SAPC blog

SAPC: A path to senior leadership and setting up a medical school: insights, philosophies and challenges. 20th November 2025

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I'm delighted to share my inner thoughts on my clinical academic and senior leadership journey.

When asked by Carolyn to give a keynote speech at SAPC North, there was no hesitation on my part. I'm very keen to share my experience if it helps colleagues to make an impact in academic practice, whether that's as a GP or Allied Health Professional, Health Services Research and in

research and education. We all co-exist in an academic eco-system and we are all greater than the sum of our parts when we all work together.

So… I talked about:

1) firstly, my career journey, the philosophies that guide me, of which there are 48! and how they have helped me with the many challenges along the way.
2) and secondly, how I set up a new medical school, both the educational journey and also my research journey.

I've unashamedly plagiarised nearly all of the philosophies that have guided me in my journey. Here's the first, **No20 Genius is 1% inspiration and 99% perspiration, coined by Thomas Edison**. This chimes well with my imposter syndrome, keeping the head down and just getting on with it.

So…

1992: GP trainee

I started my medical career in a central teaching hospital in Leeds with an aspiration to become an orthopaedic surgeon, having won the medical school orthopaedic prize and did an orthopaedic elective in Canada - I liked engineering, fixing things and DIY. I fix grandfather clocks. Unfortunately, my early hospital experience with my role model

surgical colleagues when I was a junior doctor was one of failed relationships, divorces, unhappiness and frankly misogyny – the reverse of the philosophy that I adopted, **No5. Why good things happen to good people – book by Stephen Post and Jill Neimark** AND **No41 Folks are usually as happy as they make up their minds to be**. I desired happiness and life in balance: 1/3rd work; 1/3rd family: 1/3rd selfish me. Not necessarily in terms of time but in terms of measurement on the happiness-meter. Because I'd followed a teaching hospital path and missed the GP scheme applications, I had to put my own scheme together and interview every 6 months for a job, **No32. The best way to predict the future is to create it - American president Abraham Lincol,** – 1.5 years in Leeds (A&E, O&G, General Medicine) and 1.5 years in the Northern Deanery (GP, Psychiatry, GP). In those days we had to do a mandatory audit in GP training but that didn't satisfy my desire, research inquiry did – i.e. discovering new knowledge rather than measuring already discovered knowledge mapping performance against standards. **No1. Rules and regulations are artificial boundaries that change over time, relationships are enduring and make the world go around**. I'm the proud author of that one! So, I presented the work that I wanted to do – a protocol – linked to a Newcastle university academic, **No9. seek forgiveness, not permission, is commonly attributed to Grace Hopper, Rear Admiral in the U.S. Navy**.

Subsequently my non-audit won the regional GP trainees Roche Syntex audit prize and was put forward for the national prize which it also won. I was presented with the prize in London, presented it in Stockholm Sweden in 1995 and published it in the BJGP '*Retrospective review of the prevalence and management of infertility in general practice*'. It's been cited in other international fertility work 18 times and I am still very proud of that. I didn't know it at the time but this was the launch-pad to the rest of my career. So that brings us to…

1994 GP Principal – and still a practising but now part-time GP

I selected my GP Principal job whilst reading the BMJ on my honeymoon in Corfu! – Broomhill with Dr Paul Creighton (who remains a mentor today and very influential person in my career). I realised that needed to get a job and back in those days you had to live where you worked and you had to have a partner who would answer the phone at evenings and through the night when folk needed help. And so my wife Jane and I moved to Warkworth, Northumberland, where still live. Jane bleeped me to pass on the calls and I would pick them up ringing back on the patients landline whilst hopping from one house to the next. Jane and I had trial by sherry at the partners house whom I was taking over from. At the interview I remember being apologetic for my research work about to

be published and needing annual leave to present in Sweden but that was embraced by the partners and I was offered and took the job.

