PEER REVIEW HISTORY

BMJ Open publishes all reviews undertaken for accepted manuscripts. Reviewers are asked to complete a checklist review form (**http://bmjopen.bmj.com/site/about/resources/checklist.pdf**) and are provided with free text boxes to elaborate on their assessment. These free text comments are reproduced below.

ARTICLE DETAILS

TITLE (PROVISIONAL)	Patient and informal carer experience of hip fracture: A qualitative study using interviews and observation in acute orthopaedic trauma
AUTHORS	Tutton, Elizabeth; Saletti-Cuesta, Lorena; Langstaff, Debbie; Wright, Julie; Grant, Richard; Willett, Keith

VERSION 1 – REVIEW

REVIEWER	Iain Moppett Nottingham, UK I am active collaborator with Professor Costa, also of NDORMS but not an author.
REVIEW RETURNED	09-Jul-2020

GENERAL COMMENTS	The authors have submitted a qualitative study of patient and informal carer experience of hip fracture. This is an interesting paper. Thank you. Regulatory approvals and consent. These all seem appropriate. Theoretical constructs. I am not a qualitative expert by any means - so the authors may view my comments as naive or misguided. The authors state that a phenomenological approach was used. Does this need more clarification? As I say, I am not an expert, but my reading is that the authors are following the interpretative (hermeneutic) branch of this approach. This is implied, but not really discussed, in some of the interpretations which include the researchers perceptions and interpretations of phenomena (e.g. indignity, normality of pain). (To be fair, I have just read the protocol paper and this is discussed there, so perhaps it is a question of how much detail to put in) Linked to this, the authors state that the analysis takes into account 'historical, social and cultural contexts' but this doesn't really come through in the interpretation. The current phenomena are described, but with little relation to prior experience, beyond the relatively generic 'independence' or autonomy. As a reader I am left with no feeling of how the individual's prior life experience influenced their current perceptions. Where is the keen gardener? The grandparent? The person barely able to move from their nursing home room? PPI (page 5) This section confused me. What did they actually do? 'Resonance... was found' - please can this be expanded or explained.

Page 8: again this may be my ignorance, but what does 'Rigour was demonstrated through trustworthiness' mean? (Again, this is explained in the protocol paper, but I'm not sure a single line in this paper is enough).

I can't see anything about when the study was done in relation to the participants' stay in hospital. The experience of the newly operated vs the rehabilitating vs the about to go home might be very different. It is hard to contextualise this study with other studies of the post-discharge experience.

Findings

This is simply a style / editorial issue but I got slightly lost with the heading and subheadings. Perhaps a table identifying the themes, subthemes etc. might help?

It is not my place to recode the data. But (there is always a but) I don't see how 'Patients worried about their partners and how they coped without their practical support.' maps to 'intense activity undertaken by carers... supporting their family member.' (p7)

P13: The loss of the ability to walk due to injury and subsequent pain had a devastating impact on patient's everyday life...

This was a study in the acute setting (see comments above) so I'm not sure everyday life is the correct term. The 2-3 weeks of inpatient time is not 'everyday'.

Slight bit of semantics - 'enduring' has two meanings - long-lasting and being suffered / experienced / put-up with. Perhaps needs clarification.

I am surprised that the experience of delirium - from patient and carers' perspectives is not visible. Given that it is the second most common complication (after pain) following hip fracture, it is notable by its absence. Although the authors describe data saturation, triangulation with staff might have identified this as a gap.

Was there any attempt at triangulation of described experiences. For instance p11 'nobody's actually told me that yet either'. This is the patient's experience / perception / understanding, but it doesn't mean it is objectively true (I'm not saying whether it was or it wasn't). But surely to understand that phenomenon involves understanding the context - not told, not understood, not wanting to hear?

References: I am surprised to see no reference to Bruun-Olsen V, Bergland A, Heiberg KE. “I struggle to count my blessings”: recovery after hip fracture from the patients’ perspective. BMC Geriatr. 2018;18:18. (Nothing to do with me, so not a request for referee citation).

