Submission from the Royal College of Nursing to the Nursing and Midwifery Council consultation on proposals to change Nursing and Midwifery practice learning education standards

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Executive Summary

Background

The Nursing and Midwifery Council (NMC) is consulting on a range of proposed changes to pre-registration nursing and midwifery practice learning education standards, including reducing programme hours for nursing by up to 1,000; extending the length of the midwifery programme, mandating a community placement and strengthening anti-racism and bias awareness within nursing and midwifery education.

Nursing and midwifery programmes are currently required to be 4,600 hours in length, with a strict 50:50 ratio of theory (academic) to practice (placement). The NMC is proposing that a reduction in overall programme hours to a minimum of 3,600 hours for nursing would enable more "flexible and focused routes into practice", while an extension of the midwifery programme length, keeping the current hours requirement at 4,600, would support midwifery students to attain the breadth of experience and the reflective learning needed to meet the complex needs of women, babies and families.

This is in response to a series of challenges facing nursing and midwifery education, such as inconsistency in experiences of students on practice learning placements, and variation in the quality of placement experience. When the UK left the EU, this presented an opportunity for the NMC to have greater flexibility in standard setting for pre-registration nursing and midwifery programmes in relation to theory and practice hours.

The Royal College of Nursing (RCN) as the voice of nursing across the United Kingdom and the largest professional union of nursing staff in the world, representing over half a million registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, welcomes the opportunity to respond to the NMC consultation on the proposed changes on nursing and midwifery practice learning education standards. We remain committed to nursing and midwifery as safe, evidence-led, degree-level professions, and this response sets out our position on each of the relevant proposals in turn.

The RCN's response

This paper serves as the RCN's substantive UK-wide response to the consultation. It provides additional context, discussion and nuance on the RCN's position that cannot be fully captured through the consultation survey. The RCN has also submitted a response via the NMC's online survey, this response is reproduced in the Appendix to this document.

The RCN developed this response based on UK-wide member engagement including:

- Online targeted engagement events across RCN UK Governance Committees and Professional Forums.
- A UK RCN member survey.
- A review of existing RCN member evidence including a student survey of 2,504 participants in late 2025 and student responses to the RCN's Last Shift Survey 2026.
- A comprehensive literature review, desk research, international comparisons and stakeholder engagement.

While the RCN has engaged members in this response, we also encouraged members to respond to the NMC directly, using the survey.

Key issues and risks

Following our member engagement and analysis of data collected, as outlined above, several critical, consistent themes emerged.

- Concerns regarding the strength of the evidence underpinning proposed reductions in nursing programme practice learning and theory hours.
- The NMC proposals focus on practice hours and have not given sufficient consideration to the wider assurance arrangements, including entry requirements, curricula and assessment.
- There remains a critical need to protect time for supervisors and assessors to ensure high-quality support and assessment in practice learning environments no matter the number of placement hours.
- Educational reform must be shaped by evidence-based educational and professional rationale.
- Broad support exists for strengthening anti-racism, cultural safety, and community-based learning, but only if matched by clear standards, infrastructure, and accountability.
- Perceived inequities exist in the proposal to extend midwifery programmes while simultaneously proposing to reduce nursing hours, risking the creation of an unwarranted tier between the two professions. The same rationale the NMC gives for extending midwifery training – managing increasing complexity and safeguarding quality – applies equally to nursing, and this inconsistency potentially impacts how much nursing is valued as a safety-critical profession.

The burden of responsibility for making the case to enact these proposals is with the NMC, and they have not presented sufficient evidence to support their position. The RCN has therefore arrived at the following positions in response to each of the proposals.

Nursing programme hours

The NMC is proposing to reduce the minimum nursing programme hours from 4,600 to 3,600 (retaining the 50:50 theory/practice split) and to maintain Nursing Associate hours at 2,300.

The RCN disagrees with reducing nursing programme hours due to the lack of evidence-base for the proposal and the risks posed by a reduction.

The RCN is concerned about the quality of placements, and we do not believe that the NMC has demonstrated how reducing programme hours will address these concerns. Nor has credible evidence been presented to demonstrate that a reduction in hours would maintain or improve the outcomes for nursing students, registered nurses, or patients.

RCN member feedback demonstrates that without a strong evidence base and robust quality assurance safeguards in place, there is a strong opposition to reducing programme hours within the profession.

The RCN agrees that it is the quality of nursing education that should determine whether a nurse is fit to register and practise and accept that the current quantity of programme hours is not evidence based (Kenny, A et al 2025) with a lack of robust evidence either way on the optimal number of hours required. This absence of evidence strengthens the case for robust quality assurance processes across the entire education pathway from recruitment and curriculum design through to revalidation.

While proposing that programme hours be reduced by just under 22%, the NMC will retain the requirement for a 50:50 split between theory and practice learning. While the NMC has informed the RCN that universities will continue to have the flexibility to offer above the minimum requirement of 1,800, the current context of financial and workforce pressures on universities, additional to the reduction in faculty, makes this extremely unlikely and we expect institutions will deliver the required minimum number of hours. As the Royal College of Nursing we do not support a 'race to the bottom' approach for the profession. There is also a risk of structural incentives to reduce placement provision, with practice learning providers likely to reduce the number of placement hours offered, not to improve educational quality but to relieve service pressures - reflecting wider pressures across academia as well as placement settings, and feeding into a broader reductionist approach to nursing education.

Furthermore, the reduction in registered nurse programme hours, and the proposal by the NMC to retain current programme hours for registered nursing associates risks narrowing the gap and professional distinction between these different roles, potentially devaluing registered nurses. This could lead to greater substitution of registered nurses and incorrect deployment of registered nursing associates. In practice, there are already significant concerns around inappropriate extension to the Nursing Associate role and increasing evidence of substitution of registered nurses with registered nursing associates.

Improving the quality of pre-registration nursing education requires change across the pathway as a whole, including the quality assurance measures set out throughout this

paper, from entry standards through to supervision and assessment capacity and final assessment process. The RCN is calling for the introduction of a mandatory preceptorship framework for all newly registered nurses to support the effective transition from student into the nursing workforce.

The NMC should work with governments across all four UK countries to implement and quality assure national preceptorship frameworks that are aligned to nursing professional standards. These frameworks should allow preceptees a structured, supported transition from student to autonomous registrant, embedding the standards of proficiency and supporting safe and effective transition into practice.

Simulated practice learning

The NMC has proposed to cap simulated practice learning at 25% of practice placement hours, should programme hours be reduced in line with current proportions.

The RCN disagrees with this proposal.

In the event that programme hours are reduced overall, following this consultation, the NMC should conduct a follow up consultation to review the role of simulation in nursing education. We believe that should programme hours for nursing be reduced, then simulated learning hours should be reduced to a proportion less than 25% of practice learning hours. This is because a reduction in programme hours would necessitate greater focus on real world practice learning.

Furthermore, the NMC has not provided the quality assurance that was requested by the RCN when simulated practice learning was increased to 600 hours (RCN 2017, RCN 2023). Our members tell us that the quality of simulated practice learning varies considerably across education providers. Greater assurance on quality and consistency is required if we are to rely more heavily on simulated practice learning in nursing education. This is a particular concern given the Professional Standard's Authority's most recent performance review found the NMC was not meeting the standards expected of a regulator [PSA, 2026]; the RCN lacks confidence in the NMC's ability to assure quality education without stronger independent oversight.

Community learning placements

The RCN agrees with the NMC's proposal to require all nursing students to have at least one community practice learning placement.

However, it is our view that this must only be mandated once the NMC provides a clear definition of what counts as a community placement, sets quality assurance standards for placement providers and works with governments in all four countries to publish a credible plan for scaling up capacity in the community sector to provide practice placements.

A phased approach to implementing this change must also be employed, to ensure consistency and quality, sufficient investment will also be needed to ensure that settings are equipped and incentivised to provide quality learning experiences consistently across the four UK countries.

Equality, diversity and inclusion

The RCN agrees with the NMC's proposal to strengthen anti-racism, bias awareness, cultural safety and respect requirements across nursing and midwifery education. However, this must translate into real protections for students (many students report experiencing racism and other forms of discrimination in placements). Therefore, the development of standards cannot be a paper exercise; they need embedding in everyday teaching, supervision, assessment and complaints handling, with measurable impact for students within the NMC, within PLPs and AEIs.

Reasonable Adjustments

The consultation also proposes strengthening partnership working between AEIs and PLPs specifically in relation to reasonable adjustments – a distinct proposal which the RCN strongly supports, and which we address separately later in this response.

Midwifery proposals

The NMC proposes extending pre-registration midwifery programmes from three to four years while retaining the existing 4,600 programme-hour requirement. This proposal is intended to address challenges in achieving the current requirement for students to be involved in 40 births and to respond to concerns raised through recent maternity safety inquiries.

The RCN is concerned that the NMC has not adequately explained why quality concerns in midwifery are being addressed through an extension in the number of programme years, while quality concerns in nursing are being addressed through a reduction in overall programme hours. These contrasting approaches risk creating inequity between the professions and sending an unintended message that nursing requires less preparation, thereby contributing to the devaluation of nursing education and practice.

The RCN therefore does not support the proposal in its current form.

Practice assessors and supervisors

The RCN agrees with the NMC proposal to allow SCPHN-qualified midwives to act as practice assessors for nursing students in public health settings, provided the SCPHN-qualified midwife is working in a public health role such as Health Visiting or School Nursing.

RCN recommendations

Following our analysis of the proposals, RCN member engagement and review of the evidence and literature, the RCN has compiled the following detailed recommendations for the NMC to achieve their stated objectives to improve the quality and consistency of practice learning. We acknowledge that these recommendations go beyond the scope of the survey questions but are included as the College believes that a wider range of reforms are necessary to address the issues identified. These are summarised below.

It is our view that our recommendations should be taken forward in totality, given the interconnected nature of quality assurance interventions, rather than in part. We also stress the importance that NMC revisit the areas covered in this consultation should substantive, new evidence emerge, including around any association between programme hours and graduate preparedness and patient safety.