I could not see myself only seeing patients 5 days per week for 40 years so I carried on researching and joined NoReN, the Northern Research Network, set up by Prof Pali Hungin and Prof Greg Rubin whom some of you will know. This was the first opportunity to be surrounded by like-minded GPs which I loved. I spent evenings and weekends writing protocols that I knew I could deliver, with no funding, presented the work at NoReN's annual conference and published. An example of this work at this time is '*A cross-sectional study comparing the motivation for smoking cessation in apparently healthy patients who smoke to those who smoke and have ischaemic heart disease, hypertension or diabetes'.* Published in Family Practice in 1999 it has been cited 73 times. My co-author Angela Evans a practice nurse presented this for me at NoReN because – in her words – I had the temerity to have a stroke – a posterior inferior cerebella infarction – later found to be a paradoxical embolus from a potentially patent foramen ovale, forced open on the Valsalva manoevre – subsequently closed with an Amplatzer device. This was clearly life changing for me and my family. We had a 1-year-old daughter Sarah, who now at 28 years old, sits on NICE panel evaluations of health technologies as the Lead Health

Economist. I have the most amazing supportive wife, we re-evaluated and decided that I would pursue my passion – what got me out of bed in the morning – and that was no more than curiosity, and desire to seek answers to questions – which formed into research and then an NIHR DRF.

I mentioned a stroke. Whilst I was in hospital and off work, clearly, I was banned from driving for a month, I did a couple of systematic reviews and published them, what everyone does when they off work having had a stroke. '*2008 The use of Bupropion Therapy SR in smoking Cessation*'. This has been cited 214 times, so the numbers are ticking up. I'd clearly got the bug.

2003-8 NIHR DRF

I had applied for DRF in 2000 with the support of a Newcastle University academic but sadly failed. **No27. I don't fail, I systematically eliminate ways that don't work – coined by Thomas Edison**. I didn't give up and I drew upon my experience and networks. That's when the second very inspirational colleague supported me to get my NIHR DRF, Professor Greg Rubin, the then prof of GP at Sunderland university. **No26. winners never quit, quitters never win - coined by Vince Lombardi. He was a famous American football coach, most notably known for coaching the Green Bay Packers** AND **No22. Ability is**

nothing without opportunity, coined by Napoleon Bonaparte) Prof Rubin gave me that opportunity for which I am forever in his debt. We secured the very first DRF in the university. I got my PhD in 2008 although I did not have any career plan, even at this stage, I went from one fun thing to the next.

2008-13 Hon Clinical Senior Lecturer

Greg left Sunderland and so did I, taking up an Honorary Clinical Senior Lectureship at Newcastle university and in that time amassed a few grants, led the GP element of the NIHR CLRN, then PCRN then LCRN – all GP research networks recruiting over 7000 patients each year to NIHR portfolio studies. I also chaired the NIHR RfPB during this period. One of my roles chairing the NIHR RfPB was to visit all 5 universities and hospital trusts to demystify the application process and give tips on what a successful application looked like. When I went to Sunderland university, some 5 years after I left, the Faculty Dean, Professor Tony Alabaster, said he wanted more of what I do, and my response was, I need a chair to launch the next stage in my career. **2nd time: Ability is nothing without opportunity, coined by Napoleon Bonaparte**. I was appointed Professor of General Practice and Primary Care.

2013-17 Professor of General Practice and Primary Care.

My role was to bolster the research arm of the school of pharmacy which we did having a significant number of grant successes and securing the first NIHR DRF for a pharmacist in the UK. The second task was to establish a post graduate masters and PhD route for academic GPs which I also did and have supported 12 academic GPs to their higher degrees. I thought I was cruising to retirement when in 2016 Jeremy Hunt wrote to all VCs asking if they would consider modernising medical education and introduce some new medical schools.

My VC, Dame Shirley Atkinson, and CEO of Sunderland NHSFT, Ken Bremner MBE, and myself became quite excited and giddy and we embarked upon the process.

2018 – present – setting up the medical school.

So… how do you set up a medical school. It's not easy, it's worse than a PhD! It is all consuming. But, **No32. 2nd time. The only way to predict the future is to create it**, **No44. Procrastination is the author of failure**, **and No36. A space is a space until it is occupied**.

