Role of an Integrated Care System during COVID-19 and beyond: a qualitative study with recommendations to inform future development

Lauren Bell, Maxine Whelan, Deborah Lycett

ABSTRACT

Objective Integrated Care Systems (ICSs) have recently been implemented across England to better meet health and social care needs through partnership working between clinical commissioning groups, local authorities, and health and social care providers. This qualitative study aimed to explore insights into the COVID-19 response at an ICS level and inform recommendations for ICS development.

Methods and analysis Interviews and focus groups were conducted with 19 senior health and social care professionals who were members of one ICS. A reflexive thematic analysis was conducted to develop key themes and recommendations for ICSs.

Results Working together across health and social care, responding to a prolonged crisis, managing expectations and developing the ICS formed the four master themes. Notable subthemes included changing professional roles and responsibilities, communicating and coordinating COVID-19 guidance, the availability of system resources, the local versus national contexts and a need to combat health inequalities.

Conclusion The unprecedented crisis of COVID-19 moved health and social care partners to work together like never before, and at a very quick pace. Our findings confirm that intentional collaboration must be maintained in leading and delivering effective ICSs. ICS partners, together with the public, must now agree a shared vision for health and social care as a priority. A long-term focus to improve population health and reduce health inequalities will require a cultural shift and will place a new type of demand on resource allocation and sourcing. It will also demand public health leadership, a fully coordinated infrastructure, and comprehensive, ongoing evaluation. In parallel to this, the well-being of the health and social care workforce will need to be addressed to build upon the lessons of COVID-19.

INTRODUCTION

Effective health and social care systems must support the needs of a growing population and recognise the increasing complexities of people living with multiple long-term health conditions. Recent changes to policy and legislation intend to better integrate health and social care services in England. Integrated Care Systems (ICSs) are partnerships between health and social care providers, clinical commissioning groups (CCGs), local authorities, and voluntary organisations to improve population health, reduce health inequalities, and ensure integrated and coordinated health and social care services.
While ICSs share broad goals, there is no single blueprint model for an ICS given structures can be modified to meet local needs. Cross-organisational working is built upon pre-existing structures, notably sustainability and transformation partnerships, with partnership working particularly demanded during COVID-19. To reduce COVID-19 infections and support health and social care, incident command structures were activated. A Gold–Silver–Bronze hierarchy of working was implemented, with bidirectional communication between command levels to plan and respond to issues. ‘Gold’ command (responsible for strategic direction of the multiagency response), ‘Silver’ command (responsible for tactical planning and coordination of the response) and ‘Bronze’ command (responsible for operational management of the response) brought together key partners. Gold and Silver command included senior professionals in the acute trusts, CCGs and local authorities (social care and public health), and were pertinent in leading the system response evaluated in this study. Gold (including Chief Executives) and Silver (including Chief Operating Officers) each met separately regarding their responsibilities on a regular basis. Escalation procedures were followed as appropriate (eg, Silver (tactical) escalated issues requiring system-level approvals and decision-making to Gold (strategic) command).

National reports examining COVID-19 conclude profound numbers of excess deaths and inequalities in morbidity and mortality rates, with poorer outcomes for disabled people, care home residents, and ethnically diverse and socioeconomic deprived communities. Health, societal, and economic outcomes of COVID-19 have been influenced by decisions taken at organisational, local, and national levels. An in-depth exploration of ICS partnership working was therefore warranted. This research aimed to evaluate the COVID-19 response at an ICS level (including structures, processes and outcomes) and use this learning to inform ICS development.

MATERIALS AND METHOD

Design
One-to-one, semistructured interviews were conducted by a Coventry University researcher (LB) with ICS members to explore perceptions and appraisals of the COVID-19 response. Interview findings informed two focus groups to further explore these perceptions and discuss recommendations for developing effective ICSs. The study has been written according to Consolidated criteria for Reporting Qualitative research guidelines.

