.

> The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur, and even after the start of the Healthcare Commission investigation, conducted because of the realisation that there was a serious cause for concern, patients were, in my view, left at risk with inadequate intervention until after the completion of that investigation a year later. (Francis, 2013b:9)

This quotation suggests leader's failure to make adequate reconnaissance, at all levels of leadership. There were indications of leaders displaying a predilection for initiatives (frontal assaults) of which the following are illustrative.

> …the A&E Improvement project, which was initiated after the Healthcare Commission raised its concerns about the department. (Healthcare Commission, 2009:119)

> There does not appear to have been an evidence base for the changes that were made. The attraction of the advantages – the financial savings – discouraged proper attention being paid to the disadvantages. The EAU (Emergency Admissions Unit) was established as part of the first part of the reconfiguration project. Many who worked there regarded the level of staffing as inadequate, a view not shared by the Director of Clinical Standards. The surgical floor was set up without any evidence that a risk assessment of the necessary changes was actually carried out, although the need for it was recognised. Concerns expressed by staff at the time about the proposal were welcomed by directors but were not addressed. (Francis, 2010a:17)

> The Inquiry examined the clinical floors project and the Board's management of this issue. The Board approved this without an adequate examination of the implications. While placing reliance on the advice of the Executive Director who was the architect of the project, little attention was paid to any other opinion, and little attempt was made to engage front-line staff. (Francis, 2010a:21)

These initiatives also suggest leader's belief in strength (brute force) over cunning. Hospital leaders at different levels were overtly exercising power in different ways with regards to behaviours and decision making. Similarly, the boards of the Trust, Health Authority and regulatory bodies overtly exercised power. Decision making and non-decision making may be more covert, as illustrated by the Board of the Trust when it gained Foundation Trust choosing to meet in private.

In this analysis there is a danger in losing sight of the political context of what was/wasn't happening. In the Public Inquiry report there were footnote references to *Shifting the Power within the NHS* (Department of Health, 2001). As part of the NHS Plan significant shifts in commissioning were impacting upon Primary Care Trusts, NHS Trusts and Strategic Health Authorities.

Discussion - Leadership competence and incompetence

Our understandable human tendency to focus upon success, rather than upon failures is mirrored through disproportionate interest in the competence of leaders at the expense of understanding their incompetence. In their leadership literature review, commissioned by the NHS Leadership Academy, Storey and Holti (2013:22) identified the following required new behaviours '…including a willingness to show self-doubt at times and a willingness to acknowledge mistakes and a firm intent to address systematically ways to learn from these mistakes' (see also Storey and Buchanan, 2008). They cited the work of Tamkin et al (2010) into qualities of leadership, identifying three characteristics of outstanding leaders one of which was being self-confidently humble and having enough self-doubt not to become blinkered. In the previous section, events at Stafford Hospital were analysed using the leadership incompetence questions (Table 1) which it is now informative to contrast with the NHS Leadership Framework (see Table 2).

NHS Leadership Framework	Leadership Incompetence Questions
1. Demonstrating Personal Qualities • Acting with integrity • Continuing personal development • Managing yourself • Developing self-awareness **2. Working with Others** • Working with teams • Encouraging contribution • Building and maintaining relationships • Developing networks **3. Managing Services** • Managing Performance • Managing People • Managing Resources • Planning **4. Improving Services** • Facilitating transformation • Encouraging improvement and innovation • Critically evaluating • Ensuring patient safety **5. Setting Direction** • Evaluating impact • Making decisions • Applying knowledge and evidence • Identifying the contexts for change **6. Creating the Vision** • Embodying the vision • Communicating the vision • Influencing the vision of the wider healthcare system • Developing the vision for the organization **7. Delivering the Strategies** • Embedding the strategy • Implementing the strategy • Developing the strategy • Framing the strategy	1.Did the leaders cling to outworn tradition, failing to learn from past experiences/mistakes? 2.Did leaders reject or ignore unpalatable information? 3.Did the leaders underestimate the problem (enemy) and overestimate their own capabilities? 4.Were the leaders indecisive abdicating responsibility for decision making? 5.Were the leaders obstinate in their task, despite strong contrary evidence? 6.Did the leaders fail to exploit the situation, 'pulling punches', rather than going on the offensive (attack)? 7.Did the leaders fail to make adequate reconnaissance? 8.Did the leaders display a predilection for initiatives (frontal assaults)? 9.Did the leaders believe in strength (brute force) over cunning (clever ruse)? 10.Did the leaders fail to make use of surprise or deception? 11.Did the leaders seek scapegoats for set-backs? 12.Did the leaders suppress or distort performance information (news from the front)?

Table 2 - NHS Leadership Framework and the leadership incompetence questions

Source: http://www.leadershipacademy.nhs.uk/discover/leadership-framework Please note that the leadership framework is available at this URL, at the time of writing a new Healthcare Leadership Model was being disseminated which is also accessible at the same URL.