Quality Assurance

The NMC should implement the following in relation to quality assurance:

- Work with Approved Education Institutions (AEIs) to ensure entry requirements are appropriate with academic capabilities, values and behaviours needed for students to learn effectively and practice safely and effectively throughout their programme and upon registration.
- Review and consult on the Standards for Student Supervision and Assessment (SSSA) and the Pre-registration Education Standards, before implementation of any change arising from this consultation.
- Require standardised, mandatory training for all practice assessors and supervisors, with a minimum experience requirement (for example, excluding newly registered nurses or those still in preceptorship from acting as practice assessors).
- Commission an external audit of the NMC's current quality assurance processes for Approved Education Institutions (AEIs) and placement providers
- Reinstate university programme monitoring by the NMC, to ensure consistency of education provision and outcomes across AEIs, in addition to the current AEI self-assessment.
- Develop with stakeholders including the RCN, nationally agreed standards for placements and learning environments and set clear, sufficient ratios of practice supervisors to students, to ensure greater consistency.
- Conduct a rapid review of the role a national, universal objective assessment, could play in assuring quality and consistency at the point of registration, and how this could be designed and implemented.

In support of this, Governments in all four countries should:

- Explore current funding arrangements and remove any financial disincentives for AEIs and Practice Learning Partners (PLPs), to exceed the minimum hours in programme delivery.

- Ensure that protected time for supervision and assessment is sufficiently factored into workforce planning assumptions.

Programme hours, Preceptorship and Post-Registration Transition

The NMC should:

- Retract the proposed reduction in nursing programme hours from 4,600 to 3,600 on the current evidence base, and require any future proposal to be supported by outcome data demonstrating equivalent or improved outcomes for nurses and patients as a result of the reduction in hours.
- Work with governments in the UK to develop a mandatory preceptorship for all newly registered nurses.
- Implement, irrespective of any decision on hours, the quality-assurance measures included in this document, recognising that this will require at least six months of review and consultation before any change takes effect.
- Publish a full, four-country impact assessment addressing Northern Ireland/EU cross-border recognition, the Scottish Honours degree structure, and the Welsh curriculum and commissioning context, before finalising any change to programme hours.

Nursing Associate Programme Hours

The NMC should:

- Withdraw the proposal to reduce Registered Nursing programme hours from 4,600 to 3,600 on the basis that this reduction will harm the perceived value of the nursing profession and could lead to greater substitution of Registered Nurses with Registered Nursing Associates to the detriment of patient care.
- Include in their Equality Impact Assessment an assessment of the workforce, professional and patient safety consequences of changing Registered Nursing programme hours.
- Undertake a full evaluation of the Registered Nursing Associate programme, including access to progression opportunities.

Simulated learning

The NMC should:

- Reconsult on a reduced cap for simulated practice learning, at lower than 25%, should programme hours be reduced overall.
- Urgently undertake an evaluation of quality and consistency in simulated practice learning and establish a robust quality assurance framework and programme for ongoing monitoring.

Community placements

The NMC should:

- In partnership with stakeholders, including the RCN, develop an agreed definition of a community placement to ensure ongoing quality of placement experience.

- Develop a Quality Assurance plan and establish regular monitoring to ensure students are obtaining safe and appropriate learning experiences that are of a high standard.
- Consider student safety as part of its ongoing guidance to placement providers, and the NMC's EqIA should address any issues and barriers to accessing community placements.
- Produce clear guidance for placement providers.
- Governments in all four countries must address financial barriers to providing community placement experience including financial incentives for smaller providers to pump-prime access to quality placement experiences across the independent, private sector and general practice.

Equality, diversity and inclusion

The NMC should:

- Publish the specific standard(s) it proposes to introduce or amend under Proposal 1, with indicative wording, and clarify how this relates to standards 1.10, 3.11 and 3.12 as they currently stand, to the separately published anti-racism principles, and to its ongoing Code and Revalidation review.
- Embed anti-racism, bias awareness and cultural safety as a core, assessed part of curriculum, supervision, assessment and complaints handling (for example, not a one-off session or annual e-learning module) and require AEIs and PLPs to monitor and publish placement allocation data by ethnicity and other protected characteristics, given evidence that unequal allocation of placements has disadvantaged students on racial, ethnic and socio-economic grounds.
- Commit to collecting and publishing measurable, disaggregated outcome data on student experience and progression by protected characteristics so that impact can be demonstrated rather than assumed. This could include differential attainment and progression rates, complaint resolution times, and university Fitness to Practice referral rates by ethnicity.
- Strengthen accountability for the anti-racism principles: confirm whether the gap analysis matrix used by AEIs and care providers will be independently verified, name a single, standardised destination for the data it generates (ideally routed through EdQA), and set out what happens, in practice, when an AEI or PLP does not meet the expectations set out.
- Not rely on Speak Up Guardians and existing raising-concerns routes alone as these are reactive measures. Require AEIs, PLPs and the NMC's own quality assurance processes to proactively monitor for patterns of poor culture and discriminatory treatment, with clear accountability for resolving concerns owned by a named body, rather than responsibility passed between organisations.
- The NMC's full Equality Impact Assessment does not include a mitigations column, or a named owner and target date against the risks it identifies and does not state how often it will be reviewed or whether updated versions will be published. We would ask the NMC to add each of these, and to publish the findings of any further engagement it undertakes with underrepresented groups where it has identified evidence gaps.

- The NMC should also commit to promoting and embedding practical tools that support consideration of reasonable adjustment with reference to practice requirements, such as the RCN's own Health Ability Passport and the RCM's Neurodivergence Acceptance Toolkit, in placement planning guidance for AEIs and PLPs.
- The NMC should work with UK governments and placement providers to address the financial and logistical barriers to placement access (notably travel and parking costs) as a distinct equity issue, rather than relying on a reduction in programme hours to address student hardship.

Midwifery

The RCN recommends the following:

- Withdraw the proposal to extend midwifery to four years. Any extension of programme length should be accompanied by clear curriculum expectations, greater leadership development, stronger preparation for autonomous practice, enhanced clinical immersion, and increased focus on safeguarding, anti-racism, cultural safety, mental health, health inequalities and women's health.

1. Introduction

We recognise the work the NMC has undertaken in developing these proposals. This includes the independent practice learning review commissioned from the Nuffield Trust and the Florence Nightingale Foundation (2024) and Harlow Consulting (2021), the stakeholder engagement programme approved by NMC Council in January 2025, which engaged around 1,250 participants across the UK, the NMC's evaluation of simulated practice learning (2024), and the international comparator research published by the NMC in 2022.

We acknowledge the value of this evidence-gathering and the importance of reviewing standards now that the UK is no longer bound by EU Directive 2005/36/EC. We share the NMC's ambition to ensure that nursing and midwifery education prepares students to deliver safe, high-quality care in a rapidly changing health and social care landscape.

Given that the overwhelming majority of our members are nurses, nursing associates and nursing students, the main focus of our response is on the proposals affecting nursing and nursing associate education. We have, however, considered it important to also reflect the views and interests of our midwifery members, and have therefore included a dedicated section on the midwifery proposals.

This response sets out the RCN's emerging position on each of the main areas of the consultation: nursing programme hours, simulated practice learning, community practice learning placements, equality, diversity and inclusion, practice assessors and supervision, and the midwifery proposals. Throughout, we emphasise the need for any change to be evidence-led, properly resourced, and accompanied by robust safeguards to protect the quality of education, the readiness of future registrants, and ultimately the safety of the people who use nursing and midwifery services.

2. Nursing Programme Hours

The RCN has significant concerns about the proposal to reduce pre-registration nursing programme hours from a minimum of 4,600 to 3,600 hours where there is no clear evidence base provided by the NMC to do so. Therefore, the RCN does not support a reduction in nursing programme hours.

While the RCN recognises the case, in principle, for prioritising the quality of practice learning over volume of hours, the NMC has not set out how the quality of practice learning placements will be improved, and education standards met, as a result of a reduction in hours.

Our members have consistently called for assurance on placement quality over any change in hours. They are also concerned that financial pressure across the higher education and placement sectors means there is no clear incentive for AEIs to deliver hours above the minimum required, without additional funding made available, comprehensive quality assurance of all parts of the education pathway is needed to ensure that programmes are designed and implemented to quality.

Key considerations:

The subsections below set out distinct considerations for the RCN in developing a position on this issue supported by relevant evidence (including domestic and international comparator data, evidence on student readiness, students' direct experience of placements, and financial pressures). This draws on desk-based research, a literature review, the RCN's member engagement, RCN student surveys and is sourced throughout.

International comparators

NMC-commissioned research into standards outside the EU found that, globally, the most common total duration of pre-registration nursing programmes is three years (53% of jurisdictions reviewed), followed by four-year (31%) and two-year (9%) models (NMC 2022).

Crucially, though, the comparator material is explicitly not outcome evidence. The Nuffield Trust and Florence Nightingale Foundation's independent review did not identify direct comparative outcome data linking total clinical hours to graduate preparedness – a gap that the review itself acknowledges.

An NMC report 'Understanding practice learning hours in pre-registration nursing programmes outside the EU' went on to say: "Numbers of practice hours are often the result of political factors or pragmatic decisions about the availability of practice placements, rather than based on evidence about the number of hours required for safe and effective practice." NMC's review found that jurisdictions which mandate fewer practice hours typically rely on other mechanisms to assure graduate competence, including greater use of simulation, structured mentorship, competency-based progression, and post-registration.

International comparator data, summarised in the table below, place the UK's current 4,600-hour total (split equally between theory and practice) at the upper end of international practice.

While New Zealand and the United States have lower mandated clinical hours this is paired with formal end-point national licensing examinations (New Zealand's State Final Examination and the US NCLEX-RN respectively), a mechanism the UK does not operate and the NMC has not proposed as part of this consultation.

Both the NMC's review and the RCN note that the underlying evidence base on programme hours remains thin: the comparator research does not present direct outcome data such as patient safety metrics, medication error rates, or fitness-to-practise referral rates linking clinical hour totals to graduate preparedness in any country and is best characterised as reflecting professional consensus and practice norms rather than causal outcome evidence.

Consistent with this, the review reports that regulators in Australia and New Zealand found no empirical evidence linking hour-totals directly to competency, and viewed additional hours as more likely to support student confidence than to demonstrate measurable competence (NMC 2022).

We do note the potential benefits identified by the NMC in reducing overall programme hours, including financial relief for students and easing placement capacity pressure. However, our concerns around the lack of evidence for reducing programme hours and the impact this could have on the quality of nurse education and the readiness of newly registered nurses to begin practice means that retaining the current requirement, alongside implementing the quality assurance recommendations set out in this paper, would be better for the profession and patients.

Student readiness and the complexity of nursing

Qualitative research commissioned by the RCN into student nursing attrition found a consistent pattern of practice learning environments that were unstructured or under-resourced: students describing placements with little planned activity, an over-reliance on shadowing rather than active learning, and limited or inconsistent supervision, alongside direct evidence that some AEIs have lowered entry requirements considerably to fill places. For example, one senior nurse educator described dropping their programme entry tariff from 120 UCAS points to 64 by the end of clearing (Community Research 2024).

