

<sup>1</sup> Sheffield<sup>2</sup> The BMJ

Correspondence to: E Wilkinson  
 emmalwilkinson@gmail.com; H  
 Boytchev hboytchev@bmj.com; A  
 Rimmer arimmer@bmj.com

Cite this as: *BMJ* 2025;391:r2383  
<http://doi.org/10.1136/bmj.r2383>

## BMJ INVESTIGATION

# Revealed: Thousands of NHS doctors are trapped in insecure “gig economy” contracts

Thousands of locally employed doctors—many of them international graduates and from ethnic minorities—are trapped in insecure NHS contracts with no access to training, career progression, or national safeguards. **Emma Wilkinson, Hristio Boytchev, and Abi Rimmer** report

Emma Wilkinson, <sup>1</sup> Hristio Boytchev, <sup>2</sup> Abi Rimmer<sup>2</sup>

Locally employed doctors (LEDs) are being “exploited” by NHS trusts using insecure contracts that deny them training, progression, and nationally agreed benefits, *The BMJ* has found.

Freedom of information (FOI) data obtained by *The BMJ* show that almost nine in 10 UK NHS acute trusts rely on these contracts that cover tens of thousands of doctors, many of whom are international medical graduates or from ethnic minority backgrounds. Experts warn that the NHS is effectively “behaving like a gig economy employer.”

Local contracts let trusts set terms without guarantees on pay, hours, teaching, or supervision. While locally employed jobs can provide a short term staging post, interviews with doctors from around the UK have uncovered shocking examples of experienced specialist doctors trapped in inappropriate contracts, some for more than a decade, including working long hours without supervision or the right to speak up when work deviates from their contract.

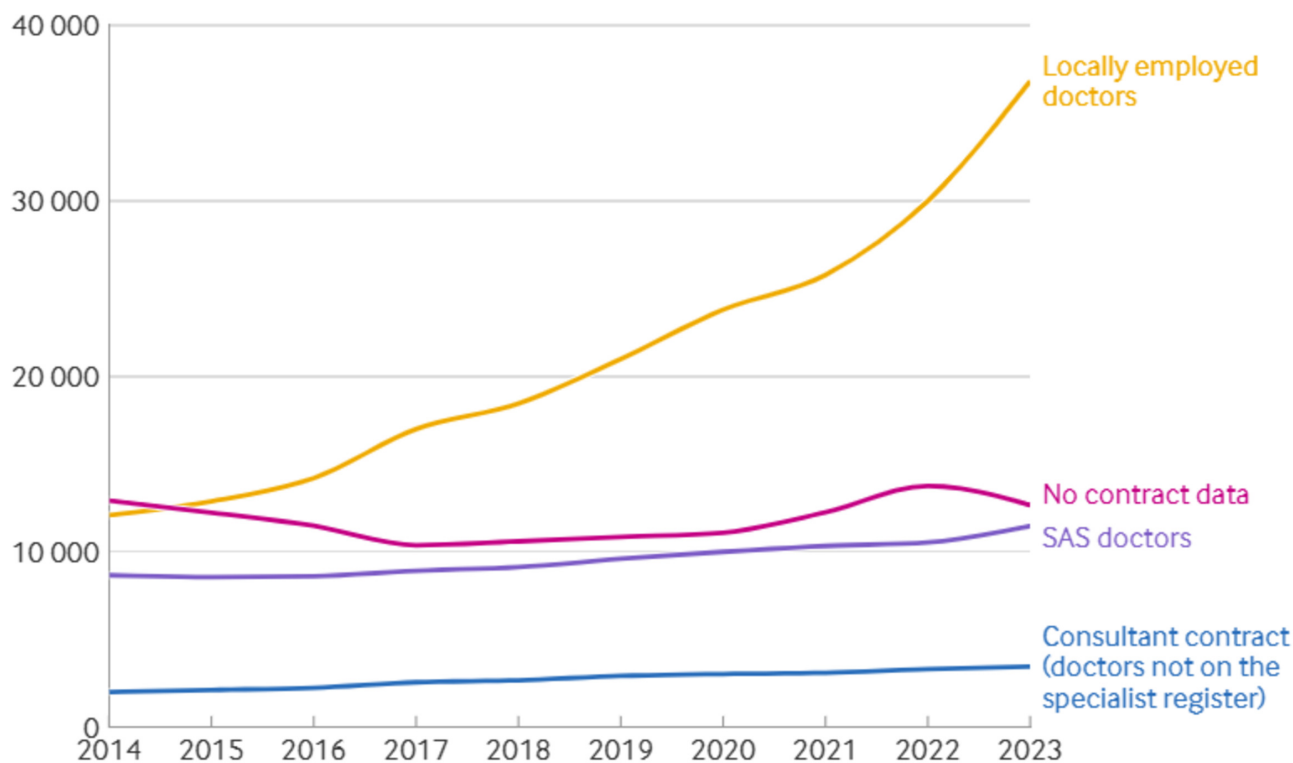
Doctors have told *The BMJ* that they are potentially losing out on thousands of pounds in pay, some

