

## 1 GROUND MANOEUVRE SURGICAL GROUP (GMSG) DEVELOPMENT – LESSONS FROM THEATRE ENTRY

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In 2017, conceptual work began to develop a Role 2 Forward Surgical Capability (FSC) that could be rapidly deployable and manoeuvrable, modular and scalable, delivering Damage Control Resuscitation, Surgery and critical care patient hold. This developmental work was underpinned by lessons from other United Kingdom (UK) Role 2 light manoeuvre capabilities and exercising with a similar French capability. To standardise UK military medical descriptive nomenclature, direction was given to replace FSC with the term Ground Manoeuvre Surgical Group (GMSG).

In Autumn 2019, 34 Field Hospital were tasked with delivering a GMSG the following year, supporting a 250-strong Long Range Reconnaissance Group (LRRG) provided by the UK, contributing to the United Nations Multidimensional Integrated Stabilisation Mission in Mali (MINUSMA).

Initial planning guidance was to expect long range patrols in a desert environment for four to six weeks duration with no or minimal resupply. Mali has ambient day time temperatures more than 40°C enduring for most of the year. This was judged likely to have significant impact on the safe storage of blood products and components, as well as temperature sensitive drugs while mobile on long range patrols. Existing in-service cold storage equipment was not designed to be operated while mobile nor to operate in a high ambient temperature, risking failure.

An innovative integrated temperature control solution was ultimately fielded, consisting of air-conditioned tentage, extended life cold boxes and a power solution to ensure cold box plates could remain frozen in a freezer while mobile on patrol. The integration of these capabilities led to successful delivery of medical support to the LRRG.

## 2 COMBINING MEDICAL FORCE ELEMENTS INTO A MEDICAL GROUP IN MALI: RECOMMENDATIONS FROM OPERATION NEWCOMBE, MALI. AN OPINION PIECE

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**Background** Op NEWCOMBE was the UK contribution to the UN Mission in Mali (MINUSMA) between 2019 and 2023. The UK deployed a Role 1 capability, a small surgical capability (Ground Manoeuvre Surgical Group) and Task Force Headquarters medical subject matter experts for a population at risk of ~300. Over subsequent deployments the Medical Group concept developed with the aim to optimise capability and resource, combining into one sub-Unit.

**Observations** Combined operation established a clear chain of command, provided learning opportunities, and enhanced the provision of care available, whilst generating resilience. The Role 1 was able to operate at an increased capacity: >1000 patient consultations over 6 months, mass vaccinations and disease outbreak management. Duplication of assurance,

governance and pre-deployment training was reduced. Patients benefited from in Theatre access to imaging, laboratory tests and consultant specialist advice, with early identification of replacement force generation requirements. The combined approach allowed rapid reaction to emergencies or periods of increased medical workload. During three of the five rotations, significant UK and international incidents were managed throughout the patient care pathway utilising the entirety of the Medical Group.

**Conclusions** Future deployment models should consider this force enabling approach in the planning, force generation and deployment phases for new Operations.

Early identification and adoption of a Medical Group composition ensures pre-deployment risks can be identified and mitigated early, team cohesion can be generated, duplication of training and governance can be prevented whilst optimising the provision of deployed care.

## 3 MANAGEMENT OF A MAJOR MEDICAL INCIDENT – A MULTI NATIONAL CHALLENGE

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Major Medical Incidents on deployed operations are increasingly likely with the utilisation of small DHC facilities with limited clinical personnel and resources. In June 2021 a Suicide Vehicle Borne IED was detonated against a DEU call sign resulting in 13 casualties. A multinational response working from the DEU Role 1+ facility was undertaken and personnel from the DEU, UK and SWE formed 'Flash' teams and utilised senior clinical SMEs to deliver care to all 13 patients, 9 directly from the incident and 4 after initial treatment at FRA and CHN facilities. 6 surgical cases were performed over 15 hours along with 2 critical care transfers being undertaken. There were no fatalities and all casualties were repatriated in a stable condition to allow immediate reconstruction.

The success of this undertaking was due to the acceptance from all of 'Right Person, Right Role' regardless of service or nationality. Recognising operational and clinical experience, combined with a shared approach to casualty management requires an adaptable mindset in order to find the best ways to deliver casualty care.

From this incident a number of key learning points were recognised:

- Have a plan, but be prepared to adapt it as the situation changes.
- Early meetings and understanding of other nations capabilities is key to being able to create multi-national flash teams with the right skill compositions.
- Have equipment, medications and blood stored together and ready to deploy at short notice.
- Be able to adapt and utilise other nations equipment and medications.
- Always re-review the patients and re-prioritise as required.
- It is not over until all the patients have been evacuated and the equipment and personnel are reconditioned.