**Network Governance Incident/ Reporting & Response Form**

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| **CMMTN SSCN Log Number:** |  |

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| **Section 1**  |
| **Incident Date**  |  |
| **Incident Time**  |  |
| **Reporting Organisation**  |  |
| **External Organisation(s) Involved** |  |
| **Trust Trauma Lead Informed?** |  |
| **Patient Safety Incident Reported Locally?** |  |
| **Form Completed By**  |  |
| **Date Form Completed**  |  |

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| **Section 2**  |
| **Patient Name**  |  |
| **Date of Birth**  |  |
| **NHS Number** |  |
| **Pre-Hospital Incident No.**  |  |

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| **Section 3**  |
| **Description of Incident:** (Please include relevant clinical information such as injuries sustained/patient outcome) |
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| **Section 4**  |
| **Specific Concerns:** (Please state fact only, avoid opinion and exclude individuals’ names) |
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| **Section 5**  |
| **Response Due by Date** |  |
| **Response** (Please state fact only, avoid opinion and exclude individuals’ names) |
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| **Completed by**  |  |

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| **SSCN Use Only**  |
| **RAG Rating**  | **Likelihood** | **Consequence**  | **Overall Rating**  |
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| **Patient Safety Incident Reported?** |  |
| **CMMTN Medical Lead & Director informed?** |  |
| **Discussion at Clinical Group Meeting Required?**  |  |
| **Date of Clinical Group Meeting (CGM)**  |  |
| **Outcome of CGM Discussion and/or further information:**  |
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| **Date Incident Closed**  |  |
| **Completed by** |  |

