

CJTF6 – RC(S) – POST TOUR REPORT – MEDICAL

10 Oct 2010

References:

- A. Annex XX to COMISAF OPLAN 38302 Rev 3 dated 01 Jun 09
- B. ACO Directive 83-2 dated 29 Mar 10 – Allied Command Operations (ACO) Guidance for Military Medical Services involvement with Humanitarian Assistance and Support to Governance, Reconstruction and Development.
- C. HQ ISAF/SOP/01154 dated 28 Jul 10 – ISAF Guidance on Military Medical Engagements in Health Sector Reconstruction and Development.

INTRODUCTION

1. This post-tour report covers the roles of the ISAF medical component within RC(S) for the period 1 Nov 09 – 1 Nov 10. In accordance with Reference A, the medical function has 3 tasks:

- a. The provision of health service support to entitled populations
- b. Supporting the development of Afghan security forces medical services
- c. Supporting the development of the Afghan civilian health sector by the government of Afghanistan, international agencies (IAs) and non-governmental organizations (NGOs).

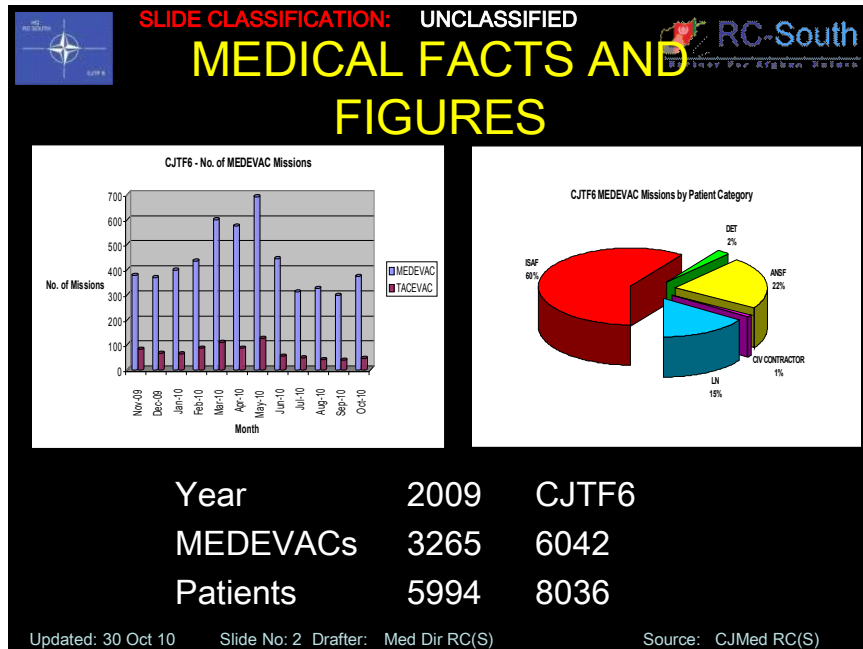
2. From the outset, we took a combined team approach to caring for casualties of conflict that linked Afghan civilian, ANSF and ISAF medical forces into a single unified plan to care for Afghan civilians, ANSF and ISAF casualties. Thus CJMed set out to be fully partnered with the Afghan health sector from the outset of the tour.

Lesson: the medical function in COIN operations should always be assumed to have the 3 tasks listed above and be planned to be partnered with indigenous security forces medical services.

MEDICAL OPERATIONS

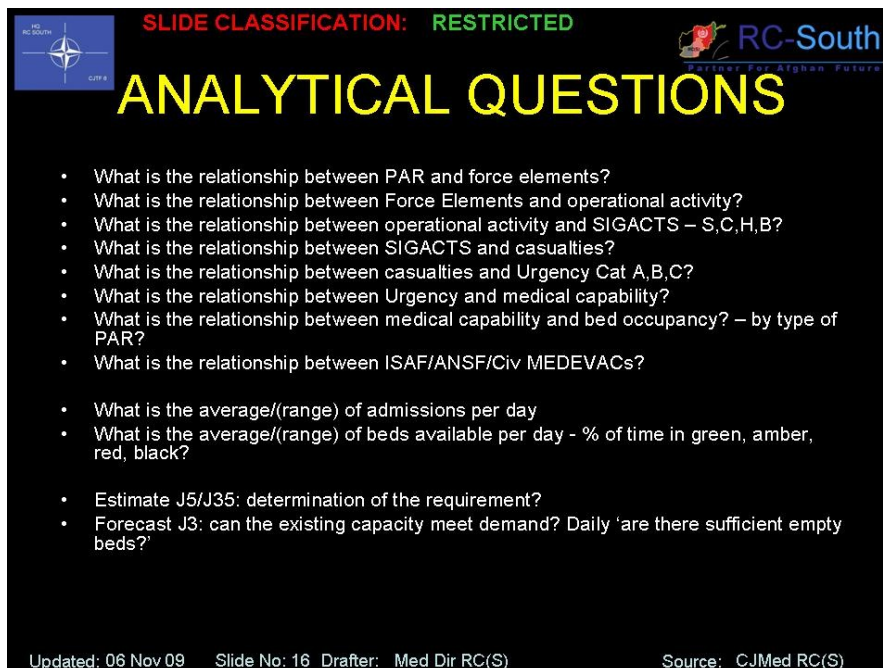
3. **Medical Activity.** RC(S) has been responsible for the largest population at risk of a UK 2* HQ since Korea. At peak, CJMed RC(S) oversaw the function of 3 Role 3 and 3 Role 2E hospitals, 8 MEDEVAC tasklines and 5 types of FW TACEVAC. During the tour the RC(S) CJMed managed the MEDEVAC of 8036 casualties compared with 5994 for 2006. The monthly distribution and patient type of this workload is shown below.