having had verbal promises of specialty doctor posts that never materialised. “We know these exploitative practices are widespread,” says Rob Fleming, specialist anaesthetist and member of a campaign group, the SAS Collective. “Every doctor who doesn’t achieve their potential is a catastrophe.”

The BMA’s deputy chair of council, Emma Runswick, describes *The BMJ*’s findings as “further stark evidence of the way that locally employed doctors are exploited in a contractual ‘wild west,’” with dire terms and conditions and a lack of clear development opportunities.

The General Medical Council<sup>1</sup> says that LEDs are the fastest growing part of the profession, driven mostly by those who graduated outside the UK (66%). From 2019 to 2023 the number of LEDs in England and Wales rocketed by 75% to 36 831 doctors ([figs 1-3](#)).<sup>2</sup> Royal medical colleges, the BMA, the British Association of Physicians of Indian Origin, and the General Medical Council have all called for better treatment of this group, including an automatic right to training and supervision.

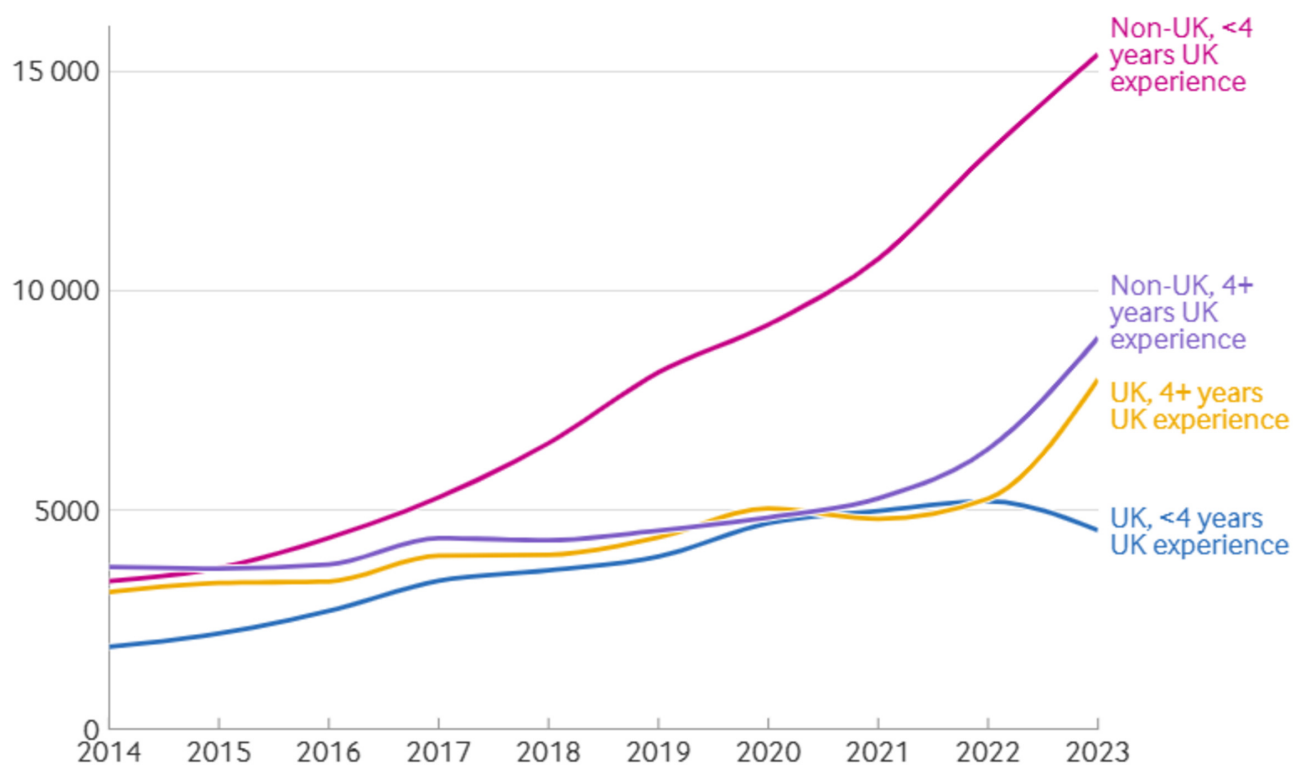
## Licensed doctors on neither register (GMC specialist or GP) and not in training in England and Wales, by NHS contract role



