Priorities for the new Government to Strengthen Integrated Care Systems

Report of the Health Devolution Commission Stakeholder Survey and Meeting

July 2024

1 INTRODUCTION

This report summarises the findings from the July 2024 meeting of the Health Devolution Commission and makes 12 recommendations to Government and for ICSs.

It draws upon the Commission's June 2024 survey of stakeholders' views on the priorities for Government in strengthening Integrated Care Systems (ICSs). The survey was undertaken by 56 stakeholders including many national charities, senior ICS board members and other health and social care leaders. Those taking part were from all the regions of England. The detailed results are shown in appendix 1. Responses to the online survey included over 70 specific suggestions for action by the new Government and contributed 25 examples of best practice for them - and for ICSs themselves - to draw on. These are detailed in appendix 2.

This report also reflects the discussion amongst Commissioners and key health sector leaders – for list of attendees see appendix 3 and to watch the webinar click here - following the very rich contributions from three keynote speakers:

- Professor Michael Marmot, Director of the Institute of Health Equity
- Greg Fell, President of the Association of Directors of Public Health
- Rukshana Kapasi, Director of Health, Barnardo's

2 THE FINDINGS AND RECOMMENDATIONS

The Commission believes that we are at a pivotal moment for our health and social care system in which resources can and should be re-directed towards the key priorities of reducing health inequalities, improving the health of the population and addressing the social determinants of ill-health. This is not just a moment for the UK but is a global opportunity as key players in multinational settings such as the G20 are now putting health equity at the centre of their thinking.

2.1 Health and social care: an engine of local economic growth.

The Commission believes strongly that the health and social care system is a major engine of inclusive economic growth in every local area: as employers (including pay levels) and purchasers of goods and services; as leaders in action through a 'health in all policies' approach to address the social determinants of ill-health (e.g. poverty, unemployment, poor housing, poor air quality); and by improving directly the quality of life for people of all ages with health, social care and wellbeing needs.

The Commission very much welcomes the new Health Secretary's statement recognising the health and care sector's role as engines of economic growth and local and regional anchor institutions.

> **Recommendation 1:** The Government should support Integrated Care Systems to use their autonomy to develop policies, strategies and actions for a mission that maximises the contribution that the NHS, social care, public health and other publicly funded services can make to being an engine of inclusive local economic growth.

> **Recommendation 2**: Every Combined Authority and/or Metro Mayor should have a statutory public health improvement duty similar to those for London, Greater Manchester and the West Midlands to ensure that regional economic growth is inclusive and supports better health outcomes.

2.2 ICS Aims: Reducing health inequalities and improving population health.

The Commission's stakeholder survey identified three top priority aims for action to strengthen ICS (fig.1 appendix 1): reducing health inequalities; improving the health of the population; and improving the performance of NHS and social care services. Crucially, improving health is not just about changing people's behaviour lifestyles but is more importantly about addressing the wider social determinants of poor health (low incomes etc) and the quality of the local environment and places in which people live.

The Commission believes that the purpose of the Government's target of greater economic growth is to deliver 'good work' and the funding for public services that enable better health and wellbeing. In the words of Professor Marmot: the overarching goal of social and economic policy is to 'create the conditions for people to live the lives that they have a reason to value'.

> **Recommendation 3**: The Government should create specific financial incentives for ICSs to focus on reducing health inequalities and improving population health; and to shift resources towards community-based health, social care and public health services. For example, a national Public Health Prevention Standard - similar to the national Mental Health Investment Standard - as a means of ensuring increased and sustainable funding each year.

> **Recommendation 4:** The Government should significantly strengthen the health equality and public health improvement powers, roles, resources and impact of the Integrated Care Partnerships within every ICS.

> **Recommendation 5**: Local Government should be given a multi-year funding settlement for both its public health services and its wider role in tackling the local social determinants of ill-health that reverses the major decline in public health and council funding over the last decade.

