PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Identifying patient concerns during consultations in tertiary burns services: Development of the adult, Burns Patient Concerns Inventory
AUTHORS	Gibson, John; Yarrow, Jeremy; Brown, Liz; Evans, Janine; Rogers, Simon; Spencer, Sally; Shokrollahi, Kayvan

VERSION 1 – REVIEW

REVIEWER	Peter Dziewulski Shriners Burns Hospital and UTMB Galveston , Texas, USA.
REVIEW RETURNED	23-Jul-2019

GENERAL COMMENTS	This paper describes development of a patient centered inventory for patient use when discussing problems with the treating team. It gives the patient a tool to help to highlight common concerns in different domains of their care. The paper is well written, concise and to the point. The references are correct to my knowledge. The tables and diagrams complement the text without duplication. I think the methodology seems sound. In general this is very useful piece of work that should benefit and help patients in the clinical setting by focusing their thoughts and attention of the Burn MDT on their concerns. I feel that it would be clinically relevant and be of direct benefit to patients. I could see my service using this inventory in a clinical setting. The only concerns are that the patient group was small and a narrow spectrum of the burn patient population. The inventory also need to be validated. The authors acknowledge these points and plan for validation and subsequent versions using a wider spectrum of patients. My other concerns that some of the concerns in the inventory are outside the remit and specialist skills of the burn teams but could help signpost issues that then require ongoing referral to specialist or primary care. In view of the potential utility of this tool I would recommend it for publication.

REVIEWER	Nancy Van Loey Association of Dutch Burn Centres, Behavioral Research, Beverwijk, the Netherlands Utrecht University, Clinical Psychology, Utrecht, the Netherlands
REVIEW RETURNED	26-Jul-2019

GENERAL COMMENTS	This is a descriptive study that reports on the development of a patient concerns inventory. The development comprised 3 stages: inspection of items of existing quality of life scales, patient interviews and a focus group with professionals. Item reduction was based on a Delphi process. This represents a sound method to develop the inventory. Strong points are the different sources and perspectives included in the study. The paper has an easy to follow structure starting with content generation, content refinement and item grouping, both in the description of the method and results. The discussion further clarifies the results. It is an interesting paper that adds to the literature. One remark concerning the subheadings of the items generated from the patient interviews, dependence on others was classified in 'PTSD symptomatology'. Why is it attributed to that cluster? Isn't it a consequence of functional problems? Could the authors provide an explanation? Another consideration relates to the presentation of the interview results. I assume the themes do not fully capture the whole content. How do the authors think about the presentation of the full topic list of expressions (this may be somewhat more detailed than what is now presented in Appendix 3). An example of such a topic list can be found in Kool et al, Burns (2017). In the discussion, I believe it would be valuable to compare the findings in the current study with the findings reported by Kool et al. because also in the latter study, unique items were mentioned by patients such as medication and side effects, appearance matters (of which colour and roughness were mentioned by patients as disturbing characteristics related to appearance which might somewhat contrast with finding that scar characteristics are not important?), indicating how important it is to hear the patient's voice. Furthermore, the two studies have significant overlap indicating the validity of the results. Last, why are topics presented in alphabetic order? How do patient perceive this ordering? Please add number of MDT members to abstract.

REVIEWER	Dr Zephanie Tyack Australia I am the developer of a profile of health-related quality of life for people with burn scars which may be perceived as a potential conflict of interest. I have considered this potential conflict in my response and do not believe I have an actual conflict particularly as the inventory developed is different to a scale.
REVIEW RETURNED	06-Aug-2019