This sits alongside a wider, fundamental challenge, that the complexity of the caseload, nurses are being asked to manage has grown faster than any corresponding change in how they are being prepared for it. The RCN's 2026 Last Shift Survey (comprised of over 13,000 respondents) found that around eight in ten nursing staff report that clinical complexity has increased in the last two years alone, that only one in ten said staffing was at the optimal level to meet all of a patient's needs on their last shift, and that 20% said registered nurse numbers were so far below what is required that there is now a high risk of harm on shift (RCN 2026 last shift survey results). This highlights a growing mismatch between the increasing complexity of care that nurses are expected to deliver

and the time, staffing capacity and support available to prepare and sustain the workforce.

RCN members and stakeholders remain concerned that some newly qualified nurses are not practice ready under current arrangements, and consider that this proposed reduction would heighten that risk further still. If programme hours were to be reduced, members anticipate reduced confidence and competence among newly registered nurses, which could then increase patient safety risks and a rise in Fitness to Practice referrals, as well as further increase early-career attrition. Readiness could be maintained if a reduction in hours was matched by a corresponding improvement in quality assurance throughout the pathway, education reform, student experience improvements etc. Overall, opposition to the proposed reduction considerably outweighed support amongst RCN members and stakeholders that took part in our engagement.

Professor Alison Leary, RCN Deputy President and Chair of Healthcare and Workforce Modelling at London South Bank University, has argued consistently that nursing must be recognised as a safety-critical activity in the same way as other safety-critical industries, where the relationship between an adequately prepared, adequately staffed workforce and patient safety is well understood (Leary, A. 2023). Reducing preparation time, without a stronger evidentiary basis, risks treating this relationship as incidental rather than central.

This is reinforced by the wider academic evidence base: a 2025 systematic review of pre-registration placement hours internationally concluded that there is a lack of high-quality evidence to underpin practice placement hours requirements at all, and that this evidence gap 'warrants global attention' given international pressure to accelerate nurse graduation (Kenny et al 2025). We read this as a call for better evidence before changes are made, not as license to reduce hours in the absence of it.

The NMC consultation paper included relatively limited detail on the safeguards intended to accompany any reduction in practice learning hours, for example strengthened standards or substitution limits on simulation, supervision ratios, minimum placement-quality criteria, or a phased transition and evaluation plan with predefined outcome measures and thresholds for course-correction. Without this detail to provide assurance of how quality will be improved as part of the reduction in programme hours, we are unable to support the proposal.

AEI incentives to exceed the minimum

There is no clear incentive for AEIs to deliver hours above the recommended lower minimum (1,800) without any requirement to do so, or any additional funding to enable this, at a time when nursing education is already under acute financial pressure across the sector. Nursing courses are frequently run at a loss, cross-subsidised by other income streams that are themselves under strain, and delivered by a nurse educator workforce experiencing redundancies, recruitment freezes and unfilled vacancies (RCN 2024a). In that context, it is unrealistic to expect AEIs to treat a reduced minimum as a floor to build upwards from, rather than a new ceiling to plan delivery around. Any assessment of this proposal's impact should proceed on the assumption that most

students will receive close to the new minimum, not more, unless funding is explicitly attached to hours above it.

The future of nursing

Members questioned whether the current proposals adequately prepare students for the evolving nursing role, citing digital developments, AI, data literacy, population health management and technology-enabled care as areas that are growing in importance but remain insufficiently visible within current education standards. The NMC should design any change to standards, hours or curriculum around the skills needed for future nursing care, rather than treating hours reduction as a standalone change ahead of this wider work.

Students' experience of placements

NMC standards require that students are supernumerary on placement instead of being counted as part of rostered staffing in order to observe and learn rather than be relied upon as pairs of hands. However, RCN's Last Shift Survey (UK wide) found that over one in three respondents (28%) reported that students did not hold supernumerary status on their last shift.

This is consistent with reports from RCN Scotland's Student Committee in 2025 where one student representative reported that, when there are shortages on placement, fellow students are "put down as members of staff, even though they are students, and our learning suffers". They added that students must be given the opportunity to learn, rather than be treated as another member of nursing staff.

RCN-commissioned qualitative research into student attrition found a similar pattern: students describing days with no planned activity and an over-reliance on shadowing rather than active learning; being sent back, with no alternative offered, to a placement where they had previously experienced a bereavement or breakdown; being addressed only as 'the student' rather than by name; and travelling hours each way to a placement calculated by the university using online mapping tools, without regard to the realities of public transport, cost or caring responsibilities. One student described starting a placement at 5am to arrive for a 7.30am shift and not getting home until nearly 11pm. Several education professionals in the same research linked these placement problems directly to under-resourcing rather than to any failing on the part of individual students or staff, describing wards so short-staffed that agency nurses supervising students had no knowledge of the student's programme or needs (Community Research 2024).

Lack of student supervision and assessment capacity is commonly raised by students and our members as an issue, alongside insufficient funding to support training and development for practice supervisor and practice assessor roles. Supervisors are reported to be insufficiently experienced in some cases and constrained by workload and a lack of protected time, and a failure-to-fail dynamic has been identified, linked to limited information about a student's progress and the additional workload that failing a student would create.

Members frequently linked these capacity pressures directly to staffing levels in clinical areas rather than to programme hours, and separately raised a distinct risk, that reduced placement hours could shrink the placement tariff income that currently

supports the practice educator workforce in England, further constraining an already stretched supervisory capacity rather than easing it.

The NMC proposals do not set out how these challenges will be addressed. Therefore, reducing overall programme hours when there are already serious concerns about the quality of clinical placements, presents too much of a risk to the readiness of students for clinical practice once they qualify.

Differences across UK nations

Academic structures vary considerably across the four UK nations. In England, Northern Ireland and Wales an Honours Bachelor's degree comprises 360 credits, while in Scotland an Honours Bachelor's degree comprises 480 credits (with anon-Honours degree at 360 credits) and Scottish Honours programmes typically run for four academic years rather than three. Funding and bursary arrangements also differ significantly by nation, as set out above, which RCN evidence-gathering has identified as a relevant factor in how students in different parts of the UK would experience any change to programme length or hours.

Northern Ireland and Cross-Border Working

Reducing nursing programme hours carries specific implications for Northern Ireland and cross-border recognition. Until the end of 2020, UK nursing and midwifery education was governed by EU Directive 2005/36/EC, which set the current 4,600-hour, 2,300-practice-hour minimum as a condition of EU-wide recognition. Since the UK left the EU, domestic requirements have remained similar to, but are no longer bound by, those of the EU. Should the UK's requirements fall below the level still applied by EU/EEA states including the Republic of Ireland, NMC-registered nurses may no longer meet the criteria for automatic recognition for cross-border practice in Ireland or the wider EU/EEA (Directive 2005/36/EC).

This issue has particular significance for Northern Ireland because of its land border, interconnected workforce, and the movement of professionals across the island of Ireland. RCN Northern Ireland has confirmed that key stakeholders oppose a change in nursing hours. Even where automatic recognition does not apply, a material difference in required hours may lead regulators to require individual assessment, adaptation periods or aptitude tests. The consultation does not provide a sufficiently detailed assessment of these consequences.

We would also emphasise that the risk is not confined to Northern Ireland: the UK nursing profession is well regarded across the EU/EEA more broadly, and a unilateral reduction below the EU-aligned minimum risks that reputation and the wider mutual-recognition relationship, not only for cross-border arrangements on the island of Ireland specifically. At a time when the UK may seek closer cooperation and professional mobility arrangements with European partners, the NMC should avoid an irreversible reduction before completing and publishing a full four-country assessment of mutual recognition, cross-border employment and workforce mobility.

Safeguarding the Honours degree in Scotland

RCN Scotland's own engagement with its Board and members raised concerns consistent with, and reinforcing, the wider UK picture. Members noted that the number

of newly registered nurses presenting with competency issues has increased in recent times, causing stress both to the individuals concerned and to the teams they join, and argued that it is unlikely that fewer practice hours will result in better practice while the current infrastructure is not yet able to properly support students. Members were clear that quality, not volume, should be the focus, but were equally clear that too few hours does not, in itself, promote better learning, and that midwifery and nursing should be treated the same in this respect.

Undergraduate pre-registration nursing students in Scotland spend a minimum of three years completing the nursing degree course and meeting the requirements for registration with the Nursing and Midwifery Council (NMC). Honours nursing degree programmes are four-years and established within Scotland's education system, which is built on a four-year Honours degree model, and is consistent across most higher education degrees in Scotland. A shift to all nursing degrees being three-years would place nursing out of step with the Scottish degree architecture, where four years is the norm for an Honours qualification. This risks lowering the perceived academic status of nursing programmes relative to other Scottish degrees and undermining the long-established position of nursing as a degree-level, graduate profession.

A reduction in hours may also have consequences for The Scottish Government's bursary for nursing students which is justified, in part, on the basis that nursing is a longer, more intensive degree than most undergraduate programmes. The bursary acknowledges the unique nature of a nursing degree, the number of academic and clinical placement hours required to meet the NMC registration requirements and the impact this has on the ability of nursing students to supplement their income through part time work.

Curriculum requirements in Wales

RCN Wales's stakeholder engagement, held in June 2026, found significant concern about reducing practice hours for nursing, with stakeholders noting that current practice exposure is already insufficient to prepare learners well, and that reducing hours without robustly addressing student support and placement quality risks lower preparedness and confidence in new graduates.

There was strong consensus that quality and consistency of placements, not number of hours, is the primary driver of preparedness challenges, alongside insufficient supervision capacity, a lack of protected time for assessors, and concern that students are used as part of the workforce rather than treated as learners.

As referenced and explored in more detail in relation to implications for Welsh Language later in this document, approved education institutions offering nursing education in Wales must accommodate bilingual delivery requirements across programmes, including learning materials, assessments and student support. Any changes to programme structure, learning time or overall hours could have unintended consequences for Welsh providers, as maintaining high-quality bilingual provision requires additional resource.

Preceptorship

Preceptorship is a structured period of support intended to ensure that newly qualified nurses can safely and comfortably transition from being a student to a registered healthcare profession. It includes access to a preceptor who provides support, training, and mentorship, and protected supernumerary time in which to embed skills.