> **Recommendation 6**: National Government should give clear and accountable leadership for reducing health inequalities, improving the public's health and maximising the role of health and social care as the engine room of inclusive economic growth. The Government should therefore agree that England becoming a "Marmot" nation is a cross-government Mission. A Cabinet-level Mission Delivery Board for health equity should then be established to agree a timetable with milestones in order to deliver the Mission. This would be chaired by the Deputy Prime Minister, with the support of the Minister for Public Health, and be the cross-government mechanism to address the social determinants of ill health as well as delivering public health services.

> **Recommendation 7:** The Minister for Public Health should at least be a Minister of State, equal in status to the Minister for the NHS and the Minister for Social Care, and should ideally attend Cabinet.

2.3 ICS Governance: User voice and meaningful partnerships.

The Commission's survey identified the top three priorities for action by Government to strengthen the governance of ICSs (fig.2 appendix 1): to involve directly people with a lived experience of care in service specification and delivery; create meaningful partnerships with the VCSFE sector; and ensure genuine power-sharing between the NHS and local government.

> **Recommendation 8:** The Government should mandate ICSs to involve directly people with a lived experience of care in the service specification and delivery of NHS and social care services.
>
> **Recommendation 9:** The Government should make it a clear expectation that ICS Boards will have to demonstrate how they have created and maintained meaningful partnerships with the VCFSE sector in their decision making, contribution to services and use of resources.
>
> **Recommendation 10**: Integrated Care Boards must show how there is a genuine power sharing relationship between the NHS and the Local Government partners in their area.

2.4 ICS population priority groups:

The Commission believes that babies, children and young people (BCYP) should be the top priority population group for ICSs (fig.3 appendix 1) in order to reverse the significant decline in their health, care and wellbeing; and to reduce the prevalence of ill-health among the future adult population. People who experience health inequalities should also be a top priority for ICSs including people with mental health needs and/or learning disabilities/autism experience, minority ethnic groups and those in disadvantaged areas.

> **Recommendation 11**: Every ICS should consider adopting the Child Health Equity Framework principles and produce a child impact assessment for the health and social care of babies, children and young people in their area, accompanied by a whole-system, outcomes-based strategy for improvement. This should be underpinned by a national cross-departmental Child Health Equity strategy, that includes, amongst other things, financial support for families, childcare support, a single child identifier, education and training, NHS and social care support for families and children, and wider Government measures to support healthy child development.

2.5 ICS delivery models.

The Commission is clear that the top priority for action by Government to strengthen ICSs is to shift NHS resources towards community, primary care, prevention and early intervention (fig.4 appendix 1). The next priorities should be to establish mature place-based partnerships and neighbourhood networks; and take steps to improve the NHS and social care workforce.

> **Recommendation 12:** The Government should not substantially re-organise ICSs but build and strengthen the structures and mutual accountability of their IC boards and partnerships, the place-based partnerships and the primary/community care networks. It should also take steps to re-direct resources towards statutory and voluntary sector health, social care and public services working in partnership in local communities.

Prepared by Phil Hope and Steve Barwick, Health Devolution Commission Secretariat, July 2024

APPENDIX 1 - THE SURVEY RESULTS

The survey asked people to rank in priority order five essential actions by Government in each of four main themes. The table below summarises the results of the survey questions. The detailed figures for each of the four topics are given in figures 1-4 below. Click results for online versions of these.

	1st Priority	2nd Priority	3rd Priority	4th Priority	5th Priority
Aims	**Reducing health inequalities**	Improving population health	Improving the performance of NHS and social care services	Ensuring a 'health in all policies' approach (e.g., housing)	Ensuring an 'economic benefit in health and social care policy' approach
Governance	**Strong voice for those who draw on health services and social care support**	Meaningful partnerships with VCFSE sector	Genuine power-sharing between NHS and Local Government	Increasing impact/status of Integrated Care Partnership in ICS	Parity of esteem between primary and secondary care
Priority groups	**Children and young people**	People with mental health needs, learning disabilities/autism	Minority ethnic groups and others experiencing health inequalities	Older people with frailty	Unpaid carers and volunteers
Delivery models	**Shifting resources towards community, primary care, prevention and early intervention**	Ensuring mature place-based partnerships and neighbourhood networks	Improving the NHS and social care workforce	Local freedom and flexibility including pooled/aligned budgets	ICS provider collaboratives reinforce place-based ways of working

