NHS
Greater Manchester

NHS Greater Manchester Operating Model

Response to feedback

January 2025

Part of Greater Manchester Integrated Care Partnership

NHS Greater Manchester operating model: Responses to feedback

Introduction

During October and November 2025/26, we asked colleagues and stakeholders to share their views and feedback on the draft organisational operating model for NHS GM, which is due to be implemented from 1 April 2026 onwards.

We received a lot of wide-ranging views, inputs and suggestions from staff, partners and stakeholders which was shared in the feedback report. The organisation has reviewed and reflected on what was said. The responses to the feedback from relevant parts of the organisation are set out in the table below.

The response to the feedback takes the form of a ‘you said’, ‘we said’, ‘we did/we will do’ so that everyone can see what feedback has been used to directly amend the operating model, and what feedback will be used more broadly for future ways of working and planning.

As linked to the engagement feedback report, we have collated the comments and themes into broad areas for the purpose of being able to provide clear responses, outcomes and calls to action. The responses are also broken down via the main internal and external audience groups, but where the same feedback has been provided from multiple audiences, we have responded once and noted that in the table.

The focus and aim of this report is to provide information and reassurance on how we have and continue to respond to areas of concern and demonstrate the opportunities for development and change.

Responses to feedback

Staff

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Some think the governance will still be too complicated, others think it will be better than now	It is acknowledged that any strategies, plans or models will be subjective, and that there will be differing opinions. We remain confident that the governance will be streamlined and improved under the new model from 1st April, but we will continue to test all parts of the governance system and adapt and make further changes as necessary following implementation.	We have ensured the specific feedback on governance has been fed into the leads / teams that work on this area for NHS GM, so that it can be considered for all future planning and delivery in this area. We have made plans to streamline the Board committee structure, and this will take effect from 1st April 2026. We have committed to reviewing and simplifying meeting and decision-making governance as a next step.
Not that different to existing operating model (this feedback was also provided by partners and stakeholders)	We have regularly received feedback that the existing operating model does not offer the clarity on delivery responsibility and decision-making, particularly between place and GM functions that was required. We understand that this will cause some concern about the new operating model. We believe that this new version of the operating model, which has been designed collaboratively, will give us the best foundation for operating as a 'new' organisation, system made up of our six constituent parts (five pan-GM portfolios and our 10 Place Partnerships) from 1 April 2026. This new organisational form is a 'step change' in how Place Partnerships and pan-GM teams work reciprocally rather than hierarchically.	We commit to communicating the difference this model is making for Place Partnerships as part of this new operating model and ensuring that teams and partner organisations are clear on their refreshed and enhancing responsibilities and decision-making in relation to Live Well, neighbourhoods, pathway design and demand management.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Place vs centralisation and the risks of too much centralisation – no one thinks we have the balance of this right, but the reasons are often directly contradictory *(this feedback was also provided by partners and stakeholders)*	We understand and recognise the concerns from both sides of the argument about the balance of place vs centralisation. However, there are elements of the place model that are still being developed that make it difficult to confirm exactly how all the connections between pan-GM functions and Place Partnerships will work in practice. For example, the detailed 'form' of Place Partnerships, including employment models, as well as needing confirmation on the governance of how decisions will be delegated, how place-level money will flow, and how corporate support will be provided as needed. This means it is difficult to offer full assurance on this at this time, but the feedback is being considered as part of the decision-making.	We will commit to continuing these conversations as the implementation of the Place Partnerships evolves, including the production of Place Partnership agreements. The new structures that have been published as part of the formal consultation provide more detail and clarity on the balance between central functions and place. We will also continue to work with everyone on a range of documents that will help to provide better clarity, including a Place Partnership grant agreement, Place Partnership Outcomes Framework, and a Place Partnership transfer / employment model options appraisal.
Risks duplication of functions and increased bureaucracy and/or fragmentation *(this feedback was also provided by partners and stakeholders)*	We are confident that the new operating model reduces some of the duplication and layers of bureaucracy that have been in place until now, which staff and partners have already told us about. Of course, the real test to this will be in implementing the model. We will ensure that we can quickly flex and adapt if it is felt that elements are not working as they should be. With the impact of NHS reform on our staff and financial resources starting to be felt, our goal will be to make sure we are able to operate our organisation and wider system as efficiently and effectively as possible.	We have fed this specific feedback to those overseeing NHS GM's strategy and system planning so that this can be closely monitored during implementation, and so that changes can be quickly enacted as needed.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