Funding: A little more transparency about 'Department of Health' funding would be good. Is this from Prof Willett's NHS role or a competitive grant?

There was a PPI group involved. Why were they not involved in authorship? Their insights would have been invaluable.

	So, overall - an interesting paper, and hearing patient and carer voices is very important. But I am troubled by some of the interpretation and the gaps compared with clinical experience and prior reports. As always, these are simply my opinions. I hope the authors find them helpful - but they are welcome to disagree. Iain Moppett, Nottingham, UK

REVIEWER	Bridie Angela Evans Swansea University Medical School Swansea University Wales UK
REVIEW RETURNED	16-Sep-2020

GENERAL COMMENTS	Thankyou for the opportunity to review this very interesting paper. Introduction P5 line first paragraph: please provide more context about hip fracture, proportion of older people who get one, impact on the NHS and social care sector, usual treatment and rehabilitation. Introduction: please explain who is an informal carer and, if reported in the literature, the proportion that are spouse, child, etc Please expand the section explaining the focus of this study. Please provide a fuller justification for exploring the experience of patients and carers while the patient is still in hospital. Methods Ethics: I am afraid I was a bit confused about the staff consent stated in the description of participants since this is not described in the ethics section. I assume that data were being collected from staff since they were part of the patient interaction being observed? Please clarify. Participants: Again my apologies but I found this confusing too. I was unclear who participated in which elements of the study and how they consented. Did only two patients take part in interviews and observations? If so, could you clarify that different people provided interviews and observation data. Also, please explain hthe carers who were interviewed linked with the participants – were they their carers or carers for different patients? Were the three patients who declined included in the 36? I also found this section of the abstract confusing and had hoped the paper would make it clearer, but sadly not! It would also be helpful to describe the participants more fully. This is often, but not always, done in the results, as characteristics of respondents. How many couples were interviewed? What was the relationship between carer and patient? Who provided interview data and who provided observational data? Did the observational data include comments by someone else (nurse) about the patient? Length of stay in hospital, stage in their treatment, likely discharge date and plan? As a reader, I want to understand the sample better to help me understand the findings. Perhaps this could be presented in a table so the reader can reconcile the respondent in the findings section with their characteristics.

How were patients and carers recruited? What were the inclusion criteria and selection process?

Interviews: Please provide more detail about the questions asked in the interviews. An interview schedule would be helpful too. Were interviews unstructured after the opening question, except for the prompts? How did the interviewers ensure the interview did provide data to answer the objectives? What happened if people didn’t want to talk or took the conversation into a different area?

While I note that the methods are reported in detail in the published protocol, it would be helpful for the reader to have some more detail than is provided in this paper. Many of the comments above result from the lack of information available.

PPI
Please say more about the people who are part of the UK Musculoskeletal Trauma group and the processes through which they were involved. Did researchers attend their meetings or members come to team meetings? For example, not knowing this makes it difficult to see how they were involved in the analysis as described, which says that analysis was discussed with the team. Also, how often were they involved? Numbers, experience? Clinical staff are not usually considered as PPI so please justify why you wanted to involve them alongside patients and public members. I can see why but think you should explain this. You may want to be guided by the GRIPP 2 checklist when reporting PPI in this paper.

Findings
The findings start with a subheading ‘sharing the journey’ which does not appear to be a theme. If not a theme, why is this heading reported in this way?

The results are very interesting and moving. But I didn’t always find this section easy to follow. It switches tenses and the punctuation is difficult: for example there are some misplaced apostrophes and too many commas which break up the reading flow. I suggest this is looked at to make it easier to read.

It seems that theme 1 is about carers and theme 3 is about patients? Is it the case that the other group in each didn’t talk about anything relating to those themes? If so, this needs to be acknowledged somewhere. The themes feel rather one sided which I would not have expected. If these are all themes equally relevant to both groups, the write-up needs to be more balanced. At the moment, the ‘journey’ as is reported does not appear to be equally shared.

Do the views of carers differ depending on their relationship to the person with a hip fracture? Please comment on this.