Article DOI: GMC workforce report 2024 • [Download data](#)

Fig 1 | Licensed doctors on neither register (GMC specialist or GP) and not in training in England and Wales, by NHS contract role

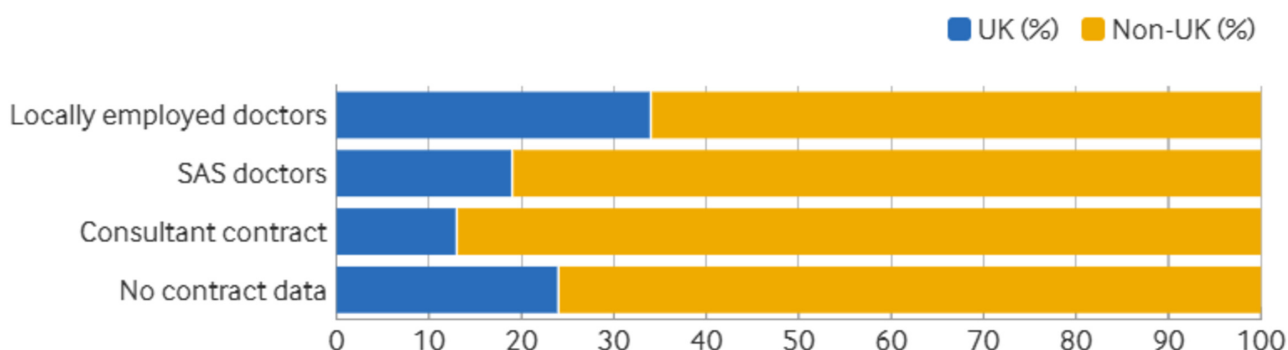
## Number of licensed LEDs in England and Wales, by primary medical qualification and years of UK experience



Article DOI: GMC workforce report 2024 • [Download data](#)

Fig 2 | Number of licensed LEDs in England and Wales, by primary medical qualification and years of UK experience

## Licensed doctors on neither register (GMC specialist or GP) and not in training in England and Wales in 2023, by contract type and primary medical qualification



Article DOI: GMC workforce report 2024 • Download data

Fig 3 | Licensed doctors on neither register (GMC specialist or GP) and not in training in England and Wales in 2023, by contract type and primary medical qualification

### Growing shadow workforce

The vast majority of UK acute trusts use locally employed contracts, *The BMJ* has found. Of 179 trusts that responded, 156 (87%) employed at least one full time equivalent doctor on a local contract in 2024. The median number of LEDs employed in each trust was 55, and the total was over 18 000. In the NHS trusts that provided usable data, around two thirds of LEDs were from ethnic minority backgrounds—more than 10 000 overall.

These figures are based on trusts' own definitions of local posts. Titles and employment categories vary widely—including “trust grade,” “clinical fellow,” and “locally employed doctor”—meaning that the numbers reported by trusts may not be directly comparable or may not capture all doctors on local contracts.

The Royal College of Physicians<sup>3</sup> recommends that once a doctor has been employed in the same specialty by the same trust for more than two years, they should be moved to a nationally negotiated contract appropriate to their training—typically a specialist, associate specialist, and specialty (SAS) doctor contract, although this isn't a legal requirement. Others, including the BMA and the SAS Collective, have echoed this call. But data and case studies gathered by *The BMJ* show that this isn't happening.

At the NHS trusts that responded, more than 4000 LEDs (around a quarter in total) had been employed by the trust for more than two years. In a second round of FOI requests, responses from nine NHS trusts showed that doctors from ethnic minority backgrounds were more likely to have been employed as LEDs for more than two years.

### Trapped despite seniority

One such doctor, a surgeon with a degree from South East Asia, told *The BMJ* that she had been on an LED contract for over 17 years. Over time her responsibilities had significantly grown and included teaching, but this wasn't reflected in her contract, making it hard for her to apply for new positions. When she raised these issues with her line manager she was told that she could either accept the situation or quit.

