NHS Employers

Transitioning locally employed doctors and dentists onto substantive contracts

11 September 2026

Version 1

BMA

About

This guidance has been jointly agreed by the contracts delivery group of the residents doctors industrial relations committee. The group is made up of representatives from the British Medical Association (Resident Doctors Committee), NHS Employers, NHS England, the Department of Health and Social Care, and employer representatives.

NHS Employers

BMA

Introduction

As part of the deal between the government and the BMA Resident Doctor Committee, it was agreed that 'From August 2026, employers will be expected to transition LEDs to substantive employment contracts, except where there is a legitimate reason to use a fixed term one (for example, where a person is employed for the purposes of covering a secondment, long-term sickness, maternity, paternity shared parental leave or adoption leave)'.

This guidance is intended to provide direction and advice on offering substantive contracts and considerations on managing short-term vacancies. Example scenarios and FAQs are included to aid understanding of the intended approach.

The offer to move locally employed doctors and dentists to a substantive contract forms part of the negotiated deal to end the industrial dispute between the BMA and the government. Trusts that do not comply or follow the detail in this guidance will therefore be in breach of the terms of that agreement.

It is important for both local and national industrial relations that progress against this is demonstrable in September, with transitions starting from September.

Employers have previously been able to determine the basis of the locally employed doctor contract and will have been used to offering fixed-term contracts as part of their work practices for a number of years. This element of the deal requiring employers to provide substantive contracts to their locally employed doctors and dentists will be a significant change, and employers will need to communicate and engage with local stakeholders to help ensure that this change in approach is understood and its implications on individuals and services are considered.

Implementation

Employers should by default offer permanent contracts to new LEDs, and transition current LEDs to a permanent contract.

Keeping an LED on a fixed-term contract or offering a new fixed-term contract should be by exception and only where there is a legitimate reason to do so, as per the detail in this guidance.

These are significant changes to current working practices, but effective implementation will also require system changes in workforce planning.

National workforce planning and the filling of training posts can fluctuate significantly between rotations, contributing to gaps at relatively short notice outside the employer's control. The current system is not fit for purpose and has exacerbated the need for temporary staffing and poorer employment practices for LEDs. The proliferation of fixed-term contracts has been a symptom of a failure to workforce plan effectively at national level, and this guidance alone will not be sufficient to address those failures of workforce planning. Ongoing work at national, regional and local level is required to enable system-wide change that will minimise poor planning practices going forwards.

The ongoing medical and education training review (METR), led by Professor Jane Dacre, aims to modernise postgraduate medical training and among other areas, is exploring rotational training and flexibility which will impact on national workforce planning. To ensure the steps taken as part of this review will positively impact short-term training gaps and the need for fixed term contracts, the Resident Doctor Industrial Relations Committee (RDIRC) will meet with leads from the METR following its interim report.

While we await the conclusion and recommendations, we are asking employers to engage with key stakeholders locally and regionally to ensure services are adequately staffed and variations in workforce are minimised as much as possible. This may include, for example, internal reviews to identify flexibilities in staffing and rostering to accommodate small variations in workforce while offering LEDs permanent positions.

Monitoring

As part of implementation, we expect trusts to put in place their own processes to monitor implementation which should include regular reporting to boards and local negotiating committees to monitor progress and address challenges as they arise.

The Resident Doctor Industrial Relations Committee (RDIRC) is monitoring the implementation of the entirety of the deal, and as part of this, will be requesting regular information from trusts. This review process is being coordinated across all deliverables in the deal to streamline and ease the burden on both employers and doctors, and information on exact processes will follow.

To support both local and national monitoring of compliance, employers are advised to keep a record of the following, which will be required to comply with future monitoring requirements:

- The current number of LEDs, and separately the current number of resident doctor LEDs within this cohort.
- The current percentage of fixed-term and permanent contracts for LEDs.
- Rationale where a decision has been taken to use a fixed-term contract (including those who have opted to remain on fixed-term contracts).
- Any plans and strategies to further increase and promulgate the use of permanent contracts.

In February 2027, the RDIRC will undertake a review of the implementation of the deal in relation to permanent contracts. The data collated will form the basis of a national benchmarking exercise, which will create a national benchmark for trusts to follow going forwards. Following the review and introduction of a national benchmark, any trust falling below this will be audited.

The review will seek to highlight challenges facing organisations, as well as identify where changes are needed to the process or to the guidance which will aid better implementation of the aims of the deal (for example whether there needs to be a cap on the total number of fixed term contracts per organisation).