P15 line 49 - why P5a and not P5?
P16 line 35 – why does the quote from P32 say ‘she’ – doesn’t sound like her words.
P16 line 49 – why had patients lived with pain for a long time? How long had they been in hospital? Or does this refer to other pain before their hip fracture?

	P17 line 3-8 - this is a quote from P31 yet it is presented as reported. Please make it clear if other people in the scene being observed are being quoted. This can be clarified in the methods. Discussion In the discussion, the authors highlight that the study included patients with memory loss. But there is no mention of memory loss in the interview data as reported, nor does it seem to have a place in the themes. If it was so prevalent, had respondents normalised it and not mentioned it or did these interviews not capture that aspect of patients' situation? At present, the findings aren't presented in a way which fully supports the statement that findings indicate the need for more clinical attention to mental wellbeing. Nor is there any evidence that the care received was not family/carer centered, since the results do not generally describe care but focus on experience as a result of the injury. It feels like a big jump from people talking about their experiences to drawing conclusions that particular care is needed. To do this, the paper would need to report data that care is not currently available or that people had failed to access what they needed. The introduction does not set up these points for discussion/conclusion at present. The introduction would need to report existing evidence about short comings in the care for hip fracture patients, both physically (e.g. pain management) and psychosocially (e.g. counselling, social care). I am also unsure that the data supports the assertion that 'This study identified the hidden work undertaken by patients and informal carers' since no evidence is provided that it was hidden. The role of carers is well documented (for example https://www.mdpi.com/2077-0383/9/5/1497/htm). The conclusion in the abstract also needs to be adjusted. If the carers interviewed are not the carers of the patients, this should be reflected on somewhere, perhaps the limitations? The second and third bullet points in the Article Summary strengths and limitations should be reviewed since are not strengths and limitations. There is no mention of a 'framework' elsewhere in the paper. This is a very interesting study and the data is compelling and moving. But overall the paper isn't completely coherent. The introduction needs to set up the message which is supported by the findings. The discussion then needs to be underpinned by what has been reported. It doesn't quite do that yet since it goes beyond the research questions it set out to answer. With further amendment, it will be a very informative and useful contribution to the literature.

VERSION 1 – AUTHOR RESPONSE

Reviewer 1
Point 1 Theoretical constructs. I am not a qualitative expert by any means - so the authors may view my comments as naive or misguided. The authors state that a phenomenological approach was used. Does this need more clarification? As I say, I am not an expert, but my reading is that the authors are following the interpretative (hermeneutic) branch of this approach. This is implied, but not really

discussed, in some of the interpretations which include the researcher’s perceptions and interpretations of phenomena (e.g. indignity, normality of pain). (To be fair, I have just read the protocol paper and this is discussed there, so perhaps it is a question of how much detail to put in)
Response
Thankyou we agree it is always difficult to get the right balance. We have strengthened the methodology with the following.
Phenomenology enabled experience to be explored within participant’s social and cultural contexts in order to illicit what was important to them. Meaning inherent in the participant’s experience was drawn out through a process of interpretation. Interpretation involved reading, listening and reflecting on elements that were of concern to participants whilst being aware of the researchers own positionality, for example role and experience. A full discussion of the methods for this study is provided in the protocol.[14] The methods used were interviews and participant observation.

Point 2 Linked to this, the authors state that the analysis takes into account 'historical, social and cultural contexts' but this doesn't really come through in the interpretation. The current phenomena are described, but with little relation to prior experience, beyond the relatively generic 'independence' or autonomy. As a reader I am left with no feeling of how the individual's prior life experience influenced their current perceptions. Where is the keen gardener? The grandparent? The person barely able to move from their nursing home room?
Response
We agree it would be great to share more about the individual participants. However this paper is a collation of many participants experience, two large data sets and individual detail is therefore less explicit. We tried to convey an essence, such as ‘55 years married’. The social, cultural and historical context was used as a theoretical point to convey experience as what is important to the individual rather than what is of concern to professionals. A different methodology such as a case study approach would probably provide this aspect more clearly. The sentence has been rephrased, see above.

