Response to the Nursing and Midwifery Council consultation on proposals to change nursing and midwifery practice learning education standards

About University Alliance

University Alliance (UA) is the voice of professional and technical universities. Our 20 member institutions educate 35 per cent of the UK's nurses and midwives, working in close partnership with NHS and social care providers and communities across the country. We welcome the opportunity to respond to this consultation.

Summary of our position

- **This review must be part of a wider review of the standards.** The standards of proficiency and the Standards for Student Supervision and Assessment (SSSA) date from 2018/19 and are in urgent need of review given the scale of change since. It is difficult to review practice learning in isolation from them: the biggest questions in this consultation, from a fourth midwifery year to the role of simulation, can only properly be answered once the proficiencies and the future scope of practice are settled. We urge the NMC to commit to a full review of the proficiencies and the SSSA, sequenced with these changes as one coherent programme of reform.
- **We support the proposed reduction in minimum nursing programme hours to 3,600 (Proposal 2),** provided the change is anchored in quality and outcomes rather than a lower hours target, and that funding through the education and training tariff is protected. Hours do not equal competence: the value lies in the quality of practice learning, supervision and assessment.
- **We are not persuaded that the case has yet been made for extending midwifery programmes to four years (Proposal 8).** The critical unanswered question is what students would actually gain from the additional year. We believe reform of preceptorship, career pathways and the standards themselves may deliver the intended benefits more effectively, without adding a fourth year of student debt.
- **We support a community practice learning requirement in principle (Proposal 5), but it must be outcome-focused rather than prescriptive**. A strict setting-based requirement risks building in inequality, is difficult for the system to deliver at scale, and must be aligned with investment in community placement infrastructure, tariff and a review of the SSSA.
- **We strongly support embedding anti-racism, bias awareness, cultural safety and respect (Proposal 1).** This must be a shared, system-wide responsibility, developed with people with lived experience, and matched by accountability in practice settings as well as in education. We ask why the new anti-racism principles are not being embedded in the Code itself.

- **We strongly support simulated practice learning, including its contribution to practice learning hours in both nursing and midwifery (Proposals 4 and 11).** Simulation is a highly effective mode of learning. In midwifery it is essential for teaching hard-to-achieve proficiencies and we welcome its fuller recognition by the regulator. A clear NMC definition of simulated practice learning, and of the standards it must meet, will give universities the confidence to invest and embed it further.
- **Any changes must be evidence-led and piloted where possible.** We ask for less prescription, not more, and for the NMC to simplify its approval and quality assurance processes.

Proposal 1: Embedding anti-racism, bias awareness, cultural curiosity, safety and respect

UA strongly supports the ambition of this proposal. The evidence on Black maternal health and on the experience of Black, Asian and minority ethnic students set out in the consultation is stark. We are clear that something is not right, and the system should not wait for further adverse events before acting.

To succeed, this work must be built on shared responsibility and collective acceptance rather than individual blame. The prevailing construction of what a “professional” looks like is still too often coded as white, middle-class and male; those cultural norms need to be made explicit and questioned, and we encourage the NMC to reflect on this within its own values, processes and expectations as well as in its standards.

Alliance universities are already doing a great deal — on awarding gaps, widening participation, experiential learning and psychological safety — but they cannot deliver culture change in practice settings alone. In our view the biggest barrier sits within the NHS, where making change is harder than in the classroom, role models of colour are in short supply, and it too often takes an adverse event to force action. Strengthened education standards must therefore be matched by accountability and change within practice learning environments, through genuinely shared decision-making between universities, practice partners and NHS system bodies.

We make four specific points:

- A shared understanding of anti-racism and its terminology is needed across education and practice, so that expectations are consistent and people can be held accountable. We ask why the new anti-racism principles, published in May 2026, are not being embedded within the Code itself, and how accountability will operate if they sit outside it.
- This work must be done with people, not to them. Deep engagement with students, staff and service users with lived experience — including on intersectionality, class, disability, faith and gender identity — is essential to avoid a superficial, tick-box approach.
- Measurement matters. Existing surveys such as the NSS and NETS lack the specificity and response rates to evidence progress; the NMC should triangulate multiple data sources and gather concrete examples of what has and has not worked.