Figure 1 – Medical facts and figures



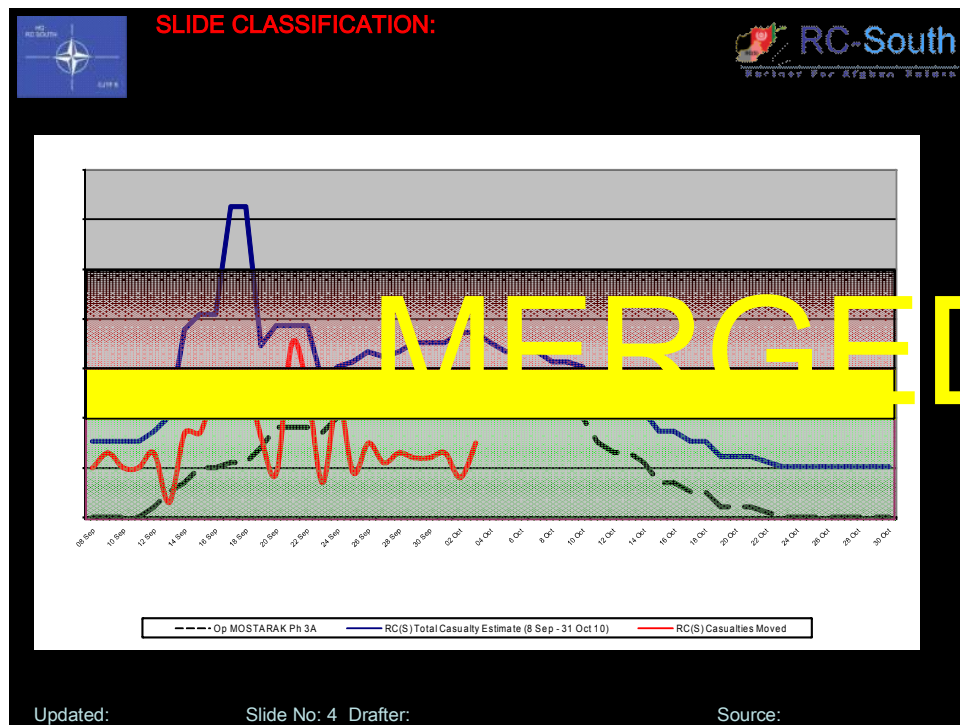
4. **Medical Planning.** CJMed supported the major planning cycles as described in the main body of the CJTF6 POTR. Whilst we attempted to use NATO medical planning processes, none of our higher or subordinate formations used any comparable planning sequence. The casualty estimate and the medical resource analysis are the two essential elements of the analysis for the medical support plan. In the absence of any NATO or ISAF approved casualty estimation methodology, RC(S) developed the analytical sequence shown below supported by contemporary data collected from operations in RC(S).

Figure 2 – Casualty Estimate/Medical Resource Planning Analytical Sequence



5. **Casualty Estimation.** This was then linked to an assessment of the capacity of the medical system based on a resource utilization model derived from an analysis of the US Joint Theatre Trauma Registry data. This provided planning factors for surgical procedures and length of hospital stay for each population group (ISAF, ANSF, Afghan civilian and detainees). The accrued result of this analytical experience is shown on the slide below that was used to illustrate the medical support requirement for HAMKARI Phase 3. The actual casualty rate is also plotted – showing the fact that SIGACTs were substantially less than predicted for both the Afghan parliamentary elections and then the peak of HAMKARI Phase 3A.

Figure 3 - Casualty Estimate and Actual Casualties – HAMKARI Phase 3A



Lesson: a methodology for casualty estimation/medical resource planning for COIN operations based on accrued experience from Iraq and Afghanistan is required

6. **Medical Evacuation.** The Patient Evacuation Control Cell (PECC) in the RC(S) Combined Joint Operations Cell was the hub for control and co-ordination of medical evacuation. This required a PECC with 24 hour manning for a minimum of an officer and a NCO with operations and clinical experience under the control of an OC. At times this went up to 3 watchkeepers. RC(S) PECC controlled 3 types of RW MEDEVAC capabilities: US Army UH-60A, USAF HH-60 and UK CH-47 MERT. It also tasked 5 types of FW aeromedical evacuation aircraft: UK C130, USAF C130 tasked using TRAC2ES, USAF HC 130 tasked via '9 liner', DEU C160 and Afghan Air Force AN 22. Each is different in capabilities of the aircraft and the medical resources. During the tour the US Army deployed an additional 15 MEDEVAC aircraft to RC(S)/RC(SW) and we developed a new concept for in-flight RW TACEVAC medical escort using ICU staff. The USAF deployed a Contingency Aeromedical Staging Facility (CASF) with supporting

aeromedical evacuation (AE) crews and critical care air-transport teams (CCATTs) split between the UK Role 3 at Camp BASTION and the KAF Role 3. This split was a new USAF concept.

