FLORENCE NIGHTINGALE FOUNDATION

NMC consultation on proposals to change nursing and midwifery practice learning education standards: FNF response

About this response

The Florence Nightingale Foundation (FNF) is a charity that develops nurse and midwife leaders, enabling them to stay, thrive, lead and transform health and care. In 2024, the NMC commissioned FNF, in partnership with the Nuffield Trust, to conduct an independent rapid review of practice learning in nursing and midwifery education (Palmer et al, 2024) that forms part of the evidence base for this consultation. This response draws on that review and on a roundtable FNF convened with senior nursing and midwifery leaders from our Academy membership held with NMC representatives on 1 July 2026.

Nursing

Q1: 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?

Disagree. We support reducing practice learning hours — but not the reduction in academic hours that follows from retaining the 50/50 theory-practice split, which we propose the NMC removes.

Our independent rapid review found no empirical evidence for an optimal number of practice learning hours. There was no evidence that more hours improve outcomes, and equally none demonstrating that fewer hours are unsafe. Stakeholders across the UK consistently told us that the quality of practice learning matters more than its quantity. We also heard and recognise the workforce-capacity benefit of releasing supervisor time back into practice that a reduction in hours would enable. On that basis, we support a reduction in practice learning hours, while also noting that any specific figure remains a policy judgement rather than an evidence-derived number, and must be accompanied by robust evaluation of newly qualified registrants' preparedness.

We cannot, however, support the proposal in the form consulted on because retaining the 50/50 theory–practice split on a reduced total converts a practice-hours question into an academic-hours cut from 2,300 to 1,800 hours. That consequence is neither necessary nor desirable. Senior education leaders among our members report that the academic component is where students most need strengthening, not reduction. Our members report that learners are increasingly dependent on staff support and less able to self-direct study, and financial pressures mean most universities will treat any academic minimum as a ceiling. Cutting academic preparation at the same time as newly registered nurses are expected to manage rising patient complexity is not the right course of action.

The underlying problem is the 50/50 theory-practice split requirement, which should be removed. It is a convention with a weak justification; we found no evidence that exact numerical parity between theory and practice produced more competent or confident registrants. It is also a false dichotomy, as theory and practice mutually reinforce each other.

Our proposal: Reduce practice learning hours as outlined in the NMC proposal from 2,300 to 1,800. Retain academic hours at their current level. Our support for the practice hours reduction is then conditional on two things:

- **A shared definition of what counts as a practice hour:** Stakeholders we spoke to during our research for the independent review, as well as roundtable participants, noted that where breaks and weekly reflection time are counted within practice hours, genuine patient or service-user contact time can fall substantially below the headline figure — potentially as low as 1,200–1,300 hours under current arrangements. Therefore, any reduction in the headline minimum must also be paired with a clear, consistently applied definition of what counts as a practice learning hour (which is then monitored) so that reduced totals cannot be further eroded.

- **Quality, supervision, and funding:** Our review found that funding and supervisory capacity - including the persistent disparity between medical and nursing/midwifery placement tariffs in England, and the lack of protected time and recognition for supervisors and assessors - are bigger practical barriers than the hours figure itself. Reducing hours will only improve quality if these enabling conditions are addressed in parallel.

Q2: Do you agree with 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)?

Agree

Anchoring nursing associate programmes to the foundation-degree equivalent of 2,300 hours is more coherent than defining them as a ratio of registered nursing programme hours. However, if the proposed reforms progress unchanged, the relative gap between nursing associate and registered nursing programmes will narrow considerably. Our review found that NMC requirements are already interpreted inconsistently across the system, so the NMC must clearly communicate how the distinct scope, outcomes, and proficiencies of each role are maintained, to protect clarity for employers, students, and the public.

Q3: Do you agree that simulated practice learning should make up no more than 25% of a nursing programme's practice learning hours (if the total minimum is reduced from 4,600 to 3,600)?

