"Ten Minutes with…. Tom Hurst, Medical Director, London's Air Ambulance"

1. First and foremost, are there any key leadership messages you want to get out to our readership?

   I think something that has served me well is the idea of positive regard, the assumption of positive intent. This particularly holds during a difficult period where people are under significant stress and strain and we don't always know what's going on for people in the other facet of their lives. This involves looking at behaviours or issues that are raised and asking yourself 'what's the most positive possible explanation for this?' and then assuming that's the case. Then you can explore it with them if you need to, rather than thinking 'They're a problem and they need to do what they're told.' That is something that has been useful for me during this...because it's all very easy to say 'don't overreact and keep calm,' but actually, what's the intellectual underpinning for that? One intellectual underpinning is you can't possibly know all of the what's going on in someone's head. You can't possibly know all the things that are relevant for that person. Everyone sees this as a major challenge we're all trying to do what we think is the right thing. Let's work with that as an assumption, that this makes sense for that person and that they think this is a helpful and positive contribution that they're making.

2. Tell us a little bit about your leadership role and how it is changing as a result of the pandemic?

   I started a new leadership role as the medical director for the air ambulance in January. I had a couple of months in the early phases of the role and I was busy doing the initial engaging and meeting people and building a team . Then in March the pandemic started to raise its head and it became increasingly clear we were going to have to respond to that. By mid-March I was heavily involved in working out what we were going to do. Although we've been quieter in terms of volumes of patients, we've still had very sick trauma patients. There's definitely been a requirement for the service to be there, and the leadership and management workload has gone up because of the need to respond to changing requirements coming up. These were principally around PPE and working practices, risk assessments, or decision-making about how we manage different groups of patients. For example, we've had to stop flying patients in the helicopters. We're using the helicopter just to take the team to the scene, which is mainly what we do anyway in London, but it's been an impediment not be able to fly patients. I've also been managing the team in terms of people's views on what we should be doing, what we shouldn't be doing, what the right balance is on different topics. In my other role as an intensive care consultant at Kings, it has been very busy. Kings is one of the biggest centres in South London, and South London has been one of the highest COVID-19 regions in the UK. Kings pretty much doubled its bed base over a few weeks. My role there was very different. I basically did my clinical shifts, and then I did some additional clinical shifts as we were all doing to support the service. But I realized because I have these air ambulance leadership responsibilities, I couldn't really dip in and out of leadership stuff at Kings. I very consciously decided to try and just be a follower there. I tried to just keep up to speed by reading emails and the daily bulletins, but otherwise just go in, do my shift, keep my head down, and not try and contribute too much to the tactical

and strategic decision-making that was happening because there are colleagues there who are excellent, and have that as their sole focus during the pandemic.

3. What events in your past experience are most informing your leadership in this pandemic?

   There's elements of the crisis that are like a more standard major incident, like a bomb or a big train crash. The time scale is very, very, different but the same principles apply. For example you have to put in place a command structure or a decision-making structure, and then you have to put in place a communication structure. The earlier you established that, and the earlier you established the tempo and get the tempo roughly right for the incident, then the sooner you're going to have a sense of control, accepting that the initial phase is always semi-chaotic. That's what I tried to do with the air ambulance. We put in place a daily WhatsApp group catch-up for the leadership team and we classified a level of strain from green to amber, red, and black. We had a daily four o'clock WhatsApp message from the chief pilot, the chief paramedic and so on just to say what the services were up to. I then sent a daily email out to the whole service saying 'Right, we are green here, but amber here, and these are some key points.' We tried to get into the rhythm of doing that, and maintained it for about the first month. Then a few weeks ago we stepped that down when we noted that actually the situation was much more stable. We're clearly on the downslope. People need to get some rest and recuperation. We don't all need to be WhatsApping each other on a Saturday afternoon if we're not otherwise at work. We stepped down to exception reporting, and then I or the clinical lead or the chief exec sends a weekly status update just say 'This is where we are, and thanks very much. Here's what we think is going to happen next week.' We've largely stepped our decision-making command structure back to normal. We normally have a weekly ops meeting and that's seems to be an adequate tempo now. So my previous experience of attending major incidents and learning about how major incidents are managed was applicable there.

4. What are you finding the biggest challenges?

   One of the big leadership challenges that I've had as the medical director of the air ambulance has been that we've been less busy. Major trauma’s fallen by about 40 percent during the lockdown. We've got a team of people who are passionate about what they do and who are used to responding to major incidents for whom my message has been 'We can't do anything really on COVID-19. But we have to keep the day-to-day service running.’ I think if the answer to the pandemic would have been, 'We're all going to work super hard for a week, and we're going to put every single team out that we can, and for a week we'll absolutely beast ourselves with back-to-back shifts treating COVID-19 patients,' then everyone would have been happy. Sadly there will still be interpersonal violence and there will still be road accidents, so we can't decommission the service for the duration and release the doctors and paramedics back to other roles. But for a number of people, there was a period where they were clearly desperate to do something that was directly contributory to the COVID-19 response, but there just wasn't anything that could be done. You have to convey 'We're one service. We treat about six people a day. There were 12,000 emergency 999 calls to the London Ambulance Service in a single 24-hour period.. If our teams are busy continuously, we can probably treat 12 patients in a 24-hour period. But it's

super hard for some people to not to be part of this response. It's been really difficult, without sounding slightly nihilistic, to convey the message that we actually need to focus on our core job, which is looking after trauma patients. They're still there. We're quieter and it's not busy and it doesn't feel super productive, but they're still there. They still need our help.