GENERAL COMMENTS	Introduction: This paper reports on the development of a novel inventory of adult burn patient concerns. The concept is important. However I would like to see greater detail regarding the context in which the inventory was developed, the groups that were used in the development and the concept that the inventory addresses. At present this detail is not clear. Until this detail is provided it is

	difficult to confident interpret the results. Whilst the inventory is not a scale per se many of the COSMIN checklist items are likely still relevant to the reporting to ensure the essential details are covered (The COSMIN Risk of Bias checklist, Mokkink, et al. 2018). I have provided feedback on each section as follows: Introduction This section would benefit from more clearly outlining the ways in which patient concerns inventories are applied in clinical practice to set the scene for the sections that follow. How does this add to the approach that is already adopted in some clinical areas where patient-reported outcome measures are used routinely by clinicians to identify patient concerns? Could it be that patient-reported outcome measures may have benefits over a patient concerns inventory as they can detect the severity of symptoms as well as symptoms that are of concern? Using the inventory it would seem difficult to detect changes in an area over time as the concern is identified as either being present or absent. How are these inventories used in other clinical areas such as oncology. The section would benefit from further detail regarding novel areas that inventory may target. Methods The development setting and context needs much greater detail to understand the environment in which the study was undertaken. Sociodemographic and clinical experience details of people involved in interviews and the multidisciplinary team is needed to understand the population included in the development (e.g., patient details such as severity of scarring, presence of contractures, type of scarring – pigmented, hypertrophic; interventions received). The experience and professional background of the interviewer in burn care and qualitative interviewing are important details to understand the information elicited. It is also important to document the experience and background of the team in coding interviews and the roles of people involved. Tables should present means and standard deviations where appropriate rather than mean and range. Is the patient concerns inventory limited to the construct of health-related quality of life as this was the area that searches related to although the actual areas of the inventory are identified as being part of well-being on page 27? Much greater methodological detail is required in the 4 sections of: HRQoL tools, one-to-one patient interviews, multi-disciplinary team and Delphi panel; so that the trustworthiness of the findings is evidence. For example, for the search strategy, dates and search terms, date last searched should be included as well as the search strategy in a table or appendix. There seem to be relevant burn-specific or scar-specific health-related quality of life tools missing such as CARE scales, SCAR-Q and Brisbane Burn Scar Impact Profile. Thus the search would not seem to have been comprehensive as these recent scales were not identified. For the qualitative interviews how was saturation established. A graphical display of when in the interviews themes first emerged and continued could be included. Were other methodological processes included for methodological rigour such as member checking? What was the date that ethical approval was obtained and when did the study data collection commence and end? These details are important to establish the time and context of the study. Did ethical approval extend to participants in the patient and public involvement session?

	Could the authors comment on whether they consider caregiver concerns should be reflected in the same inventory? How were decisions made regarding the wording of the inventory? For example, was any cognitive interviewing conducted to check the wording that patients preferred? Why was energy chosen rather than fatigue; exercise rather than fitness; nerve pain rather than stabbing pain or shooting pain? Conclusion Suggest that the final statement needs to be revised or omitted. Refer to the copyright statement. Page 27 At present the inventory is introduced by referring to 'issues'. I think 'concerns' which are of interest need to be much more clearly outlines in an introductory statement to patients. As per scale development this introductory statement should also be tested with patients and staff in interviews.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1

This paper describes development of a patient centered inventory for patient use when discussing problems with the treating team. It gives the patient a tool to help to highlight common concerns in different domains of their care. The paper is well written, concise and to the point. The references are correct to my knowledge. The tables and diagrams complement the text without duplication. I think the methodology seems sound.
In general, this is very useful piece of work that should benefit and help patients in the clinical setting by focusing their thoughts and attention of the Burn MDT on their concerns. I feel that it would be clinically relevant and be of direct benefit to patients. I could see my service using this inventory in a clinical setting. The only concerns are that the patient group was small and a narrow spectrum of the burn patient population. The inventory also need to be validated. The authors acknowledge these points and plan for validation and subsequent versions using a wider spectrum of patients. My other concerns that some of the concerns in the inventory are outside the remit and specialist skills of the burn teams but could help signpost issues that then require ongoing referral to specialist or primary care.

In view of the potential utility of this tool I would recommend it for publication.

We would like to thank the reviewer for his comments. We acknowledge the both the benefits of the PCI tool as experienced in other clinical specialties as well as limitations of the tool and we look forward to collaborating with other burns services to validate the tool.