In Table 2, the first column is positive, competence focussed and looks to the future (development), whereas the more negative second column is incompetence focussed and critically reflects upon past mistakes. The NHS leadership framework prescribes what leaders should do, yet remains susceptible to the weaknesses of leadership competencies highlighted earlier (Bolden et al, 2006). Whereas the leadership incompetence questions inducted from military tragedies offer an alternative perspective upon events at Stafford Hospital. Leadership competence frameworks shape how we think about leadership, what we look for and where we look for evidence (Bolden and Gosling, 2006), whereas leadership incompetence questions as an alternative and post-heroic conceptualisation of leadership shift the focus and require the gathering of different evidence.

There has been a long history of attempting to improve NHS management and leadership (Kings Fund, 2011). The NHS leadership framework offers a compassionate account of leadership positively imagining a new NHS. However, in seeking to understand leadership within a healthcare context a very real need for compassion remains.

> The crucial point concerning leadership in healthcare settings is that leaders should seek to help create a climate which discourages the negative sets of emotions such as indifference and cynicism and encourages positive emotional sets such as compassion, commitment, empathy and optimism. (Storey and Holti, 2013:16)

This insight helps to make sense of the positive spin of NHS leadership language, particularly evident on NHS Leadership Academy web pages. The challenge is that reports of failures of leadership such as what happened at Stafford Hospital chime with broader critical leadership studies highlighting; narcissistic leadership (Maccoby, 2003), bad leadership (Kellerman, 2004), leadership pathologies (Kets de Vries, 2006) and a dark side of transformational leadership (Tourish, 2013). Leadership within a compassionate context needs to be sufficiently reflexive to address such critical leadership concerns without fuelling cynicism.

In the NHS leadership framework we see a change-focused account of leadership; we may even imagine a 'new NHS'. This postalgia of longing for a paradise yet to come can be contrasted with nostalgia which longs for a paradise apparently lost (Ybema, 2004), for example, returning to the days of matrons and starched linen. History tells us '…that people like to be inspired by the promise of a good prospect and by prophets who willingly show them the way to utopia' (Ybema, 2004:832). The NHS leadership framework offers that promise universally appealing to most of us as NHS users. Inquiries featured here into Stafford Hospital raise a different temporal dimension. Instead of overly optimistic postalgia or rose tinted nostalgia, Robert Francis QC repeatedly drew attention to the prevalence of the word 'hindsight'. As an antidote to excessively optimistic leadership, critical forward looking leadership has been encouraged by the King's Fund.

> Leadership development must not focus purely on technical competencies, but on the ability to create climates in which individuals can themselves act to improve services and care. Staff at all levels need to be given the skills to have the courage to challenge poor practice. (Kings Fund, 2011:30)

This discussion has focused specifically upon the contribution the concept of leadership incompetence could make as a counterbalance to overly optimistic NHS leadership, raising questions about the generic applicability of leadership incompetence.

Conclusions

Incompetence has been acknowledged as a minimally explored variable in organization theory (Ott and Shafritz, 1992) and more recently the lack of engagement with leadership incompetence has been highlighted (Diefenbach, 2013). However, potential research into and engagement with leadership incompetence has been eclipsed by excessive preoccupations with leadership competence (Hogan and Hogan, 2001). The persuasiveness of the competence refrain (Bolden and Gosling, 2006) made it difficult to disrupt current beliefs in the value and efficacy of competencies (Hollenbeck et al, 2006) and by association belief that leadership resides within a few special people.

Theories of leadership can be exceptionally obtuse and abstract from our lived experiences. In this sense extracting the learning from what happened at Stafford Hospital and Dixon's accounts of military disaster directly confront human consequences of incompetent leaders. These accounts are far more immediate, real, personal and disturbing than our typical academic abstractions. Through focusing upon incompetence, rather than competence, Dixon (1976) offered an alternative and provocative explanation for military disasters, explained through the repetitive patterns of behaviour of the generals. Military disasters which drove Dixon's (1976) analysis should never have happened, yet they kept repeating themselves over many decades. Similarly patterns of leadership incompetence were repeated at Stafford Hospital, with leaders at different levels failing to effectively address warning signs between 2001 and 2009. Robert Francis QC acknowledged the many times 'hindsight' was referred to in submissions to his inquiries and reminded readers also of its prevalence within the Bristol Royal Infirmary Inquiry (2001). The conclusions answer four significant questions:

- What is leadership incompetence?
- When is leadership incompetence visible?
- Are leaders conscious of their incompetence?
- What are the implications for leadership development?

What is leadership incompetence?

> The story of Stafford, as disclosed in the report of the first inquiry shows what can happen when there is a lack of competent leadership. (Francis, 2013d: 1589)

If competency is defined '…as an acceptable standard of practice and/or a behavioural predictor of improved performance' (Bolden and Gosling, 2006:150), lack of competence could be reversed to become an unacceptable standard of practice or a behavioural predictor of failure. Certainly, the current academic/practioner orthodoxy is to encourage/look for leadership competence and highlight in a manner similar to Robert Francis QC its absence.

The Stafford Hospital inquiries contained nine times as many references to competence as incompetence, these leaders were either competent or lacked competence. However, the danger in thinking about leadership incompetence as either the absence or opposite of leadership competence is that the five weaknesses of leadership competence (Bolden and Gosling, 2006) are replicated.