5. Any particular surprises?

   I was slightly surprised at how many people took a while to accept that the scale of the problem was such that we, as an air ambulance service, didn't have an prominent role to play that was directly focused on the pandemic. Also, we've had some arguments between a couple of the team There's this book called *An Astronaut's Guide to Life on Earth* (1). In it there's this wonderful phrase, 'expeditionary behaviours'—the sort of behaviours that keep people together in a team when they're on an expedition. It's actually really simple stuff. It's just that ability to recognize when someone's having a bad 10 minutes and make them a cup of tea, and to recognize that when you thrust a whole lot of people together for a protracted period of time, really little things will become areas of tension. You need to find ways to manage yourself and manage other people and resolve it. While in most cases on our team this has been the case, there have been some exceptions.

6. Are you seeing any behaviours from colleagues that encourage or inspire you?

   There has been lots of really good stuff. We are doing a review to think about our recovery, and recognizing that there are lots and lots of things which are good. We're using a 2 x 2 Matrix of good things and bad things that have started or stopped. For example there are some bad things that we've stop doing, and we should resist restarting them. There are things that we have started that we should reinforce or try and make routine. As a service, we've got people that come and do our ambulance shifts from different places. A lot of our paramedics live outside of the M25, so they come for that shift, but coming in for meetings or for debriefs is harder for them. Using things like Zoom has been good. We did a clinical governance day meeting for the whole team last week on zoom--it works really well. We're getting better attendance at some of those meetings than we did before. So that's been really good. The fact that people are in the main resilient and adaptive and finding ways around problems is really positive. The fact that we're able to identify some of the good things and say, 'we want to keep that' or 'let's do more of that' has been good. The crisis has actually brought the operational and the charity and fundraising side of the service closer together because, again, they used to operate on separate sites and now that we're doing Zoom stand-up meetings there's a bit more integration. There's just a general sense of the adaptability or indomitability of the human spirit... that there has been a huge amount of stuff going, but life goes on. The things that make us human and the bonds that connect us and the basic needs that people have are still there and find expression.

7. How are you maintaining kindness and compassion?

   One of the things I said to the team was how positive I thought it was that we kept, and in some ways almost enhanced our ways of actively reaching out to people after difficult jobs and making sure that people were okay, and were debriefed and supported. In some ways when you know that you're not going to run into them incidentally, it almost gives people

permission to be a bit more formal about it and to say, 'I heard there was a really bad job yesterday, do you want me to debrief it with you?' I think the positive intent stuff that I spoke about at the beginning has helped. That's been really helpful for me to just remind myself that everyone is trying to make their own way through this and that how it looks to each individual will be different. It helps me remind myself that the main thing is that we just need to be kind to each other through this difficult time and how we come out the other side of it will be largely down to how we've treated each other during it.

8. Are there any readings that you find helpful for inspiration and support that you would recommend to others?

   Compassion for other people starts with compassion for yourself. Last year I read quite a lot of stuff by Brene Brown (2)(3). She's written a lot on vulnerability and bravery and the impossibility of having compassion for people if you don't have compassion for yourself. She writes about the impossibility of having compassion if your response to threat is to develop armour. She's got this lovely metaphor about the extent to which people armour up to protect themselves because they think it will make life easier. Then every time they get hurt they add an extra bit of armour until the point where they're just carrying so much armour that just walking through life is exhausting. Brene Brown is brilliant. She's an academic social worker and started out wanting to research connectedness, but couldn't really find a cohesive theory. She then started working around shame, which she defines as the pain of feeling unworthy of connection. She built from there this very compelling narrative about how fundamentally, if we're unacceptable to ourselves and we fear disconnection from other people, then that drives a whole host of addictive and pathological and dysfunctional behaviours.

9. What are you looking for **from** your leaders?

   It is a different in the two roles. In my Kings role, I've found it relatively straightforward. I've got a clear to job to do being the ICU consultant on call, and more than ever I just need to run my unit and when someone rings me up and says there's a patient coming I just say, 'Yes, fine. Tell me what I need to know about them and what you want me to do.' What I want from operational leaders is basic, timely, concise, helpful communication. Stepping into the medical director role has been really interesting because I have a chief executive and a board chairman and then other trustees on the board. What I'm looking for there is very different. That's really about development and an opportunity to flourish in that role. I want to have quite a lot of autonomy, and to be able to lead the service and evolve the strategy, and for the interactions with my leaders there to be supportive and formative. I want to be able to benefit from their experience but not in a way that's directive or didactic

(1) Hadfield, C. (2013). *An astronaut's guide to life on Earth*. Toronto: Random House.

(2) Brown, B. (2015). Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead. Penguin.

(3) Brown, B. (2017). Braving the wilderness: The quest for true belonging and the courage to stand alone. Random House.

Biography: Tom is a consultant in pre-hospital care at Bart's Health and consultant in intensive care medicine at King's College Hospital. He trained predominantly in Greater Manchester before undertaking a secondment to London's Air Ambulance in 2008. He is the medical director of London's Air Ambulance.