Reviewer: 2

This is a descriptive study that reports on the development of a patient concerns inventory. The development comprised 3 stages: inspection of items of existing quality of life scales, patient interviews and a focus group with professionals. Item reduction was based on a Delphi process. This represents a sound method to develop the inventory. Strong points are the different sources and perspectives included in the study. The paper has an easy to follow structure starting with content generation, content refinement and item grouping, both in the description of the method and results. The discussion further clarifies the results. It is an interesting paper that adds to the literature.

One remark concerning the subheadings of the items generated from the patient interviews, dependence on others was classified in ‘PTSD symptomatology’. Why is it attributed to that cluster? Isn’t it a consequence of functional problems? Could the authors provide an explanation?

Thank you. We agree with your comments and have moved those sentences to the cluster of symptoms with Mental Health. Whilst we agree that it is attributed to functional problems, participants that described dependence as a concern, it was attributed to low mood.

Another consideration relates to the presentation of the interview results. I assume the themes do not fully capture the whole content. How do the authors think about the presentation of the full topic list of expressions (this may be somewhat more detailed than what is now presented in Appendix 3). An example of such a topic list can be found in Kool et al, Burns (2017).

Thank you. The full topic list of expressions in Appendix three does indeed capture the whole content. The purpose of the interview analysis within this study was identify the common concerns that patients wished to discuss in their consultation. Therefore we did not seek to explore each aspect of HRQoL that are described by Kool et al.

In the discussion, I believe it would be valuable to compare the findings in the current study with the findings reported by Kool et al. because also in the latter study, unique items were mentioned by patients such as medication and side effects, appearance matters (of which colour and roughness were mentioned by patients as disturbing characteristics related to appearance which might somewhat contrast with finding that scar characteristics are not important?), indicating how important it is to hear the patient’s voice. Furthermore, the two studies have significant overlap indicating the validity of the results.

Thank you for bringing our attention to this comprehensive paper. We have read the above study and compared our findings in the discussion.

Last, why are topics presented in alphabetic order? How do patient perceive this ordering?

Thank you. During the interviews, patients placed variable emphasis and weighting on the concerns outlined. We decided to list the topics in alphabetical order so that the tool did not seek to place significance on the individual concerns. Participants of the interviews agreed with the layout. Furthermore, in other versions of the PCI as used in other specialties, this format has been deemed the most appropriate.

Please add number of MDT members to abstract.

Thank you. This has been changed accordingly.

Reviewer: 3
Reviewer Name: Dr Zephanie Tyack

Please leave your comments for the authors below
Introduction:

This paper reports on the development of a novel inventory of adult burn patient concerns. The concept is important. However I would like to see greater detail regarding the context in which the inventory was developed, the groups that were used in the development and the concept that the inventory addresses. At present this detail is not clear. Until this detail is provided it is difficult to confident interpret the results. Whilst the inventory is not a scale per se many of the COSMIN checklist items are likely still relevant to the reporting to ensure the essential details are covered (The COSMIN Risk of Bias checklist, Mokkink, et al. 2018). I have provided feedback on each section as follows:

Introduction

This section would benefit from more clearly outlining the ways in which patient concerns inventories are applied in clinical practice to set the scene for the sections that follow. How does this add to the approach that is already adopted in some clinical areas where patient-reported outcome measures are used routinely by clinicians to identify patient concerns?

Could it be that patient-reported outcome measures may have benefits over a patient concerns inventory as they can detect the severity of symptoms as well as symptoms that are of concern? Using the inventory it would seem difficult to detect changes in an area over time as the concern is identified as either being present or absent. How are these inventories used in other clinical areas such as oncology. The section would benefit from further detail regarding novel areas that inventory may target.

Thank you for your comments. We would like to stress that the Patient Concerns Inventory (PCI) is an entirely different concept to, and has an entirely separate purpose to that of a Patient Reported Outcome Measure (PROM). The PCI is essentially a prompt list that acts as a communication tool that aids patients to raise issues in clinical consultations that may easily get missed. Compared to a PROM, a prompt list can have a wider range of topics as there is less need to have item reduction. Furthermore, if a patient scores badly in a domain it does not necessarily mean they wish to be reminded of them and talk about it within a consultation. A PROM deals with something that has already been highlighted as ‘an issue’, either by clinicians or patients. The PCI concept is a pathway from which these ‘issues’ may be generated or flagged, and indeed possibly spawn future generations of PROMs. Hence, whilst PCIs do not generated any outcome measures themselves, they can be the drivers to PROMs and more patient-centred clinical care.