Figure 1: ICS Aims

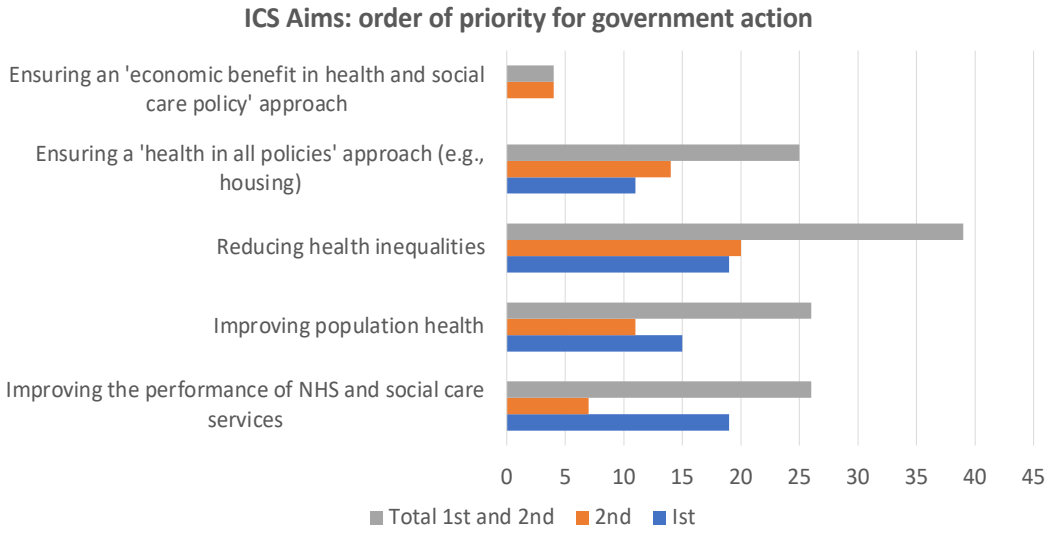


Figure 2: ICS Governance

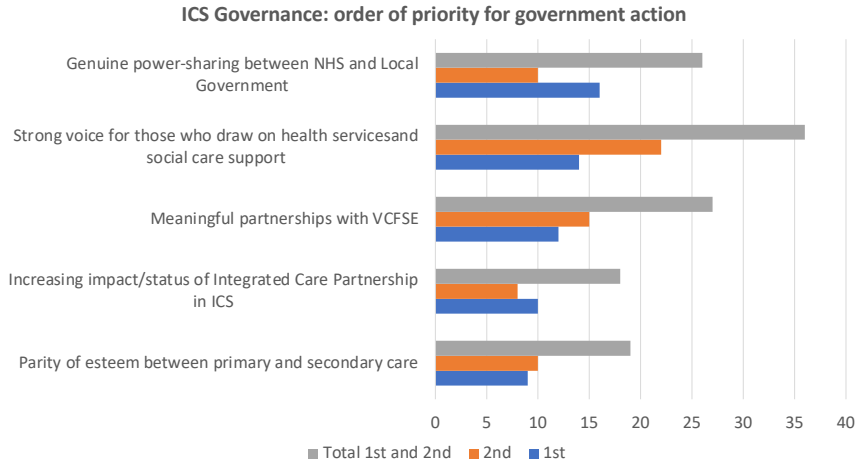


Figure 3: ICS Population Groups

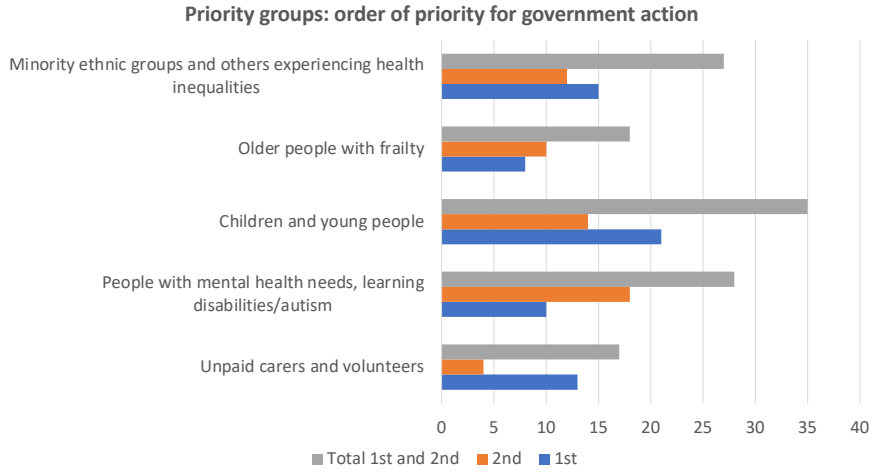
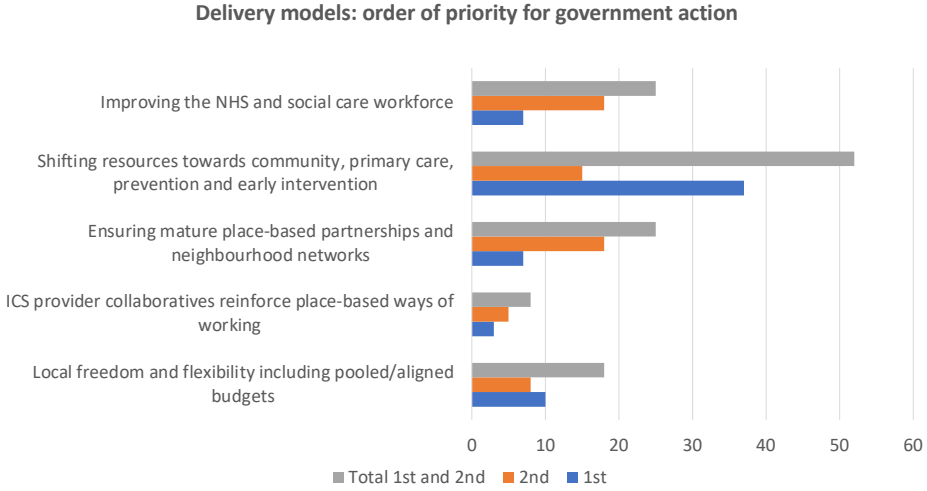


Figure 4: ICS Delivery Models



APPENDIX 2 - SUGGESTIONS FOR ACTION AND BEST PRACTICE EXAMPLES FROM RESPONDENTS

Aims of Integrated Care Systems

a) Suggestions for action

- Prevention and reducing inequalities have to be at the heart of any new policy
- National leadership and direction on shifting towards prevention and mechanisms to support ICSs to enact the change
- Ensure NHS services and social care services and action on population health all have equal status regarding importance. Find more funding for all three priorities not just one of them.
- Shift the focus to prevention and the determinants of health and make clear the role of ICS organisations to support that, including through resourcing.
- Encourage and support them (ICSs) to focus resources on prevention and health inequalities
- Ensure and ringfence money for improving health and tackling inequalities, it always gets squeezed.
- Start to incentivise improving health and tackling inequalities instead of all the perverse incentives in the system. Why are we not paying QOF for the proportion of people general practice keep healthy and off their disease registers rather than how many they have on them?
- Should ringfence funding for health inequalities
- Implement the Hewitt review recommendation of increasing NHS ICS spend on prevention.
- investment into prevention services
- Require all ICSs to employ at least one public health specialist (consultant level or above) to lead on population health and health inequalities programmes.
- Giving Integrated Care Partnerships the responsibility for how this (funding for health inequalities) is spent and for using outcome measures to assess the effectiveness of the spend.
- Stand by the purposes of ICSs to improve health. It is the responsibility of the NHS to improve health services
- Support the concepts of integration, prevention and equity.
- Prioritisation of health outcomes when allocating funding, especially regarding the provision of housing services and housing development projects more generally.
- There is widespread recognition of housing's health impacts; high-quality accommodation will ultimately lead to savings for NHS and social care budgets. (In addition, there are multiple, comprehensive recommendations for government in the "What Creates Healthy Cities?" 2022 report from the Commission on Creating Health Cities.)
- Reprioritise systems on preventative initiatives, channelling more funding through the Better Care Fund in the first instance
- Upstream prevention, community support and early intervention must be reinforced as a priority and short-term grant funding discouraged.
- Services that support wellbeing, physical activity and independence and those that play a role in tackling loneliness should all be prioritised by systems.