At present, despite the strong recommendations of the NMC, employers are not required to offer preceptorship to newly registered nurses. In England, the Department of Health and Social Care has in 2026 committed to establishing a national nursing preceptorship to improve quality and consistency across employers.

The NMC should ensure, in partnership with Governments, that mandatory preceptorship frameworks are implemented in each of the four countries. These frameworks should be quality assured and aligned to nursing professional standards. Preceptorships should explicitly embed nursing standards of proficiency through standardised and mandatory supernumerary time for preceptees.

In its role in setting standards and assuring quality, the NMC should use its regulatory position to influence government policy and strengthen employer accountability for preceptorship. Evidence from RCN members for example shows that some NHS employers are offering Band 5 (entry-level) roles without structured preceptorship, creating inconsistency in early career support and access to roles for newly registered nurses. Preceptorship should therefore be recognised as a core and compulsory component of all NHS Band 5 roles to ensure safe and effective transition into practice.

A preceptorship model would be more aligned with Irish pre-registration nursing programme. These programmes are aligned with the UK's current 4,600-hour, 2,300-practice-hour structure, but add a mandatory, paid 36-week clinical internship in the final year, during which students move from supernumerary status to paid employment at 0.5 FTE, managing caseloads under supervision while retaining dedicated hours for guided reflection.

Embedding quality, consistent and high-quality preceptorships across all settings is key in safeguarding the transition of newly registered nurses into practice. Preceptorships must include clear learning opportunities and periods for supernumerary learning, to avoid situations where early career nurses are not supported to continue building expertise and confidence in their clinical skills.

Recommendations in response to the proposals on reduction in programme hours

The RCN disagrees with reducing nursing programme hours due to the lack of evidence-base for the proposal and the risks posed by a reduction. However, irrespective of any changes to overall programme hours the following recommendations must be adopted by the NMC to address ongoing concerns around the quality of clinical placements, quality assurance measures and to ensure readiness of newly registered nurses.

The NMC should:

- Retract the proposed reduction in nursing programme hours from 4,600 to 3,600 on the current evidence base, and require any future proposal to be supported by outcome data demonstrating equivalent or improved outcomes for nurses and patients as a result of the reduction in hours.
- Work with governments in the UK to develop a mandatory preceptorship for all newly registered nurses.
- Implement, irrespective of any decision on hours, the quality-assurance measures included in this document, recognising that this will require at least six months of review and consultation before any change takes effect.
- Publish a full, four-country impact assessment addressing Northern Ireland/EU cross-border recognition, the Scottish Honours degree structure, and the Welsh curriculum and commissioning context, before finalising any change to programme hours.

Further recommendations on quality assurance

The RCN considers quality assurance across the whole education pathway to be the central ask of this response. The NMC should therefore implement the following in relation to quality assurance:

- Work with Approved Education Institutions (AEIs) to ensure entry requirements are appropriate with academic capabilities, values and behaviours needed for students to learn effectively and practice safely and effectively throughout their programme and upon registration.
- Review and consult on the Standards for Student Supervision and Assessment (SSSA), the Pre-registration Education Standards, before implementation of any change arising from this consultation.
- Require standardised, mandatory training for all practice assessors and supervisors, with a minimum experience requirement (for example, excluding newly registered nurses or those still in preceptorship from acting as practice assessors).
- Commission an external audit of the NMC's current quality assurance processes for Approved Education Institutions (AEIs) and placement providers.
- Reinstate university programme monitoring by the NMC, to ensure consistency of education provision and outcomes across AEIs, in addition to the current AEI self-assessment.
- Develop, with stakeholders including the RCN, nationally agreed standards for placements and learning environments, and set clear, sufficient ratios of practice supervisors to students, to ensure greater consistency.
- Conduct a rapid review of the role a national, universal objective assessment, could play in assuring quality and consistency at the point of registration, and how this could be designed and implemented.

In support of this, Governments in all four countries should:

- Explore current funding arrangements and remove any financial disincentives for AEIs and Practice Learning Partners (PLPs)to exceed the minimum hours in programme delivery.
- Ensure that protected time for supervision and assessment is sufficiently factored into workforce planning assumptions.

3. Nursing Associate Programme Hours

The proposed reduction in programme hours for the registered nursing degree and the NMC proposal to maintain the current minimum 2,300 hours for the Nursing Associate programme would narrow the attainment gap between registered nurses and registered nursing associates. The RCN disagrees with the reduction in nursing programme hours as this may lead to greater substitution of Registered Nurses with Registered Nursing Associates.

The RCN has significant concerns about the increasing evidence of the substitution of Registered Nurses (RNs) with Registered Nursing Associates (RNAs). Those concerns are further strengthened by the increasing evidence of inappropriate extension to the role and responsibilities of the NA across health and care settings (RCN 2024c). Extensive research has demonstrated the impact of registered nurse staffing levels on patient outcomes (for example, Aiken et al 2024, Griffiths et al 2018), and that greater substitution of RNs leads to increased mortality, more adverse events, increased missed care and greater turnover of RNs (Griffiths et al 2023, 2025, 2026; Dall'ora and Griffiths et al, 2026). There is no evidence to support the view that substitution is safe or cost effective (Dall'ora and Griffiths et al 2026).

Nursing Associates make a vital contribution to patient care, however their role is complementary, not interchangeable with, Registered Nurses. RNs have expertise in advanced clinical judgement, risk assessment and decision-making skills that RNAs are not trained or authorised to perform.

To date there has been no formal evaluation of the role of Registered Nursing Associates in the workforce and with RNA positions implemented across the whole health and social care landscape, there is little steer for providers on the scope of practice, reporting structures and line management, and potential for Nursing Associates to be deployed incorrectly.

The NMC should ensure that any changes to pre-registration nursing education do not inadvertently narrow the educational and professional distinction between Registered Nurses and Registered Nursing Associates. A narrowing of this gap risks leading to:

- Increased risk of employers substituting Registered Nurses for Registered Nursing Associates in response to workforce pressures and financial constraints.
- Harm to the perceived value and distinctiveness of Registered Nursing registration.

Recommendations

The NMC should:

- Withdraw the proposal to reduce Registered Nursing programme hours from 4,600 to 3,600 on the basis that this reduction will harm the perceived value of the nursing profession and could lead to greater substitution of Registered Nurses with Registered Nursing Associates to the detriment of patient care.

- Include in their Equality Impact Assessment an assessment of the workforce, professional and patient safety consequences of changing Registered Nursing programme hours.
- Undertake a full evaluation of the Registered Nursing Associate standards, including access to and uptake of progression opportunities.

4. Simulated Practice Learning (SPL)

Although the RCN opposes the reduction in programme hours overall, it is the position of the RCN that any reduction in programme hours would necessitate a further reduction in SPL. The RCN therefore disagrees with the NMC's proposal to cap the maximum threshold for SPL at 25% of overall practice hours, in case of programme hours reductions. We believe that simulation should be capped at a lower percentage, which must be re-consulted upon in the event of programme hours reduction.

It is the RCN's long held position however that simulation should be complementary to,and not replace practice-based education. The RCN supported the increase in the number of practice hours that could be achieved through SPL to 600 hours, on the basis that this be monitored on an ongoing basis to assess effectiveness. However, the NMC has not provided the quality assurance that we requested in 2017.

The NMC should continually evaluate the role of SPL in meeting the evolving learning requirements of nurses. SPL has the potential to change healthcare education positively. For example, students should expect simulation to prepare them for working in environments increasingly shaped by technology.

SPL should reflect the diversity of the nursing working environment. The lack of diversity in nursing and midwifery education has been highlighted (NMC 2020). This is evident in the absence of nurses or midwives from different ethnic backgrounds in the curriculum and the lack of diversity of models used in simulation exercises.

Access to high-quality simulation is not consistent across nursing education. Across the UK, students identified key areas for improvement during their studies, with almost half (49%, 1,233) highlighting the need for better access to simulation or skills labs. A similar proportion also pointed to the need for better integration of theory and practice (45%, 1,133), indicating that many students struggle to connect what they learn academically to practical application. Together, these findings suggest that students would benefit from more in practice learning opportunities and stronger links between classroom teaching and real-world practice to support their development and confidence. (RCN Student Survey 2025).

There are also significant disparities in the funding available to support simulation across the UK. In England, simulated practice learning is supported through the clinical placement tariff, whereas equivalent funding arrangements are not consistently available in the devolved nations. This creates inequitable access to high-quality simulation and may disadvantage nursing students and education providers outside England in their ability to utilise simulated practice learning hours.

RCN members broadly support the use of simulation within practice learning and quality improvement, provided it is underpinned by clear parameters, robust quality assurance, and well-defined limits on its use as a substitute for practice-based learning. Simulation should complement rather than replace supervised experiential learning, highlighting the importance of direct patient contact in developing safe and effective clinical practice.

Meaningful exposure to real-world care environments remains the most essential component of practice learning. While there are benefits of simulation in supporting more consistent and controlled skills acquisition, particularly where high-quality simulation standards are in place and educators are appropriately trained and prepared to deliver it.

Recommendations

The NMC should:

- Reconsult on a reduced cap for simulated practice learning, at lower than 25%, should programme hours be reduced overall.
- Urgently undertake an evaluation of quality and consistency in simulated practice learning and establish a robust quality assurance framework and programme for ongoing monitoring.

5. Community Practice Learning Placements

Meaningful community placement experiences for nursing students provide a foundation for preparing a workforce capable of meeting changing population health needs, including the growing demand for care closer to home.

While the RCN agrees in principle with the NMC's proposal to require all nursing students to have at least one community practice learning placement, this is contingent on the NMC providing a clear definition of what counts as a community practice placement, setting quality assurance standards for placement providers and publishing a credible plan for scaling up capacity.

Exposure to community-based practice learning is an important component of nursing education. Greater engagement with community settings can strengthen students' understanding of prevention, public health and early intervention, while reflecting the wider shift towards delivering care closer to home. Community placements also provide opportunities for students to develop a broader understanding of patient journeys and integrated care pathways across health and social care systems.

The NMC should however employ a phased and carefully managed approach to implementation. This is necessary to ensure consistency and quality of placement experiences across different regions and providers, as currently the availability and quality of partnerships with community organisations varies considerably. Sufficient investment is therefore needed to ensure community placements are financially viable and consistent in quality of learning experiences for students.

Clear national guidance will be required to define what constitutes an appropriate community placement. This guidance should ensure that placements are directly relevant to nursing practice, aligned with learning outcomes, and provide students with opportunities to develop core clinical and professional competencies and competency sign off. It will also be important to establish robust quality assurance mechanisms to maintain high standards across all settings.