There is a human tendency to accentuate the positive, yet real learning potentially happens for us, when things go wrong. We assume that events at Stafford Hospital will be a catalyst for leadership development. However, Dixon (1976) induced from his analysis of military disasters generals repeatedly failing to learn from past experiences/mistakes, and this was echoed within the literature cited in this paper (Gabriel, 1992; Hogan and Hogan, 2001; Storey and Buchanan, 2008; and Storey and Holti, 2013). The last thing we need is a leadership incompetence framework; classifying, categorizing and defining leadership incompetence. As an alternative, the open leadership incompetence questions (Table 1) offer a means of beginning to understand and engage with leadership incompetence in very different settings, with different open questions having relevance to particular settings. There were similarities but also differences between the military disasters and what happened at Stafford Hospital. Leadership competency frameworks reassure us that this is what leaders are doing/and that they should be doing (Bolden et al, 2006). Engaging with leadership incompetence requires awkward open questions designed to provoke – lest we forget.

When is leadership incompetence visible?

Assessments/evaluations of leadership competence look hopefully to unknown futures in gauging how a leader might perform within a new role or within a new organization (see Holmes, 1995). Stafford health service leaders successfully convinced different regulators/evaluators of their visible leadership competence in order to secure Foundation Trust status, which was awarded on the 1st February 2008. Whilst, these judgements can be informed by historic information, particularly previous leadership experience, they remain expectations about leading within particular unique and evolving contexts, in this case a new Foundation Trust. The visibility of leadership competence appears to be prospective, whereas leadership incompetence appears to be retrospective. This is not to deny visible leadership incompetence as it happens, but that it is more visible with the benefit of hindsight (as highlighted by Robert Francis QC).

Health service leaders constant refrain was '…that no cause for concern was drawn to their attention, or that no one spoke up about concerns' (Francis, 2013b:47). We may also find that we perceive our own competence (certainly job/promotion application forms are predicated upon this), rather than our own incompetence. Leadership studies have been hampered by a disproportionate focus upon studying leadership at the expense of understanding followers and followership (Kellerman, 2008). Followers may be better able to identify leadership incompetence, rather than leaders themselves (see also Hogan and Hogan, 2001 and Diefenbach, 2013).

In this context, 360 degree feedback which Bolden et al (2003) found being used in association with leadership competency frameworks may be equally applicable for identifying leadership incompetence. A dilemma remains that as long as leadership competence frameworks remain in fashion they reinforce beliefs that leadership resides within a few key individuals undermining the potential agency within followers.

Are leaders conscious of their incompetence?

An adaptation of Broadwell's (1969) original differentiation between conscious/unconscious competence and incompetence is informative.

Conscious	Conscious leadership incompetence	Conscious leadership competence
Unconscious	Unconscious leadership incompetence	Unconscious leadership competence
	Incompetent	**Competent**

Table 3 - Conscious/unconscious – leadership incompetence (adaptation of Broadwell, 1969)

The two quadrants on the left hand side feature leadership incompetence. If leaders were consciously incompetent, this would suggest troubling leadership behaviours discussed earlier (Maccoby, 2003; Kellerman, 2004; Kets de Vries, 2006; Tourish, 2013) with leadership incompetence closely aligned with the dark side of leadership. However, neither in the case of the generals, nor NHS leaders was it possible to assert that the leaders were conscious of their own incompetence. If leaders were unconscious of their incompetence, this would result in same failings and tragic human consequences, yet imply that their actions were not premeditated. If this was the case leadership shortcomings could potentially be remedied through leadership development or new appointments. However, a similarity between Dixon's (1976) analysis of the generals and the NHS leaders was the reoccurrence of patterns of mistakes, suggesting something more systemic and more problematic.

What are the implications for leadership development?

As well as the normal reassuring dualism between competent leaders and leaders lacking competence, a problematic middle ground of incompetent leadership has been surfaced, with such leaders either conscious or unconscious of their incompetence. Traditional leadership development needs to be complemented by developing leaders in such a way that they can recognise incompetence ideally within themselves, but certainly within others. We all have weaknesses, as well as strengths, but 'happy talk' may obscure critical reflection upon leadership practices. Leaders need to be able to accurately benchmark themselves against other leaders and leadership in other organizations.

The Stafford Hospital inquiry reports are in the public domain, containing the testimonies of those who suffered and those who are still suffering, the goal is not forgetting what happened and extracting the learning, however uncomfortable. More broadly leaders need to look at incompetent leadership in other contexts, with Seeger and Ulmer (2003) encouraging leadership learning from the fall of Enron. The theme running through this paper has been leaders failing to critically reflect upon what was happening. Reflecting through the lens of leadership incompetence, whilst uncomfortable has the potential to encourage reflection-for-action (Thompson and Pascal, 2012). Critically reflective practice incorporates reflecting as a mirror does in order to look back on itself. The strength of Dixon's analysis was his encouragement for extensive and fruitful introspection (Penner, 1981). Competency based frameworks despite their limitations (Bolden and Gosling, 2006) are likely to remain the norm, but they could be counter balanced with encouragement to critically reflect upon what we lack, as well as, what we believe we possess.

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