Agree

A proportionate cap broadly preserves the current position (600 of 2,300 practice hours, approximately 26%) and is preferable to a fixed number of hours applied to differing programme totals. Simulation has clear value, particularly for high-risk, low-frequency scenarios and proficiencies that are hard to achieve reliably in placement, and as a means of offering equitable access to certain learning experiences across all nursing fields (Holt, 2024).

However, our rapid review identified a significant evidence gap around how simulated learning contributes to the competency of new registrants and recommended the NMC do more to fill it. Our review also identified patient and public concern over the inappropriate use of simulation. A percentage cap is a useful safeguard, but we believe it should also be accompanied by clear quality standards for what counts as simulated practice learning, and by a commitment to evaluate its contribution to preparedness – so that simulation supplements, and does not become a substitute for, real-world practice were placements are available.

Q4: Do you agree that nursing students must have at least one community practice learning experience in health or social care?

Strongly Agree

This aligns with the direction of national policy toward care delivered in community and neighbourhood settings, and with our review's recommendation for dedicated national strategies to ensure an appropriately broad range of high-quality placements. Many programmes already achieve this; making it a requirement will help ensure that all do.

However, for this to be successful there are at least three important implementation points. Firstly, community, social care, hospice, and third-sector settings often lack the education infrastructure of acute providers. This means that supervisor capacity, preparation, and support must be resourced, and our review's findings on placement funding and tariff disparities apply with particular force here.

Second, the definition of a qualifying community experience should be broad and clearly articulated, explicitly encompassing social care, hospice, and voluntary sector providers. Third, expanding placement settings should not be used to absorb capacity pressure elsewhere; it must be a genuine learning opportunity.

Midwifery

Q5: Do you agree with strengthening the requirement around holistically assessing labour and birth?

Strongly Agree

This proposal responds directly to one of the clearest findings of our rapid review: numbers-based requirements, most notably the 40-births requirement, were found to distort learning toward task qualification rather than holistic care. The reduction of complex, relational care to a task checklist was a strong and well-evidenced theme, and one of the few areas where stakeholders nearly unanimously agreed change was needed even where they disagreed on the mechanism. We support assessment of holistic and confident, not merely competent, care for women and birthing people having physiological vaginal births, including those with additional and complex needs, assessed across the full maternity continuum rather than in isolated episodes of care.

Q6: Do you agree with increasing the minimum length of midwifery programmes, including degree apprenticeships, from three years to four years?

Neither agree nor disagree — we fully recognise and accept the case for change, but put forward alternative models the NMC should test before committing to a uniform fourth year.

We accept the NMC's rationale that maternity services must change and pre-registration education standards should be a part of that change. Feedback on the intensity of the current three- year programme is consistent and, if more holistic care is to be delivered as above, the programme will need to radically change. Additionally, recent maternity investigations, including the Ockenden Review into Nottingham University Hospitals NHS Trust (Ockenden, 2026) and the National Maternity and Neonatal Investigation (Amos, 2026), make strengthening the preparation, confidence, and support of newly registered midwives an

imperative. Our concern is not whether to change, but whether a fourth year is the right mechanism.

Senior leaders at our roundtable identified two unresolved problems with the proposal as framed. First, the educational case: if no additional programme hours or birth requirements are added, it is unclear what the extra year achieves and how that will be measured. If hours do increase with length, the implied step-change in academic and practice capacity is not currently resourced. Second, access and unintended consequences: an additional year of tuition fees and living costs will fall hardest on certain groups, such as mature students or those from more deprived backgrounds, risking a narrower, less diverse pipeline, in direct tension with the widening-participation and anti-racism ambitions elsewhere in this consultation.

We propose alternatives that could deliver the intended benefit, and ask the NMC to test them before committing to a uniform extension:

- **A funded final preceptorship year, paid rather than fee-paying.** The Republic of Ireland operates a model across both nursing and midwifery in which the final period before registration is a paid, supported preceptorship placement, reported to produce confident, resilient registrants with well-honed clinical skills. Crucially, this inverts the access problem: instead of students bearing an additional year of tuition fees and living costs, they could be salaried, for example at Band 4 or equivalent, during a transition preceptorship year. For employers, remuneration below Band 5 for near-registrant staff contributing to care, in place of vacancy and temporary staffing costs, means the model could be cost-neutral or even cost-saving to the system.