System groups/programmes are overlooked	We acknowledge that the system groups and programmes were not as explicit as they could have been in the draft operating model. It is important that all parts of the system are being built into the operating model and reflected appropriately.	We have amended the operating model to reflect this. Specifically, we have incorporated the changes on slides 18. We have also committed to working with the Trust Provider Collaborative to make sure we can make the best use of the capacity and expertise in our system groups to help us deliver long term outcomes for our population.
CHC staff align better to clinical portfolio than commissioning	We understand the concerns raised by CHC colleagues and have carefully considered their feedback. Across the model, there are many teams that could be aligned to several different portfolios. In this case, it was agreed that it was important for CHC to be aligned into the commissioning portfolio due to this area being a core way of informing future healthcare improvements, pathway design and partnership working. We do not believe that this will reduce the ability for CHC teams to link across NHS GM clinically, as this is the same for some other clinical roles where they been assigned to portfolios that have been determined to be the most appropriate. Our aim is to create an organisational and cultural model that enables individuals and teams to work in a matrix way across the portfolios. In other words, there is a framework for us all to operate within, whilst allowing flexibility, development, and empowered working.	We will work to ensure that a matrix way of working is embedded into a new 2-year organisational development and change plan for NHS GM. We will commit to communicating to staff more information on matrix working. For example, what it is and how it can work (as this action supports several areas of feedback that we have received). Some of this has already started in staff briefing sessions. In addition, we will ensure that staff with clinical and/or care professional registrations will receive professionally appropriate supervision, leadership, support, development and education, regardless of which portfolio their role is in. Any current lines of professional support will be maintained during the reorganisation process. Once the new structures have been populated, we will map professional support across the organisation to ensure that there are no gaps.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Risks delivery of some statutory functions such as safeguarding, and requests for more information on safeguarding delivery models *(this feedback was also provided by partners and stakeholders)*	We appreciate there are concerns in relation to these areas, and the design in relation to this area has evolved since the operating model was released for engagement. The Safeguarding function will continue to deliver against our statutory accountabilities in this area. More details on how the function will work will be set out in the specific function and workstream plans.	We have ensured that statutory safeguarding and appropriate staffing, including the named and designated leads, has been built into our new organisational structures. This includes ensuring there are leads at a Board level, a lead clinician with responsibility for safeguarding, and a place-aligned lead withing the GM team. We will commit to continuing to communicate with our safeguarding leads, teams and partners, to ensure that everyone is clear and aware of how this function will be delivered going forward.
Risks delivery of some statutory functions such as SEND (this feedback was also provided by partners and stakeholders)	We appreciate the concerns about this area of the operating model and have been reviewing this since release of the draft. We are committed to ensuring we have a feasible model for safely delivering this statutory duty.	We have met with some representatives of the Designated Clinical Officers for SEND and listened to their feedback and have been discussing the potential model with key leaders in our partner organisations to ensure we get this right. Recognising that SEND is a key programme that needs particular focus, this area will have its own strategic plan dedicated to ensuring common pan-GM improvement. We have also reflected this in the staffing structures with the establishment of a dedicated SEND team. We have amended the operating model to better reflect SEND. Specifically, we have incorporated the changes on slide 17.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Concern about the transfer of Medicines Optimisation	We appreciate this concern and acknowledge that for medicines optimisation teams there have been a lot of unknowns and exclusions that have not been helpful due to the different timings of change for this area. While the future arrangements for Medicines Optimisation are being determined there will continue to be a model for pan-GM and Place.	We will commit to ensuring that we support our medicines optimisation colleagues through the next period of change, both in terms of providing stability currently, and connecting the teams into discussions about the future arrangements.