b) Examples of best practice

- West Yorkshire ICS putting tackling health inequalities for people with a learning disability explicitly in their strategic priorities. As Amanda Pritchard said - if we make health services accessible for people with a learning disability everyone benefits
- One Devon NHS is working in partnership with the VCSE sector to roll out a rural community practice study approach to addressing rural health inequalities at a place based, micro-local level.
- Healthy Hyde Primary Care Network for tackling health inequalities

- Devon County Council has commissioned the Rural Community Council of Devon to conduct a desktop rural proofing review of core Adult Social Care policies.
- GM Moving as a whole society partnership to change lives through physical activity

2 Governance of Integrated Care Systems

a) Suggestions for action

Partnership working with people with lived experience of care

- Use a variety of levers to ensure that people with lived experience have a much greater role in service specification and delivery.
- Actually listen and employ those with lived experiences on these boards and funding panels
- Listen and learn from the direct voice of individual unpaid carers, who deliver 90%+ of adult social care for free, but at risk to own health. They support ASC, to support NHS. The house of cards will fall, if they are left unsupported.
- Genuine co-production and employing those with lived experience
- Ensure there is a continued focus on the timely roll-out of CQC assurance of Integrated Care Systems and that the need to identify and support carers is properly considered within these assessments

Partnership working with the VCFSE sector

- Create a national research programme which is partly designed by, and works closely with VCFSE Alliances to explore the economic and health outcomes impact of investing in and with the VCFSE, both in partnership development and in service delivery, and addressing the perennial question of how to measure preventative action created by the VCFSE in health economics terms.
- Following this issue guidance to ICSs which provides NHS and LA commissioners (and nervous financial teams) with the fiscal tools and assurance which supports such investment.
- Ensure that NHSE regional teams understand this value and so avoid penalising systems which invest in partnership, and instead understand it as an investment in the future preventative, community-based health and care system you say you want to achieve.
- In support of all this, an England-wide Alliance of VCFSE Alliances should be supported to inform H&SC policy and practise when it comes to HI and working with communities via the VCFSE - the experience and expertise in these Alliances should be a powerful force but it is not visible enough.
- Hard wire in ways for the VCSE to have a much greater power over how the ICS budget (or part of the budget) is spent.
- Ensure there is clear national guidance about the importance of ensuring the VCSE are effectively engaged with, and have the resources and ability to be an equal partner within the ICS. This guidance gives us a tool locally to hold the statutory bodies accountable to.
- There needs to be more transparency of what ICSs are doing and how the VCSE can connect into them - currently the Health and Social Care Act has worsened connections with VCSE and this needs to be immediately resolved for the benefit of patients.
- Much greater involvement of and investment in VCFSE through Integrated Care Systems. This should not solely be focused on Urgent and Emergency Care Pathway support or winter preparedness, although this is obviously important work.
- Commissioning arrangements with voluntary sector organisations commissioned by Integrated Care Boards, in particular local carer organisations.