Many doctors trapped in local contracts spoke to *The BMJ* on condition of anonymity, as they were afraid that raising concerns might jeopardise their careers. Another senior doctor in the East of England region has been trapped in an inappropriate contract for nearly a decade, despite repeatedly attempting to secure the specialty doctor position that she believes she should have had since 2015. She says, “There's not many people like me who will stay 10 years in the job. I have family and health issues, so I can't physically move to a new job—I'm just not in a position to.”

Also in a surgical specialty, this doctor had completed six years of training before having to leave because of health problems. Once recovered, she returned to a role that later turned out to be a trust registrar contract. Ongoing clerical errors, repeated changes to staff management, and constant “changing of goalposts” mean that she's now paid thousands of pounds less a year than she should be: £25 000 less, she estimates.

“I was never told that there will be a point that this contract isn't right for you or that there needs to be an end to this contract,” she says. “So, even though I went for help and information, I wasn't given the information to make a sensible decision.”

### Two tier system

Partha Kar, consultant endocrinologist and a Royal College of Physicians elected councillor, has been working to raise awareness of the issue. Last year he coauthored the college's guidance<sup>3</sup> on how LEDs should be treated by NHS trusts. The guidance notes that this rapidly growing part of the NHS medical workforce lacks standardised educational support and career development. All doctors working in the NHS, it advises, should have access to high quality education, training, and leadership opportunities, with fair pay and supervision.

Kar's inbox is full of examples of LEDs who have no structured supervision or education, are refused leave, and are just being used to fill rota gaps. He believes that the lack of national guidance is deliberate and that local trusts have been left “to do whatever they want.” Accurate data are also hard to come by, as trusts use a variety of names for these posts.

The General Medical Council's own research<sup>4</sup> has concluded that this group of doctors have "vastly different workplace experiences and need targeted and specific support to make the most of their expertise." In response to *The BMJ*'s investigation a General Medical Council spokesperson said, "Locally employed doctors provide a vital resource for the NHS—among them are many highly skilled and experienced professionals. Our own data show that many currently feel unsupported and unable to progress their careers in the way they want."

Kar describes a "two tier system" for doctors in the NHS. "It's like having a parallel shadow industry within the NHS workforce," he says. "It's all very messy at the moment." He adds that, without benchmarks or standards, no one knows what contracts and opportunities everyone should be aiming for or even what the "basics" should be. "NHS England doesn't have national guidance—at least some basics of what an LED contract should look like, which anybody can compare it to," he says. "That's a big issue, and it opens up all sorts of issues around pay, working conditions, and training conditions."

Kar wants to see a national framework that holds trusts to account. There should be no such thing as a non-training doctor, he says, and everyone should have access to clinical and educational supervision and the ability to progress their career.

Kantappa Gajanan, SAS and LED forum chair for the British Association of Physicians of Indian Origin, says that in recent years the association has been approached by a growing number of LEDs. He tells *The BMJ*, "Through our work we have reviewed a wide range of LED contracts across various NHS trusts—some short term, others extending for several years. Many of these doctors are international medical graduates, and there's a clear need to raise awareness about the implications of LED contracts."

"Unfortunately, many doctors feel unable to challenge their employment status due to multiple factors, including family responsibilities, financial pressures, visa constraints, career progression concerns, and the fear of uncertainty. These circumstances often compel them to accept contracts that may not reflect their skills, experience, or contribution."

## Dead end roles

The lack of progression has left many LEDs feeling stranded. A doctor working in plastic surgery in the North West region on a trust grade registrar contract said that this was his second "trust grade" post since moving from India. "This is a stagnant post—there is no scope for growth," he says. He has an educational supervisor, but there's no time for teaching and no pathway for him to progress.

He tells *The BMJ*, "I have seven or eight years of experience, so the consultant, the clinical lead here, has asked them to offer me an associate specialist post, but I don't know when. I don't have anything in writing."

"The previous doctor worked for four years, and she was two years more senior than me. The clinical lead was promising to get an associate post for her, but it didn't happen, and this is why she left."

He has lots of colleagues in the same position, he adds, who feel as though they are there just to fill a service gap, with no thought given to their career development. He explains, "That's the problem with the locally employed doctors—the local trust, they have their own rules, and we're just doing the gap filling role in the service delivery system here."