Frequently asked questions

1 Which locally employed doctors and dentists are within the scope of this deal and guidance?

For the purposes of the deal and this guidance, LEDs in this instance refer to locally employed doctors and dentists paid according to a pay point equivalent to a pay point that exists under the 2016 Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) (TCS) or 2002 TCS. When we refer to doctors in this guidance we mean both doctors and dentists.

2 Do we need to give doctors the choice of moving to a substantive contract?

Yes, an existing locally employed doctor must be given a choice on whether to accept a substantive contract or not. Any substantive offer must be on terms which are equivalent to the doctor's existing employment. Unless otherwise agreed with the doctor, the offer must retain the same contracted whole-time/ less-than-full-time equivalent status and pay point. A refusal of an offer which does not meet these requirements will not discharge an employer's obligation to offer a substantive contract. If a doctor chooses to retain a fixed term contract over a substantive contract, this should be recorded.

If a doctor chooses to remain on a fixed term contract but then chooses to end their employment or the contract expires then the next doctor in that post should be offered a permanent contract as the default.

3 When should we be offering substantive contracts?

Offering substantive contracts to locally employed doctors will now be the default position.

The deal mentions there will be exceptions where fixed-term contracts can be offered when there is a legitimate reason (for example, maternity cover, paternity cover, adoption leave, long-term sickness, covering for a secondment). These exceptions are not expected to be the norm. Further examples of scenarios which can be considered a legitimate reason are included in FAQ 4.

4 What are other legitimate reasons to offer a fixed-term contract rather than a permanent contract?

Employers should by default offer permanent contracts to new LEDs, and transition current LEDs to a permanent contract. Offering a fixed term contract should be by exception and only where there is a legitimate reason to do so as per the detail in this guidance. As a result, it is the expectation that the overwhelming majority of LEDs are on substantive contracts.

The deal recognises that there will need to be some exceptions and some examples are listed in the deal: employed for the purpose of covering a secondment, long term sickness, maternity, paternity, shared parental or adoption leave.

Other specific examples include:

Example 1. Short-term additional capacity in response to unpredictable demand

Where there are temporary short-term capacity requirements, such as surge pressures or specific waiting list initiative requirements there may be a need for a short-term workforce. Winter pressures are generally predictable and therefore are not in themselves a legitimate reason to offer fixed-term contracts.

In the first instance, employers should look to utilise the flexibility provided by their cohort of substantive locally employed doctors, through the following steps:

a) Consider flexibility within existing rotas

   i Employers should review the working hours of doctors within the department and relevant rota tier to identify opportunities to flex working arrangements, which could help reduce the need for a fixed-term appointment. Any such arrangements would be subject to the doctor's agreement.

   ii Where this is not feasible, employers may find it helpful to undertake a rota review to assess workforce capacity,

opportunities for flexibility, and the overall number of doctors on the rota.

b) Explore opportunities to meet service requirements through existing workforce capacity

i Employers should consider whether other LEDs within the organisation have the appropriate clinical experience and skills to support temporary increases in service demand. Any such arrangements would be subject to the doctor's agreement and any necessary amendments made to their work schedule.

ii Additional consideration should be given where rotas are particularly complex or involve contributions from multiple teams or specialties. For example, an organisation may operate an on-call rota supported by several specialties. In these circumstances, it may be worth exploring whether adjustments to specialty contributions could help address workforce pressures.

c) Consider whether a broader substantive LED role may be appropriate

Before creating a department specific LED post, employers should consider whether there is a broader organisational need that could support the creation of a substantive role spanning multiple departments or services, where appropriate.

i Effective workforce planning across the medical workforce may help identify opportunities for wider roles. For example, a role described as a "locally employed clinical fellow in medicine" may offer greater flexibility than a "locally employed clinical fellow in respiratory". In all cases, job descriptions and advertisements should accurately reflect the work the postholder is reasonably expected to undertake.

ii Where such an approach is adopted, employers are encouraged to ensure that the doctor's skills, experience and qualifications align with the duties and requirements of the role.

d) Consider temporary staffing options

Employers may wish to consider the use of bank arrangements where these are appropriate and represent a suitable solution to meet short-term service needs.

If none of the above addresses the workforce need, a fixed-term contract can be offered for a period of up to six months. Where a fixed-term contract is due to expire but the need for the post remains then the existing post holder should be offered a permanent contract. If the existing postholder chooses to end their employment at the expiry of their fixed-term contract, then the next doctor in that post should be offered a permanent contract as the default.