Structures

- No significant reorganisations! Don't reorganise again. Don't reorganise us again. Build on existing arrangements rather than start with reorganisation
- Increase parity of esteem between health services and local government within Integrated care systems.
- Build ICSs to make change happen
- Articulate a clear vision of what good looks like; resist mucking about with the structures; provide consistency of approach and funding
- Be clear that ICSs are a critically important part of the future and key to the incoming Government's goals both in the medium term - around prevention and population health - and short term - around immediate improvements in access to service
- Review social care.
- Don't reorganise but consider the relationship between NHSE and ICBs. Give more accountability to ICBs but ensure they have the right staff and size to be effective.

Collaboration and Accountability

- In addition to authorising the new CQC ratings for ICSs, the Secretary of State should instruct the CQC to develop a specific "integration index". This would evaluate and compare how well ICSs co-ordinate different services in their area. This should be in addition to the overall qualitative ratings and would give greater granularity than the planned 1–4 scale. The index should take account of activity levels, care pathways, population outcomes and assessments of structures.
- Setting out accountability more clearly. Giving greater involvement and power to Local Authorities and the Mayors could be a great vehicle for driving local accountability. At the moment it feels quite muddy with NHSE holding ICSs accountable for budgets, but Systems holding themselves to account for outcomes.
- There needs to be clear, simple, process-driven evaluative frameworks put in place, easily comprehensible to all ICB workers, with identifiable responsibility and accountability within the ICSs for evaluating, and processes for addressing any kinds of failures within these evaluations.
- There should be a role for proper public accountability - and that needs rethinking stakeholder relationships too. Sticking a token patient on an ICP isn't the answer - and doesn't cover social care in any way
- There should also be a push for seriously improving communication and transparency between national policy decision-making and the ICSs.
- Address centralised NHS problems and bureaucratic management which disconnects policy / initiative development from the 'frontline' / local, place-based working
- Health, social care, and voluntary sector leaders should work together closely as equal partners, as they are likely to possess a deep understanding of their respective communities. This will encourage integrated policy making and service provision, as well as a more preventative approach to public health.
- Encourage collaboration with universities to support evidence, innovation and workforce development

Resources and Priorities

- Incentivise integration. Incentivise true transformation and enforce where ICS does not do that rather than just focus on balancing budgets and as a result cutting services
- Strong focus on digital technologies including AI
- Priorities reflect sequencing - i.e. what needs to happen first to support other changes/ actions - rather than value. For instance, improving care for frailer older people isn't just the right thing to do, it's essential to improving flow and, therefore, capacity to address some of the other challenges.

- Focus on the strategic objectives and not the arbitrary secondary care performance targets.
- While local priorities are important, we are also worried that the lack of central direction is creating significant postcode lotteries
- Payment by outcome, weighted by the level of deprivation—as well as payment by activity or capitation—should help incentivise integrated and preventative work.
- Recognise the importance of investing in infrastructure to support collaborative working and learning across different organisational cultures, and in a way that mitigates power dynamics
- Providing multi-year funding arrangements would help secure financial and structural security,
- More pooling and aligning of budgets and strategies across the whole ICP would be an important first step

b) Examples of best practice

- Greater Manchester Integrated Care Partnership (launched in March 2021): collaboration between the Greater Manchester Combined Authority, Greater Manchester Health and Social Care Partnership, and Greater Manchester Housing Providers. This is a strong step towards a fully integrated, holistic approach to health based on the needs of a specific community.
- Provider collaboratives across West Yorkshire on MHLDA, Acute and Community providers https://bnssghealthiertogether.org.uk/about-us/integrated-care-system-strategy/joint-forward-plan/ provides examples of what an ICS can achieve collaboratively.
- Listening to the leads and members of the 42 VCFSE Alliances across England. Statutory organisations working with the VCFSE have achieved great things but we don't appear to be good at sharing the outcomes, never mind implementing across England (appropriately in a devolved system).
- There are 3 allocated seats on the One Devon ICP for VCSE Assembly nominated members
- Development of between and lower cost market solutions by social enterprise and vol sector. Including co-production with the sector. Better services for less.
- BOB ICS and their approach to winter pressures and working with the VCSE.
- West Yorkshire ICB's commitment to embedding creative health at a systems level as evidenced in their Joint Forward Plan
- Gloucestershire ICB for their delivery of creative health programmes and work with the VCSE sector
- The WorkWell programme provides an opportunity for ICSs to co-develop services with other local partners which support their local communities to stay in and access work. To improve people's health through work, services should be co-designed with local communities so that they meet genuine need rather than be 'done to' people which risks low referrals and widening health inequalities. https://www.selondonics.org/hsj-award-for-partnership-working-to-address-mental-health-inequalities-in-lambeth/