Another doctor, who has been on a local contract since 2016, tells *The BMJ*, "I'm kind of trapped in this LED contract." After training

in Greece he was put on an LED contract in the UK, but he didn't understand its significance. He says that his total pay is similar, but it has less pension entitlement, no career progression, and no spare time. The lack of progress was what made him start asking questions, but nothing has changed. When he asked his line manager how to change the contract, they didn't know how. The situation has made him angry and upset. "It's been so annoying, and it's been going on for years," he says. "It's so unfair."

A neurosurgeon working in the North West region since 2013 tells *The BMJ* that only when a colleague suggested that he was "overworked and underpaid" did he realise the implications of his local contract. He came to the UK as a senior clinical fellow after training in South Africa. Despite performing thousands of operations and passing his Royal College of Surgeons exams in 2019, he's frustrated at the lack of career progression. Yet moving to another trust leaves him in fear of being "messed around" again.

Another doctor, working in Yorkshire after moving from Pakistan more than two years ago, says that he felt "stuck." Despite being fully qualified he was initially put on a local contract for 18 months that mirrored foundation year 1 pay, before the BMA got involved and the trust was ordered to award him back pay. He's now in a core training level job, although still a local contract, as he was able to share the rota with someone less than full time. But many of his colleagues are stuck in foundation level roles with nowhere to progress and are paid £7000-£8000 less than they would be, had they been able to progress to other roles.

The worst part, he says, is that they're all expected to do "service provision" jobs with no training opportunities and no chance to get experience in different specialties. "I've been working for two years and three months now, and I haven't had a specialty ward yet," he explains. "I haven't been to geriatrics. I haven't been to an acute medicine ward. I haven't been to respiratory or neurology, or any other ward."

At his stage an SAS contract isn't relevant, he adds, but he wants more opportunities to develop. "Many of our trust grades have not had appraisals for the past two years," he says. "The trainees do get their appraisals. We don't have teaching opportunities, and we don't have time for learning. We can't be stuck like this."

## Fear and frustration

Several international medical graduates described having experienced depression, burnout, and discrimination. One told *The BMJ* how he'd left surgical training after experiencing mental health problems but on returning to work in London was given a trust grade post and was expected to work unsafe hours. He found a permanently short staffed team with "minimal consultant oversight," irregular last minute rotas, and overtime beyond safe limits. The adjustments he needed were refused.

He says that the contracts for LEDs are often incomplete or vague, referencing "trust policy" without providing access to those policies. He tried to rally his colleagues on several issues, including exception reporting overtime—but, being international medical graduates, many of them didn't want to rock the boat. He's now decided that, despite many years of experience, he needs to leave surgery and apply for radiology training positions.

One of his colleagues was facing deportation and was offered only a three month extension, which didn't meet his visa requirements. A BMA local representative tells *The BMJ* that visa dependence leaves LEDs with little leverage. He says, "People who need visas might end up taking a less desirable job because it offers them a

permanent contract. That gives the doctors themselves less leverage, because they don't want to jeopardise any sort of position."

### "Contractual wild west"

Responses to *The BMJ*'s FOI requests to see sample contracts confirm that many trusts use contracts that mirror older, nationally agreed contracts—some dating back as far as 2002. These contracts offer none of the safeguards introduced in the 2016 resident doctors' terms and conditions, such as reporting when a doctor's work varies from their agreed work schedule.

*The BMJ* spoke to one BMA representative in the South East region, where doctors have been battling against the use of a 2002 contract. He says, "It doesn't have any of the same protections in terms of things like exception reporting, so the mechanism for declaring unsafe hours and hopefully unplanned overtime, any of that sort of stuff, doesn't exist for locally employed doctors at this trust."

Managers repeatedly say that doctors will move to the 2016 contract, he adds, but they've been saying this for a long time with no change. He explains, "These are pure service provision-type LED contracts, which come with all the hard work and disruption of long on-call shifts, busy on-call rotas, and none of the protections." He says that people end up in an "indefinite loop," repeating the second year of foundation training again and again.

The Royal College of Physicians has urged trusts to take a consistent and proactive approach to supporting internationally qualified doctors who are new to the NHS and on local contracts, while campaigners in the SAS Collective<sup>5</sup> have called for automatic transition to SAS contracts after two years.

