**1) Define the patterns of emergency presentation among the population of Southend-on-Sea and consider causative factors**

**While placed in the A+E of Southend University hospital, I experienced the range of presentations that is to my mind fairly typical of emergency departments across the country, with numerous admissions for acute respiratory complications- of these mainly infective exacerbations of COPD followed by pneumonia- many patients with cardiac sounding chest pain, with generalised abdominal pain following closely behind, plus the seemingly endless injuries presenting to minors, of which uncomplicated fractures of the wrist and hand appeared to predominate, followed by lacerations sustained at work. Given the generality of these presentations, it is difficult to comment on what distinguishes the cause of this in comparison to the national average. A few factors did appear to be perhaps over-represented during my short span in the department, foremostly exacerbations of COPD especially considering the time of year- it being the coming of summer when one would perhaps expect these presentations to diminish relative to late autumn/ winter. From this I can speculate that the area has a higher than average proportion of long term smokers, or at least a sub-group of the elderly population that continue to smoke against medical advice. Further to this, dementia was often co-morbid with respiratory issues, suggesting a lack of self-care could be a contributory factor in these cases. Of patients presenting with abdominal pain, this tended to turn out to be related to gallstones, often in male patients with high BMIs suggesting dietary cause.**

**2) Appraise the difficulties and limitations in providing emergency medical care with limited funding and bed availability**

**During my time in the department difficulties relating to bed availability did not manifest- though it was often very busy, patients were able to be accommodated and the rapid assessment team was broadly speaking able to see patients well within the 4 hour target window. I believe the main tightrope to walk from an emergency department persepective is dissuading the public from attending for non-emergencies, instead seeking appropriate help from a GP, pharmacist or other avenues as appropriate, whilst insuring people with genuine emergency presentation symptoms do not delay attendance believeing themselves wrongly to be a unnecessary bothersome burden of an overstretched service. On one occasion however the impact of funding was felt, as the department was visited by a cadre of suited men and women, that the staff understood were there as part of an assessment with a view to merging the accident and emergency department with that of Basildon and Broomfield Hospitals. Rightly or wrongly, this was felt by some to be a cost saving measure and this exacerbated a simmering sense of uncertainty regarding the future of the department and security of jobs. While collaboration between hospitals is laudible and there may well be genuine efficiency savings to be made, it seemed that in the current political climate in which NHS strain is being felt more keenly and looks to continue ad**

**infinum, it is important to manage the transitional period carefully so as not to disturb staff morale or be seen to be cutting a vital service to the detriment of patients.**

**3) Analyse the frequency and type of emergency presentations of different socio-economic groups in Southend**

**As mentioned in objective one, infective exacerbation of COPD appeared commonly during my time in the department, almost universally in retired, working class smokers. As a public health issue in relation to socio-economic factors, it may be more difficult to change the habits of the elderly, who may have been smoking for 40 years or more. Lower socio-economic groups may be more resistant to medical advice of public health education initiatives, as generally speaking the are less health-conscious than those better off. Wounds sustained while at work also prodominate in the working class, such as a hand crushed on a construction site, and a forearm slashed with a box cutter in a packing depot. Though less frequent, admissions with the police in attendance were relatively common place. This included a homeless man whose situation left him vulnerable to be assaulted, and there may be a sub-group of people of lower socio-economic class that are therefore overrepresented in the emergency department for non-accidental injuries.**

**4) Improve Clinical Skills in High-pressure Situations**

**This elective provided a valuable opportunity to practice practical procedures, including those in an amore acute setting. There was a steady supply of patients requiring venepuncture/cannulation, including in resus where I enjoyed feeling an element of time-pressure to what I was doing, hopefully this will have afforded me some confidence that I can do such tasks quickly and proficiently. Now approaching the final stage of medical school, the pressure and expectation continues to rise, and though I think myself confident in most basic procedures it always becomes more difficult when people are watching and I very much appreciate the chances I have had to refine my techniques before stepping into a role in august where people are more dependant on me to perform these procedures successfully but also quickly, and in which the pressure and expectation is higher still. I also got to witness and assist with many practical procedures that I was not very familiar with such as traction reduction of a colles' fracture and a logroll on a patient with c5 fracture. Although my contribution to these was minimal, it was a much needed refreshing of my mind into the practical realities of how these are performed, and being amongst the team has hopefully ensured that if I am assisting in such a procedure as a doctor, I will more confident. The staff in the department were keen to approach us with practical procedure thats needed doing and I appreciate them going out of their way to lend us learning opportunities.**