To this point I attended some really helpful NIHR senior leaders in health leadership development courses. They changed me into an optimist and believing **No40. The pessimist sees difficult in every situation, the**

optimist sees opportunity in every difficult situation – Winston Churchill.

I had a VC and CEO who asked if it could be done and crucially, they believed that I could deliver it - **No13. Power is invested in you by the people around you** AND 3rd time **- No22 Ability is nothing without opportunity - Napoleon Boneparte**. I simply brought together all my learned leadership skills in my GP practice, the NIHR CRN, RfPB, CCG, CSU and applied it.

I went to the GMC with a vision and not a set of buildings.

I wrote to all stakeholders: HEE, Trust CEOs, GP CCG leaders,

I sought a contingency medical school – Keele – built upon similar values.

I had overwhelming support – trust CEO letters of support within 24 hours. It became apparent that I was being swept up in a wave of regional power, they wanted it! it just so happened that I was sat on the surfboard on the top of the wave. Once it was in train it was not going to stop.

I approached Newcastle Medical school, **No29 Keep your friends close and your [perceived] enemies even closer**. Newcastle University did not support the notion of a new medical school at

Sunderland at first, and I had some tricky conversations to navigate in the region. The region's NHS machinery and in particular the TRUST CEO's were central to the endeavour. I had a focus on the Northeast and complementarity to our excellent medical school at Newcastle University who has a big out-turn into the medical specialties and many doctors moving south in specialty training - **No2 United we stand, divided we fall – the Ancient Greek, Aesop**. I knew I had to get Newcastle on board. Clearly, I was responding the government's drive and bid metrics which were a focus upon Widening Access, Shortage medical specialties of GP and Psychiatry, and coastal regeneration of health and wealth. I felt like the bid metrics had been written for me – pennies from heaven!!!! Newcastle and I now work together closely with joint NIHR bids and a governance process linking both medical schools. The region is getting stronger.

There are two parallel processes to open a new medical school, One, the GMC regulatory compliance process, or new schools process and Two, the HEFCE (now OfS) and HEE (now NHSE, soon to be reborn again) bidding process for commissioned numbers.

So… Setting up a new medical school: how do you do it, and what are the priorities? There's 23!

The 23 priorities setting up a medical school

1. Staff: March 2017 n=1 me; Sept 2018 1 year before students arrived n=5; March 2019 6 months before students arrived n=12.
2. Facilities: Already had facilities for nursing, paramedic and pharmacy: Labs, OSCE suites, mock wards, clinical simulation and lecture theatres. We needed to build Anatomy and a medical school. £1m then £5m anatomy then £8 medical school.
3. GMC – I'll come back to that – that's the big-ticket item
4. Medical Schools Council. It's a place where all Heads/Deans work together on national processes and policies e.g. MLA AKT.
5. HEENE (now NHSE NE&NC WTE), this is where my £10m tariff flows from central government to hospital trusts and GP practices under a tripartite agreement.
6. Trusts: Historically where medical students were taught and all tariff flowed. Still central and key but harmonisation of tariff was thankfully championed by the UK academic GPs. We all get paid the same as our hospital colleagues for teaching medical students, i.e. a share of the £33,000 tariff attracted for each student each year in clinical years 3, 4 and 5.
7. GP Practices. We have the biggest GP curriculum in the UK. It's led by a GP, all Year 1 and 2 early clinical skills is taught by GPs. Our vision and philosophy is centred around the generalism of

General Practice, knowing a little bit about everything (rather than everything about a little bit, aka specialist). We create pluripotential stem cell graduates who can differentiate into any medical specialty. I led a crusade to embed funded Masters degrees in medical education into general practice to build the GP educator workforce.

