SHIFT INSIGHT

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GMC | Corporate Strategy and Perceptions Survey 2022

Technical Report

1.0 INTRODUCTION

This report presents the technical details of the GMC's corporate strategy and perceptions tracking survey 2022. The research was conducted by Shift Insight on behalf of the General Medical Council (GMC). A main report, presenting the findings from the research in detail, has been published separately.

1.1 OVERVIEW

Seven audiences were surveyed in this research: doctors, educators, medical students, patients/the public, providers, Responsible Officers (ROs) and stakeholders. Six audiences (doctors, educators, medical students, patients/the public, providers and ROs) were invited to take part in an online survey, whereas stakeholders were surveyed by telephone. All surveys were live from 23/05/2022. Five surveys (for doctors, educators, medical students, patients/the public and ROs) closed on 03/07/2022, whereas the remaining 2 surveys (for providers and stakeholders) closed on 18/07/2022. Note that the survey was sent at a slightly different time of year compared to the previous wave (January–March 2020).

The following table summarises the key details of the approach used and the responses achieved for each survey audience.

Audience	Method	Number invited to participate	Number of responses	Response rate
Doctors	Online survey, sample from GMC database	33,722	2,619	8%
Educators	Online survey, sample from GMC database	158	35	22%
Medical students	Online survey, sample from GMC database	8,223	758	9%
Patients/ public	Online survey, sample from third-party provider (Dynata)	N/A	2,033: 1,010 patients (49% of total), 1,023 public (51% of total)	N/A
Providers	Online survey, sample from third-party providers (Oscar Research, Wilmington Healthcare)	1,354	158	12%
Responsible Officers	Online survey, sample from GMC database	515	97	19%
Stakeholders	Computer Assisted Telephone Interviewing (CATI), sample from GMC database	86	50	58%

2.0 SAMPLING AND WEIGHTING

2.1 SAMPLING

The sampling strategy for each audience is outlined in detail below.

Doctors

The sample of doctors was sourced from the GMC's medical register. Records were provided for licensed doctors where the GMC held an email address for an individual, they had a UK registered address and had not opted out of previous research exercises. Further exclusions were also applied, for example, doctors who were suspended or involved in a current Fitness to Practise (FTP) investigation at the time the sample was extracted were excluded.

From this file, Shift Insight drew an anonymised, stratified sample that was representative of the licensed doctor population by age, gender, ethnicity, region, Primary Medical Qualification (PMQ) area and registration type. The selected sample was then contacted by the GMC to provide them with the opportunity to remove themselves from the research prior to the commencement of fieldwork.

Once this process was completed, an initial survey invite was sent to doctors by Shift Insight. Over the rest of the fieldwork period, 4 further 'reminder' invites were sent. The penultimate 'reminder' invites utilised a more targeted approach by recruiting those in specific roles (for example, SAS or locally employed doctors) and those who had qualified outside of the UK and EEA – since these groups were under-represented.

Shift Insight aimed to achieve a sample that was as representative of the population as possible. For this audience, any small differences between the population and the survey profile were corrected using weighting described in the 'weighting' section below.

Educators

The GMC provided the records of undergraduate and postgraduate Deans and Quality Leads at medical education institutions in the UK. A census approach was taken due to the limited number of this sample available (158 records).

Once the appropriate sample was identified, an initial survey invite was sent to educators by Shift Insight. Over the rest of the fieldwork period, 4 further 'reminder' invites were sent.

Medical students

The sample for all final-year UK medical students was sourced from the GMC's medical register. All medical students with an email address were contacted by the GMC to give them the opportunity to remove themselves from the research. An initial invite was followed by reminder emails over the fieldwork period. A chance to enter a £250 prize draw was offered to all who completed the survey.

Once the appropriate sample was identified, an initial survey invite was sent to students by Shift Insight. Over the rest of the fieldwork period, 4 further 'reminder' invites were sent.

Shift Insight aimed to achieve a sample that was as representative of the population as possible. For this audience, any small differences between the population and the survey profile were corrected using weighting described in the 'weighting' section below.

As noted, the survey fieldwork period was later this year (May-July) compared to previous years (February-March), which could have had an impact on the results for medical students. This is because the fieldwork was conducted after they had submitted their applications for provisional registration to the GMC, which is a key interaction between them and their regulator, whereas previous surveys were conducted before this process began.

Patients and the public

The public and patients survey was carried out over 5 weeks via an online panel, Dynata. Careful response tracking was used to ensure the sample was nationally representative of the UK population for the following demographic variables: age, gender, ethnicity, socioeconomic grade and NHS region.

Shift Insight aimed to achieve a sample that was as representative of the population as possible. For this audience, any small differences between the population and the survey profile were corrected using weighting described in the 'weighting' section below.

Providers

The sample for the providers research was initially sourced from the healthcare database provider, Oscar Research. An initial survey invite was sent to this sample and, over the rest of the fieldwork period, 4 further 'reminder' invites were sent. This sample was boosted by sourcing data from another healthcare database provider, Wilmington Healthcare, partway through the fieldwork. This sample received 2 'reminder' invites alongside the initial survey – since this sample was only engaged midway through recruitment. Compared to the 2020 survey, a more targeted sample of providers was engaged – therefore, the results from this survey will be more relevant despite lower response rates than in 2020.