Benefits of Community Placements

The RCN supports increased exposure to community-based practice learning as an important component of contemporary nursing education. Greater engagement with community settings can strengthen students' understanding of prevention, public health and early intervention, while reflecting the wider shift towards delivering care closer to home. Community placements also provide opportunities for students to develop a broader understanding of patient journeys and integrated care pathways across health and social care systems.

The evidence suggests that clinical placement experiences shape students' career preferences and future employment decisions. Clinical placements have been shown to strongly influence the first employment destinations of newly qualified nurses (Wareing et al., 2018). Exposure to high-quality community placements can therefore play an important role in encouraging more graduates to enter this part of the workforce. A

recent RCN survey found that 64% of nursing students were open to working in community settings following graduation.

Community-based placements support the development of a broad range of skills, including autonomy, communication, and holistic patient care, while strengthening students' confidence to practise and fostering valuable interprofessional relationships (Baglin & Rugg, 2010). In addition, settings such as care homes offer particularly rich learning environments, enabling students to develop expertise in managing complex, long-term conditions and contributing to workforce sustainability in the context of an ageing population (Adeboye et al., 2025).

Evidence from the RCN's *Student Survey* (2025) suggests that students are open to this approach. Community placements were viewed as more attractive than hospital placements by 41% of respondents, and 64% said they would be open to working in community settings after graduation. In addition, 24% identified increased practical experience in community nursing as a way to improve both the student experience and the quality of education.

In our engagement with members ahead of this consultation, members highlighted that community learning should encompass a wide range of settings, including primary care, schools, prisons, homelessness services and social care, rather than focusing solely on district nursing. Members felt this breadth of exposure would help students better understand the diversity of nursing careers and the wider care pathways experienced by patients across different services.

Capacity and Delivery Challenges

While the RCN is supportive of the principle of increased community exposure, significant capacity and delivery challenges must be addressed before any mandatory requirements are introduced. Community placement opportunities vary considerably across geographical areas and service models, and differences between rural, coastal and urban locations may affect both placement availability and accessibility and the learning experiences on offer. Existing workforce pressures also create challenges for supervision, assessment and placement quality.

These concerns were reflected strongly in member engagement findings. Members consistently stressed that the quality of community placements depends on access to appropriately prepared practice supervisors and practice assessors, as well as sufficient organisational capacity to support learners. Members highlighted the need for clear definitions of what constitutes a community placement, minimum expectations for placement duration and assessment, and appropriate quality standards to ensure consistency.

Members also raised concerns about infrastructure and resourcing. Several noted that funding and placement prioritisation within primary care can favour medical students over nursing students, potentially limiting placement opportunities. Others emphasised the importance of supporting mechanisms such as placement tariffs and long-arm assessment models. While there was broad support for strengthening community exposure, the overall message from members was that any move towards mandatory

requirements should be accompanied by clear standards, effective supervision arrangements and investment in placement capacity to ensure high-quality learning experiences can be delivered consistently across all settings.

Recommendations

The NMC should:

- In partnership with stakeholders, including the RCN, develop an agreed definition of a community placement to ensure ongoing quality of placement experience.
- Develop a Quality Assurance plan and establish regular monitoring to ensure students are obtaining safe and appropriate learning experiences that are of a high standard.
- Consider student safety as part of its ongoing guidance to placement providers and the NMC's EQIA should address any issues and barriers to accessing community placements.
- Produce clear guidance for placement providers.
- Governments in all four countries must address financial barriers to providing community placement experience including financial incentives for smaller providers to pump-prime access to quality placement experiences across the independent, private sector and general practice.

6. Equality, Diversity and Inclusion (EDI)

The RCN overall supports Proposal 1 of the NMC 2026 consultation, focusing on the strengthening of standards on anti-racism, bias awareness, cultural curiosity, safety and respect. Our support, however, is conditional on real, tangible protection for students, not restated principle. Many students already tell us they experience racism, exclusion or other discrimination in practice learning, so the strengthened standard needs to be embedded in everyday teaching, supervision, assessment and complaints handling, and its impact on students' needs to be measured, not assumed.

The NMC should publish the specific standard(s) it proposes to introduce or amend, with indicative wording, and to set out how this relates to the anti-racism principles it has already published and to its ongoing Code review. We return to this, and to how the NMC will know the strengthened standard is working, below.

We recognise that the anti-racism principles and the Code review are separate pieces of work on their own timelines and look forward to engaging fully with that consultation when it opens, and would welcome the NMC setting out, at that point, how the new Code will relate to the standards arising from this consultation and to the anti-racism principles already published.

Anti-Racism, Bias Awareness and Cultural Safety in Practice Learning

The NMC's own evidence base supports the case for strengthened standards: its commissioned research found discrimination affecting Black, Asian and minority ethnic students, disabled students and students from lower socio-economic backgrounds (Palmer, W et al 2024), and the NMC's Insight report (February 2026) found that 40% of 37,961 registrants surveyed had experienced discrimination, most often on the grounds of ethnicity or age.

Across the UK, the RCN's Student Survey found that 55% of respondents reported some form of negative experience linked to discrimination or exclusion. The most prominent single issue was not feeling included in team or group activities, affecting 28% (702 respondents) – so relating to belonging and everyday inclusion, not only overt discrimination, is where students most often report falling short.

Cultural factors were also significant: 8% reported language-related bias and a further 8% reported insensitive comments or stereotypes. More direct forms of discrimination were less prevalent but still substantial: 7% reported ethnicity-based discrimination and 4% nationality-based discrimination. Note that these are only the reported figures and much more will be un-reported.

This is consistent with the RCN's wider member engagement. In a dedicated Slido poll of representatives and senior staff on what needs to be in place to strengthen anti-racism, bias awareness, cultural curiosity, safety and respect, the dominant and repeated message was that this work needs to be embedded throughout education and practice learning (in curricula, assessment, supervision and revalidation), rather than delivered as a one-off session or annual e-learning module.

The RCN welcomes the anti-racism principles for AEIs and PLPs (NMC May 2026). Our members consistently call for mandatory, regularly refreshed training for students,

educators and practice supervisors and assessors; clear and safe routes to report discrimination, paired with visible consequences and follow-through when concerns are raised; and greater diversity among educators, senior nursing and midwifery leaders, and in the case studies and materials used in teaching.

A number of respondents pointed to international models, for example, the way New Zealand and Australia embed cultural safety as a first-principles regulatory and revalidation concept, as worth the NMC exploring further.

A recurring theme raised by members is accountability for tackling student concerns: several respondents specifically described concerns being passed between the university and the placement provider with no one taking ownership of resolution. The principles point students towards existing channels for speaking up, such as Speak Up Guardians or the NMC's Raising Concerns policy, and expect AEIs and PLPs to make sure students know how to use them at every placement, alongside a suggestion that Chief Nursing Officers (CNOs) and Chief Midwifery Officers (CMOs) offer regular confidential listening opportunities. In 2022, research by Jones, A. et al found wide variability in how the Speak Up Guardian role is implemented and resourced across NHS organisations, with a lack of protected time significantly limiting their ability to respond to concerns and identify patterns. Therefore, the principles do not go far enough.

Placement quality, range and allocation

For nursing students specifically, across the four nursing fields of practice, we think a significant practical concern is not only how students are treated once on placement, but whether they get equal access to a good placement in the first place.

The NMC's own commissioned evidence found that racial, ethnic and socio-economic discrimination has disadvantaged students partly through unequal allocation of high-quality placements (Palmer, W. et a 2024), compounded by a lack of diverse representation in placement and practice leadership. We think this deserves much more direct attention in the strengthened standard than it currently receives: experience of discrimination within a placement, and inequitable access to good placements in the first place, are related but distinct problems, and a standard focused only on how students are treated risks leaving the second largely unaddressed.

The RCN's Student Survey found that 61% of students rated the organisation of their placements as effective or very effective, and 16% rated it as ineffective or very ineffective, but the RCN does not hold this broken down by ethnicity or other protected characteristics. We cannot currently say, aside from anecdotal data, whether students from Black, Asian and minority ethnic backgrounds are disproportionately represented among the 17% who report poorer placement organisation, or whether they are being allocated a narrower range of placement types or settings. Nor, as far as we can establish, can the NMC. We think this is a basic evidential gap that needs to be closed in order to determine whether unequal placement allocation is improving or getting worse.

This connects to two other findings elsewhere in this response. Some nursing fields already offer a narrower range of practice learning experiences than others: RCN evidence-gathering found that students in the mental health, children's and learning disabilities fields in particular valued simulated practice learning precisely because it let

them practice proficiencies they were not otherwise exposed to in their allocated placements. If placement allocation is also affected by discrimination, students in these fields who also experience bias in allocation could face a double narrowing of their practice learning experience - both fewer placement types available in their field generally, and a worse allocation within what is available. Similarly, our evidence on community placements shows that more than a quarter of students who wanted a community placement were not offered one; we do not currently know whether this varies by ethnicity and think it should be examined together with the point above rather than separately.

The anti-racism principles, while detailed on culture and treatment within placements, do not address placement allocation directly. There is no expectation that AEIs or PLPs monitor or report on whether students from different ethnic backgrounds are allocated comparable placement settings, specialisms or quality ratings. The principles do expect care provider organisations to ensure inclusive, fair placement environments and to report progress on racial inequity within their own quality metrics, but this is about the treatment students receive once placed, not about whether they were fairly placed to begin with. We think this is a gap the strengthened standard should close, given the evidence set out above.

Finally, the principles are specific about the kind of training content AEIs should deliver, including addressing named clinical stereotypes such as assumptions about Black women's pain thresholds, the misreading of sickle cell pain as drug-seeking behaviour, and disproportionate use of the Mental Health Act to section Black patients, and recommend resources such as the "22+1" film. We welcome this level of specificity and think the strengthened standard should require it, rather than leaving training content to individual AEIs to define.

How this will be measured

Having reviewed the anti-racism principles in full, the RCN has concluded that the mechanism by which their impact will be measured needs considerably more clarity, for three connected reasons: who does the assessing, where the resulting data goes, and what happens if an organisation falls short.

First, the principles' primary measurement tool is a gap analysis matrix, to be completed by AEIs and by care provider organisations themselves, as a self-assessment of their own starting and progress points. Universities are asked to use this at the start of the academic year and report development through annual self-reporting cycles from 2027; healthcare settings are asked to complete a self-assessment by the end of September 2026 and repeat it in 2027.