Patient and public involvement
Formal patient and public involvement activities were not conducted. As our study focused on the recruitment of senior health and social care professionals involved in delivering an ICS, we felt it was more appropriate to prioritise involving professionals in checking our study design and procedures.

Participant selection
Participants were professionals contributing to the ICS COVID-19 response. The research design was shared with Silver and Gold command. Feedback resulted in expanding eligibility criteria from Silver and Gold command to include wider professionals in the ICS. Relevant gatekeepers facilitated convenience sampling via email distribution and ICS meetings, and 19 participants provided informed consent via online forms. All interviewed participants expressed interest in attending a focus group. One participant scheduled to attend a focus group was unable to attend due to workplace priorities.

Setting
Interviews and focus groups were conducted at a suitable time for participants. Interviews were conducted via video-call or telephone during May and June 2021, and two focus groups were conducted in June and July 2021 via video-call. One researcher was present with participants.

Data collection
The interviews and focus groups lasted approximately 30 and 45 min, respectively. The schedules that guided the interviews and focus groups are provided (online supplemental material). Participants reported their age group, gender, role, organisation and years in current role. All data collection sessions were audio-recorded with no repeat interviews.

Analytical plan
Audio-recordings were transcribed verbatim and identifiable information removed. Transcripts were analysed using reflexive thematic analysis approach. Following data familiarisation, LB coded transcripts inductively and without the use of automated research software. Three transcripts were coded by two researchers (LB and MW) to consider alternative interpretations and aid reflexivity. Themes were reviewed alongside data extracts and revised among the research team. Participants were not involved in developing or reviewing themes. For reflexivity purposes, we are public health researchers; however, we were not involved in ICS establishment or delivery.

RESULTS

Participants
In total, 19 unique participants were recruited. Sixteen participants were interviewed (15 via video-call and 1 via telephone), and seven unique participants took part in the focus groups. Participants reported holding (highly) senior roles in health and social care (eg, Directors) (table 1).

Themes and subthemes
Master themes and subthemes (table 2) and broad codes aligning to subthemes (online supplemental material) are presented.
Theme 1: working together across health and social care

Building organisational and sector collaboration

Participants agreed that uniting on the pandemic response improved organisational collaboration, with increased networking between individuals and organisations to combat problems and greater understanding of challenges faced by other organisations.

The priority of COVID took people away from their organisation’s culture and they had a similar driver. (Participant N)

Participants reported that while the response initially focused on the acute sector, the community perspective became more vocal, with better integration of social care and guidance from public health teams.

The beginning was very much dominated by the acute trusts...slowly I think the dialogue between different partners, including public health, has become a little bit more balanced. (Participant J)

The relationship with social care’s improved, 'cause we all felt so awful about what’s going on there, so there’s a kind of emotional attachment to that. (Participant 3, Focus Group 1 (FG1))

Concerns were raised that competing organisational priorities and limited resources could hinder collaboration when COVID-19 becomes less of a shared priority.

It’s not one objective, there’s probably multiple, and every organisation’s got different ones as well, which starts to then play into some of the challenges across the system. (Participant K)

The role of structures and processes in system coordination

Silver and Gold command meetings were appraised as well represented and attended.

It [Gold command] was inclusive in terms of the health and care partners, and it was always appropriately senior individuals that were there. (Participant C)

Table 1  Characteristics of participants in the interviews and focus groups

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Interviews (n)</th>
<th>Focus groups (n)</th>
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<tbody>
<tr>
<td>Organisation</td>
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<tr>
<td>Clinical commissioning group</td>
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<td>1</td>
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<tr>
<td>Local authority</td>
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<td>2</td>
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<tr>
<td>Acute hospital</td>
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<td>4</td>
</tr>
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<td>Other health or social care provider/organisation</td>
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<tr>
<td>COVID-19 command</td>
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<td></td>
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<td>Silver member</td>
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Table 2  A list of developed themes and subthemes