- The approach should be proactive and asset-based rather than deficit-based, extending beyond anti-racism alone to inclusive environments in the round, with clearer escalation routes for students and staff affected by poor practice.

Proposal 2: Reducing minimum nursing programme hours from 4,600 to 3,600

UA supports this proposal. Hours do not mean competence, and value should be placed on the quality of practice learning — supervision, assessment, simulation and reflection — rather than the accumulation of time. The current requirement can leave students remaining in practice simply to complete hours after proficiencies have been achieved, which undermines motivation and adds little to learning, and it drives an assessor culture of "gatekeeping hours" rather than assessing achievement. Aligning the minimum with the 3,600 hours implied by a 360-credit bachelor's degree is a coherent basis for the change, and shorter programmes could ease cost-of-living pressures, create scope for students to work alongside their studies, and improve pipeline sustainability, particularly in smaller fields of nursing.

Our support is, however, conditional on the following:

- **Quality and outcomes must be the explicit test.** The reduction should be accompanied by a clear shift to outcomes-based assessment, revisiting the standards of proficiency, so the change cannot become fewer hours and lower quality. We see a strong case for piloting different approaches and evaluating the impact on students and patients before or alongside full implementation.
- **Tariff and placement funding must be protected.** Fewer practice hours must not translate into a proportionate loss of the education and training tariff and practice education support, which underpin quality in placements. We suggest the NMC and system partners explore an enhanced tariff linked to the quality of learning rather than volume of hours.
- **Supervision and assessment capacity must be assured.** The quality dividend depends on effective practice supervisor and assessor support, and on peer-learning models such as CLiP. Consideration should also be given to innovative final-year models, including paid placements, which would benefit both students and practice areas.
- **The reduction must not dilute theoretical content.** Because of the 50:50 split requirement, a lower overall minimum reduces theory hours as well as practice hours, and the consultation says little about how this will be managed. The theoretical underpinning of nursing — the evidence base, critical thinking and academic content that define a degree-level profession — must not be thinned out by default. We ask the NMC to set out, working with AEIs and alongside the proficiencies review, how the theory component will be worked through so that essential content is retained and redesigned for fewer hours rather than simply cut.
- **Equality and mobility impacts need working through.** These include implications for students with reasonable adjustments who may need longer to complete; recognition of a shorter UK programme for graduates wishing to work in the EU; and consequences

for direct-entry MSc programmes and recognition of prior learning. There may also be implications for the “long course” status of nursing programmes: if reduced hours shorten the teaching year below the thresholds for long course funding, students in England could lose entitlement to the additional maintenance payments from Student Finance England that nursing students currently receive — a material loss for the very students already experiencing placement poverty. This must be modelled and resolved with the funding bodies before any change is implemented.

There is also a compelling case for reviewing the 50:50 theory–practice requirement itself. We understand neither Australia nor New Zealand mandates a fixed theory–practice split, and simulation there sits outside practice hours altogether — within programmes requiring far fewer practice hours (around 800–1,100) than even the reduced UK minimum would. We recognise the important differences: those standards do not encompass the advanced skills within the NMC’s, and both countries rely on graduate-year consolidation models of the kind discussed for midwifery. But the comparison demonstrates that a fixed 50:50 ratio is not a precondition of safe, effective preparation for practice — and that the UK can comfortably accommodate simulation at up to 25% of practice learning. Removing the fixed split, or converting it to a flexible range, would allow AEIs to protect or increase theory hours within a reduced overall minimum, directly reinforcing our point above that the reduction must not dilute theoretical content. We ask the NMC to review this requirement as part of the wider reform programme.

We are also alert to a presentational risk: a perception that nursing is being “reduced” at the same time as midwifery is being told it needs more. The NMC’s communication of these changes should confront this directly, emphasising that programmes remain at degree level — which we regard as essential — and that the change is about quality, not less nursing. Ultimately this is a public protection argument: registrants formed through high-quality, well-supervised, outcomes-focused practice learning are safer practitioners than those formed through hours-counting, and a change that raises the quality of every practice hour serves the public better than a target that pads the total.