In both cases, the body being assessed is also the body doing the assessing, with no independent verification, moderation or audit of the self-assessment described anywhere in the document. The NMC should consider whether this is the fairest way to measure progress, particularly given that the same evidence base identifies differential attainment in assessment itself as part of the problem: concerns have been raised by our members that nurses of African heritage are less likely to pass assessments than their peers, and research from the NMC indicates that students of mixed ethnicity and

disabled people experience higher drop-out rates from approved courses, alongside lower acceptance rates for Black and Asian applicants.

This would therefore mean the institutions responsible for assessment are also being asked to self-certify their own progress on tackling that same problem, without external check.

Second, the principles are largely silent on where the resulting data goes. AEIs are expected to recognise, measure, address and report awarding gaps and differential attainment, but no recipient is named. Care provider organisations are expected to publish actions and progress on racial inequity within their own quality metrics, meaning each organisation reports through its own existing channels, in whatever format it chooses, rather than into a single, standardised, comparable dataset. The one measurement step that is not self-assessment (a survey of students, registrants and service users within the year) is not described in any further detail: there is no information on its methodology, sample size, whether it will be broken down by AEI, PLP, nation or protected characteristic, or whether results will be published. We would ask the NMC to name a single destination for this data, for example routing it through EdQA, which does not otherwise appear to feature in the principles document, to commit to a standardised and comparable reporting format across AEIs and PLPs, and to publish the survey's methodology and findings.

Third, the principles do not set out any organisational-level consequence for an AEI or PLP that does not complete its self-assessment, does not act on what it finds, or continues to show poor outcomes. The only enforceable mechanism described anywhere in the document is the updated Code, due in October 2027, and that operates at the level of individual registrant conduct through Fitness to Practice. This is not a lever over an AEI's or a placement provider's organisational performance. We are therefore asking the NMC to confirm what, if anything, connects an AEI's or PLP's gap analysis and self-reported progress to any consequence, for example, to Education Quality Assurance (EdQA) approval or reapproval decisions, or to placement commissioning, in the period before the Code takes effect, and for organisations as well as individuals thereafter. Without this, the principles risk describing what good looks like without describing what happens when it is not delivered, which is exactly the accountability gap our members have already told us they experience in practice.

Members were also clear that any strengthened standard needs clear, fair and consistently applied processes for raising and resolving concerns, so that students feel safe to speak up and can be confident that concerns will be acted on rather than passed between organisations. Several respondents noted that additional support or adjustments put in place for some students need to be transparently explained to the wider placement team, so they are properly understood rather than a source of friction.

Members also raised the importance of considering intersectionality, notably recognising that students are not one-dimensional, and that the same student may experience multiple, overlapping forms of disadvantage, and of addressing power dynamics within placement teams and universities, not only individual behaviour, drawing on the wider evidence base on compassionate and inclusive leadership in health and care settings. We note that the principles themselves also recognise

intersectionality explicitly, including in relation to socio-economic status, domestic abuse and LGBTQ+ identity, which we welcome.

Finally, the RCN's evidence-gathering identified a tension that neither the consultation nor the anti-racism principles fully addresses: several respondents noted that embedding anti-racism and cultural safety content more deeply within an already full curriculum is not cost-free, and cautioned that doing this well, through genuinely decolonised content, co-produced with global majority students and service users, rather than as an add-on, will need protected curriculum time, or will otherwise come at the expense of other content, particularly if overall programme hours are reduced as proposed elsewhere in this consultation (see section 2). We therefore see this proposal as linked to, rather than separate from, the RCN's position on programme hours.

The NMC's Equality Impact Assessment

The RCN has reviewed the NMC's published Equality Impact Assessment (EqIA) summary, which would benefit from greater transparency in three areas.

First, the NMC should publish a clear action plan alongside any equality impact assessment, setting out the action being taken in response to each risk identified, a named owner, and a target date rather than a general narrative account of risks and considerations. This would enable stakeholders to track progress and hold the NMC to its own commitments. The NMC has failed to provide within the body of the full EqIA a clear and transparent explanation of how its overall conclusion has been reached, including how identified negative impacts have been considered alongside anticipated benefits. Where risks to protected characteristic groups have been identified, the EQIA should set out specific mitigating actions, responsible owners, and implementation timescales, and explain how these measures will address the identified impacts and support the conclusion that the proposal can proceed. This would strengthen the robustness of the assessment and provide assurance that equality considerations have been fully and meaningfully addressed.

Second, the NMC should set out the evidence and methodology underpinning its conclusions on each protected characteristic, including where it has identified evidence gaps (for example, in relation to trans and non-binary students' experience of practice learning) and to publish the findings of any further engagement undertaken to close those gaps, with a clear timeline.

Third, on race specifically, the NMC should clarify how it intends to use the standards, together with existing quality assurance mechanisms such as the Standards for Student Supervision and Assessment (SSSA) and EdQA monitoring, to influence placement culture directly. RCN evidence (5.2 above) shows real and current experience of ethnicity- and nationality-based discrimination among students, and we would be concerned if the equality impact of Proposal 1 were assessed primarily as a matter of placement culture, separate from the standards themselves, when the standards and the NMC's own monitoring and assessment mechanisms are precisely the levers available to influence that culture.

We set out what we think this should mean in practice, in the form of specific recommendations below.

Reasonable Adjustments

Proposal 12 proposes to strengthen the requirement for AEIs and PLPs to work in partnership on reasonable adjustments, and to make clear that the standards are referring specifically to reasonable adjustments as legally defined, distinct from flexible working requests[1]. The NMC's own rationale for this proposal is that reasonable adjustments made in academic settings can fail to transfer into practice learning placements, in part due to poor communication and misunderstanding around data protection, leaving students repeatedly having to re-explain their needs. The RCN strongly supports this proposal and the clearer legal definition it introduces.

Our support goes further than the communication problem the NMC has identified. RCN member feedback points to a more fundamental issue: reasonable adjustments agreed between a student and their academic institution/occupational health at the point of entry, or during the academic part of the course, are not always adjustments a placement area considers reasonable and/or different adjustments may be required during the placement and no consultation about that prior to placement creates difficulties. Furthermore, reasonable adjustments required at the academic stage, and during placement may differ to what may be required by the same individual as a registered nurse working independently in practice. The necessity for reasonable adjustments is subjective and evolves depending on the environment and disability and that must be recognised.

Guidance for occupational health practitioners advising AEIs is explicit that reasonable adjustments cannot alter the proficiency standards themselves, and that functional capability assessment should look ahead to registered, unsupervised practice, not only to completion of the academic and simulated components of the course[2]. In our view, this distinction is not always being applied consistently across AEIs or before acceptance onto a pre-registration nursing programme. Some adjustments appear to provide what is needed to complete the academic course, rather than what will be required of the same individual as a registered nurse.

This creates a systemic misalignment that places expectations that they might not consider reasonable on placement providers and future employers or an absence of information regarding adjustments, and this gap must be addressed. This requires early-stage intervention, ideally integrated into initial program admission protocols. Currently, there is an established framework for this purpose (specifically, functional capability assessments aligned with medical fitness to train standards) but those standards are inconsistently applied across AEIs. Ensuring consistency will address that problem.

Nursing student cohorts are increasingly diverse and have increasingly complex support requirements, but PLPs often receive limited information about a student's reasonable adjustments before they arrive on placement, leaving too little time for proper support planning. Earlier and better-structured communication between Occupational Health, AEIs and PLPs is needed, consistent with what Proposal 12 itself is seeking to address. However, communication about an adjustment that may not be workable in a placement setting does not solve the underlying problem. New conversations at the outset of placements regarding reasonable adjustments need to be had as early as possible so the PLPs can consider and implement them if they deem them reasonable.

Simulated practice learning quality and resourcing varies significantly between AEIs, and this variability could disproportionately affect vulnerable learners and those needing reasonable adjustments if simulation is expected to play a large role in the overall practice learning offer (see section 3).

The RCN would welcome the NMC committing, as part of its response to this consultation, to promoting and embedding practical tools that support consideration of reasonable adjustments with reference to practice requirements, such as the RCN's own Health Ability Passport and the RCM's Neurodivergence Acceptance Toolkit, in placement planning guidance for AEIs and PLPs.

Socioeconomic barriers and placement access

Financial and logistical barriers to placement access is consistently raised by RCN members. Travel and parking costs associated with placements are a major challenge. However, we are concerned that the proposal to reduce programme hours is the right solution to student financial hardship, as opposed to addressing the underlying cost barriers directly. RCN members have also cautioned that measures intended to help students financially by freeing up time for paid work do not, on their own, address the position of students with caring responsibilities, who may not be able to take on additional paid hours regardless of how programme hours are structured.

Caring responsibilities and financial pressures

According to the RCN's State of the Nation Student Survey, many students across the UK have caring responsibilities: 904 said yes, and 1,053 said no. These responsibilities are considerably more common in older age groups, with only 84 respondents aged 17–24 reporting caring responsibilities, compared with 350 respondents aged 35–44, where caring responsibilities are the majority. This shows that students in their mid-30s to mid-40s are most likely to be balancing study with caring duties and are therefore more likely to face compounding financial pressure from the additional costs this can bring.

Welsh language considerations

The NMC should explicitly consider the implications of any changes to pre-registration nursing education on the delivery of bilingual education programmes in Wales. The Welsh language is not simply a pedagogical preference but is underpinned by legislation and national policy. The Welsh Language (Wales) Measure 2011 established Welsh as an official language in Wales and requires public bodies to ensure that Welsh is not treated less favourably than English.

Nursing education in Wales operates within a distinct legislative and policy context that supports the Welsh Government's ambition to increase the number of Welsh speakers and expand opportunities to access education and services through the medium of Welsh. This commitment has been further strengthened through recent Welsh language and education legislation and the wider Cymraeg 2050 strategy.

For approved education institutions in Wales, significant elements of nursing programmes are provided bilingually. Many Welsh universities have commitments to make substantial proportions of learning materials, assessments, student support and educational resources available in Welsh. These requirements create additional

curriculum, assessment, translation and workforce considerations that are not experienced uniformly across the UK.

Any reduction in programme hours, protected learning time or flexibility within programme structures could have unintended consequences for Welsh providers. Delivering high-quality bilingual education requires additional planning, academic capacity and resource. If overall programme hours are reduced, there is a risk that opportunities for Welsh-medium learning and assessment could be disproportionately affected, undermining both legal and policy commitments in Wales and reducing student choice.