Before deciding that a fixed-term contract is the most appropriate option, employers are encouraged to consider the factors outlined above and retain a record of the considerations undertaken. As part of the national review process in February 2027 outlined in this guidance, organisations which fall below the national benchmark that will be introduced will be audited and therefore an audit trail of decisions made to offer fixed-term contracts and the rationale, should be maintained.

Example 2. Short-term funding for a post

Where an employer has received external funding, for example though charitable or research funding, which necessitates the creation of an LED role, a fixed-term contract may be offered. If the employer offers a fixed term contract, the employer must note its legal obligations around ending fixed-term contracts.

For research or academic posts which are funded by employers internally, then the LED should be offered a permanent contract as a default, except where there is a genuinely time limited requirement for the role such as a six-month project. If the funding is extended, the LED should be offered a permanent contract.

Where funding has been consistently renewed over the past two years, a permanent contract should be offered. For example, a clinical teaching fellow whose salary is partially or wholly funded through university funding should be offered a substantive contract if funding will remain the same going forward into the next year or the role will continue to be required.

Example 3. Converting LED funding to a future training post

The deal references that some training posts will be partly funded by some LED roles coming to an end. Employers will identify to NHS England the posts which they wish to place within this category. NHS England will then work with the BMA via the Training Allocation and Distribution Group to confirm that the requested fixed-term contracts do not exceed the number of expressions of interest (EOIs) submitted by the employer.

5 Secondment is listed as a legitimate reason to continue to offer a fixed term contract. Does secondment in this instance include covering a doctor on out of programme (OOP) activity?

Yes, however only if the secondment gap is based on a named resident doctor who has a start and expected return date with the organisation.

6 When does this exercise need to be initiated?

The deal states that this exercise is “From August 2026”. The expectation is that there is demonstrable evidence of progress of this being rolled out in September.

As outlined in the monitoring section, we expect that trusts put in place their own process to provide assurance that the deal is being implemented as intended. This should include regular reporting to the trust board and engagement on the plans for roll out with the relevant JLNC.

All new contracts should by default be substantive except where there is a legitimate reason. The option of a substantive contract should be made available where there is no legitimate reason creating an exemption. This is particularly important for doctors who have been employed continuously by the employer for two years or more, as they may have statutory protection against unfair dismissal under the Employment Rights Act.

7 How does this interact with the requirement in the deal to move LEDs onto repurposed 2016 contracts by September 2026 should the doctor wish to?

A “repurposed contract” refers to the 2016 Terms and Conditions of Service (TCS), which have been adapted for locally employed doctors rather than creating a new contract. As the 2016 TCS were originally designed for fixed-term training appointments, amendments are required to make them suitable for permanent contracts.

These are two separate elements of the deal that both need to be completed.

It is important however to remember that:

- It may be that some doctors choose not to move onto a repurposed 2016 contract, and it is important that they are still offered a substantive contract, unless there is a legitimate reason their contract should remain fixed term.
- There may be a legitimate reason why a contract is fixed term rather than permanent, but they should still be offered a move to a repurposed 2016 contract.

Further guidance on moving LEDs onto repurposed 2016 contracts will be shared soon.

8 Who should be involved in implementation?

This approach of offering substantive contracts to locally employed doctors will require a change in thinking and working practice across the organisation and may require different approaches in the future to how things might have been undertaken historically. It is important to make sure that staff involved in finance and budget management and workforce planning are aware of this change in practice.

It is recommended that employers set up a short-term working group to bring together key staff required to implement this change. This would include staff required to implement the

contract change, and staff responsible for workforce planning for locally employed doctors in the short, medium and longer term. This might include workforce teams, medical directors, staff-side resident doctor LNC reps, the LNC chair, directors of medical education, operations managers and finance colleagues.

With a more permanent LED workforce, day to day management, induction, support and appraisal of the workforce will also need to be given due consideration.

9 What are some of the implications of this change in relation to workforce planning?

Employers will be used to utilising fixed term contracts for locally employed doctors and this change will require more rigorous consideration of how employers utilise locally employed doctors. Employers should consider whether it is appropriate to appoint a permanent locally employed doctor in each circumstance and consider how they need to use this workforce more flexibly to avoid unnecessary redundancies. Examples of the considerations employers should make are outlined in paragraphs a to d in FAQ 4 “Short-term additional capacity in response to unpredictable demand” section.

Employers may also wish to consider how they recruit and manage pending offers with regard to the changes in workforce planning.