Point 3 PPI (page 5) This section confused me. What did they actually do? 'Resonance... was found' - please can this be expanded or explained.
Response
Thank you, the following has been added to clarify this aspect.
Four PPI partners read the findings, could relate to them and felt that many aspects of their own experience were reflected in the paper. Additional individual perspectives were feeling alone in your own emotional bubble, not realising others have similar feelings.

Point 4 Page 8: again this may be my ignorance, but what does 'Rigour was demonstrated through trustworthiness' mean? (Again, this is explained in the protocol paper, but I'm not sure a single line in this paper is enough).
Response
Thank you, the following has been rephrased to clarify trustworthiness.
Key elements of trustworthiness are that the researchers were immersed in the data, provided a clear audit trail of the research process, and supported the thematic framework with quotes to illustrate the themes. The sample and context has been described to enable transferability of the data. To maintain anonymity participants were allocated a number and letter P for patient and C for informal carer. A copy of their transcript was offered to participants but they declined. Observations were written by the researcher in the form of field notes and include quotes from the patient.

Point 5 I can't see anything about when the study was done in relation to the participants' stay in hospital. The experience of the newly operated vs the rehabilitating vs the about to go home might be very different. It is hard to contextualise this study with other studies of the post-discharge experience.
Response

Thank you, details of the range of time in hospital have been added. Time since injury was 4-19 days (median 9 days). Our analysis demonstrated that the themes were evident across this period with variation of course depending on the individual.

Point 6 This is simply a style / editorial issue but I got slightly lost with the heading and subheadings. Perhaps a table identifying the themes, subthemes etc. might help?
Response
Thank you, the categories have been added to the text and figure 1 created to help the reader follow the findings.

Point 7 It is not my place to recode the data. But (there is always a but) I don't see how 'Patients worried about their partners and how they coped without their practical support.' maps to 'intense activity undertaken by carers... supporting their family member.' (p7)
Response
Thank you. This has been removed.

Point 8 P13: The loss of the ability to walk due to injury and subsequent pain had a devastating impact on patient's everyday life...
This was a study in the acute setting (see comments above) so I'm not sure everyday life is the correct term. The 2-3 weeks of inpatient time is not 'everyday'.
Response
Thank you, everyday life has been removed.

Point 9 Slight bit of semantics - 'enduring' has two meanings - long-lasting and being suffered / experienced / put-up with. Perhaps needs clarification.
Response
Thank you, this is helpful, we have used your term, ‘putting up with’ to clarify this point.

Point 10 I am surprised that the experience of delirium - from patient and carers' perspectives is not visible. Given that it is the second most common complication (after pain) following hip fracture, it is notable by its absence. Although the authors describe data saturation, triangulation with staff might have identified this as a gap.
Response
We agree this is a big issue. Patients and carers used lay terms and talked more about confusion, she doesn’t understand, not thinking right. It is conveyed in the category ‘working with emotions’ with the examples of deterioration and babbling. The patient and carer data was saturated. Including staff experience would have been ideal but we would need more time and funding. This has been noted in the limitations.

Point 11 Was there any attempt at triangulation of described experiences. For instance p11 'nobody's actually told me that yet either'. This is the patient's experience / perception / understanding, but it doesn't mean it is objectively true (I'm not saying whether it was or it wasn't). But surely to understand that phenomenon involves understanding the context - not told, not understood, not wanting to hear?
Response
We agree this a big issue particularly when there is memory loss. The key element from the patient data was that they feel they don’t know what is happening a lot of the time, due to the impact of injury and frailty. In this study we were not looking at the quality of care provided and they may well have been told many times. We have identified that the study could be developed by including staff in the limitations section.

Point 12 References: I am surprised to see no reference to Bruun-Olsen V, Bergland A, Heiberg KE. “I struggle to count my blessings”: recovery after hip fracture from the patients’ perspective. BMC

Geriatr. 2018;18:18. (Nothing to do with me, so not a request for referee citation).
Response
Thank you we agree a useful paper so have added. There are a wealth of papers and we chose the ones that we felt conveyed key developments, drawing where we could on systematic reviews.