The PCI should be viewed as an intervention, that guides treatment that in turn has the potential to improve HRQoL. It is not intended as a measure and therefore it’s purpose is not to detect changes.

Methods

The development setting and context needs much greater detail to understand the environment in which the study was undertaken. Sociodemographic and clinical experience details of people involved in interviews and the multidisciplinary team is needed to understand the population included in the development (e.g., patient details such as severity of scarring, presence of contractures, type of scarring – pigmented, hypertrophic; interventions received).

Thank you. Patient details have been added to the patient demographic table. Unfortunately, the full medical records were not available for those that had injuries over twenty years ago and therefore the number of interventions was not possible to ascertain. Likewise severity of scarring was not assessed and is more relevant in the context of a PROM rather than a concerns inventory.

The experience and professional background of the interviewer in burn care and qualitative interviewing are important details to understand the information elicited. It is also important to document the experience and background of the team in coding interviews and the roles of people involved.

Interviewer and coding team members experience have been added.

Tables should present means and standard deviations where appropriate rather than mean and range.

Thank you. This has been changed accordingly.

Is the patient concerns inventory limited to the construct of health-related quality of life as this was the area that searches related to although the actual areas of the inventory are identified as being part of well-being on page 27?

The PCI is limited to concerns that patients wish to discuss with their treatment team. We feel that this is clearly explained throughout the manuscript.

Much greater methodological detail is required in the 4 sections of: HRQoL tools, one-to-one patient interviews, multi-disciplinary team and Delphi panel; so that the trustworthiness of the findings is evidence. For example, for the search strategy, dates and search terms, date last searched should be included as well as the search strategy in a table or appendix. There seem to be relevant burn-specific or scar-specific health-related quality of life tools missing such as CARE scales, SCAR-Q and Brisbane Burn Scar Impact Profile. Thus the search would not seem to have been comprehensive as these recent scales were not identified.

We acknowledge that we did not include the tools mentioned. The search was conducted in June 2017. Tools that were not psychometrically validated in a burns population were excluded. At this time point the CARE burn scales, SCAR-Q and Brisbane Burn Scar Impact Profile were in development. However, having looked at those tools and scales, there is nothing within them that was not already included in our ‘long list of’ over one hundred patient concerns from the widespread sources we used.

For the qualitative interviews how was saturation established. A graphical display of when in the interviews themes first emerged and continued could be included. Were other methodological processes included for methodological rigour such as member checking?

Thank you. Recruitment for the interviews continued until data saturation was achieved whereby interviews did not identify new issues or concerns. A total of twelve interviews were completed; interviews number 11 and 12 did not lead to the emergence of any new codes. As over 57 themes emerged we don’t believe a graphical display would be the best method of displaying the results.

What was the date that ethical approval was obtained and when did the study data collection commence and end? These details are important to establish the time and context of the study. Did ethical approval extend to participants in the patient and public involvement session?

Yes, ethical approval was sought for the entire study. This detail has been added.

Could the authors comment on whether they consider caregiver concerns should be reflected in the same inventory?

Thank you for this comment. The tool has been developed to specifically reflect the concerns of the patients and not their caregivers. During the interviews, patients described multiple accounts of when their concerns differed from those of caregivers. In addition, numerous concerns were expressed towards caregivers. We therefore considered it inappropriate to include carer’s concerns in the tool.

How were decisions made regarding the wording of the inventory? For example, was any cognitive interviewing conducted to check the wording that patients preferred? Why was energy chosen rather than fatigue; exercise rather than fitness; nerve pain rather than stabbing pain or shooting pain?