10 Do we need to interview existing LEDs or follow a further recruitment process?

No. Employers do not need to interview current LEDs prior to transitioning to substantive contracts, nor follow a separate recruitment process. Offers to make LEDs permanent should be seen as making existing roles permanent, not appointing to new/distinct permanent roles.

As part of implementation, employers should have due regard to equality, and it is recommended that an equality impact assessment is conducted.

11 How does this interact with the eligibility and permanency framework (EPF) and SAS contracts?

The transition of locally employed doctors to substantive contracts should not prevent or discourage appropriate progression into SAS roles. Read further guidance and a comparison of the two frameworks.

Example scenarios

Scenario one – education fellow funded through external education funding streams

An education fellow is employed on a fixed-term contract funded through an external grant. Although the requirement for the role and the associated funding is predictable and ongoing, the position currently continues to be offered on a fixed-term basis.

The external education funding stream has been consistently renewed over the past two years, and discussions with the funding body indicate that support is expected to continue into the next financial year. Consequently, there is no current indication that the funding for the role will cease, and a substantive contract would be appropriate and should be offered.

Scenario two – clinical fellow within funded workforce establishment

A department has a number of clinical fellow posts within its approved and funded workforce establishment. These posts are included in the annual budget and are therefore considered permanent positions within the department's staffing structure. Historically, however, the department has filled these posts on fixed-term contracts rather than on a substantive basis, aligning fixed-term contracts to rotation lengths for rostering convenience.

As the posts themselves remain part of the funded establishment year after year, a substantive contract would be appropriate and should be offered.

Scenario three – recurring gaps on a medical training or dentistry rota

A large NHS trust operates a medical training or dentistry rota that has experienced recurring gaps over previous rotation cycles. Analysis of rota fill rates and staffing patterns shows a consistent trend of vacant training posts and periods where resident doctors are unavailable due to leave or other workforce pressures.

Based on this established pattern, the trust/organisation can be reasonably confident that similar gaps will continue to arise on an ongoing basis. As a result, additional staffing cover will regularly be required to maintain safe service delivery and ensure continuity of patient care.

Given the size of the trust/organisation and the scale of the rota, these gaps are not viewed as isolated or exceptional events, but rather as a predictable feature of workforce planning. The trust therefore anticipates an ongoing requirement to provide cover for training rota vacancies as they arise and substantive contracts would be appropriate.

Within this guidance, we have outlined the variability within national workforce planning for training posts which can contribute to short-term training gaps for individual employers outside of their control.

Further work to address this is being undertaken including through the METR, however in the meantime we recognise that in limited circumstances employers may require a fixed-term contract to cover short-term gaps (six-12 months) as a result of training gaps. Employers should exhaust the steps outlined in paragraphs a to d in FAQ 4 under the “Short-term additional capacity in response to unpredictable demand” section, before using a fixed-term role to cover a short-term gap. These steps should be recorded and be readily available for monitoring and auditing. As per the above, should the training gap continue beyond the end of the fixed-term contract resulting in an extension or renewal, then the LED should be offered a substantive contract.

This scenario is considered an exception for a time limited period while the system failures that generate these gaps are identified and addressed through further work, including the METR. During this period, it is still the expectation that the overwhelming majority of LEDs will be offered or transitioned to permanent contracts. At the point of the review of this guidance in February 2027, a decision will be made to either remove this scenario as an exception, or an employer level cap on the overall number of LED fixed term contracts will be introduced. The interim findings of the METR will be out before February 2027, and will help inform next steps.

Scenario four – Secondment cover for out of programme

A specialty registrar (ST6) is undertaking an approved out of programme research (OOPR) placement. The employer has confirmation of:

- the name of the resident doctor occupying the training post
- the reason for the absence
- the expected return date.

The organisation/trust recruits a locally employed doctor to provide service cover during the resident doctor's absence. In this scenario, a fixed-term contract would normally be appropriate because the requirement for the post is temporary and linked to the absence of a named individual with a known return date.

The contract could be issued for the duration of the OOP period, or until the substantive resident doctor returns to the post if earlier.

Scenario five – fellowships for doctors who have a CCT

A trust offers roles in a department for doctors who have recently been awarded their Certificate of Completion of Training (CCT) to enable them to gain experience by working in that sub-specialty.

The expectation is currently that these doctors will apply for a substantive consultant post in that specialty/ sub-specialty once they have gained the relevant experience however, the organisation/ trust should offer these roles as substantive contracts.

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