8. Admissions. We now have 12 applicants for every place, one of the most popular medical schools in the UK. Our standard offer is AAA with contextual offer AAB. We retain the top 8 deciles of the UCAT where most other select only the top 2 deciles of UCAT including to those with BBB offers. Clearly the UCAT screens them out.
9. Curriculum. Very modern curriculum, largest GP, early clinical placements in year 2, PBL with detailed student and tutor support materials, spiral with CBL in clinical years and a full year 5 clinical assistantship. We bought it off Keele, which was top of the NSS ranking for 5 years in a row, the students loved it and Keele have the highest out-turn in GP.
10. Quality. The smartest thing I did was to get externality into the medical school. My Quality Committee has NHSE, LEPs, Lay members, students. The quality framework is a process that I'm extremely proud of.

11. Finance. I don't have a budget, yet! I also don't see the higher tariff OfS budget flow to support MBChB. However, I do benefit from sunk costs in e.g. mock wards, anatomy, clinical simulation facilities. I'm also supported with staff requirements in the face of recent university financial challenges.

12. Administration. Strong administration leads to good governance which in turn leads to high quality and for me that's clinical excellence, safe doctors and patient safety. When I set out at Sunderland University, I was told I'd be lucky to get a PA. Supported by Keele and GMC oversight, we have and administrative team of 12 staff - **No43. I can calculate the motion of heavenly bodies, but not he madness of people – Isaac Newton**. This teaches me to be data and metrics driven.

13. Governance. What 13 committees run a medical school including setup. Management Committee has oversight of everything, Quality Committee links to the GMC Quality Reporting System, Admissions Committee, Assessment Committee, ED & I committee, Health and Conduct Committee, Progress Panel, Examination Boards, Programme Studies Board, LEP Liaison, Professional Development and Welfare committee, Staff-student Liaison Committee, Joint Curriculum and Implementation Board (JCIB) and Steering Group. The JCIB oversaw the faithful

implementation of a tried and tested GMC approved curriculum. The Steering group was the university's exec level governance oversight of a high-risk programme in setup.

14. Contracts including Clinical Academic. This has been a challenge. In fact, I was asked to share my challenges at the University and Colleges Employers Association, in February 2025, in London, with university HR staff on how I navigated the challenges. As an example, a Clinical Academic Contract which I'm not on, and which preserves NHS pension, can be discharged in 3 ways – all substantively with the university but with 20%, 50% or 80% recharge to the NHS for clinical commitments. Most research intensive, high performing universities, have their clinical academics on a 20% NHS commitment, because any less diminishes their clinical academic ability.

15. University processes. OMG, don't get me started. Some highlights, firstly medicine does not fit, all courses are 30 credit modules lasting a few months, medicine has year-long modules of 180 credits, there were no suitable fitness to practise processes, it was built up by the school from the ground.

16. OfS. They hold us to account for student numbers which was a challenge during the pandemic, when grades were inflated and

too many students entered the system, students were horse-traded around the country for £10,000.

17. Assessment. The most gratifying thing that happened was the introduction of the national Medical Licensing Assessment, Applied Knowledge Test (MLA AKT) where Sunderland has been immediately benchmarked with validity against all other medical schools and in the first two years of AKT delivery at Sunderland, our medical students achieved a 99% and 95% pass rate at first attempt, out-performing many other medical schools in the UK. There's so much more to say about assessments.

18. Student support. At Sunderland we were commended by the GMC for the breadth and depth of support, our Progress Panel and Health and Conduct panel, Student Support Plans and reasonable adjustments. We have had some tricky cases and our processes have been wonderful to date. The students have produced a wonderful YouTube 'single-panel story'.

19. Fitness to Practise. This is a big-ticket item. The most heinous crime in medicine is dishonesty. Following this is lack of insight and failure to submit to remediation. We have had a few students go through this process. The best thing I did was to get support from HEE and appoint an experience FtP lead and train and pool of FtP GMC registrants.

20. Equality and Diversity. Our Regulator, the GMC, is hot on this subject. It is one of the most impressive committees in my medical school. We've managed some tricky issues such as the GLADD charter and banning 'conversion therapy' – signed by the BMA and all medical schools – remove discrimination and societal bias against LGBTQ+ people.