Lesson: the PECC function needs to be properly resourced in the HQ controlling medical evacuation.

Lesson: RW TACEVAC is a separate task to RW MEDEVAC and requires designated aircraft and medical escorts.

7. **Hospital care.** At peak, RC(S) controlled 3 Role 3 hospitals and 3 Role 2E hospital facilities. This required detailed knowledge of the clinical capacities and capabilities of each facility plus an understanding of medical resource planning to balance resources between facilities. During the tour the KAF R3 moved from a temporary facility (that had been in use for 4 years!) to a sophisticated, NATO common-funded, enduring facility. Additionally the US Army deployed 31 Combat Support Hospital (CSH) to FOB Dwyer in South of HELMAND. This was the first tented US CSH since Iraq 2003. We also surged medical resources to Role 1 to mitigate MEDEVAC delays due to weather and between Role 3 facilities to adjust for expected casualty demand.

Lesson: military medical planners need to have detailed knowledge of the organization and employment of hospital capabilities.

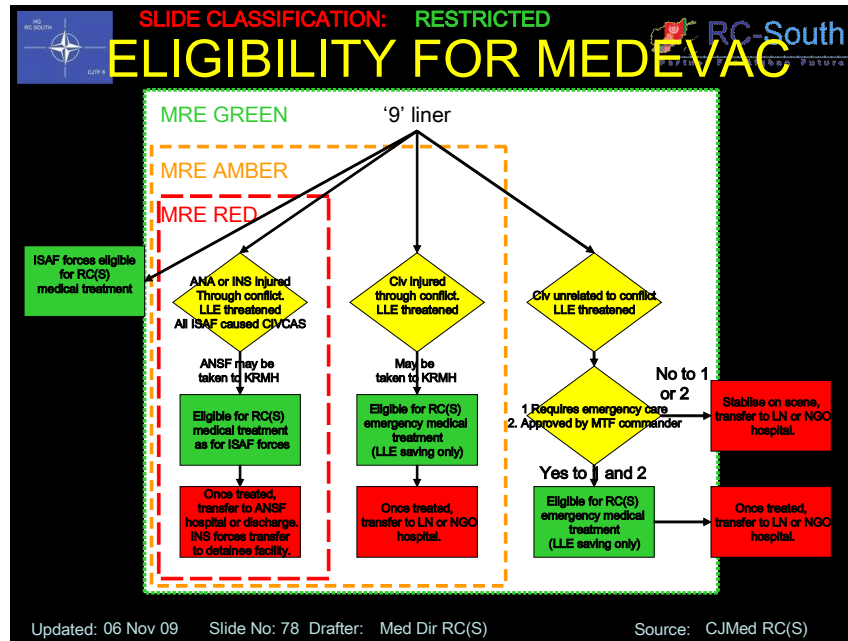
Lesson: the medical function needs an identified reserve than can be assigned between medical units to match predicted casualties flows.

8. **Medical Situational Awareness.** It is essential that the Medical Director is able to monitor the status of the medical system in order to regulate patient flow. RC(S) developed a daily medical situational briefing slide that evolved into an IJC directed medical common-operating picture (MEDCOP). This was supported by a weekly medical reporting cycle based on Medical Situational Reports from subordinate Task Forces and Role 2/3 units that was combined into a RC(S) MEDASSESSREP. JFC-B developed an excel-based reporting framework that imported subordinate reports into an aggregated ISAF MEDASSESSREP.

Lesson: medical reports and returns need to be designed to provide sufficient medical situational awareness for medical commanders to control the medical force.

9. **Medical Rules of Eligibility (MRE).** The capability of host nation medical care available is below that of NATO member nations. As such, there is a tendency on humanitarian grounds for ISAF MTFs to treat local nationals (LNs), even when their injuries are not a result of military operations. Medical Rules of Eligibility (MRE) were established to ensure that the instinctive desire of ISAF health care providers to help LNs is balanced against operational requirements to maintain capacity in support of ISAF personnel. MRE were refined during the tour in order to achieve this balance. The slide below summarises the decision flow for MRE for MEDEVAC and admission to MTFs.