The NMC should therefore undertake a specific Welsh language impact assessment as part of any proposed changes to pre-registration nursing education standards and ensure that sufficient flexibility remains to support bilingual delivery, maintain equity of access for Welsh-speaking students, and continue to meet Welsh legislative and policy requirements.

The NMC should recognise that Wales operates within a distinct legislative and policy framework for the Welsh language, and any changes to pre-registration nursing education should not inadvertently diminish opportunities for Welsh-medium learning, assessment or student support. Such opportunities are essential to developing a nursing workforce capable of meeting the linguistic needs of the population of Wales.

Recommendations

The RCN broadly agrees with the proposal to embed anti-racism, bias awareness and cultural curiosity, safety and respect across nursing, nursing associate and midwifery education and training. However, our support depends on it translating into real protections for students, many of whom report experiencing racism and other forms of discrimination in placements, so that the standard does not become a paper exercise. It needs to be embedded in everyday teaching, supervision, assessment and complaints handling, with measurable impact for students.

The NMC should:

- Publish the specific standard(s) it proposes to introduce or amend under Proposal 1, with indicative wording, and clarify how this relates to standards 1.10, 3.11 and 3.12 as they currently stand, to the separately published anti-racism principles, and to its ongoing Code and Revalidation review.
- Embed anti-racism, bias awareness and cultural safety as a core, assessed part of curriculum, supervision, assessment and complaints handling (for example, not a one-off session or annual e-learning module) and require AEIs and PLPs to monitor and publish placement allocation data by ethnicity and other protected characteristics, given evidence that unequal allocation of placements has disadvantaged students on racial, ethnic and socio-economic grounds.
- Commit to collecting and publishing measurable, disaggregated outcome data on student experience and progression by protected characteristics so that impact can be demonstrated rather than assumed. This could include differential attainment and progression rates, complaint resolution times, and university Fitness to Practice referral rates by ethnicity.

- Strengthen accountability for the anti-racism principles: confirm whether the gap analysis matrix used by AEIs and care providers will be independently verified, name a single, standardised destination for the data it generates (ideally routed through EdQA), and set out what happens, in practice, when an AEI or PLP does not meet the expectations set out.
- Not rely on Speak Up Guardians and existing raising-concerns routes alone as these are reactive measures. Require AEIs, PLPs and the NMC's own quality assurance processes to proactively monitor for patterns of poor culture and discriminatory treatment, with clear accountability for resolving concerns owned by a named body, rather than responsibility passed between organisations.
- The NMC's full Equality Impact Assessment does not include a mitigations column, or a named owner and target date against the risks it identifies, and does not state how often it will be reviewed or whether updated versions will be published. We would ask the NMC to add each of these, and to publish the findings of any further engagement it undertakes with underrepresented groups where it has identified evidence gaps.
- The NMC should also commit to promoting and embedding practical tools that support consideration of reasonable adjustment with reference to practice requirements, such as the RCN's own Health Ability Passport and the RCM's Neurodivergence Acceptance Toolkit, in placement planning guidance for AEIs and PLPs. They should work with UK governments and placement providers to address the financial and logistical barriers to placement access (notably travel and parking costs) as a distinct equity issue, rather than relying on a reduction in programme hours to address student hardship.

7. Practice Assessors and Supervision

The RCN agrees with the NMC's proposal to allow registered midwives with a SCPHN qualification to act as practice assessors for pre-registration nursing students, who are in a public health practice learning setting. This is a sensible development as long as the Midwife is working in a public health role such as Health Visitor or School Nurse.

Our members consistently raise concerns about placement capacity and the ability of practice supervisors and assessors to provide high-quality supervision, a lack of consistency is often reported, and assessors and supervisors lack the protected time needed to carry out this important work. This proposal is sensible, but the NMC should go further to ensure that quality and capacity issues are addressed in assessment and supervision of students.

8. Midwifery

Our analysis of the midwifery-specific proposals primarily focuses on the broader impact of Proposal 9, examining how this structural shift inadvertently destabilises professional parity and educational standards for our nursing membership.

The RCN recognises serious challenges and failings in maternity care identified by recent national enquiries, including the Ockenden Review and the National Maternity and Neonatal Investigation led by Baroness Amos, and shares the NMC's ambition to ensure midwifery education equips students to deliver safe, high-quality care. However, we are concerned that extending midwifery programmes to four years creates artificial hierarchy and an unnecessary divergence from nursing standards. Our central concern is that the NMC has not explained why extending midwifery training is being presented as a route to improving quality, while reducing nursing training by 1,000 hours is. If more time is what safeguards quality in midwifery, the NMC has not set out why less time does the same for nursing, and if quality is genuinely independent of hours, that undermines the rationale for extending midwifery just as much as it undermines the rationale for cutting nursing.

By positioning midwifery as requiring an extra year of training while nursing requires less, these changes also risk signalling that nursing is less complex or less important. This divergence actively undermines efforts to value the nursing workforce and exacerbates existing Band 6 progression challenges for nurses, who face immense clinical complexities within a three-year framework. Furthermore, adding an uncompensated fourth year introduces severe financial barriers for midwifery students, which will likely worsen already critical attrition rates across healthcare education, as discussed in further detail below.

We therefore disagree with Proposal 8 on this basis. Our position on how this divergence should be resolved, and on an alternative model we think deserves serious consideration, is set out in full below.

Proposal to extend programmes to four years

RCN evidence-gathering has identified a genuine tension within the case for extending midwifery programmes, rather than a one-directional risk. On the one hand, the RCN recognises the case for reforming pre-registration midwifery education. Midwives practise as autonomous professionals, frequently acting as the principal clinical professional throughout pregnancy, labour and the postnatal period, and must recognise and respond to increasingly complex physical, psychological and social needs, including deterioration and conditions that may not be directly pregnancy related. We recognise that the NMC has identified concerns that the existing three-year programme can produce task-oriented learning and may not provide sufficient time for students to experience a sufficiently broad range of practice situations or to develop the confidence required for autonomous practice.

RCN evidence-gathering similarly found that some students and senior midwifery staff consider the existing programme too compressed. Students were reported to be seeking more comprehensive preparation before registration, while members identified potential value in broader medical learning and greater exposure to complex and co-existing conditions. A four-year programme could therefore provide more time for high-quality learning, reflection and the consolidation of clinical judgement, rather than requiring students to accumulate the existing requirements within an exceptionally intensive three-year period.

However, RCN member engagement points to a more specific diagnosis than needing more time. Members who raised concerns about the 40-delivery requirement told us this was less about the number of deliveries than about case complexity, noting that a growing proportion of births are complicated rather than straightforward (for example, instrumental delivery, caesarean section and so on), and that what would actually help was a dedicated placement in adult nursing and stronger clinical competence modules on recognising and managing a deteriorating patient, rather than simply lengthening the existing programme. This is a materially different diagnosis from the NMC's own, and points toward a specific structural fix rather than a generic extension.

RCN member engagement on the proposal itself found only modest explicit support, with high uncertainty. The strongest and most consistent message was that considerably more detail is needed before forming a clear view ahead of a position being agreed. Notably this includes assessing rationale, funding, workforce impact and implications for apprenticeship routes. Where participants did support a four-year midwifery programme, this was generally linked to protecting standards and readiness; where they were unsure or opposed, concerns focused on cost, debt, recruitment, and whether a longer route would be practical for students, many of whom are mature learners with family and financial commitments already at higher risk of attrition.

International comparators

Midwifery education in Europe varies significantly, with several countries requiring extended, high-intensity pathways that exceed the basic three-year standard seen in the UK. The table below sets out the core structural differences, theory-versus-practice allocation, and compensation arrangements across a range of comparator countries.

Country	Programme Length (years)	Theory vs Practice Split (hours)	Preceptorships & Internships
UK (Current)	3	50:50 (4,600 total, 2,300 theory / 2,300 practical)	Unpaid placements
UK (proposed)	4	50:50 (4,600 total, 2,300 theory / 2,300 practical)	Unpaid placements
France	5	720h theory + 40+ weeks intensive hospital blocks	Unpaid / small grant only
Spain	6 (4y nurse + 2y EIR specialism)	936h theory & 2,664h practice	Fully Paid Residency Contract
Greece	4	2,800h theory & 2,000-2,500h practice	Unpaid Preceptorship
Republic of Ireland	4	4,600h total (min 1/3 theory, min 1/2 practice)	Unpaid years 1-3. Year 4 is 36-week salaried HSE internship. (45 weeks of supernumerary clinical instruction and 36 weeks of internship clinical placement)
Belgium	4	50:50 (4,600 total, 2,300 theory / 2,300 practical)	Unpaid placements (final year full internship is unpaid)

Spain stands apart by making midwifery an advanced, post-graduate nursing specialisation, ensuring all midwives train as nurses first. Conversely, France, Ireland, and Greece offer direct-entry tracks distinct from standard nursing. Ireland's model is popular among students because it protects academic learning time early on, but closes the degree with a long, financially compensated transitional roster.

Student finance, equality and access

The financial, attrition and workforce considerations set out below apply broadly to any extension of pre-registration midwifery education, whether structured as the NMC currently proposes or as the phased model the RCN sets out above; we would expect the NMC to model both.

A fourth year would expose midwifery students to an additional year of tuition fees, living costs, placement-related expenditure and reduced earning capacity. This is especially significant because midwifery students undertake extensive clinical placements and cannot generally supplement their income through paid work to the same extent as students on other courses.

The Royal College of Midwives' UK student-finance research demonstrates the scale of the existing problem. In England, nearly three quarters of surveyed midwifery students expected to graduate with debts exceeding £40,000; 87.5% said they always or often worried about their debt; more than three quarters worried that financial problems might cause them to leave their programme; eight in ten had taken on additional debt; and almost half had paid employment that adversely affected their studies. The same

research found that 91% knew somebody who had left midwifery education because of financial problems. (RCM 2024).

These pressures are likely to be particularly acute for mature students, parents, carers, disabled students and students from lower-income backgrounds. Midwifery programmes commonly attract applicants bringing substantial life and caring experience, but these students may face mortgages or rent, childcare costs and other family responsibilities. Extending the programme without corresponding support could narrow access to the profession and have adverse equality consequences. It could also undermine the NMC's wider objectives on inclusion and reasonable adjustments by making participation financially impracticable for some otherwise suitable candidates.

The position differs across the four UK countries: although Scottish students receive bursary support, RCM (2024) research found that 71% of respondents in Scotland had taken on additional debt, while nearly half had caring responsibilities and many reported difficulties meeting basic living and travel costs. The financial implications must therefore be assessed and funded across each of the four nations rather than assuming that existing national schemes will absorb the additional year.