Proposal 3: Nursing associate programme length

UA agrees that, if nursing programme hours reduce, the nursing associate minimum should be set at 2,300 hours rather than pegged at 50% of the nursing minimum, preserving alignment with the foundation degree. However, this exposes a more strategic question about the viability of the nursing associate role: if the gap between nursing associate (2,300) and registered nurse (3,600) hours narrows this far, employers may reasonably ask why they would support a nursing associate when a registered nurse is within closer reach.

We therefore ask the NMC to consider the nursing associate pathway in the round alongside this change, including: retaining the ability to recognise prior learning for up to 50% of programmes, allowing nursing associates to RPL 1,150 hours and, where appropriate, years one and two of a nursing programme; making “top-up” to registered nurse status easier through a clear dual-registration route; whether the 50:50 theory–practice split should flex, with greater theory content supporting career pathways and movement between fields and specialties; and whether the foundation degree remains the right award. Creative use of digital and virtual placements and simulation should also be part of this picture.

Proposal 4: Simulated practice learning in nursing programmes (no more than 25%)

UA supports simulated practice learning and its continued contribution to nursing programmes. Simulation is a highly effective mode of learning — including for situations that are hard to access reliably in placements — and we see growing potential in digital and virtual placement models. Retaining a proportionate cap is sensible, and 25% of practice learning hours is a reasonable translation of the current position.

The key enabler is a clear definition. A shared understanding of what counts as simulated practice learning, the standards it must meet, and how it will be quality assured will give universities the confidence to invest in and embed simulation further. We ask the NMC to publish clear guidance alongside any revised standards. We also encourage the NMC to test the mechanics of a percentage-based limit against a stated number of hours, to establish which formulation is clearer and less prone to inconsistent interpretation across programmes of different lengths.

This position now has clear cross-party parliamentary support. *Trained for Tomorrow: A Plan for the Future NHS Workforce*, published by Policy Connect in July 2026 following an inquiry led by the Higher Education Commission and the All-Party Parliamentary Health Group, recommends that professional regulators formally recognise simulation-based learning as a valued, quality-assured complement to clinical placement hours, with hours counting towards practice learning requirements where providers meet defined quality standards aligned with those of the Association for Simulated Practice in Healthcare. The report highlights the strong and growing evidence base for simulation in healthcare workforce development, including the NMC's own evaluation and the largest randomised controlled study of simulation in nursing education, which found no significant difference in outcomes when simulation replaced up to half of traditional clinical hours. It is equally clear-eyed about cost: high-quality simulation carries significant infrastructure, staffing and training costs, and simulation tariff funding currently extends only to undergraduate medicine. We endorse this analysis, and its emphasis on quality over quantity: what should matter is not how many simulation hours are delivered, but that every hour counted is delivered to a defined, quality-assured standard.

Proposal 5: A required community practice learning experience

UA agrees in principle. Community exposure is vital, the direction of travel across all four nations is towards care closer to home, and many of our members already maximise community placements wherever capacity allows. The University of Brighton, for example, works in partnership with Skills for Care to secure community placements with nursing homes, drug and alcohol charities, sexual health clinics and a local prison. Oxford Brookes University offers final-year students a dedicated community pathway in which placements are based entirely in community settings. Other members run dedicated general practice and community nursing pathways that centre students' placement experience in out-of-hospital settings while retaining some exposure to in-hospital environments. However, placement capacity means these pathways can be offered to only a limited number of students, illustrating exactly the constraint that a mandatory requirement must reckon with. This is why

the requirement must be outcome-focused rather than prescriptive. The key question is whether it is the setting that matters or the learning outcomes: well-designed outcomes can enable students to understand prevention, public health and community models of care across a range of settings, whereas a prescriptive setting-based rule risks becoming a tick-box exercise and creating compliance jeopardy for programmes in areas where suitable placements are scarce.