- **An intermediate programme length.** The consultation presents a binary choice between three and four years. Does the extension have to be a full year? The NMC should also test whether three and a half years — broadly the shape of the Irish model, where the taught programme is followed by a paid preceptorship period rather than a further year of study — delivers the intended reduction in intensity and consolidation before registration, at materially lower cost to students and to academic and placement capacity than a uniform fourth year.

- **A Master's level integrated route.** If the programme is to be extended, an integrated Master's (undergraduate entry, exiting after four years with a Master's award) would give the additional year a defined educational purpose. Level 7 outcomes map closely onto the capabilities recent maternity investigations have found wanting, for example around leadership, critical decision-making during uncertainty, human factors, and quality improvement.

If, having tested these options, the NMC concludes that a four-year programme is right, our support would depend on the funding model and access safeguards being agreed before implementation.

Q7: Do you agree that the length of 'shortened' programmes (for registered adult nurses to qualify as midwives) should also be lengthened, keeping the 50:50 split, to a minimum of two years (if direct-entry programmes are increased)?

Neither agree nor disagree

We recognise and support the principle behind this proposal. Midwifery is a distinct profession requiring its own full preparation and if direct-entry programmes are lengthened there is a clear consistency argument for the shortened route to follow. The shortened route is not a shortcut to midwifery; it is a recognition that registered nurses do not start from the same baseline as direct entry students.

We are unable to fully support the proposal, however, without a clearer understanding of its workforce consequences. The shortened route already has a long history of recruitment challenges, and some maternity workforces now have no dual-registered midwives at all. At a time of rising complexity and multimorbidity among women and birthing people using maternity services, dual registration brings a complementary perspective that strengthens multidisciplinary working within maternity teams. Lengthening the conversion route risks further deterring registered nurses, a group who typically carry existing financial and family commitments, from making the transition, and losing that perspective from teams altogether.

Our position would be informed by evidence on both points. We would encourage the NMC to model the likely impact of an extension on uptake of the shortened route, and to consider approaches that recognise prior learning and registration rather than applying a uniform extension. We also note that the proposal is premised on retaining the 50:50 theory and practice split, a requirement we question in principle (see our response to Question 1).

Q8. 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

An extended placement immediately prior to registration supports consolidation, confidence and a managed transition into practice. Evidence from extended transition models elsewhere suggests meaningful gains in clinical confidence and resilience at the point of registration (Edwards et al, 2015).

Q9. Do you agree that we should make it clear that continuity of supervision for student midwives throughout the practice learning journey should be provided wherever possible?

Agree

Members reported students encountering very large numbers of different practice supervisors within a single placement - in some cases reported to exceed twenty across a six-to-eight week placement. Fragmentation on this scale undermines the reliability of assessment, the student's sense of belonging and psychological safety, and the relational learning that midwifery in particular depends on.

The NMC should define what continuity is expected to look like in practice, require providers to monitor and report on it, and recognise that continuity depends on supervisor capacity being resourced. Our independent review specifically recommended better protection of supervisors' and assessors' time in job plans and recognition through pay and progression.

Q10. Do you agree that simulated practice learning should contribute towards practice learning hours in pre-registration midwifery programmes?

Agree – subject to a clear cap and quality standards

Simulation is already widely and effectively used in midwifery for proficiencies that are hard to achieve reliably or safely in placement and it is anomalous that this counts as theory rather than practice. Recognising high-quality simulation within practice hours, as we do for nursing, is reasonable on that basis.

However, stakeholder feedback, both in our review and at our roundtable, consistently favoured real-world practice with women and birthing people, babies and families over simulated replacement, and showed little appetite for simulation expanding by default. If simulation is to count toward practice hours, the NMC should pair this with a proportionate cap (as proposed for nursing), clear quality standards, and an expectation that simulation is targeted at proficiencies genuinely difficult to achieve in placement rather than used to absorb placement capacity pressure.