Thank you for this comment, we appreciate that this is not clear in the manuscript. During the interviews, wording was chosen using the language commonly used by patients. For example Nerve pain was used rather than shooting pain. A secondary outcome of the Delphi study was to gain feedback on the wording of individual items on the PCI. Significant overlap was generated from the three sources of content development. All items generated, included those that had similar definitions (e.g energy and fatigue) were included in the Delphi. Participants were asked to review the wording of the items to ensure that the list was deemed comprehensive by the intended audience and to select the term they considered most appropriate. Energy received a greater consensus than fatigue. We acknowledge that this is a limitation of the study and will seek to explore this in future validation studies.

Conclusion
Suggest that the final statement needs to be revised or omitted. Refer to the copyright statement.

Our comments regarding copyright are important, not only to highlight and lubricate the adoption of the PCI, but importantly to specifically point out the issue of branding for individual services that may wish to use it. These are concerns already highlighted to us by early adopters, and which is not a specific issue clearly dealt with in the standard copyright information. It is important to the authors that we deliver absolute clarity to the readership on this issue, so that clinicians do not feel the need to seek further clarity from their hospital or legal team

Page 27

At present the inventory is introduced by referring to 'issues'. I think 'concerns' which are of interest need to be much more clearly outlines in an introductory statement to patients. As per scale development this introductory statement should also be tested with patients and staff in interviews.

Thank you. The wording on the PCI is consistent with the wording on the previous versions of the PCI which patients have found easy to use. We will be evaluating this during future validation studies.

VERSION 2 – REVIEW

REVIEWER	Nancy Van Loey Association of Dutch Burn Centers, Beverwijk, the Netherlands Utrecht University, the Netherlands
REVIEW RETURNED	11-Sep-2019

GENERAL COMMENTS	Thank you for your response. My concerns were satisfactorily adressed. This is an important study for clinical practice.

REVIEWER	Dr Zephanie Tyack The University of Queensland, Australia I developed a patient-reported outcome measure of health-related quality of life which differs to the patient concerns inventory developed but which may be perceived as a potential conflict of interest.
REVIEW RETURNED	10-Sep-2019

GENERAL COMMENTS	This paper has the potential to be a very influential paper in the field of burns as a means of identifying individual concerns of patients in clinical consultations is greatly needed. However, so that readers can determine whether the results are transferrable to their setting and population greater detail is required regarding the setting, population demographics and timing of the study. Whilst the authors have addressed some of the comments that were raised, there are previous comments that require further consideration. These areas are: (1) Although the authors have argued that the severity of scarring is more relevant in the context of a PROM than a concerns inventory, the severity of the condition of interest still seems very relevant for the development of a concerns inventory particularly where a relatively small number of patient participants is involved in the development. A patient with a hypertrophic contracted scar maybe more likely to have concerns over sensory experiences such as itch and tightness than a patient who has minimal scar raising or a pigmented scar, as these symptoms may be more severe. The list of concerns may be biased towards concerns of people hypertrophic contracted scars if participants with that scar type predominated, which may differ at least somewhat to concerns of people with minimal hypertrophic scarring or pigmentation alone. While the authors have added some data regarding clinical characteristics of the participants it would be good to at least acknowledge the lack of data on severity of scarring for participants and other clinical characteristics such as burn depth in the limitations section. (2) Details of the data collection period for patient interviews is present but could the authors please add details regarding when the multidisciplinary team data collection commenced and ended to give greater context. I also suggest that further detail be added regarding the context, particularly for international readers who may not understand what a regional burn unit and multidisciplinary team is like in Wales (i.e., number of inhabitants supported by the hospital, type of services provided, number of burn cases seen each year, dedicated burn team members). The importance of this is highlighted by Maher 2018 in the International Journal of Qualitative Methods who states “Because qualitative research is specific to a particular context, it is important a “thick description” of the particular research context is provided allowing the reader to assess whether it is transferable to their situation or not.” (3) Can the authors add the interview questions that participants were asked in an appendix so that the focus of the interviews is clearer (i.e., a focus on concerns rather than HRQOL)? By searching topics related to health-related quality of life is it possible that generating initial items outside of this construct such as shared decision making with health professionals, the patient’s experience of hospital, health information concerns may have been limited, and biased the concerns inventory towards reflecting health-related quality of life content. It is suggested that this should be acknowledged as a limitation. (4) Could the authors add the range in years post-burn and age for the patient participants to give context regarding the time in the patient’s recovery and life when the interviews took place? Could the standard deviation of the percentage TBSA be added? Could further details be added regarding the multidisciplinary team such as whether all multidisciplinary team members were dedicated