There are significant delivery challenges that the NMC must address alongside any new requirement:

- **Definition and design.** What does "community" mean for these purposes, how long should the placement be, and how will it be managed? These questions need answering before a requirement is set, and the answer should be developed in line with the proficiencies review and a review of the SSSA.
- **Equality impacts.** Community placements typically involve more travel from a base or the student's home, at greater cost, and fewer students now have driving licenses or access to cars. Without careful design and financial support, a mandatory requirement builds in inequality.
- **Infrastructure and capacity.** Community infrastructure for practice learning is weak in many areas: practice assessor and supervisor capacity is limited, hubs often do not exist, quality is variable, and supervision models designed around ward-based care (including for placements delivered in people's homes or virtually) sit uneasily with current SSSA requirements. Student safety, supervision quality and exposure to poor practice all need attention. There is a clear role for tariff in building community placement capacity — we regard a community placement tariff as a priority — and a joined-up approach with ICSs/ICBs and national NHS bodies is required. We note that the *Trained for Tomorrow* report (Policy Connect, July 2026) likewise recommends ICB-led regional placement coordination networks, with capacity mapped across all settings including social care and the voluntary sector, and with local tariff allocation decisions published so there is scrutiny of whether funding reaches the providers bearing the cost of supervision.
- **Support, not hurdles.** We ask how the NMC will support universities and partners to deliver this, and caution that each additional prescriptive requirement adds complexity and risk. Our consistent message is less prescription, not more, and evidence underpinning any change.

Proposals 6 and 7: Holistic assessment of labour and birth, and caring for women with additional needs

UA supports the intent of both proposals. A more holistic assessment of caring for women through physiological birth, and strengthened requirements around women with additional care needs across the continuum of maternity care, are consistent with our view that current requirements can drive task-oriented learning and counting (for example, towards the required number of births) at the expense of quality, holistic practice learning with a diverse range of women, newborn infants and families. Any strengthened requirements should be framed around outcomes and proficiency rather than additional numerical targets, and

should be developed with Lead Midwives for Education and practice partners so they are deliverable within real placement capacity.

Proposal 8: Extending midwifery programmes from three to four years

UA is not persuaded that the case for a four-year programme has yet been made. We recognise the context — high-profile inquiries, the imperative of safe maternity care, and genuine concerns about newly registered midwives' preparedness — and we support the goal of midwives qualifying with greater confidence, competence and breadth. But the central question remains unanswered: what would students actually get from the extra year? Extension must be driven by defined learner outcomes, not simply more time, and emphatically not "more of the same." The length of the programme should follow from a reviewed set of proficiencies and a clear vision for the scope of midwifery practice, not precede them.

Our concerns fall into three groups:

- **Impact on students and the pipeline.** A fourth year means a fourth year of loans and living costs, in a context where placement poverty is already a significant problem. The likely equality impacts — on mature students, students with caring responsibilities, and those from lower socio-economic backgrounds — could reduce applications and worsen the very diversity of the workforce the wider consultation seeks to support, while delaying entry to a stretched workforce.
- **Design of the additional year.** If there is to be a fourth year, its content and purpose must be specified first. We would identify abnormal physiology, neonatal care, leadership and management, and simulation-rich, outcomes-based learning as candidate priorities — alongside clarity about the future vision and scope of midwifery practice that a longer programme would serve. The approval and re-approval costs for universities and the regulator also need to be recognised.
- **Alternatives should be considered seriously before extending.** We believe many of the intended benefits could be achieved by rethinking the transition to practice rather than lengthening the pre-registration programme. Options include a structured, funded preceptorship — potentially a two-year programme supported through the apprenticeship levy, moving decisively away from tick-box competencies — drawing on models such as the MPharm's structured post-qualification year; clearer post-registration career progression, including better use of advanced practice roles, which are currently little used in midwifery; and a wider review of the midwifery standards taken beyond Lead Midwives for Education. Clarity is also needed on where responsibility for preceptorship sits between employers and universities.