Figure 4 - Medical Rules of Eligibility



10. **MRE states.** There were occasions when the MRE had to be constrained because of predicted or actual demand on ISAF medical facilities. The constraints were termed 'MRE States' and shown below:

a. **MRE GREEN.** The normal state. The MRE GREEN algorithm enabled LNs requiring LLE-saving treatment to be treated by the ISAF military medical system. Admission was assumed and managed by the RC(S) PECC.

b. **MRE AMBER.** A more limiting state was used to reserve capacity for ISAF/CF personnel. MRE AMBER constrained the eligibility of LNs to only those requiring LLE-saving treatment due to conflict-related activity. LNs requiring LLE-saving treatment due to reasons *unrelated to conflict* did not have access to the military medical system unless explicitly agreed by the MTF commander. MRE AMBER was called in two instances: first, when predicting an overwhelming demand on ISAF MTFs with ISAF/CF and MRE-eligible LNs (i.e., injured as a result of conflict-related activity); second, when, during operations, a situation develops where there is an acute shortage in capacity and there is a requirement to reserve room for expected ISAF/CF casualties.

c. **MRE RED.** MRE RED was used when ISAF medical facilities were at BLACK (100% occupied) and it was not possible to accept civilians into the ISAF medical system.

Lesson: the military medical plan requires a system of MRE to regulate access of local nationals into the medical system.

11. **Continuous Improvement in Health Support to Operations (CIHSO).** Allied Command Operations (ACO) directed the introduction of a process for the assurance of the quality of health support to operations (CHISO). RC(S) has been the pilot for this process through the establishment of a formal three weekly Medical Executive Board.

This is attended by all of the commanders of medical units in RC(S) plus the Task Force Medical Advisers/Surgeons. This meeting reviews the performance reports for medical activity (MEDEVAC, TACEVAC, out-of-standards MEDEVAC mission reports, MEDINCREPs, disease outbreak reports), reviews the medical support plan for current and future operations and receives back-briefs from all attendees. This meeting is minuted and shared with national and ISAF chains of command.

Lesson: medical services require a system of assurance in order to assess the performance of the medical system.

SUPPORTING THE DEVELOPMENT OF THE AFGHAN NATIONAL SECURITY FORCES (ANSF) HEALTH SYSTEM

12. **Situation.** ANSF were unable to presently meet mission objectives without the use of ISAF medical resources. In general, medical elements were undermanned and suffered deficiencies in the areas of governance, training, logistics and personnel. With respect to ANP, there was virtually no visibility on their manning or capabilities. They lacked effective mentoring/partnering and were completely dependant upon the ISAF or Afghan civilian medical systems for effective casualty management. Other challenges include, but are not exclusive to, individual & collective training, class VIII logistic procurement, and lack of incentive pay initiatives and other basic leave entitlements.

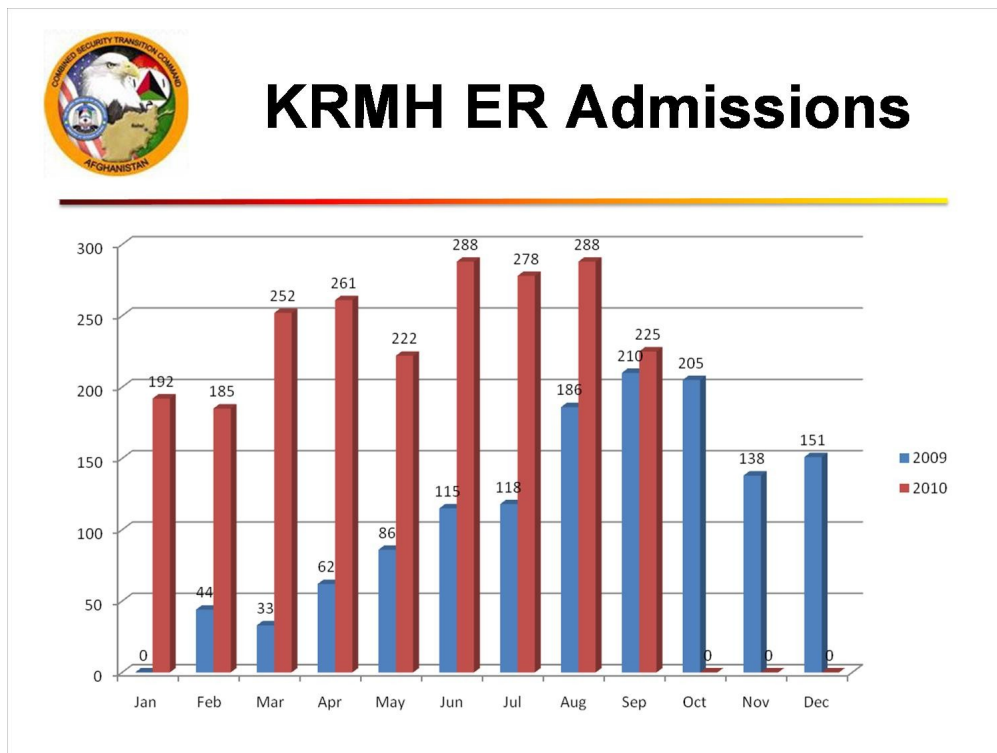
13. **ISAF/IJC perspective.** The development of ANSF capabilities is the key to transition from ISAF to ANSF lead for security and the reduction in ISAF force levels. In 2009 CSTC-A withdrew from delivery of US mentoring activity at Corps and below leaving this to IJC and deployed units. This substantially reduced the number of mentors but this was compensated by the adoption of partnering, whereby ISAF units linked directly with ANSF units in the same battlespace. This was not reflected in the medical arena leaving a significant gap in development of ANSF capability at the tactical level. There was also a significant policy void between NTM-A engagement with the ANA and ANP Surgeons General and the force development of fielded ANSF medical forces. By the end of the tour, IJC had agreed to take a theatre view on ANSF health sector development at the operational and tactical level. This was to include the development of a framework for tactical ANSF health sector development activities including an agreement that these would be reported to the RC.