	burn team members and their experience treating patients with burns? (5) Whilst data sharing of data that can truly be made non-identifiable is ideal, the authors' qualitative study components, which included a small sample size of 12 participants, may be very difficult to make non-identifiable. It is suggested that the authors confirm how they intend to ensure the data will be non-identifiable prior to it being shared or otherwise remove the intent to share the qualitative data.

VERSION 2 – AUTHOR RESPONSE

Reviewer(s)' Comments to Author:

Reviewer: 3

This paper has the potential to be a very influential paper in the field of burns as a means of identifying individual concerns of patients in clinical consultations is greatly needed. However, so that readers can determine whether the results are transferrable to their setting and population greater detail is required regarding the setting, population demographics and timing of the study. Whilst the authors have addressed some of the comments that were raised, there are previous comments that require further consideration.

These areas are:

Although the authors have argued that the severity of scarring is more relevant in the context of a PROM than a concerns inventory, the severity of the condition of interest still seems very relevant for the development of a concerns inventory particularly where a relatively small number of patient participants is involved in the development. A patient with a hypertrophic contracted scar maybe more likely to have concerns over sensory experiences such as itch and tightness than a patient who has minimal scar raising or a pigmented scar, as these symptoms may be more severe. The list of concerns may be biased towards concerns of people hypertrophic contracted scars if participants with that scar type predominated, which may differ at least somewhat to concerns of people with minimal hypertrophic scarring or pigmentation alone. While the authors have added some data regarding clinical characteristics of the participants it would be good to at least acknowledge the lack of data on severity of scarring for participants and other clinical characteristics such as burn depth in the limitations section.

Thank you for your comments.

In relation to the number of patients involved in the development, both patients and staff and a literature search brought to bear every feasible concern imaginable 'to the table'. The Delphi process whittled these down in the way described in the methods. We very much feel that the PCI is representative of the major concerns of burn patients.

We acknowledge that we have not captured the entire demographic of the adult burn population and we have mentioned this as a limitation in the discussion.

In terms of the point about scarring and PROMs, the essence of our work is that some patients come to us with very severe scarring and that scarring is NOT their primary issue even when we as clinicians think it should be. Hence a clinical episode that should be focussed around other issues is instead focussed on scarring that is a secondary issue at that time. Furthermore, it is only if and when scarring is highlighted by the patient as a concern that the clinical pathway that involves PROMS and scar assessments is activated. Furthermore, the nature of a PCI is that it is formulated in a way that is accessible to patients. Hence the elements that clinicians find to be similar or overlapping is not necessarily true from a patients' perspective. In addition, what is scar severity? – a facial acid attack scar of 1.5 % can be devastating when a 18% TBSA scar to the back might not be and depends on so many factors. Our final point that overlaps with the preceding one is that psychologists have often quoted to us that the published evidence suggests psychological impact is not correlated to the clinically-assessed severity of the scarring or TBSA of injury. We made it clear that a range of patients with generally severe burns from two burn centres were representative of the patients typically seen in burns services, especially outpatients.

(2) Details of the data collection period for patient interviews is present but could the authors please add details regarding when the multidisciplinary team data collection commenced and ended to give greater context. I also suggest that further detail be added regarding the context, particularly for international readers who may not understand what a regional burn unit and multidisciplinary team is like in Wales (i.e., number of inhabitants supported by the hospital, type of services provided, number of burn cases seen each year, dedicated burn team members). The importance of this is highlighted by Maher 2018 in the International Journal of Qualitative Methods who states "Because qualitative research is specific to a particular context, it is important a "thick description" of the particular research context is provided allowing the reader to assess whether it is transferable to their situation or not."

Thank you. This information has been included in the methods section.