We would also caution against a framing that locates the problem in universities and programme length, when many of the failings identified by maternity inquiries concern the culture of practice environments. Universities should not be blamed for the culture of practice; extending programmes will not, by itself, fix it. Public protection cuts both ways: a poorly designed extension that shrinks and narrows the midwifery pipeline — deterring the mature, diverse applicants the profession most needs and delaying entry to an already stretched workforce — would itself be a risk to safe maternity care. We also strongly support

the role of simulation in midwifery education — it is essential to teaching midwifery effectively, particularly for hard-to-achieve proficiencies — and we therefore see Proposal 11, which gives simulation fuller recognition within practice learning, as an important complement to, and arguably a precondition of, any reforms.

The consultation asks whether, if direct-entry programmes are extended, shortened programmes for registered adult nurses should also be lengthened to a minimum of two years. Our position follows the same logic as our response to Proposal 8: any change to programme length must be driven by defined learner outcomes, settled after the proficiencies and the future scope of midwifery practice have been reviewed — not applied as an automatic proportional adjustment. Students on shortened programmes are experienced registered professionals who bring substantial prior learning; recognition of that prior learning, and an outcomes-based assessment of what they still need to achieve, should determine programme length. If the evidence from a proficiencies review shows more time is needed, we would support that; extending these programmes simply to preserve a ratio with the direct-entry route would not be justified, and would risk closing off an important, experienced pipeline into midwifery at a time when the workforce can least afford it.

Proposal 9: A final placement of at least eight weeks

UA can see the value of a substantial consolidation placement in the final part of the programme: the experience of Welsh AEIs cited in the consultation, and our own emphasis on consolidation, supervision continuity and a well-designed transition to registration, support this. Consistent with our position elsewhere, however, we encourage the NMC to frame this as an outcome — a consolidated, well-supervised transition to practice — with flexibility over precise length and structure, and to design it alongside the reformed approach to preceptorship discussed under Proposal 8, so that consolidation before registration and support after registration form one coherent pathway.

Proposal 10: Continuity of supervision for student midwives

UA supports this proposal. Fragmented supervision makes assessment of skills harder and allows students' learning needs to fall through the net, and supervision continuity is part of what makes final consolidation placements successful. The "wherever possible" framing is sensible, given real-world rostering constraints. Delivery will, however, depend on practice supervisor and assessor capacity — a recurring theme of this response. And if this change proceeds, it should apply consistently across the professions: the case for continuity of supervision is no weaker for nursing and nursing associate students than for student midwives, and divergent expectations would be hard to justify. The SSSA review we recommend is the natural vehicle for both — assuring supervisor capacity and extending the same expectation to all pre-registration programmes.

Proposal 11: Simulated practice learning counting towards midwifery practice hours

UA strongly supports this proposal. Simulation is essential to teaching midwifery effectively — especially for hard-to-achieve proficiencies such as breech birth, episiotomy and suturing — and we warmly welcome the fuller recognition of its value within practice learning that this proposal represents. Allowing appropriately governed simulation to contribute to practice learning hours, delivered within the SSSA, is the right step and one we encourage the NMC to take.

As with Proposal 4, the essential enabler is a clear NMC definition of simulated practice learning and the standards it must meet, which will give universities the confidence to invest in high-quality simulation at scale. The University of Greenwich, for example, has invested in birthing manikins capable of simulating both normal and complex delivery scenarios, with students also practising postnatal and neonatal care alongside other members of the interprofessional team. The university was shortlisted for a 2026 Student Nursing Times teaching innovation award for a sequential simulation that followed a young single mother from the community, through maternity services and, ultimately, to a coroner's court — precisely the kind of complex, sensitive learning that simulation makes uniquely possible.

The NMC should also be mindful that high-quality simulation carries significant ongoing costs — in specialist staffing, estates, equipment and the involvement of service users and actors — identified both in its own evaluation and, most recently, in the Trained for Tomorrow report (Policy Connect, July 2026), which recommends formal regulatory recognition of simulation across the healthcare professions and protection and extension of tariff and other funding streams. The test throughout should be quality over quantity: simulation hours should count because they meet defined quality standards, not simply because they are delivered.