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
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</thead>
<tbody>
<tr>
<td>1. Working together across health and social care</td>
<td>▶  Building organisational and sector collaboration</td>
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<tr>
<td></td>
<td>▶  The role of structures and processes in system coordination</td>
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<tr>
<td>2. Responding to a prolonged crisis</td>
<td>▶  Developing and implementing a system response</td>
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<td></td>
<td>▶  Outcomes of the system response</td>
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<td>▶  Communication and coordination of COVID-19 guidance</td>
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<td>▶  System resources</td>
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<tr>
<td>3. Managing expectations for ICS delivery</td>
<td>▶  Supporting health and social care professionals</td>
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<tr>
<td></td>
<td>▶  Changing professional roles and responsibilities</td>
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<td></td>
<td>▶  The national and regional contexts</td>
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<td>4. Developing the ICS</td>
<td>▶  A need for shared system goals</td>
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<td></td>
<td>▶  Combating health inequalities and improving population health</td>
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<td></td>
<td>▶  Building system infrastructure</td>
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<td></td>
<td>▶  Required system resources</td>
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<td>▶  Incorporating evaluation</td>
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ICS, Integrated Care System.
Open access

Wider advisory groups (eg, of care providers) and reports (eg, of lab capacity) fed into command meetings, yet some participants considered that direct inclusion may have been beneficial.

The more direct voice of the care sector, as in delivery of care, wasn’t there [Silver meetings]. (Participant B)

On-call or deputy professionals attended command meetings to maintain organisational presence. Further consideration was needed for how to support a diverse group of professionals to maintain oversight and understanding of system activities:

[It was] quite difficult as an on-call director to dip in and out of those [meetings]… [and there needs to be] less jargon…to remember sometimes that people are joining them from very different perspectives and background. (Participant E)

Participants appraised meetings as effectively led, administered and scheduled, with the frequency of meetings varying according to need. Silver command effectively led many decisions, and although some participants identified that the balance of leadership came more so from Silver than Gold at times, communication and escalation processes were used where required.

Silver command was quite well-organised and they gave a briefing to Gold Command … it did give me the opportunity to check in with my operational teams to say, ‘We’re being asked about this at Gold, what’s your view?’ (Participant C)

System coordination was also facilitated by changes to procedures and funding streams. Notably, the removal of Delayed Transfer of Care (DToC) procedures, replaced with Discharge to Assess, enabled organisations to move beyond boundaries, reduce organisational blame and coordinate care.

Once we hit COVID thankfully they got rid of DToC and they just said, ‘let’s work together, let’s get people out of hospital as soon as we can’…it’s really helped both social care and health. (Participant M)

Theme 2: responding to a prolonged crisis
Developing and implementing a system response
COVID-19 was a new crisis that required learning at individual, organisational and system levels, alongside establishing processes and Incident Control Centres.

We wrote standard operating procedures for [electronic inbox communication], we communicated those out, we trained everybody on that. (Participant D)

Decisions and actions were quickly implemented, and although participants noted this pace was not sustainable long term, participants valued increased flexibility in regulatory processes.

[High level decisions] were actioned really quickly, I think it gave us the opportunity to have the shackles removed. (Participant A)

On the other hand, some participants noted difficulties maintaining other system activities.

Getting decisions made about business as usual has been quite challenging over the last 15 months. (Participant E)

Outcomes of the system response to COVID-19
Many participants identified that a core success was the COVID-19 vaccination programme, with rapid delivery by primary care. System mutual aid (ie, sharing system resources across organisations) was positively appraised.

No matter who you worked for, it was, ‘who’s best placed to get this done for the system’? (Participant L)

The concept of ‘blue beds’, facilitating patient discharge from hospital to complete COVID-19 isolation with ‘out of hospital’ providers, was also described as innovative.

[Blue beds] really helped because it got people out of hospital that had been in contact or had got COVID-19, and gave them time to do their isolation again outside the hospital. (Participant M)

One challenging aspect of the response was agreement about whether intensive care/therapy units should be locally managed.