Concerns around capacity to deliver statutory engagement (this feedback was also provided by partners and stakeholders)	We need to be aware of this and have kept this in mind when designing both the new operating model and the functional and place structures. We need to shift from transactional consultation to co-production and deep community engagement, wherever possible. We have examples of where this has worked well already, such as when developing the GM women's health strategy. We expect that the on-going engagement of communities to inform health needs and shape solutions will be delivered at a Place Partnership level (utilising the expertise and understanding in local areas), but we acknowledge we will need to make sure we can also connect this into strategic planning pan-GM and with all GM partners as needed.	We have ensured this was fed into the structure design to secure some dedicated expert resource, as well as access to additional engagement capacity when needed. We would expect this to be delivered through enhanced matrix and partnership working. We will also ensure that engagement is built into all plans and workstreams, and that advice, support and expertise for formal consultation processes will be provided as needed. In addition, as part of a new leadership and management framework, we will build in engagement and involvement into core skills for everyone. We will also look at how we can further utilise areas such as paid volunteering time, and how we better link citizens with NHS GM leadership to ensure our strategic commissioning activities provide real social value.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Need a genuine focus on supporting staff, with kindness and compassion, prioritising wellbeing during change	We agree that this is vital for moving us all forward following years of multiple changes and unsettled feelings. Our values remain unchanged, and the implementation of our new operating model gives us the opportunity to reinvigorate the behaviours which underpin the values.	We will continue to make a wide range of wellbeing support available for all staff. We commit to promoting the existing range of wellbeing support and development available for all staff, which includes building resilience (as this action supports several areas of feedback that we have received). The new organisational development and change plan will incorporate ways of working and culture. We will ensure that the values we want to embody are at the forefront of this plan. We expect to include a detailed training and development plan for NHS GM staff (individual and collective development), and include support for new ways of working, including working to matrix methods and partnership working. This feedback has been passed onto the leads working on this planning area for us.
Concern about the impact of NHS Reform on whether it can be delivered	This operating model is a response to the national NHS reforms, so whilst we acknowledge that delivering against our statutory functions and strategic objectives will be challenging with limited staffing and financial resources, we believe that the proposed model gives us the best chance to guide us through the reforms and change and into a high performing health and care system.	We have used this feedback when developing our detailed descriptions of how our portfolios and Place Partnerships will work. This includes discussions on how we create efficiencies, how we will decide what we will stop doing, and how we build the appropriate structures to deliver this. In addition, we have passed on this specific feedback to our system leads and will commit to continuing to have conversations and check-ins on the next phases of change and implementation, to ensure that we are creating a new organisation and wider system that is fit for purpose.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Concern that when staff and resources are reduced, it will create burnout and unachievable workloads (Recognise the *"trauma," "low morale,"* "stress" and *"burnout"* that people feel and try to mitigate it)	We are fully aware that this is a real risk. Work is already pressured for everyone, and we share the concerns that this will be a risk with the reduced level of staffing. However, we do believe that this operating model and the new structures will help to mitigate some of this, as these have been designed in line with the revised responsibilities for all ICBs.	We have already communicated the agreed prioritisation process via staff briefings and will commit to doing more of this. Our Operational Leadership Group will oversee the process for escalating and resolving business critical gaps where these arise. We have developed a three-tiered approach to support this decision-making (for example, is it statutory/legal, business/performance critical, or strategic?). Aligned with this, we will continue to use the existing staged process for dealing with any business-critical gaps, including accessing mutual aid when needed. We will also continue to invest in packages of wellbeing support for staff and will promote these to everyone.
Some roles are split across several portfolios and concern about how this will be handled	We understand why this would be of concern about how this would work in practice. Details of how roles are affected by the new operating model are available in the new organisational structures.	You will be able to comment and provide feedback on the structures including individual roles as part of our collective consultation.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Concern we will lose key knowledge and relationships (this feedback was also provided by partners and stakeholders)	We do not believe that the potential change or loss of relationships will be an issue. In the contrary, we believe the changes will give us the opportunity to nurture and enhance existing relationships and build new partnerships as we begin to work differently. We do, however, acknowledge that there will be a risk in relation to the loss of legacy knowledge and experience as people leave the organisation.	We will ensure that support is in place for everyone to enhance their ability to build relationships and work in existing or new partnership arrangements. We will also ensure that there is a robust process for those exiting the organisation, with clear handovers and transfer of information and knowledge. We are producing enhanced leaver checklists to ensure that managers can work with leavers to receive clear handovers and retain key documents. In addition, we are creating business continuity plans for NHS GM and its teams to help manage this transition period.