3 Priority groups

Unpaid carers

- Carers Trust case studies of how Integrated Care Systems are considering the needs of unpaid carers and seeking to involve them and local carer services in different areas of their work. Please e-mail the Carers Trust policy team on policy@carers.org.
- Family carers are a protected group in Northern Ireland. We have co-designed and embedded their places/roles on ICS Area Boards in NI.

Children and young people

- The Children and Young People's Health Equity Collaborative (CHEC) The CHEC is a partnership between Barnardo's, University College London's Institute of Health Equity and three Integrated Care Systems (ICSs) – Birmingham and Solihull, Cheshire and Merseyside and South Yorkshire – to shape the way ICSs create health and address health inequalities among children and young people.

- The Child Health Equity Framework. A Framework has been developed by the CHEC with direct input from children and young people. It describes the main drivers of children and young people's health and wellbeing inequalities with a focus on the social determinants of health. The Framework's main purpose is to underpin action for achieving greater equity in children and young people's health and wellbeing, and will be used to support the development of pilot interventions in the three partner ICS areas. The Framework has several intended purposes:

    - To set out the key drivers of health and wellbeing for babies, children and young people.
    - To guide the analysis of data to assess and monitor health inequalities for children and young people in each ICS.
    - To support and guide ICSs in the commissioning and development of interventions and services to improve children and young people's health and wellbeing.
    - To strengthen partnerships between healthcare, public health and local authorities and the community and voluntary sector, so they can work effectively together to take action on the social determinants of health.

To view the Child Health Equity Framework, to read our children and young people's insights report or to find out more about the CHEC programme, head to our website: https://www.barnardos.org.uk/health-equity-collaborative

Older people

- Age UK Blackburn with Darwen is working with colleagues from the ICB Population Health Management team and other partners to develop and pilot an improvement approach to reducing non-elective attendance/admission to acute care. The work is part of a broader 'priority ward' programme which has identified wards within the ICS footprint which have higher than expected non-elective admissions, even when taking into account factors such as deprivation levels. The pilot is focussed on one particular ward in the Borough which, for over 65's has the highest levels of non-elective admissions and the longest lengths of stay. A project group is established including partners from Population Health, Public Health, Adult Social care, and primary care along with Age UK. This group has looked at the clinical data related to conditions causing most admissions and with the longest lengths of stay and will be triangulating this with other clinical data including clinical frailty scores; other health and care related data including access to support via the integrated neighbourhood teams and adult social care support; and selected wider determinants data including housing tenure. Alongside looking at the data, engagement activity is being planned within the identified ward to gather insight and co-produce a different approach to supporting people in the target cohort.
- Working with primary care to use risk stratification partners will work together to have strength-based discussions and proactively develop care and support offers. The intended outcome from the work is to develop pathways of support within the community that enable people to better manage their health conditions and to access relevant support and services to prevent a deterioration in health and to manage their needs within their own homes. The longer-term aim is to develop an approach which can be replicated across the borough to manage frailty and reduce the risk of increasing numbers of people experiencing more severe levels of frailty.