14. **RC(S) perspective.** Within RC(S), we tried to make TF MEDADs responsible for oversight of ANSF health development activities in their AOs. This had variable results dependant on individuals and also national perspectives on the use of their medical for ANSF development. In addition there were NTM-A owned medical resources operating in the RC(S) battlespace without clear accountability to regional priorities. Initially the responsibility for ANSF health development lay with the SO1 Health Adviser in Stability Division as there was no other person available. It became clear that this function required a dedicated staff officer detached from the CJMed Branch into ANSF Development. This was achieved with the arrival of an AUS WO but really required a staff-trained officer.

Lesson: the development of the indigenous security forces medical system requires a minimum of one dedicated staff officer in a 2* HQ.

15. **Kandahar Regional Military Hospital (KRMH).** This is the hub of ANSF medical support for both RC(S) and RC(SW). By the end of the tour, this was the preferred receiving hospital for all ANSF and civilian casualties covered by the ISAF Kandahar MEDEVAC range ring and for all ANSF TACEVAC in the South. It was agreed that KAF R3 would be the partnering unit to KRMH with multiple clinical exchange programmes running between the facilities. The main constraint on development was the failure of ANA OTSG to increase the ANA medical staff to match the increase in clinical workload. The graph below shows the increase in admissions to KRMH in 2010 compared to 2009.

Figure 5 - KRMH Admissions to Sep 2010



16. **ANA TACEVAC.** Considerable progress was made over the year to improve TACEVAC of ANA casualties from KRMH to the National Military Hospital in Kabul. We closed the tour with a weekly flight by an Afghan Air Force (AAF) AN-22 with AAF medical staff with USAF mentors. This was achieved through persuading IJC to host a virtual ANSF TACEVAC co-ordination workgroup, supported by a similar workgroup at RC(S), and aggressive mentoring and partnering engagement between RC(S), AAF medical mentors, KRMH mentors and 451 Expeditionary Aeromedical Evacuation Squadron. The picture below shows one of these TACEVAC flights.

Figure 6 - AAF TACEVAC



17. **205 (HERO) Corps.** From the start, RC(S) CJMed set out to partner with both the 205 (HERO) Corps Surgeon and the CO of KRMH. We supported the medical planner in the Corps Surgeon's officer to be able to brief the medical plan at each of the formal Afghan orders briefings. This was only possible because of the re-assignment of an AUS medical services officer from an administrative role to become mentor to the 205 Corps surgeon. We worked together to ensure that a coherent request for augmentation of ANA medical staff for OP MOSHTARAK and HAMKARI was submitted via ANA, ISAF and NTM-A command chains and reinforced all the way to the Afghan MOD.

Lesson: medical mentors are essential to the development of medical staff capacity in formational HQs in the ANA.

18. **Realities of manning.** In spite of our effective staff engagement, the reality is that the ANA created a new Corps (215 Corps) in RC(SW), a new brigade in 205 Corps and deployed 3 external Kandaks for HAMKARI Phase 3B without any increase in ANA medical staff to support the theatre Main Effort. In spite of considerable investment, there has been no net increase in doctors nor medics in the ANA due to desertions and refusal to serve in the South. ISAF underwrote all of this risk through MEDEVAC and hospital capacity at KAF R3. The table below shows the manning for the ANA medical system in RC(S).

Eff Aug 2010 UNIT	% STAFFED		
	OFFICER (Physician)	MEDIC (Soldier + NCO)	TOTAL
205 Corps HQ COY	0%	100%	67%
Garrison Clinic	64%	50%	61%
1 BDE	50%	60%	59%
2 BDE	46%	54%	53%
2 BDE TMC	45%	50%	52%
3 BDE	7%	21%	19% *
3 BDE TMC	0%	0%	0%
4 BDE	43%	33%	34%
4 BDE TMC	36%	50%	39%
Totals	38%	42%	41%

1 CDO (HERO)	50%	83%	78%
2 CDO (?)	75%	96%	93%

Lesson: if development of the medical services for the ANA does not occur at the same pace as combat forces, ISAF will have to underwrite the risk.

19. **Partnering to improve Afghan clinical care.** It was essential that the ANA medical personnel who were present were able to provide the best possible quality of clinical care to ANA personnel. TF Strike led RC(S) in proving that partnering at the tactical level (Regimental Aid Posts and ‘dressing stations’) could provide an apprenticeship type of coaching for ANA medical staff. This made a substantial difference in the performance of ANA medical staff and provided a strong incentive to draw them away from Camp HERO and into partnered FOBs. This is illustrated in the picture below:

Figure 7 – An ANA Medic caring for an ANA soldier under ISAF observation



Lesson: medical elements of partnered forces should partner Afghan medical personnel.

