The aspects of the course that trainees found most useful were networking, hot topics in paediatrics and simulation training. Many trainees felt that attending the course had helped them create an ongoing informal support network that would last beyond the single day of the course.

Conclusion Increasing numbers of junior doctors are taking time out of their training for maternity leave. No targeted educational support currently exists for this group.

We have demonstrated that a return to clinical practice course specifically targeting trainees on maternity leave was popular with participants all of whom stated that they had improved confidence and enthusiasm for returning to work.

**Supporting Trainees Returning from Maternity Leave – Establishing a Return to Clinical Training Course**

doi:10.1136/archdischild-2013-304107.029

1 A Brightwell, 1 S Minson, 1 A Ward, 1 A Leigh, 1 C Fertleman. 1 London School of Paediatrics, London Deanery, London, UK; 2 Community Paediatrics, Camden PCT, London, UK; 3 Paediatric Oncology, University College London Hospitals NHS Trust, London, UK; 4 General Paediatrics, Whittington Health NHS Trust, London, UK

**Background** Time out of clinical practice is common in postgraduate paediatric training. Our Deanery can expect around 60 paediatric trainees to be on maternity leave at any time; the majority of whom choose to take the full year available to them.

There is limited evidence to describe how and when doctors’ competence is lost during a period of absence from work, although a key factor appears to be how well the skills and knowledge were learned and practised before the career break. There is wide variability internationally and across specialty in the degree of support offered to doctors returning from a career break, and those schemes that do exist focus on doctors who have been absent from work for over two years.

**Aim** We developed, delivered and evaluated a one day return to clinical practice course for doctors in paediatric training.

**Methods** We invited all paediatric trainees who were on maternity leave to attend a free one-day return to clinical training course.

We developed a course to include recent updates in Paediatrics, low-fidelity simulation and discussion regarding anxieties around returning to work and strategies to maximise learning and training opportunities.

The course was facilitated by senior trainees who had recently returned to training from maternity leave as well as senior paediatricians who have successfully combined career and family life.

**Results** The course was attended by 22 trainees all of whom completed an evaluation.

**G17(P) AN OSCE IN SOMALILAND: MEDICAL ASSESSMENT IN A RESOURCE POOR COUNTRY (RPC)**

doi:10.1136/archdischild-2013-304107.030


**Aims** To improve medical outcomes in a RPC by using improved assessments to drive up standards in learning.

**Background** Basic health indicators in Somaliland are among the worst in the world with high rates of maternal, newborn and child mortality and morbidity and poor immunisation coverage. There is a shortage of qualified healthcare professionals. This is exacerbated by Somaliland not being recognised internationally and therefore excluded from government aid. Hargeisa and Amoud Universities have established Faculties of Medicine with the aim of producing future doctors in Somaliland to address these healthcare issues.

**Methods** Five UK external examiners (including one paediatrician) travelled to Somaliland to work with the local faculty in implementing OSCE’s to replace traditional clinical exams. Each examiner worked with local faculty in his own specialty in designing the exam and acted as lead examiner in his own subject but also as a station examiner in other subjects.

**Outcomes** Barriers to implementing the OSCE’s were encountered. Somaliland has few experienced doctors many having fled the civil war. At Amoud University the most senior paediatrician had been qualified for 3 years. Very junior doctors had to be used as examiners and surrogates threatening the validity of the exam.

Transport problems meant it was difficult to use out-patients as examination subjects and in-patients were generally too unwell. Local faculty varied in their understanding of the principals of an OSCE some marking generically while others followed the marking scheme rigorously but without considering overall performance. Having to repeat each OSCE three times led to potential and actual breaches in security.

Nonetheless an 8 station paediatric OSCE was delivered (2 clinical exam, 2 history, 2 counselling, and 2 unmanned data interpretation stations).

The exam and counselling stations demonstrated a good level of discrimination. Of 32 candidates in Hargeisa 2 failed and 2 were borderline. Individual candidate’s performance across the 5 OSCE’s showed a high degree of concordance suggesting that the results were valid and reliable. Feedback from candidates was overwhelmingly positive.

**Conclusions** OSCE’s are deliverable in RPC’s. Ethical and professional behaviour needs reinforcing. Validating medical students’ achievements will encourage further input from key stakeholders.