Change fatigue	We recognise that people understandably feel this way. As we know, this is not just related to the current changes, but changes and restructures that have happened over many years in the NHS. We expect that we will be able to implement frameworks that can secure us from any further change for the time being (aside from anything announced that is not in our control), but with enough flexibility so we can 'tweak' it in response to feedback rather than undertake more substantive change.	We will aim for timely flexibility and innovation that operates within our solid frameworks. We will ensure this is kept in mind as we continue to develop together and as we implement our new operating model, ways of working, and team structures.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Involve us and do it with us rather than to us – still a feeling of lack of transparency	We appreciate that things can feel this way, and whilst we have always aimed to provide transparent and timely information, we can always learn and improve with your input. We also appreciate that with the reduction of staff teams, we will need to do this in more innovative ways going forward.	We will look to better utilise the intranet and our new digital corporate system (currently being implemented) to ensure that we can continue to keep communications channels open for staff to feed into the organisation and engage / co-design with us at every step of the way. We will strengthen our staff and Freedom to Speak Up networks, and will review our system groups, so that a range of views can have a direct voice to the Board.
Better expectation management	It is acknowledged that this has been an extremely challenging time for everyone. There have been national announcements that have been unexpected, asks from national and regional teams that we have put into motion that have had to change at the last minute, and then plans that have had to be halted and brought back again. We have done all we can to try and mitigate this for people, but we also acknowledge that we can also learn from this by ensuring we are better managing expectations for the areas that are within our control.	We will do all we can to better manage everyone's expectations in the areas that we can wholly control.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Better prioritisation for all teams, so they know where to put their limited resource	We agree that this is important. We have all been in the situation where we talk about prioritisation, but too often we make everything a priority. We need to ensure that everyone has clarity, and that we are being mindful of the limitation of staffing resources – we need to ensure we can effectively deliver a smaller number of things.	The new structures that have been published feature detailed descriptions of portfolios, functions and priorities, including information on what work may be stopped or reduced. We will commit to utilising our new operating model and new ways of working together to undertake on-going prioritisation processes, to plan strategically and tactically, and also to support when we need to flex and adapt to things outside of our control. (For example, pandemic planning, outbreaks, national strategies, and/or changes in the provider landscape). This links to the agreed prioritisation process already outlined that has been communicated via staff briefings. This will be monitored, supported and delivered via robust risk management and business continuity processes.
Communicate clearly, transparently and with less jargon	We all know how easy it for the NHS and wider public sector to get bogged down in specific language, particularly when there are specialist and/or clinical elements to the work we do. We are sorry if the operating model wasn't as clear as we wanted it to be for everyone and are committed to improving this.	We will continue to adapt our communications to make things as clear as possible, and we will make quick changes when we get that feedback. When there is a need to use more specialist language, we will commit to ensuring that this is accompanied by a glossary of terms and/or an 'easier read' version. A glossary has already been incorporated into the operating model, and we will commit to producing an 'easier to read' version as well.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Offer an organisational wide training programme on how to collaborate and matrix work to support culture shift	We agree that this is vital for us to all move forward together for the next part of the journey as our organisation and wider health and care system develops, particularly to ensure that everyone has the skills and coping mechanisms to deal with the challenges ahead and be part of a high performing organisation.	As mentioned previously, we have fed this into the leads for organisational development, and training and development will become a key part of our new organisational development and change plan.
Encourage functions to meet together to understand each other better	We expect this to be a key part of developing our people and teams, to enable everyone to work in a more adaptable, flexible and matrix way.	This has been fed into the work to develop our new organisational development and change plan, as well as to help inform new ways of working with colleagues, partners, and as part of the whole health and care system in GM.