SUPPORTING AFGHAN CIVILIAN HEALTH SERVICES DEVELOPMENT

20. ACO and HQ ISAF developed clear policy guidance for ISAF engagement in the Afghan civilian health sector (References B and C). RC(S) intimately influenced these policies and was widely recognised as leading by example. The UK has had responsibility for fill the RC(S) Stability Division Health Adviser since 2006. This CJTF6 tour was the first time the UK nominated individual was properly trained for the role and had a tour length that was long enough to make a difference.

Lesson: in COIN operations a 2* HQ should have a civilian health sector SME within the Stability Function.

21. In RC(S), each province (less Day Kundi) has a Provincial Reconstruction Team (PRT) Subject Matter Expert (SME) member who is directly responsible for the provision of advice and co-ordination of health system development. Where District Stabilisation Teams (DSTs) or Battle Space Owners (BSOs) identify potential health development projects they were directed to discuss their ideas with health development Subject Matter Experts (SMEs) before making any promises or conducting and development activity. Previous experience had shown that BSOs were unaware of Provincial Directors of Public Health (DoPH), their Basic Package of Health Services & Essential Package of Hospital Services health providers, financial donors and PRTs development plans. BSO unilateral activity such as donating medical supplies or providing direct medical support (sometime referred to as a MEDCAP or MEDRETE) had the potential to skew healthcare markets, undermine confidence in local providers and disrupt development plans. RC(S) directed that PRT health development team must be the first point of contact for all BSOs when considering civil sector health initiatives.

22. Inadequate availability of and obstructed access to health services are often a key grievance. At first glance military units may believe that the solution is MEDCAPs and building clinics, and as a result, the construction or refurbishments of BPHS facilities or schools are often selected as PRT development projects. However it should be noted that buildings are not health capabilities and the military role in improving access to health services should be considered within the wider 'Shape-Clear-Hold-Build-Transfer' (S/C/H/B/T) construct. The end state is the Afghan Government delivering health services to the Afghan population without any form of external assistance with a District and Provincial Health Sector plan. From this end state TFs should then work backwards from Transfer/Build to Hold to Clear to Shape. This is illustrated in the slide below.

Figure 8 – Supporting Civil Health Development



23. **Build and Transfer.** Ideally there would be no international military medical engagement during the Build and Transfer phase because the implementation of the District Stabilisation Plan would have been handed back to civilian leadership. In reality, there should be continuing dialogue between all health sector stakeholders to ensure co-ordination and co-operation. There may be scope for the international military medical community to continue to assist the civilian health sector through training and education programmes, access to capital investment or other capacity building activities.

24. **Hold.** During the Hold phase, there may be a gap between the imposition of military control and the ability of the civilian sector to establish routine medical services. During this period it may be necessary to provide access to healthcare using temporary, mobile services. Ideally this should use civilian capacity agreed upon with the Provincial Director of Public Health during the planning in the Shape phase. Medical care should always be planned in reverse from an end state of MoPH provision to the current situation; the purpose being that medical engagement by non-civilian health actors should only be considered as a stepping stone to endstate transition. Where civil sector delivery can not be immediately achieved, a sliding scale from right to left being MoPH, NGO, ANSF and as a last resort ISAF as health providers can be considered. There is a symbiotic relationship between security conditions and health provision deliverer. Given the improving security situation all operations should be partnered, the far left option of an ISAF-only delivered MEDCAP or MEDRETE should now (after 9 years of operations) be redundant.

25. **Clear.** The focus of this phase is the emergency care of casualties from conflict. Close co-operation across the health sector is required to ensure all casualties are transported to the most appropriate health facility for both immediate and long-term care. An example was the facilitation of safe passage of war wounded across military lines as brokered by the ICRC during OP MOSHTARAK in Feb 2010. This generated discussion over the authority of both international forces and Afghan forces to screen these casualties to identify wounded insurgents. It was emphasised that all casualties have right of access to medical care independent of allegiance but Afghan security forces have the authority to detain them whilst in medical care for further investigation. It may be necessary to provide military support to the provision of emergency medical supplies to the civilian sector, ideally by assisting with the transport of previously earmarked resources or by 'in extremis' emergency donation.