Cross-cutting

Q11. Do you agree with strengthening requirements for AEIs and PLPs so that all nursing, nursing associate and midwifery professionals can develop evidence-based skills, knowledge and experience around anti-racism, bias awareness, cultural curiosity, safety and respect?

Strongly agree with the aim. However, the proposal is too vague to assess. The NMC should specify which requirements would change and what AEIs and PLPs would actually have to do.

The aim that every nursing, nursing associate and midwifery professional is equipped to deliver anti-racist, culturally safe and respectful care for every patient and service-user is right and urgent. The disparities it targets are well documented, especially within maternity services. We support making this an explicit, assessable part of pre-registration preparation across the professions.

However, the proposal as consulted on does not say what is actually being proposed. It only asks whether we agree with "strengthening requirements" without specifying which standards would be amended, what the strengthened requirements would entail, or how compliance would be assessed and enforced. We are also unclear as to how this proposal relates to the NMC's recently published anti-racism principles (NMC, 2026). If the intention is to incorporate the principles, currently adopted voluntarily by education partners, into enforceable education standards, that is a change we would strongly support. However, that is currently not clear.

We would also like to point out that preparing the future nursing and midwifery workforce to deliver anti-racist and culturally safe practice is not the same as addressing the unequal allocation of high-quality placements and biased treatment and assessment our rapid review identified. The two are, however, connected: students cannot credibly be taught cultural safety in learning environments that do not practise it, and supervisors and assessors need capability both to teach and model anti-racist care and to assess all students fairly. But they require distinct requirements and distinct monitoring.

Q12. 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

The evidence base for this proposal comes substantially from the rapid review we conducted with the Nuffield Trust. Our research found that reasonable adjustments agreed in academic settings routinely fail to transfer into practice learning placements, mostly because of poor communication and/or misunderstandings around data protection regulation.

The consequence falls on the student via repeated disclosure of their needs in each new setting, added stress, and inequitable practice learning experiences. We also heard concerning examples of inadequate needs assessment being conducted. Our research further highlighted the importance of students feeling able to communicate their needs early, so that adjustments are in place in time for both the student and the placement provider.

We support the proposed definitional clarification. Anchoring 'reasonable adjustments' to the definition in the Standards framework for nursing and midwifery education and distinguishing them clearly from flexible working requests, matters because the two are categorically different. Reasonable adjustments are a legal duty under equalities and human rights legislation, not a discretionary accommodation to be negotiated. Conflating them has allowed adjustments to be treated as favours that placements may or may not grant. Clarity protects students, and it also protects practice learning partners by giving them certainty about what they are required to do.

However, a clearer definition will not, by itself, fix the transfer problem our research identified. The strengthened standards should require:

- **A clear transfer mechanism,** with the student's consent, so that agreed adjustments follow the student from AEI to every practice setting — ending the cycle of repeated disclosure. This should be a shared responsibility with named owners on both sides, not an expectation that the student carries their own case.

- **National guidance on data protection and lawful sharing.** Our research found data protection being misunderstood as a reason not to share adjustment information. The NMC, working with system partners, should publish or endorse clear guidance on consented sharing, so data protection stops functioning as a barrier to a legal duty.

- **Standards for the quality and timing of needs assessment.** Requirements should address both the quality of assessment and structured, supported early disclosure conversations, so adjustments are in place before a placement begins rather than negotiated during it.

Finally, the wider weakness in AEI–PLP partnership was the single most consistent theme raised by our members. Practice learning partners working across five, six or seven universities face divergent processes, documentation and interpretations of the same standards; escalation routes between university and practice are unclear, with members citing live cases where this caused real harm; the link between academic assessors and practice supervisors and assessors is weak; and practice partners are frequently not involved in universities' annual self-reports or provider feedback to the NMC, despite the standards already requiring joint working.

Reasonable adjustments will only reliably transfer where this partnership infrastructure exists. Strengthening should therefore include verified joint completion of annual self-reports and provider feedback; explicit, named linkage between academic assessors and practice supervisors/assessors; and NMC support for shared or streamlined documentation across AEIs working with the same practice partners.

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