NHS Greater Manchester

Partners and Stakeholders

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Concerns around gaps in relation to equality and inclusion, as well as a range of feedback from GM VCFSE Leadership Group and Equality Alliance	We acknowledge the extensive feedback we have received as we can always improve in this area, and we all need to ensure that equity, inclusion and reducing health inequalities is embedded into everything we do, in the same way that quality and financial effectiveness is. It is also important that through the implementation of this new operating model, we commit to distributing the balance of power and decision-making wherever possible.	We will commit to further raising the status of these areas and will ensure that a detailed reflection of what we will do to reduce life and health inequalities will be incorporated into our planning. We have fed the comments received in relation to equity, equality, diversity, and inclusion to all portfolio leads, to ensure that this is embedded throughout all our work. We have enhanced the references to these areas in the operating model. Specifically, on slides 2 and 18 in relation to the VCFSE sector, slide 11 in relation to health inequalities, and slide 11 in relation to co-design with communities. In addition, we have created a model for ensuring we undertake strategic commissioning and the key ‘shifts’ through an equity lens so we can ensure that we are always working to reduce health inequalities. This includes describing leaders as “collaborators and community champions”. Health equity has been built into all of NHS GM’s new job descriptions to ensure that this is a focus for the entire workforce, and we are retaining director and board-level leadership of this area. We will be producing an ‘easier to read’ version of the operating model to help communicate it to our staff, partners and communities.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
A need to show explicit recognition of primary care as key to delivering the priorities for neighbourhoods and communities, and a suggestion to enhance the point that strong primary and community services are a real benefit to patients	We acknowledge that the role of primary care is not as explicit as it could have been in the draft operating model. It is important that all parts of the system are being built into the operating model and reflected appropriately.	We have included a mention of this in the foreword on slide 2, and on slide 9. In addition, we will ensure that this is built into the strategy and planning for primary and community services that we will collectively design to cover the pan-GM contractual and Place Partnership delivery elements.
An ask for more clarity on the mechanisms through which services would transfer to primary care	We believe this is covered at a high level and on a strategic basis in the operating model, but we recognise that people want to see more detail on this.	We will ensure that the strategy and planning for primary and community services will provide more detail on the mechanics of how services will transfer to primary care.
Digital ambition welcomed but vague - requests for more information on digital innovation and mobilisation	We thank people for this feedback. As the operating model is our strategic guiding document, we are not able to reflect in detail every area of delivery, including digital. NHS GM has published a Digital Transformation Strategy for health and care where this detail can be found.	We have added some wording to slide 21 in the operating model to reference back to the Digital Transformation Strategy, and to include a high-level reflection of digital ambition and priorities. We will ensure that areas of digital innovation and mobilisation are built into all planning processes and pathway redesign work.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Mixed views on hosting options for place partnership staff, with some preferring NHS employment and others open to alternatives	This is to be expected, and we acknowledge that there may not be a 'one size fits all' approach. This is a piece of work and a conversation that will need to be part of the next phase of planning and delivery as more of the detail of the Place Partnerships is designed and agreed.	We will commit to having ongoing and open conversations with our place team staff and place partner organisations so that we can collectively shape options and design hosting arrangements that work for all parties. We will also ensure these diverse views are built into our option appraisal work for this area. Any changes for staff of this nature would be subject to separate formal consultation processes for the relevant Trade Unions, individual staff, and the sending and receiving organisations, and all would be subject to legal requirements.
Lack of confidence in the ability to deliver financial 'left shift' due to entrenched acute sector pressures and unclear mechanisms for transferring services to primary care, and there is some contradictory language in relation to the 'oversight' of health spend in places	We acknowledge this and we will all need to ensure that we are collectively discussing how this can reasonably be delivered (including operational and performance improvements to support this) as more detail in this area is agreed.	We have passed this feedback onto the relevant portfolio and service / function leads to ensure that there is consideration when planning these areas. We have also ensured that the language in relation to health spend on slides 10 and 20 are aligned. Namely, that outside of budgets that Place Partnerships will be responsible for, places will be able to view and track the health spend for their populations.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Some stakeholders feel their role or contributions have been omitted or not acknowledged or under-recognised in the new operating model, such as provider collaboratives, GM Alternative Provider Collaborative, Cancer Alliance, Public Health, Green Plan, Health and Justice	We acknowledge this, and we do not want any parts of our health and care system, or our partner organisations, to not be reflected in the new operating model. However, it does need to be recognised that it is, of course, a high-level organisational operating model for NHS GM rather than a description of the entire system architecture. This means there isn't necessarily the room to list all parts of the wider health and care system in detail, however, slide 13 outlines how we will work in partnership across the GM health and care system.	Whilst we haven't listed all additional parts of the system and/or partner organisations, on slide 24 we have enhanced recognition of provider collaboratives as vital delivery partners.
Concerns about workforce challenges	This is a concern for all partners. We have existing system-wide workforce challenges across all the public-sector, even before these new NHS reforms were announced. We believe that by agreeing a new framework to work to via this operating model, and new ways of working, we can create a more effective and efficient system to help us better collectively solve problems and begin to innovate and truly transform. We will also need to ensure that we work with the NHS at a regional level, as we expect many of the responsibilities around health workforce to move there.	We have ensured that this feedback has been passed onto our colleagues who are working on the areas of workforce, as well as to colleagues working on delivery programmes. As there is already a programme in place for workforce efficiency, we will continue with our ambition to build on areas such as Transforming People Services to help create efficient corporate services across the whole city region.
A suggestion to be bolder in relation to individual responsibility for health, as well as co-production	This is helpful feedback and aligns with the principles being embodied by our communities, local authority colleagues and partners, particularly in relation to individual and collective empowerment, and also the prevention agenda as part of Live Well.	We have made the reference to this area stronger on slide 10 of the operating model. We will also ensure that via the delivery of our new 2-year organisational development and change plan, we are supporting everyone to develop their core technical and leadership skills in this area.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
Suggestion to include an outcomes framework so we can measure our success	We agree that this is a useful framework to reference.	We have included a reference to the national and local outcomes framework in the operating model (slide 11) and have also added an additional slide (slide 12) to describe this in more detail. We will also ensure that this is incorporated fully as part of our strategy development and operational planning processes.
More detail desired on strategic commissioning and social impact	We have been having discussions with system partners in relation to commissioning principles and our strategic direction. There will be a 5-year commissioning strategy that will be connected to provider delivery plans, neighbourhood plans and our clinical strategy. Our priority commissioning intentions for 2026/27 are: • elective transformation, • urgent and emergency care improvement, • cancer and diagnostics, and • mental health. Sustainability will be a large part of the strategy, as will our outcomes framework that will measure seven key impacts, covering health, wellness and social aspects.	We will continue to discuss this area within the organisation and with our system partners. We will sign up to the GM VCFSE Accord, and we have referenced this in the operating model.