Point 13 Funding: A little more transparency about 'Department of Health' funding would be good. Is this from Prof Willett's NHS role or a competitive grant?
Response
Thank you, yes this was not competitive funding and was not linked to Prof Willett's many and varied roles.

Point 14 There was a PPI group involved. Why were they not involved in authorship? Their insights would have been invaluable.
Response
PPI partners were involved in shaping the original research question, identified the importance of inclusion of those with memory loss, took part in two discussions of the findings and helped in crafting the paper. The earlier PPI partners have moved on due to frailty and death. It was felt that as no one was left who had been through the whole of the study, being a co-author was difficult. However one PPI partner who has been involved in the drafting of the paper is very happy to do this, if it is allowed by the editorial team. The PPI section has been developed in light of this comment and that of reviewer 2, point 6.
PPI was through the Oxford led UK Musculoskeletal Trauma group who at the time met regularly with clinical and research staff to discuss research studies. This group were involved in shaping the research question, design of the study and identified the importance of including patients with memory loss. Two PPI partners were involved in two discussions during analysis to reflect on the evolving structure. Four PPI partners read the findings, could relate to them and felt that many aspects of their own experience were reflected in the paper. Additional individual perspectives were feeling alone in your own emotional bubble, not realising others have similar feelings.

Reviewer: 2

Point 1 Introduction
P5 line first paragraph: please provide more context about hip fracture, proportion of older people who get one, impact on the NHS and social care sector, usual treatment and rehabilitation.
Introduction: please explain who is an informal carer and, if reported in the literature, the proportion that are spouse, child, etc Please expand the section explaining the focus of this study. Please provide a fuller justification for exploring the experience of patients and carers while the patient is still in hospital.
Response
This section has been strengthened.
This study explores the experience of patients who have had a hip fracture and their informal carers, a term used to describe supportive and caring relationships with family and friends. This could be a partner, their daughter or son, relative or a friend. In the 2011 Census 5.8 million people provided unpaid care to family or friends.[1] In England, Wales and Northern Ireland the National Hip Fracture Database (NHFD) identified 66,313 people aged 60 or older who experienced a hip fracture in 2018, with a mortality rate of 6.1% up to 30 days after injury.[2] Estimates of 12% mortality at 4 months and 20% at 1 year have been made for those over 80 years of age. Treatment for hip fracture is normally surgery either fixation or arthroplasty [3] and UK health care costs have been estimated to be 2 billion pounds.[4] In addition, there is a significant reduction in ability to walk and Health Related Quality of Life at 1 year compared to preinjury.[3] Increased support for independent living, or a change in living arrangements is evident. In 2018 in England, Wales and Northern Ireland 31% of patients did not return to their original residence.[2]

There is growing evidence of the prolonged burden of recovery from hip fracture and generic evidence of the quality of care for older patients in acute care. However there is limited evidence specifically related to the experience of hip fracture from patient and carer perspectives during early recovery whilst in acute care. Therefore this study aims to provide direction for support and rehabilitation by exploring the research questions, i) what are older people's experiences of hip fracture, including those with memory loss and ii) what are informal carers' experiences of being alongside them whilst they are in acute care.

Point 2 Methods

Ethics: I am afraid I was a bit confused about the staff consent stated in the description of participants since this is not described in the ethics section. I assume that data were being collected from staff since they were part of the patient interaction being observed? Please clarify.

Response

Sorry this is not clear. They were indeed intended as participants and provided consent to take part in the observation. However in reality the pace of work and high level of acuity of other patients made taking part in the study challenging.

This has been strengthened.

In addition, clinical staff caring for the patient provided written informed consent to take part in the observation and identified the patient's mood, activities and when the observation could safely take place. However due to the high level of acuity of other patients and pace of work during the study period staff involvement was limited.

Point 3 Participants: Again my apologies but I found this confusing too. I was unclear who participated in which elements of the study and how they consented. Did only two patients take part in interviews and observations? If so, could you clarify that different people provided interviews and observation data.

Also, please explain the carers who were interviewed linked with the participants – were they their carers or carers for different patients? Were the three patients who declined included in the 36?