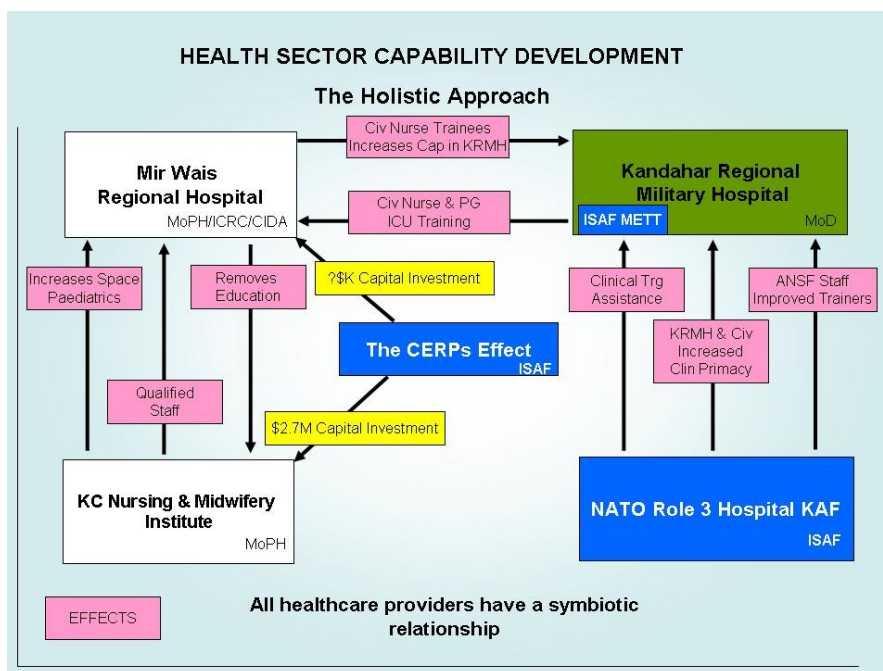
26. **Shape.** Military medical representatives should be actively engaged with representatives from the indigenous health sector during the formulation of the District Stabilisation Plan. At the local level, this ensures that the location, capability and capacity of the civilian health facilities are known and that this information can be compared with the reported community's grievances. It may be appropriate to use military transport (e.g. helicopters) to assist Afghan or international civilians to visit Districts in order to conduct 'health shuras'. The most important outcome is to agree the roles and responsibilities for the management of civilian casualties that may occur during the surge of security operations during the Clear phase.

Lesson. The provision of access to health care is an essential basic service. For stability operations the SCHBT construct should be planned 'backwards' towards the endstate of Afghans providing for Afghans within a regionally appropriate resource model.

27. **RC(S) Civil Health Sector Signature Projects.** At the RC(S) we established 2 signature projects; the building of a replacement for the Kandahar Nursing and Midwifery School and the development of the Kandahar civilian ambulance service.

a. The Kandahar Nursing and Midwifery School represented the largest capital investment (\$27.7M) in the health sector in the South since the 1970s. It was a true capability development project by allowing the relocation of the existing school from the Mir Weis civilian hospital thus freeing up space for the creation of additional space for a paediatric ward that the ICRC had agreed to fund. The additional nursing staff could then be supported in their education through attachments to KRMH for educational activities supported by the KAF R3. These inter-relationships are summarised in the slide below.

Figure 9 – Health Sector Capability Development



b. The requirement to enhance the civilian ambulance system within Kandahar City emerged during the medical combined planning for HAMKARI. This was broken down into the following projects: C2 and communications, ambulance vehicles, medical supplies and medical training. This holistic programme required the MoPH, ANP, ANA, ISAF and ICRC to collaborate thus building the collective team into an integrated emergency planning system. This team-building will be the main outcome of this programme.

FORCE HEALTH PROTECTION/PREVENTIVE MEDICINE.

28. **Medical Intelligence (Med Int).** This is a key function that provides an assessment of the risk of identified threats to health impacting on the force. In the second half of the tour, CJMed placed a Med Int officer into CJIATF. This proved a valuable resource to follow-up asymmetric threats such as deliberate poisoning of an ANP checkpoint and a vulnerability assessment of the ISAF food and water procurement

chain. The relationship between CJMed and CJ2 was not fully exploited during the CJTF6 tour.

Lesson: NATO and the UK need to properly develop the linkage between CJMed and CJ2.

29. **Preventive Medicine (Prev Med).** There are two key Prev Med issues: health surveillance and disease outbreak reporting.

a. For the first time in the ISAF mission, RC(S) demonstrated that it was possible to achieve sufficient compliance with the NATO EpiNATO health surveillance system by nations to establish a reliable multi-national health surveillance system. However the EpiNATO system needs refinement based upon operational experience by both NATO and the UK.

Lesson: the UK and NATO need to refresh the EpiNATO health surveillance system based upon ISAF operational experience.