YOU SAID…	WE SAID…	WE DID / WE WILL DO…
More detail requested on funding flows and in relation to finances and Place Partnerships, as there is a concern that the operating model information is at odds with the desire to provide autonomy at place level	We are aware that more information is needed on this and all elements of funding flows and “left shift” and the perception of both decision-making and control’.	We will commit to continuing conversations on this, and the detail will need to come through the implementation phase of the new operating model. We will ensure that a grant funding arrangement is established to enable the “left shift” and the mechanisms for doing this, and the governance that sits alongside it will need to be agreed and embedded into the grant agreement. With this in mind, an engagement document and proposal for place funding is currently being finalised to help provide clarity on how this will be delivered. The key principles will be to give places greater control and influence over resources, ensure true collaboration and action at all levels, provide shared accountability, and enact flexibility to ensure standardisation and ‘bespoke local’ is utilised as appropriate.
There is a concern from the VCFSE sector that they could be marginalised even though they are essential alternative providers in the GM health and care system, and therefore assurance is needed on the relevant financial flows	We appreciate and understand why this is a concern. We want to reassure those in the sector that they are vital to the innovation, improvement and sustainability of health and care planning and delivery across GM. We have referred to the sector throughout the operating model as key partners, not just in relation to them being community connectors, but also as providers and collaborators. We believe that the GM VCFSE Accord and the Place Partnership grants will be real enablers of this. The sector will also be key within our 2026/27 operational plan (commissioning intentions) and the 5-year commissioning strategy we are developing.	We have enhanced referenced to the VCFSE sector throughout the operating model, with specific mentions of the GM VCFSE Accord on slide 18, which we fully endorse and will sign up to.

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