The RCN could support a four-year midwifery model, only where governments and education commissioners provide a credible, funded settlement covering the full additional year. This should include: the abolition or full reimbursement of additional tuition costs; maintenance support reflecting actual living costs and inflation; prompt and complete reimbursement of travel, accommodation and placement expenses; and targeted support for students with caring responsibilities and other groups at heightened risk of withdrawal. Funding must be confirmed before implementation, rather than left to individual students, universities or employers to resolve after the regulatory standard has changed.

Attrition and completion

It is key that any proposal is evaluated against existing attrition rates in midwifery. RCM evidence indicates that around 15% of midwifery students did not complete their degrees in 2021–22, with financial pressures, inadequate support and difficulties in clinical learning among the factors identified. RCN representatives likewise reported that a meaningful proportion of students are already unable to complete within the existing three-year period.

A more equally paced four-year programme could improve completion by reducing intensity and recognising that some students already need longer to qualify. Conversely, simply adding another year without reducing workload or addressing financial hardship could increase attrition by extending students' exposure to the same pressures that currently cause withdrawal. We would add that Health Education England's RePAIR project, examining student and newly-registered-practitioner retention, found that a clear, well-articulated transition plan from student to newly registered practitioner is a vital factor in both completion and retention, reinforcing that the transition into practice, not only the length of pre-registration training, is where the evidence says investment should be concentrated.

Any extension should be accompanied by published outcome tracking from the point of implementation including completion and attrition rates, the effect on mature and lower-income students, and the number of newly qualified midwives entering the workforce in each UK country, broken down by protected characteristic and socioeconomic background.

Workforce supply and employment

Extending the programme would create at least a transitional one-year delay in the supply of newly qualified midwives, at a time when the evidence already shows a serious disconnect between the number of midwives being trained and the number of secure roles available to them. The RCM's February 2026 survey of 312 graduate midwives found that 31% of those who had received their NMC PIN had not secured a midwifery post; of these, 61% were not working at all. Even among those who had secured a role, 55% were on fixed term rather than permanent contracts, and 53% were not working full-time (RCM 2026) Any workforce case for extending training must be reconciled with this evidence: it is difficult to justify a policy that further delays the supply of new midwives into the workforce while a third of last year's graduates cannot find a substantive post at all.

At the same time, the current problem is not solely one of insufficient graduate supply. Respondents to the same survey reported very limited numbers of Band 5 vacancies, intense competition and an inability to find suitable local employment, sitting alongside continuing reports of staffing shortages elsewhere. This illustrates a significant failure to align education commissioning, funded establishments and local recruitment, which any extension would need to resolve rather than compound.

Divergence between nursing and midwifery

The RCN is highly concerned in regard to the NMC's proposal to move the two professions in opposite directions: retaining 4,600 hours and extending midwifery education by a year while reducing nursing education by 1,000 hours. Adult, children's, mental health and learning-disability nurses also care for people with increasingly complex needs, exercise autonomous judgement, identify deterioration, and work in environments that have experienced their own serious safety failures and public inquiries; the same case made for midwifery on the basis of complexity and safety could equally be made for any field of nursing. The consultation does not adequately explain why concerns about the intensity and sufficiency of midwifery education justify an additional year, while comparable pressures in nursing justify removing 1,000 hours, and the NMC has not established that reducing nursing hours will itself improve learning quality.

Divergence of this kind raises a longer-term risk to nursing's standing as a degree-level, safety-critical profession, particularly if reduced hours are perceived, whether accurately or otherwise, as a lowering of educational requirements relative to a cognate profession moving in the opposite direction. The underlying rationale is also inconsistent: nursing hours are proposed for reduction on efficiency and modernisation grounds, while midwifery hours are proposed for extension in response to concerns about safety and preparedness, without a clear shared evidential basis linking programme length or hours to outcomes in either case.

The RCN recommends that the NMC clarify the rationale for this differential treatment, including whether resourcing or workforce-cost considerations (for example, the comparative cost of progressing a much larger nursing workforce through banding uplifts) have influenced the proposed approach to nursing hours specifically. Should the divergence proceed, the RCN further recommends that the NMC and UK health departments set out explicit mitigations to preserve equity between the professions, particularly in relation to career progression frameworks, pay banding, and public and employer perceptions of relative educational standing.

Separately, and whatever model is ultimately adopted, we think the final placement proposed under Proposal 9 (requiring student midwives to undertake at least one placement of a minimum of eight weeks during the final part of their pre-registration programme) is insufficient. A placement intended to prepare a student for autonomous, unsupervised practice immediately on registration should run for at least 16 to 24 weeks, continuously, under a designated clinical preceptor, with students permitted to manage a caseload under student status. This mirrors the logic of the Republic of Ireland's model, in which a substantial final-year placement bridges the gap between training and registration.

Recommendations

The RCN recommends the following:

- Withdraw the proposal to extend midwifery to 4 years. Any extension of programme length should be accompanied by clear curriculum expectations, greater leadership development, stronger preparation for autonomous practice, enhanced clinical immersion, and increased focus on safeguarding, anti-racism, cultural safety, mental health, health inequalities and women's health.

9. Conclusion

Overall, the case for the key proposed, namely on the reduction in nursing hours and simultaneous extension of the midwifery programme hasn't been made yet, at least not to the standard needed for something this significant.

Our key concerns are as follows:

- Nursing programme hours: the RCN does not support the proposed reduction from 4,600 to 3,600 hours without a stronger evidence base and binding quality assurance safeguards.
- Preceptorship: the RCN calls for a mandatory, quality-assured preceptorship to be implemented across the four countries. This must be adopted if any reduction of programme hours is implemented.
- Simulated practice learning: the RCN opposes raising the SPL cap without further profession-wide engagement and stronger quality assurance.
- Community placements: supported but only once capacity, definitions and quality standards are in place.
- EDI: support for strengthened standards, conditional on measurable, embedded implementation rather than a paper exercise.
- Midwifery: concern remains about unresolved divergence from nursing and the evidence base for extending programmes.
- Practice assessors: supported, subject to the SCPHN-qualified midwife working in a relevant public health role.

The RCN urges the NMC to ensure that any changes to practice learning standards are evidence-led, phased, and accompanied by the resourcing and quality assurance safeguards necessary to protect students, the public, and the future of both professions. With that in mind, we also stress the importance that the NMC revisit the areas covered in this consultation should substantive, new evidence emerge, including around any association between programme hours and graduate preparedness and patient safety. We welcome ongoing conversations with the NMC on these issues going forward.

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Appendix: NMC Consultation Survey Questions

For the NMC's background explanation for all these questions, please see NMC Consultation Survey in Full.docx

Nursing programme hours

Do you agree with changing the programme hours that pre-registration nursing students complete from a minimum of 4,600 hours to a minimum of 3,600 hours?
Strongly disagree

Length of nursing associate programmes

Do you agree with this removing the requirement that a nursing associate programme is no less than 50% of a nursing programme (if the minimum hours of nursing programmes is reduced)?
Strongly disagree

Simulated practice learning in nursing programmes

Do you agree that simulated practice learning should make up no more than 25% of a nursing programme's practice learning hours (if we reduce the total minimum number of nursing programme hours from a minimum of 4,600 to a minimum of 3,600)?
Strongly disagree

Practice learning placement settings for student nurses

Do you agree that nursing students must have at least one community practice learning experience in health or social care?
Strongly agree

Standards for pre-registration midwifery programmes

Do you agree with strengthening our requirement around holistically assessing labour and birth?

Strongly agree

Please tell us how you think we could strengthen student midwives' care for women with additional needs including if this should be across the whole continuum of maternity care.

See Section 8 of our published response for further detail.

Length of midwifery programmes

Do you agree with increasing the minimum length of midwifery programmes, including degree apprenticeships, from three years to four years?

Strongly disagree

Do you agree that the length of 'shortened' programmes (courses designed for registered adult nurses to qualify as midwives) should also be lengthened (keeping the 50:50 split between theory and practice) to a minimum of two years (if the length of direct entry pre-registration midwifery education programmes is increased)?

Yes

Do you agree with requiring student midwives to undertake one of their practice placements during the final part of their pre-registration programme and that this placement should be at least eight weeks?

Agree

Continuity of supervision for student midwives

Do you agree that we should make it clear that continuity of supervision (having the same practice supervisor) for student midwives throughout the practice learning journey, should be provided wherever possible?

Strongly agree

Simulated practice learning in midwifery programmes

Do you agree that simulated practice learning should contribute towards practice learning hours in pre-registration midwifery programmes?

Agree

Questions for nursing, nursing associate and midwifery programmes

Strengthening anti-racism, bias awareness and cultural curiosity, safety and respect

Do you agree with strengthening our requirements for AEIs and PLPs so that all nursing, nursing associate and midwifery professionals can develop the evidence-based skills, knowledge and experience they need around anti-racism, bias awareness, cultural curiosity, safety, and respect?

Strongly agree

Questions related to nursing and midwifery practice learning standards

Standards framework for nursing and midwifery education

Do you agree that we should strengthen the focus on partnership and collaborative working between AEIs and PLPs to support reasonable adjustments to this standards framework?

Strongly agree

Standards for student supervision and assessment (SSSA)

Do you agree that registered midwives with a SCPHN qualification should be allowed to act as practice assessors for pre-registration nursing students, who are in a public health practice learning setting?

Strongly agree

Is there anything else you would like to share on the proposals to improve nursing and/or midwifery practice learning standards that was not covered in the previous questions?

See Section 6 of our published response for further detail.

EDI

When thinking about the proposed changes to practice learning standards, can you identify any potential impacts – positive or negative – on some individuals more than others based on their protected and other characteristics?

By protected characteristics we mean age, disability, gender reassignment, marriage and

civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Other characteristics can include socio-economic status and caring responsibilities.
Yes

When thinking about the proposed changes to practice learning standards, can you identify any potential impacts – positive or negative – on either the promotion of the Welsh language or on Welsh speakers?
Yes

Any other comments?

These survey responses should be read alongside the RCN's substantive narrative response to this consultation.

Specifically, regarding the question on the length of nursing associate programmes, the RCN's "strongly disagree" position is based on the organisation's strong disagreement with the proposed reduction in nursing programme hours. The reduction in nurse programme hours risks narrowing the gap and professional distinction between the RN and RNA professions and could lead to greater substitution of registered nurses by registered nursing associates, which is already a significant issue. The RCN calls for no changes to be made to RNA programme hours without a full consultation.