(3) Can the authors add the interview questions that participants were asked in an appendix so that the focus of the interviews is clearer (i.e., a focus on concerns rather than HRQOL)? By searching topics related to health-related quality of life is it possible that generating initial items outside of this construct such as shared decision making with health professionals, the patient's experience of hospital, health information concerns may have been limited, and biased the concerns inventory towards reflecting health-related quality of life content. It is suggested that this should be acknowledged as a limitation.

Thank you. The interview questions have been included in the appendix. We do not believe the tool is biased towards HRQoL. The focus of the patient interviews and staff content generation was to identify the maximum number of concerns. During this aspect of the study we did not focus on HRQoL. Whilst we acknowledge that the literature review focussed on tools that covered HRQoL, this decision was made as the literature for unmet needs in the burns population is sparse and similar tools to the PCI do not exist.

(4) Could the authors add the range in years post-burn and age for the patient participants to give context regarding the time in the patient's recovery and life when the interviews took place?

Could the standard deviation of the percentage TBSA be added?

Thank you, this information has been added.

Could further details be added regarding the multidisciplinary team such as whether all multidisciplinary team members were dedicated burn team members and their experience treating patients with burns?

Thank you. Staff were eligible for the study if they were a dedicated member of the burns MDT and had been working in burn care for a minimum of one year. This detail has been added to the methods section.

(5) Whilst data sharing of data that can truly be made non-identifiable is ideal, the authors' qualitative study components, which included a small sample size of 12 participants, may be very difficult to make non-identifiable. It is suggested that the authors confirm how they intend to ensure the data will be non-identifiable prior to it being shared or otherwise remove the intent to share the qualitative data.

Thank you for your concerns regarding data confidentiality. The parameters of the research study and ethics approvals including levels of patient consent were such that we are satisfied that patient identification is not an issue. There is no need or intention to share the qualitative data collected from the study.

Reviewer: 2

Reviewer Name: Nancy Van Loey

Institution and Country: Association of Dutch Burn Centers, Beverwijk, the Netherlands, Utrecht University, the Netherlands Please state any competing interests or state 'None declared': None declared

Please leave your comments for the authors below Thank you for your response. My concerns were satisfactorily addressed. This is an important study for clinical practice.

VERSION 3 – REVIEW

REVIEWER	Dr Zephanie Tyack The University of Queensland I led the development of a patient-reported outcome measure, the Brisbane Burn Scar Impact Profile, measuring health-related quality of life. I don't consider this to be a competing interest as the focus of the paper being reviewed is a patient concerns inventory not a measure of health-related quality of life but it is possible that others could perceive it as such.
REVIEW RETURNED	14-Oct-2019

GENERAL COMMENTS	Thankyou for addressing most of the comments raised and for elaborating on the rationale for not including more detailed information regarding the severity of scarring. I recommend that the manuscript be accepted for publication following one small revision. From the information presented in the tables it seems that consumer participants were greater than 9 months post-burn. If this information is correct then it should not be assumed that the concerns inventory may not be relevant for adults earlier post-burn which is when the majority of consultations occur. It is recommended that a specific statement be added to the discussion to indicate that further work is needed to determine the relevance of the inventory for patients up to 9 months post-burn. I look forward to seeing the manuscript in print.

VERSION 3 – AUTHOR RESPONSE

Reviewer Three
From the information presented in the tables it seems that consumer participants were greater than 9 months post-burn. If this information is correct then it should not be assumed that the concerns inventory may not be relevant for adults earlier post-burn which is when the majority of consultations occur. It is recommended that a specific statement be added to the discussion to indicate that further work is needed to determine the relevance of the inventory for patients up to 9 months post-burn.

Thank you for bringing this to our attention, the information in the table is incorrect; the earliest patient was 6 weeks post injury. We have changed this accordingly in the manuscript. During each interview patients were asked to consider their concerns at each stage of treatment including the early stages of treatment. We therefore feel that we have adequately captured concerns at this time point in treatment. We acknowledge that further work is required to validate the tool in the clinical environment and this is already detailed in the discussion.

Once again, I would like to thank you on behalf of my fellow authors for the peer review. We certainly believe that it improves the quality of the manuscript and hope that you will feel we have addressed the points raised appropriately.