The following job titles were invited to take part:

CCG – Chair, CCG – Chief Operating Officer, CCG – Vice Chair, Chair – Member Council, Chairman, Chairperson, Chief Executive, Chief Officer, Committee Chairperson, Director of Education and Quality, Director of Medical Education, Director of Modernisation, Director of Public Health, Director Specialised Commissioning Group, Directorate Manager, Directorate Matron, Directorate Service Manager, Executive Director, Head of Personnel, Improvement Director, Medical Director, National Director, National Programme of Care Director, Non-Executive Director, Other Directorate Manager, Performance Management Director, Programme Chair, Programme Director, Regional Director, Research and Development Director.

Responsible Officers (ROs)

The GMC provided the records of ROs from the GMC's medical register. ROs were excluded from the doctors' data extract so they could be surveyed separately. All ROs were contacted by the GMC to

give them the opportunity to remove themselves from the research. A census approach was taken due to the limited number of this sample available (515 records).

Once the appropriate sample had been identified, an initial survey invite was sent to ROs by Shift Insight. Over the rest of the fieldwork period, 4 further 'reminder' invites were sent.

Stakeholders

Stakeholders included education bodies, employer organisations, health departments, public bodies, professional bodies and regulators. The GMC provided the records of the person within each stakeholder organisation who it was felt had had most prior contact or engagement with the GMC. For some organisations, a secondary contact was also provided in case the primary contact was unavailable to take part. A census approach was taken due to the limited number of this sample available (157 records, including secondary contacts). Referrals were also taken within each organisation where this was requested by the original contact.

Once the appropriate sample had been identified, Computer Assisted Telephone Interviewing (CATI) was employed to engage stakeholders. All primary contacts received 4 further 'reminder' invites, whereas secondary contacts received 2 further 'reminder' invites.

2.2 WEIGHTING

Final cleaned data for doctors, medical students and patients/the public were weighted prior to analysis to ensure that results were reflective of each population. Applying weighting adjusts the results of a survey to bring them in line with some known characteristics of the population. For example, the collected sample of doctors was 41% female and the population is 49% female, therefore weighting was used to adjust the data to correct for this discrepancy.

As the number of weighted variables goes up, the greater the risk is that the weighting of one variable will confuse or interact with the weighting of another variable. In order to reduce the impact of weighting the data, it was applied to as few variables as possible. An effort was also made to minimise the size of the weights. A general rule of thumb was to not weight a respondent less than .5 (a 50% weighting) nor more than 2.0 (a 200% weighting).

Doctors

Survey responses were weighted to reflect the population of licensed doctors by region, doctor type, registration status and gender. The following table shows the demographic profile achieved in the survey, the weighting targets and then the post-weighting profile of doctors. The post-weighting profile does not match every target exactly as rim weighting on several variables works to achieve a 'best fit' – i.e. not weighting a respondent less than 0.5 (a 50% weighting) or more than 2.0 (a 200% weighting).

Profile category	Survey profile (%)	Population figures/ weighting targets (%)	Post-weighting profile (%)

Region	England (incl. Channel Islands and Isle of Man)	75%	85%	79%
	Northern Ireland	3%	3%	3%
	Scotland	13%	8%	10%
	Wales	7%	4%	6%
	Outside of the UK (Europe)	<1%	N/A	<1%
	Outside of the UK (elsewhere)	<1%	N/A	<1%
	Would prefer not to say	1%	N/A	1%
Registration	Licensed on the Specialist Register	22%	11%	17%
	Licensed on the GP Register	34%	25%	30%
	SAS/LEL doctors	16%	32%	26%
Gender	Female	41%	49%	44%
	Male	51%	51%	48%
	Prefer not to say	9%	N/A	9%

Educators

The survey data for educators were not weighted due to the smaller sample size (35).

Medical students

Survey responses from medical students were weighted by age, region and gender to bring the profile in line with the population. The post-weighting profile does not match every target exactly as rim weighting on several variables works to achieve a 'best fit' – i.e. not weighting a respondent less than 0.5 (a 50% weighting) or more than 2.0 (a 200% weighting).

Patients/the public

Survey responses from patients and the general public were weighted by age, gender and ethnicity to bring the profile in line with the population. The post-weighting profile does not match every target exactly as rim weighting on several variables works to achieve a 'best fit' – i.e. not weighting a respondent less than 0.5 (a 50% weighting) or more than 2.0 (a 200% weighting).

Providers

The survey data for providers were not weighted due to the smaller sample size (158).

Responsible Officers (ROs)

The survey data for ROs were not weighted due to the smaller sample size (97).

Stakeholders

The survey data for stakeholders were not weighted due to the smaller sample size (50).

3.0 DATA ANALYSIS

3.1 Q SOFTWARE/READER

Q Software/Reader was used for data analysis. By default, Q conducts various tests of statistical significance on tables, such as independent t-tests and Chi-square tests, where applicable. Multiple comparisons correction was applied where appropriate. A p-value of 0.05 was used for significance testing.