Proposal 12: Reasonable adjustments and partnership working

UA supports strengthening the standards framework on reasonable adjustments and on partnership between AEIs and PLPs. The failures described in the consultation — adjustments agreed in academic settings not transferring to placements, students repeatedly having to explain their needs, and inadequate assessment of complex needs — match our members' experience.

Clarifying the definition of a reasonable adjustment, and distinguishing it from a flexible working request, is helpful. We would go further: we would welcome clear NMC support on what is and is not "reasonable" — including how adjustments interact with patient safety, professional requirements and the resources of clinical settings — so that decisions are consistent, defensible and made through shared decision-making between universities, practice partners and the NHS, with appropriate occupational health input. Better, earlier and appropriately data-protection-compliant communication of students' needs between academic and practice settings should be an explicit expectation on both sides of the partnership. This links closely to Proposal 2: students with reasonable adjustments may need longer, and flexibility within programme design should work for them, not against them.

We also flag a specific delivery risk: where an adjustment means a student needs a longer placement — or the same hours over an extended period — practice learning providers may be reluctant or unable to offer it, leaving an adjustment agreed in principle but undeliverable in practice. The strengthened standards should make clear that accommodating extended placements is part of the partnership's shared responsibility, supported by realistic placement planning and capacity.

Proposal 13: SCPHN-qualified midwives as practice assessors for nursing students

UA supports this proposal. It is a pragmatic change that recognises how professionals actually work in public health settings and increases the pool of practice assessors — directly relevant to the assessor capacity constraints we identify throughout this response, particularly in community settings. We encourage the NMC to consider whether further, similarly pragmatic flexibilities within the SSSA could safely expand supervision and assessment capacity, as part of the fuller SSSA review we recommend.

Cross-cutting issues

Evidence, piloting and sequencing. We ask the NMC to set out the evidence base underpinning each change and, where evidence is limited, to pilot changes and evaluate their impact on students and patients before wholesale adoption. As set out in our summary, the proposals also depend on the standards of proficiency and the SSSA, and we believe both must be reviewed in step with these changes so that hours, outcomes, supervision and assessment form a coherent whole.

Funding and tariff. Tariff runs through almost every proposal in this consultation: protecting placement quality as nursing hours reduce, building community placement capacity, sustaining high-quality simulation, and supporting midwifery placements and any reformed preceptorship. We ask the NMC to work with governments and NHS bodies across the four nations so that funding follows the quality of learning, and to model tariff and apprenticeship funding impacts transparently before final decisions are taken.

Apprenticeships and levy funding. The NMC has asked specifically for feedback on apprenticeship implications, and UA members are leading providers of nursing, nursing associate and midwifery degree apprenticeships. Three points follow. First, on midwifery: because funding is dictated by programme hours and no increase in hours is proposed, extending programmes to four years would spread unchanged funding across an additional year. That creates a genuine viability problem for employers and providers and risks reducing apprenticeship places — often the most accessible route for the mature and diverse entrants the profession needs — which reinforces our reservations about Proposal 8. Second, we welcome confirmation that nursing associate apprenticeship funding would be unaffected by Proposal 3. Third, the levy could be used more creatively: as set out under Proposal 8, a levy-funded structured preceptorship may deliver more for safe practice than a longer pre-registration programme. In all cases, delivery models vary across the four nations, and the NMC should model funding impacts transparently with employers and providers before decisions are taken.

Equality Impact Assessment. The consultation states that EDI-related feedback will directly inform the NMC's ongoing EQIA, and we ask that the equality evidence in this response be fed into it explicitly. In particular: placement poverty and the cost of travel to community placements, which fall hardest on students without driving licenses and/or cars and those from lower socio-economic backgrounds; the disproportionate impact of a fourth year of loans and living costs on mature students and those with caring responsibilities; the interaction of reduced programme hours with students who need reasonable adjustments and may require longer to complete; the risk that reduced hours cost students their 'long course' maintenance entitlement from Student Finance England; and the experience of Global Majority students in practice settings.