I also found this section of the abstract confusing and had hoped the paper would make it clearer, but sadly not!

It would also be helpful to describe the participants more fully. This is often, but not always, done in the results, as characteristics of respondents.

How many couples were interviewed? What was the relationship between carer and patient? Who provided interview data and who provided observational data? Did the observational data include comments by someone else (nurse) about the patient? Length of stay in hospital, stage in their treatment, likely discharge date and plan? As a reader, I want to understand the sample better to help me understand the findings. Perhaps this could be presented in a table so the reader can reconcile the respondent in the findings section with their characteristics.

How were patients and carers recruited? What were the inclusion criteria and selection process?

Response

Sorry this was not clear. A table has been included to improve clarity we hope this helps. Further detail regarding the sample selection has been included.

Table 1 Information about the participants
Characteristics Number of participants
Patients
Sex
Male 10
Female 15
Age (years) median 83, range 63-91
Time since admission for hip fracture (days)
Median 9, range 4-19

Participation in interviews 25
Participation in observation 13
Consented 25
Personal consultee due to lack of capacity 11
Participation in interview and observation 2
Invited but declined to participate 3
Patient and carer dyads 12

Carers
Sex
Male 11
Female 14
Age (years) median 62, range 42-95
Relationship to patient
Husband 4
Wife 1
Daughter 9
Son 6
Other relative 4
Friend 1
Participation in interviews 25

Staff
Consent to be involved in observation 12
A purposive sample of thirty six patients with a hip fracture took part. There were 25 patient interviews and 13 patients took part in 52 hours of participant observation (2 patients chose interviews and observation). Eleven of the 13 patients did not have capacity to consent and personal consultees were obtained. The patient sample aimed to obtain a range of sex, age, and include those without capacity. The carer sample aimed to obtain a range of sex, age and a range of relationships with the patients. Details of the sample are supplied in Table 1, Information about the participants.

Point 4 Interviews: Please provide more detail about the questions asked in the interviews. An interview schedule would be helpful too. Were interviews unstructured after the opening question, except for the prompts? How did the interviewers ensure the interview did provide data to answer the objectives? What happened if people didn’t want to talk or took the conversation into a different area?
Response
Thank you. I understand the need to know more however in this study the questions reflect the aim of the study to gain an understanding of the participant’s experience and what was important to them. Very few questions were needed to illicit participant’s experience. Prompts such as how did you feel, what did you think when that happened were enough to encourage participants to tell us what it was like for them. The interviews were conversation in style and participants could direct the conversation. We find in studies with older people it is important that they have an opportunity to share their lives and feel in control of the conversation hence topics important to them (family, dogs, cats) are also shared.
An additional sentence has been added to help clarity.
Interviews took place on the ward, in a meeting room or ward area. The interviews were conversational in style, often including aspects of daily life to enable participants to feel comfortable and able to tell the researcher what was important to them. For patients the interviews led with the question, tell me about what it is like to have a hip fracture? Informal carers were asked, tell me what it is like caring for your relative/friend with a hip fracture? Prompts were used to enable participants to expand on aspects of their experience such as what did that feel like? What did you think? Tell me more about that?

Point 5 While I note that the methods are reported in detail in the published protocol, it would be helpful for the reader to have some more detail than is provided in this paper. Many of the comments above result from the lack of information available.
Response
Thank you, this links to the points from reviewer 1. The balance is something we struggle with when handling the large amount of data from qualitative findings. Hopefully this balance has been improved with the additional information.

Point 6
Please say more about the people who are part of the UK Musculoskeletal Trauma group and the processes through which they were involved. Did researchers attend their meetings or members come to team meetings? For example, not knowing this makes it difficult to see how they were involved in the analysis as described, which says that analysis was discussed with the team.
Also, how often were they involved? Numbers, experience? Clinical staff are not usually considered as PPI so please justify why you wanted to involve them alongside patients and public members. I can see why but think you should explain this. You may want to be guided by the GRIPP 2 checklist when reporting PPI in this paper.
Response
Thank you, this has been strengthened.
PPI was through the Oxford led UK Musculoskeletal Trauma group who at the time met regularly with clinical and research staff to discuss research studies. This group were involved in shaping the research question, design of the study and identified the importance of including patients with memory loss. Two PPI partners were involved in two discussions during analysis to reflect on the evolving structure. Four PPI partners read the findings, could relate to them and felt that many aspects of their own experience were reflected in the paper. Additional individual perspectives were feeling alone in your own emotional bubble, not realising others have similar feelings.