4 *Delivery models*

a) Suggestions for action

Place-based partnership working

- Actively support and fund Primary and Community Care.
- A focus on primary and community care and place-based working should take us on this journey
- Primary and community clinicians should work more collaboratively at place and the individual patient levels. Their work should put a greater emphasis on public health and preventative health care.
- Follow the King's Fund recommendations and the Fuller Report
- Devolved, place-based commissioning and funding should be the default option. Local stakeholders have a close knowledge of local needs and understand how services can work together. They have closer relationships that come from geographical proximity and better understand the opportunities for (and challenges of) integrated working in their local areas.
- Place is where delivery happens
- There should be an expectation that good practice at neighbourhood and place is shared and scaled up system wide where it is appropriate to do so
- Services should be community led and in partnership with VCSE, local government and other local partners.
- Have greater confidence in local partnerships.

Shifting resources into the community

- Investment in primary care, local authority public health and social care which we can, within existing arrangements, channel in to local communities and VCSE.
- Get money and resources out of acutes and into the communities they serve.
- Honest conversation with the public about what is needed: shift away from acutes and targets/ place-based working/ person-centred integrated community care etc
- Payment by outcome, weighted by the level of deprivation—as well as payment by activity or capitation—should help incentivise integrated and preventative work.

b) Examples of best practice

- Long term ICS funding in Somerset for integrated models of community care, designed locally - e.g. https://healthconnectionsmendip.org/
- BNSSG trauma informed practice work
- Place based partnerships in Nottingham and Nottinghamshire.

The partners of the Health Devolution Commission are NHS Confederation, Local Government Association, London Councils, West Yorkshire Helth and Care Partnership, Mencap and Barnardo's.

APPENDIX 3 - ATTENDEES

Dr Nik	Johnson	Co-chair and Health lead for M10 Group of Mayors
Imelda	Redmond	Co-chair and Non-Executive Director, NE London ICB
Rt Hon Stephen	Dorrell	Commissioner and former Health Secretary
Cllr David	Fothergill	Commissioner and LGA
Mairead	Rooney	Commissioner and LGA
Michael	Wood	Commissioner and NHS Confed
Eloise	Crockett	Commissioner and NHS Confed
Lisa	Nicholson	Commissioner and London Councils
Cllr Izzi	Seccombe	Commissioner and Warwickshire County Council
Jackie	O'Sullivan	Commissioner and Mencap
Peter	Hay	Commissioner and former ADASS
Jennifer	Connolly	Commissioner and West Yorks Health & Care Partnership
Dr Linda	Patterson	Commissioner and Bradford District CARE NHS Trust
Naomi	Eisenstadt	Commissioner and Northamptonshire ICS
Nadra	Ahmed	Commissioner and National Care Association
Prof. Michael	Marmot	Speaker: Director of the Institute of Health Equity
Greg	Fell	Speaker & President, Association of Directors of Public Health
Rukshana	Kapasi	Speaker and Director of Health, Barnardo's
Baroness Claire	Tyler	Liberal Democrat Spokesperson on Mental Health
Cllr Wayne	Fitzgerald	LGA
Mark	Norris	LGA
Steve	Mulligan	BACP
Mariah	Kelly	The Health Foundation
Natasha	Owusu	Chartered Society of Physiotherapists
Charlotte	Nicholls	Richmond Group of Charities
Alexandra	Coulter	National Centre for Creative Health
Marie	Phelps	Royal College of Psychiatrists
Alexandra	Houston	Royal College of Psychiatrists
Ed	Jones	NHS Confederation
Sarah	Weld	South Gloucestershire Council
Helen	Asquith	South Gloucestershire Council
Joe	Hannett	Community Futures
Bethan	Spacey	Living Wage Foundation
Helen	Buttivant	Lewisham Council
Sonal	Mehta	VCSE Partnership Lead, BLMK ICS
Caroline	Cook	Luton All Women Centre
Jack	Newman	University of Bristol
Dan	Corry	New Philanthropy Capital
Warren	Escadale	VSNW
William	Pope	NHS Suffolk and North East Essex ICB
Jane	Harvey	Healthy Hyde
Phoebe	Dunn	The Health Foundation
Nileema	Patel	The Health Foundation
Mimi	Launder	HSJ
Steve Barwick &	Phil Hope	Health Devolution Commission Secretariat