21. Research. With Dr Tullo, a local trust geriatrician we landed a £2.2m bid to establish a Clinical Academic Training Office (CATO). We have a vibrant research environment, increasing grant success and impactful outputs, papers and a healthy pipeline of ACFs.

22. Biomedical Science. This team forms the core of on-campus tutor support and run year 1 and 2 and a proportion of year 3. They are Personal Academic Tutors, PBL tutors, Year Leads, they lecture and participate in the huge governance machinery. Sunderland is now running a national process through Medical Schools Council to answer the question 'what science do doctors need to know?' The Scientific Foundations of a medical degree. This is really exciting for us and will draw upon the national experience of MSC setting up the MLA AKT. The science bedrock also defines the medical profession from other healthcare professions.

23. Contingency. Keele. I selected them as our contingency school because of their metrics and the head of school was born in Sunderland and a Sunderland football fan! A contingency school is a GMC requirement, so that if it all goes wrong the experienced school steps in and takes over. It is of course an incremental contingency from educating the new school's educators to transferring the students to the contingency school to graduate with their degree. The Keele Head and Undergraduate Lead met with me, my deputy and manager every Wednesday evening for 1 hour over 5 years to support us in the implementation of their curriculum. There was an overarching governance committee The Joint Curriculum Implementation Board (JCIB) where the formal business took place.

So they are the 23 priorities which I led and worked upon, and that's how you set up a medical school.

I did say I would come back to the GMC

GMC

They have an multi-stage process to quality assure the opening of a new medical school. In summary, they require a lot of documents to answer questions about 5 areas: The learning Environment and Culture, Governance and Leadership, Supporting Students,

Supporting Educators and The Curriculum & Assessment – with 10 standards and 78 requirements. Over the 6 years they visited on average twice each year, observe OSCE delivery held one- or two-day board room style grilling events of the senior management team, staff and students. At each node an 80-page narrative on progress against GMC's 'Promoting Excellence' standards and a proportion of the 400 policies and procedures that run the medical school were submitted.

All progress reports are published on the GMC website.

You'll see on our reports the many highlights, e.g. placements in GP being one, student feeling valued and supported and the learning opportunities including IPL and SIM.

What about the future?

The last government produced the NHS Long Term Workforce Plan and in that an expansion from 7,500 to 15,000 undergraduate places. We have reached 9000 now but the expansion is on hold until the new government decides on its priorities.

The GMC still registers, each and every year, more than half of the required doctors to meet the needs of the UK population. Many feel that this is morally wrong, the UK being a brain drain on many areas that

need their own doctors. We also know that we have a large AAA talent pool to enable the UK to become self-sufficient in high quality health care – doctoring.

The stark fact is that the UK government cannot afford to train sufficient doctors to meet UK demands, hence innovative ways of healthcare delivery have sprung up. Lets touch on a few.

The first is/was the Medical Doctor Degree Apprenticeships where students train while they work and use the NHS levy to help trusts fund the programme. Unfortunately the financial model is ill thought through, student welfare not adequately thought through, time to train and hence patient safety also not well thought through. At the time of writing the future of MDA's remains uncertain.

Then there are graduate entry programmes. However, access to second degree funding among other issues has led to a lukewarm response especially when the issue of widening access is missed, in large part, with this route.

The next is 4-year school leaver degrees. This does not have huge support from my Heads/Deans of medicine counterparts in the UK who believe that the excellence in medical education is not broken and it's already difficult to fit in all of the science and ologies in the 5-year programme. They may be right. If a 4-year programme was to emerge,

things would have to go. That may be selected student components, the medical elective, shorter holidays, longer days, etc. It may not be very popular with students, however, 1 year less of tuition fees may be.

Then there are Physician Associates which you have seen play out in the press and in the courts with the BMA and GMC. Our own college, the RCGP, has serious patient safety concerns, concerns over regulation and the definition of scope of practice. On 15th December 2024 the GMC became the regulator of Physician Associates/Assistants – we will watch that and the play out with the BMA, Leng review, courts, GMC etc.