There was a little bit of a debate about how the ITUs were going to support each other…it was felt that we ought to support the regional network rather than the local network because they would have a better overview of the Covid demand…but it was resolved in the end. (Participant F)

Communication and coordination of COVID-19 guidance
Infection prevention guidance was appraised as effectively disseminated from the system, particularly from local authorities to wider social care providers, through regular bulletins and communications.

[Commissioning] almost took that pressure away because they took it on to update us [about the guidance]. (Participant P)

However, providers needed further opportunities to feed back their specific needs to the system.

I think it’s too one way, where we just keep sending [care providers] the info and the advice, but what do they need from the system going forwards? (Participant B)

Participants were asked about the system-wide Outbreak Control Plan, where familiarity varied widely. Perhaps unsurprisingly, participants involved in developing the
plan were highly familiar, while it was perceived as less relevant, or less of a priority, to others.

I’m more familiar with our own [Trust] plan...[the system-wide plan] changed a lot and I was more focused on ours. (Participant F)

System resources
Some participants highlighted that intelligence dashboards, which presented data from across the system, were a beneficial resource to inform system planning.

The joint intelligence about what was happening in terms of community rates, what was happening within the hospitals, what was happening within the care sector...being able to plot, plan and coordinate responses, I think it has proved quite successful. (Participant L)

However, the system experienced delays in accessing needed resources, and public health and social care were considered particularly under-resourced. Staffing levels were concerning across the system, and laboratory capacity hindered the response.

The resources that we had to gear up to deliver that were a bit slow...we all struggled at various points with pathology capacity. (Participant H)

Care providers described that although resources needed to deliver services were available, longer-term and flexible funding arrangements were needed to effectively facilitate safe provision.

It’s just continued drips and drops of money’s been coming in... the commissioner was really helpful... and said, ’Ok can [care provider] use their infection control money for this because that is what’s making them Covid-safe’? (Participant P)

Theme 3: managing expectations for ICS delivery
Supporting health and social care professionals
Many participants described larger workloads and longer working hours, with the prolonged nature of the pandemic raising concerns for physical and mental workforce well-being. Lengthened patient waitlists and the upcoming ICS transition further risked harming well-being:

We’ve all basically been flogged for 12 months or so. And I think we just need to take a bit of time out and recognise it as being really, really difficult for a lot of people, but there’s a lot of work in that [ICS] transition. (Participant D)

As a result, many participants proposed that staff must be better supported at individual, organisational and national levels. Participants reflected upon changing public perceptions throughout COVID-19.

What followed from that [people clapping during pandemic] is the rise in abuse against people in all care industries and a pay cut in real terms. (Participant 6, FG2)

Changing professional roles and responsibilities
Responding to the COVID-19 crisis, some participants adopted new roles and responsibilities, including secondments and increased leadership and problem-solving responsibilities.

There are many of us who work in what I would call the back office of the NHS... I think for a lot of us it’s actually brought us a lot closer to actually be able to impact and actually save peoples’ lives. (Participant E)

Participants described that colleagues had adapted successfully to role changes and reflected on their own professional development. However, adequate training and guidance were needed elsewhere.

They’ve [ward staff] never been involved in that exit or that discharge home, so that referral information is not detailed enough. (Participant O)

The national and regional contexts
In reflecting upon the ICS response, several participants situated the ICS in a regional and national context. Owing to rising infections and acute demands in other geographical areas, working with other ICSs to share resource was impactful.

[Outside upper tier area] has really struggled, and [our hospital trust] we’re having to help [outside upper tier area] ... that did have an impact on how the ICS was trying to manage its own work. (Participant H)

Furthermore, ICS decisions and communications were based on national guidance, which many participants described as frequently changing. Participants described how the ICS was impacted politically and by national decision-making.

There was a fragmentation between local definitions and national definitions... there appeared to be some local interpretation of an outbreak that would mean the hospitals would never be able to declare themselves outbreak free. (Participant G)

Theme 4: developing the ICS
A need for shared system goals
Moving forward, participants widely agreed that for ICSs to be successful, all organisations must agree and work in collaboration towards system goals.