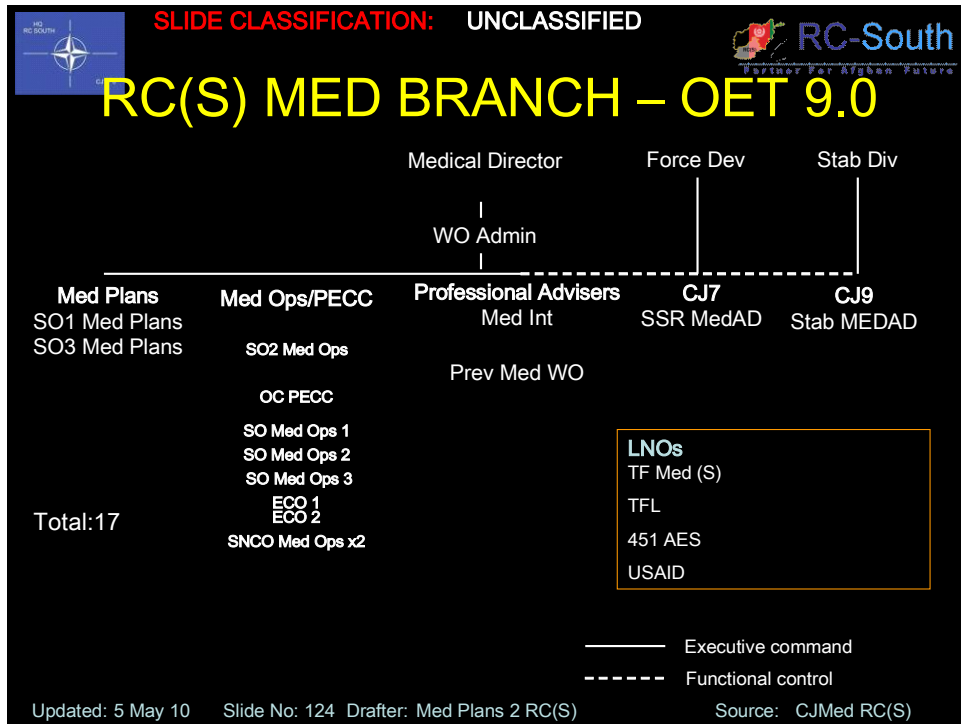
b. The management of reported outbreaks of disease and sharing of information by nations remains very poor. Approximately bi-monthly there were significant outbreaks of disease in RC(S) that were inadequately followed-up by nations leading to inconclusive investigations and consequently inadequate results for sharing between nations.

Lesson: both the UK and NATO need to refresh the management of outbreaks of disease on operations in order to improve national and multi-national response.

WIDER CJMED LESSONS LEARNED

30. **Organisation of CJMed Branch in 2* HQ.** This tour confirmed my experience from my tour as Medical Director in HQ ISAF in 2006/07. The CJMed Branch needs to be established in 5 separate cells: Medical Plans, Medical Operations, Professional Advisers, ANSF Development and Civil Sector Development. The PECC sits within Medical Operations. The overall manning is around 17 people dependant on the exact requirement. This is substantially more than the current manning in the Medical Branch of either HQ 1 (UK) Div or HQ 3 (UK) Div. The CJTF6 CJMed Branch structure and establishment is shown below.

Figure 10 - CJTF6 CJMed Branch Structure and Establishment



Lesson: the medical branches of 1 (UK) Div and 3 (UK) Div would require substantial increase to deliver the outputs of a CJMed Branch in a COIN operation.

31. **External Engagement.** Under NATO doctrine, the resourcing of medical support is a national responsibility. However the NATO commander shares the responsibility for delivering medical support on operations with national commanders. Therefore the Medical Director needs to influence both NATO and national medical staffs in order to ensure the NATO operation is properly resourced, especially if the plan required a collective contribution by the troop contributing nations (TCNs). This requires the Medical Director to have both sufficient rank (Col/OF-5/US O-6 is the working level) and authority to attend out-of-theatre decision conferences. During my tour I attended: CENTCOM Surgeon's Conference x2, NATO Multi-national Military Medical Steering Group X2, ISAF/IJC Medical Adviser's Conference x 4 and briefed the US Joint Staff Surgeon, the UK Surgeon General, the CENTCOM Surgeon, the CAN Deputy Surgeon General, the NLD Director Medical Operations, the ANA Surgeon General and their subordinate staffs. It was this engagement that ensured the necessary multi-national collective contributions to the medical resources required to support the substantial increase in ISAF and ANSF combat forces in RC(S) during 2010.

Lesson: the Commander Medical of a 2* HQ must be a OF5/US O6 and must expect to engage with TCN medical senior leadership.

32. **Pre-deployment preparation and tour length.** Medical support to the ISAF mission is a complex business that requires a knowledge of NATO and national medical doctrine, an understanding of medical support in resource poor security services and principles of civilian health sector development. The PECC function is procedural but intense, personnel in this role should do short tours (4 months with no R+R). The post of Med Dir, SO ANSF and SO Stability Health Adviser need long tours (9 months – 1 year)

because of the need to understand local context and build personal relationships. Remaining posts can be covered by 6 month tours.

Lesson: tour lengths should reflect the nature of individual posts.

KEY ISSUES FOR FUTURE MEDICAL SUPPORT TO ISAF OPERATIONS

33. The ISAF operation is in constant evolution. The following 3 strategic questions will require answers during the next 6 months:

- a. What is the best balance between MEDEVAC timeline and clinical capability of receiving MTF? – this will determine the enduring requirement for the 31 CSH Role 3 capability at FOB Dwyer.
- b. What is the hospital capacity requirement for summer 2011? – this will determine the capacity statement for 31 CSH, UK Role 3 Camp BASTION and KAF R3 as UK, CAN and US re-balance combat forces.
- c. What is good enough in ANSF health sector development? – this will determine the goals for medical transition to ANSF delivered medical support to ANSF.

MCM BRICKNELL
Col GBR-A
Medical Director
HQ RC(S)/CJTF6