All of this links to ‘what makes a doctor different to other health care professionals and I invite you to think about that and to cogitate on my lens.

The first is autonomy, accountability and responsibility – also known as professionalism, a country mile away from AI which also lacks emotional intelligence and clinical reasoning capabilities.

The second is the way doctors are taught to think, in a neural network pattern and not ‘taught to task’ or an algorithm leading to a predetermined answer.

The third is the scientific underpinnings of medical degrees, which doctors draw upon when patterns don't fit, and which enable you to solve the problems that patients present to you.

I would argue that the latter is under threat and hence the very meaning of being a doctor and that is why Sunderland, I and my Phase 1 biomedical science lead and Immunologist Dr Jane Falconer is at the fore leading a national review with all medical schools and the Medical Schools Council on this very issue.

Challenges along the way

I've certainly had challenges along the way in almost all sectors of my career as the story above unfolded but here's summary of a few other philosophies that kept me sane and on track.

Have a healthy questioning attitude, **No16. Assume makes an ass out of 'u' and 'me' – Oscar Wilde**.

I've learned watching my seniors as I've developed pick out the best traits. I watched my senior partner Dr Paul Creighton invite challenge openly to help him hone his ideas - **No29 2nd time. Keep your friends close and your enemies even closer**. This helped me enormously as my time as an honorary clinical senior lecturer at Newcastle and running the research networks.

I've experienced career threatening bullying on 4 occasions in all decades of my journey – it must be called out - **No8. For evil to prevail, good must do nothing – Edmund Burke 18th century Irish philosopher**.

The next is your achievements as a clinician, politician, academic, or other… your track record speaks for itself, trust in yourself, believe in yourself, **No 14. Respect can never be demanded, only earned**, you have earned it.

Do I have any remaining challenges that are guided by my philosophies – Oh yes!!!

My weight has fluctuated over the years and I've found myself to be more energetic and productive when I am fitter, hence, **No7. Fit body, fit mind, AND No39. Nothing tastes as good as fit feels**.

The medical school is seen as elitist in the University, which not uncommon in all universities with medical schools. Medicine and medical science is powerful, and mutual respect and a proper understanding of equality and equity will help with my next philosophy to enable everyone to be their best no matter what background or disadvantage - **No42 We build too many walls and not enough bridges – Ghandi**. We see that in America, Russia, Gaza and around

the world. My challenge is to enable growth of medicine for the benefit of the Faculty, University, the NHS and the general public.

Do I have any final words of wisdom to help with your ambitions – yes.

No11. Everywhere you go always take the weather with you – Crowded House song. I pay great attention to this. If you smile at people, they'll smile back, and vice versa. I watch my Associate Head of School and she is a master of this.

One, among many things, that I learned from my mentor and retired GP Dr Paul Creighton, was **No12 Never present a problem, always present a problem with a solution**.

What am I most proud of?

That's easy – the medical students and the staff.

Our metrics are phenomenal and everyone who works at the medical school is bought into the vision '*to make medicine accessible to those with talent who might not have had the opportunity*' AND '*to graduate socially responsible doctors who meet the needs of society and improve lives*'.

80% (versus 56% nationally) state school entrants

40% local

30% (double the national average) socioeconomically disadvantaged

50% ethnic minorities

Our state school students are outperforming our independent school students.

99% and 95% passed the MLA AKT at first sit (national 82-99%)

100% passed the PSA at first attempt.

NSS: ranked 5/39 then 6/42 overall and 1/39 1/42 for academic tutor support.

97% graduation rate, we select them, they succeed.

Finally

Be guided by the values of openness, honesty and integrity – I am, and it has helped me enormously. And the penultimate philosophy **No31 Sooner or later we all face decision of what is right and what is easy – CS Lewis**, do what is right.

The final philosophy, **No18. Be a better listener than a talker**. I've practiced hard with this one, to get better at over the years.

If you remember only one philosophy that makes a difference to your senior leadership journey, then I think reading this may have been worthwhile.

Now go and lead within your sphere of influence.

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