From FG2:
Participant 6: Actually having something to talk through that is relevant to everyone will be the biggest barrier, because if that doesn’t naturally exist, they won’t naturally engage in it.
Participant 1: Agree, but [the ICS] I think has been established… to save the NHS and to recover social care… we need to do things differently.

Some participants highlighted the importance of listening to individuals and communities when determining priorities for ICSs.

Just a plea that we don’t forget the patient or the person in all this restructuring… how is the patient voice going to be kind of represented? (Participant 2, FG2)

Participants also suggested that ICSs must focus on strategic and long-term goals to make substantiated changes.

We have to accept that there is strategic role here… what’s the longer-term plan? What will stop people requiring bypasses - which will take 10 to 15 years? (Participant 3, FG1)

Combating health inequalities and improving population health
Several participants suggested that the direction and goals of the ICS should be to improve population health and reduce health inequalities, issues highlighted through COVID-19.

There’s definitely something around inequalities in health across the system… building on what we’ve got but also really developing and evolving with the key aim of ensuring equity of access. (Participant 3, FG2)

Participants described that ICSs must recognise and respond, including through commissioning, to inequalities across their geographical area.

83% of the patient population in [hospital trust] that we serve are in the top five more affluent deprivation indexes… In [a different hospital trust] it’s the bottom five, but we’re all part of the same system. (Participant 6, FG2)

Building system infrastructure
After agreeing the goals of the ICS, participants advocated for the development of clear structures and communication strategies.

We need to be clear about what we’re aiming to do by this restructure or whatever, and then we can say, well, who are the partners? (Participant 2, FG2)

Integrating public health teams in the system infrastructure was perceived to be essential in developing an ICS equipped to target population health and reduce inequalities.

Public health has experience of working in primary care trusts, in the local authority, with social care, with acute trusts, and … [to make] cost effective decisions, it would be necessary to have public health skills to review patient journey and pathways. (Participant J)

Strong integration of primary care providers and the voluntary sector was similarly important.

There needs to be a strong voice for general practice around the table… you have to work with [primary care providers] and really build that relationship. (Participant E)

The voluntary and community sector, who are often very close to communities, could potentially support us with some of this. (Participant 2, FG2)

Effective partnership working in the ICS could be maintained through regular action-focused meetings, building upon the successes of the COVID-19 command meetings.

I don’t think we have enough of these reflective conversations… where we think some of these issues through as a collective. (Participant 2, FG2)

Required system resources
Participants described the importance of an adequately resourced system, with financial resources available to providers to facilitate decision-making.

I think we should be a little bit braver and move more budget their [providers] way and trust them to deliver it, with appropriate governance and assurance in place. (Participant E)

In addition, participants discussed how the system could work together to increase recruitment of frontline staff through working with universities or system-wide programmes to expose trainees to different areas of the health and social care system.

We need to have more apprenticeships and in-house things. Because I don’t think we’re going to get the staff coming through. (Participant 1, FG1)

It was important that the workforce was provided with appropriate training and capacity to deliver these activities.

Teachable moments are really powerful and provide a really good opportunity to transform lives and do something differently, but the workforce has got to be equipped and signed up to be able to deliver that. (Participant 5, FG2)

Incorporating evaluation
Robust evaluation was perceived as essential to assess progress towards ICS goals. Data were collected by different organisations, however it was essential that data could be accurately integrated to monitor system outcomes.

Maintaining that understanding around system activity and joint solutions across partners for system issues, I think, is key. Communication and integrated data sets is absolutely key to that. (Participant L)

Evaluating changes to population health and inequalities was also important.

From FG2:
Participant 2: We’ve always, always struggled with how to measure outcomes from preventative work and attribution - what is it that you’ve done that’s caused that to make the difference?