Regulation that enables. Our consistent message is "less prescription, not more." We do not want a national curriculum: universities should retain the freedom to design programmes collaboratively around the needs of their local populations and systems. Alongside this, we find the NMC's programme review and approval processes too variable and complex; simplification would materially reduce the cost and risk of implementing the changes consulted on here. The *Trained for Tomorrow* report (Policy Connect, July 2026) reaches the same conclusion, recommending that regulators streamline pre-approval processes for curriculum changes and publish a shared framework for curriculum innovation, citing the NMC's current review of standards inherited from the EU Directive as one of the reform processes to build on.

Implementation support. A transition period of at least two years is welcome. We ask that it be accompanied by clear guidance (especially on simulation and community placements), realistic re-approval timelines, and active NMC engagement with ICSs/ICBs and national bodies to unblock the placement infrastructure on which several proposals depend.

Our recommendations

For ease of reference, UA's recommendations to the NMC are:

1. **Commit now to a full review of the standards of proficiency and the SSSA**, sequenced with the practice learning changes so that hours, outcomes, learning environments, supervision and assessment are reformed as one coherent programme.
2. **Proceed with the reduction of minimum nursing programme hours to 3,600**, piloting and evaluating the change for its impact on students and patients, revisiting the standards of proficiency so quality and outcomes are the explicit test, and reviewing whether the fixed 50:50 theory–practice split remains necessary.
3. **Work with governments and NHS bodies to protect education and training tariff funding as hours reduce**, explore an enhanced tariff linked to the quality of learning, prioritise a tariff for community placements, and protect and extend the funding streams that sustain high-quality simulation.
4. **Publish a clear definition of simulated practice learning, the standards it must meet and how it will be quality assured**, alongside any revised standards for both nursing and midwifery.

5. **Set the nursing associate minimum at 2,300 hours and review the nursing associate pathway in the round**, including recognition of prior learning and an easier top-up route to registered nurse status.
6. **Frame the community practice learning requirement around learning outcomes rather than prescribed settings**, and work with ICSs/ICBs and national bodies to build community placement infrastructure before compliance is required.
7. **Do not extend midwifery programmes to four years ahead of a review of the proficiencies and the future scope of midwifery practice**; instead, develop a structured, funded preceptorship — potentially through the apprenticeship levy — alongside clearer post-registration career progression.
8. **Apply the same outcomes-led test to shortened midwifery programmes for registered adult nurses**, with programme length determined by recognition of prior learning rather than an automatic proportional extension.
9. **Frame the final midwifery placement as a consolidation outcome**, with flexibility over precise length and structure, designed as one pathway with reformed preceptorship.
10. **Embed the anti-racism principles within the Code**, **establish a shared understanding of anti-racism across education and practice, and match strengthened education standards with accountability for change in practice settings**.
11. **Provide clear support on what is and is not a "reasonable" adjustment**, including its interaction with patient safety, delivered through shared decision-making between universities, practice partners and the NHS.
12. **Model tariff and apprenticeship funding impacts transparently with employers and providers before final decisions** — particularly for a four-year midwifery programme — and feed the equality evidence in this response directly into the ongoing EQIA.
13. **Simplify the NMC's programme review and approval processes, and support the transition period of at least two years with clear guidance**, especially on simulation and community placements.

An offer to the NMC

University Alliance and its members want this review to succeed, and we can offer practical capacity to help it do so. Our members educate 35 per cent of the UK's nurses and midwives across a wide range of settings and communities, which makes the Alliance a ready-made testbed for reform. Specifically, we offer to:

- Convene our Deans of Health, practice partners and students where and when it would be helpful.
- Share member data and case studies to inform the NMC's further work on financial, workforce and equality implications.
- Host and support pilots across the UA network — for example of reduced-hours programme models, community placement approaches, simulation-based practice

learning and reformed preceptorship — with evaluation of the impact on students and patients built in from the start.

We would be pleased to discuss any aspect of this response. Please contact Susanna Kalitowski, Director of Policy, University Alliance, susanna@unialliance.ac.uk