The BMA's Runswick calls out the "fundamentally unfair" treatment of LEDs. "These doctors are disproportionately from ethnic minority backgrounds or are international medical graduates—contributing to the institutional racism within the health service," she says. "It's a profound waste of talent and expertise to keep doctors trapped in roles where they can't offer their full potential or are expected to do so without the proper recognition."

She adds that the government must mandate fair, standardised contracts. "This means the use of the appropriate SAS national contracts to those working at the level of a specialty doctor and above, and the 2016 resident doctors' terms and conditions for early career LEDs," she says.

A spokesperson for the Department of Health and Social Care says that LEDs are "an integral and highly valued" part of the NHS and that it is aware of reports from doctors that "trusts are not appropriately treating staff . . . This is completely unacceptable, and we are committed to improving working conditions through the implementation of elements of the SAS pay deal."

NHS Employers also says that LEDs are "valuable" to the NHS and should be supported to help develop their careers. But nationally agreed contracts, although recommended, are not always suitable, says its chief executive, Danny Mortimer.

"LED contracts work in a wide variety of roles, and employers should make these roles clear, equitably managed, and appropriate for that post," he advises. Mortimer adds that NHS Employers would like to see greater use of SAS contracts where appropriate and is working with the BMA to enable LEDs who do SAS level work for more than two years to move onto SAS contracts.

Fleming, who has been campaigning for change with the SAS Collective after seeing some of the worst excesses of LED contracts, says that the NHS must be stopped from "behaving like a gig

economy employer." He concludes, "We believe that locally employed doctors should be offered the appropriate permanent SAS contract for their work. As well as employment rights, this would give these folks the professional identity they are currently being denied."

### "It took seven years to escape my contract"

Peter Rose, a paediatrician at Peterborough City Hospital, spent seven years on a locally employed registrar contract before successfully moving to a specialty doctor SAS contract owing to specific service need and persistence from medical leadership.

After leaving training in 2016 because of burnout he was retained locally in a general acute job. In 2021 the healthcare trust was struggling to fill a post for a paediatrician specialising in epilepsy, and he was offered a substantive SAS (specialist, associate specialist, and specialty) post. By this point he was on a locally employed doctor (LED) contract, but he met all the criteria for a specialist working independently.

Even with that clear service need, however, it still took two years for the paperwork to be signed off and the post agreed, he notes. He now leads the trust's large and extremely busy paediatric epilepsy service, overseeing 600 patients.

"I've been able to rebuild a service from the ground up," says Rose. "It's been quite rewarding in that sense." But had that opportunity not arisen, he adds, he's not sure that he would have been moved to an SAS role.

LED contracts are inherently insecure, he explains, as they're usually fixed term and you don't know whether they will be rolled over. He's seen the important difference that the move to an SAS contract has made in his own career, and he now works to advocate the same for others as the Royal College of Paediatrics and Child Health's SAS committee representative.

Rose says, "There's a financial element to it, because it's cheaper to keep someone in a locally employed contract, but it's quite exploitative in the sense that you can keep people stuck in essentially indentured servitude indefinitely."

Competing interests: We have read and understood the BMJ Group policy on declaration of interests and have no relevant interests to declare.

Provenance: Commissioned; externally peer reviewed.

We thank Kate Relton for additional support with the FOI queries.

- 1 Review Body on Doctors' and Dentists' Remuneration. Fifty third report—2025 (CP 1321). May 2025. [https://assets.publishing.service.gov.uk/media/682f3674b33f68eba9539c9/DDRB\\_53rd\\_Report\\_2025.pdf](https://assets.publishing.service.gov.uk/media/682f3674b33f68eba9539c9/DDRB_53rd_Report_2025.pdf) (p 76)
- 2 General Medical Council. The state of medical education and practice in the UK: workforce report 2024. Nov 2024. <https://www.gmc-uk.org/cdn/documents/somep-workforce-report-2024-full-report.pdf-109169408.pdf>
- 3 Royal College of Physicians. Educational and career support for locally employed doctors (LEDs) and international medical graduates (IMGs)—guidance for doctors and employers. Aug 2024. <https://www.rcp.ac.uk/media/tfkj52qc/educational-and-career-support-for-locally-employed-leds-and-imgs.pdf>
- 4 General Medical Council. SAS and LE doctors need targeted and specific support, GMC report shows. 9 Oct 2023. <https://www.gmc-uk.org/news/news-archive/sas-and-le-doctors-need-targeted-and-specific-support-gmc-report-shows>
- 5 SAS Collective. Empowering SAS doctors across the NHS. <https://www.sascollective.com/>