Participant 1: …you can always evaluate things in terms of process, structure and outcome. To see the preventive outcome does take time, but there is an evidence base.

A final comment was how involving public voices, including via advocacy organisations, was necessary to evaluate ICS progress.

We need critical friends to challenge us...the voice of the citizen is really required in this. (Participant 2, FG2)

**DISCUSSION**

Senior health and social care professionals revealed their views and experiences of the ICS-level response to COVID-19, and shared recommendations for how ICSs could move forward effectively.

**Working across health and social care**

With priorities aligned to tackling the pandemic, participants described greater collaboration and fewer boundaries between organisations, aligned with ICS aims. Public health and social care particularly became more integrated, promoting a system response not only focused on acute hospitals, but also community, mental health and social care services. The system response was further enhanced through the implementation of new processes and the removal of DToC, a measure of how long patients remain in hospital after meeting defined criteria for discharge or transfer. As a performance measure often used to judge health and social care provision, participants described how this change reduced organisational blame and increased patient-centred care. Together, these insights reveal that the ICS worked well across health and social care in the pandemic response.

**Responding to a prolonged crisis**

In responding to a novel and prolonged crisis, there was a rapid need to establish new processes, procedures and pathways. The vaccination programme was judged to be effectively and rapidly delivered, with successes in infection rates and hospital admissions. Some participants supported understanding and responses to local priorities during COVID-19 and decisions evoked a mixture of positive and negative emotions.

**Managing expectations for ICS delivery**

Participants highlighted the huge impact of the pandemic on health and social care professionals, including on their health and well-being, changing responsibilities and increased workloads. These concerns extended to retention of and recruitment of the workforce, as widely reported elsewhere. Participants also noted the broader political and legal climate, including frequently changing government guidance, which contextualised the ICS response.

Qualitative work involving policymakers and healthcare professionals has echoed this sentiment, with concerns about delays in the national response and underutilisation of local public health teams.

**Developing the ICS**

As ICSs develop according to local needs, identifying a shared vision and key goals was declared important by participants and may drive motivation to collaborate.

The pandemic highlighted existing health inequalities, including increased mortality rates among care home residents, people with learning or physical disabilities, and ethnically diverse groups. Participants perceived that greater system inclusion of public health teams, social care, primary care, and the voluntary sector was crucial to drive a collective long-term agenda towards improved population health, illness prevention, and reduced health inequalities. The public voice was also deemed integral with a co-produced ICS.

An urgent need to increase staff retention and recruitment and promote staff well-being at individual, organisational and national levels was also reported. Finally, although COVID-19 intelligence dashboards were positively appraised, stronger consistency and integration of data collected across the system were needed to effectively evaluate ICS-related outcomes. These areas highlighted for ICS development are consistent with previous recommendations.

**Recommendations**

- Identify system priorities including long-term goals to improve population health, directed by communities themselves.
- Schedule regular forums to maintain wider ICS communication, with core involvement of public health and community-based teams alongside acute trusts.
- Ensure the system is adequately resourced and effectively aligned with system goals, including a strong and supported workforce and sufficiently flexible commissioning.
- Integrate health and social care data to facilitate an accessible, comprehensive view and evaluation of ICS activities.

**Limitations**

While participants represented a range of organisations, Silver command was better represented than Gold command. Prospective participants held competing priorities during COVID-19 that restricted participation.
Similarly, although participants were informed questions would be pseudonymised, the potential sample pool was limited and as a result, participant responses may not fully reflect participants’ views. Finally, while the research was conducted by university researchers independent of the ICS, this study was commissioned by a public health team who acted as gatekeepers to the wider ICS.

Conclusion
COVID-19 required an integrated and united system response across health and social care. Senior health and social care professionals reported strengthened collaboration and rapid implementation of supporting structures and processes while handling limited system resources and an impacted workforce. Lessons from the COVID-19 response can valuably inform future ICS development. Health and social care partners must be effectively supported by procedures and infrastructure that can sustain intentions and capabilities to improve population health.

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