Point 7 Findings
The findings start with a subheading ‘sharing the journey’ which does not appear to be a theme. If not a theme, why is this heading reported in this way?
Response
Thank you, yes a useful point. Sharing the journey is the overarching concept (collection of ideas) that encompasses the three themes, connecting, uncertainty and change. It is defined in the paper as the work carer’s and patient’s do to remain connected and move forward. It evolved through the process of analysis and through discussion with PPI partners and clinical staff involved in the study. We have found using an overarching concept as a useful way of presenting findings in a cohesive way and have used it regularly in other published studies.

Point 8 The results are very interesting and moving. But I didn’t always find this section easy to follow. It switches tenses and the punctuation is difficult: for example there are some misplaced apostrophes and too many commas which break up the reading flow. I suggest this is looked at to make it easier to read.
Response
Sorry this was not easy, we have changed this, hopefully it is better.

Point 9 It seems that theme 1 is about carers and theme 3 is about patients? Is it the case that the other group in each didn’t talk about anything relating to those themes? If so, this needs to be acknowledged somewhere. The themes feel rather one sided which I would not have expected. If these are all themes equally relevant to both groups, the write-up needs to be more balanced. At the moment, the ‘journey’ as is reported does not appear to be equally shared.
Response

Sorry this was not clear enough. The analysis was built from the data and you are right carer's experience is more evident in connecting and patient's experience more evident in being changed. This has been clarified in the methods.
Carer and patient data contributed to all the themes but carer data led theme i) connecting in order to sustain relationships and patient data led theme iii) being changed.

Point 10 Do the views of carers differ depending on their relationship to the person with a hip fracture? Please comment on this.
Response
We picked up all sorts of family dynamics and agree the nature of caring relationships are complex within the context of dependency and family history. We feel this is a topic for further research with a different methodology. We tried to convey some of the nature of the emotional work required to remain connected but agree it goes way beyond the content of this particular paper.

Point 11 P15 line 49 - why P5a and not P5?
P16 line 35 – why does the quote from P32 say 'she' – doesn't sound like her words.
P16 line 49 – why had patients lived with pain for a long time? How long had they been in hospital? Or does this refer to other pain before their hip fracture?
P17 line 3-8 - this is a quote from P31 yet it is presented as reported. Please make it clear if other people in the scene being observed are being quoted. This can be clarified in the methods.
Response
Thank you this is an error, P5a changed to P5.
Line 16 and 17 The observations are written field notes by the researcher and include what the patients said. This is now highlighted in the methods.
Observations are written by the researcher in the form of field notes and include quotes from the patients.
Pain. This refers to chronic pain from other conditions has been added. Time from admission to interview has been added.

Point 12 Discussion
In the discussion, the authors highlight that the study included patients with memory loss. But there is no mention of memory loss in the interview data as reported, nor does it seem to have a place in the themes. If it was so prevalent, had respondents normalised it and not mentioned it or did these interviews not capture that aspect of patients' situation?
At present, the findings aren't presented in a way which fully supports the statement that findings indicate the need for more clinical attention to mental wellbeing. Nor is there any evidence that the care received was not family/carer centered, since the results do not generally describe care but focus on experience as a result of the injury. It feels like a big jump from people talking about their experiences to drawing conclusions that particular care is needed. To do this, the paper would need to report data that care is not currently available or that people had failed to access what they needed. The introduction does not set up these points for discussion/conclusion at present. The introduction would need to report existing evidence about short comings in the care for hip fracture patients, both physically (e.g. pain management) and psychosocially (e.g. counselling, social care).
I am also unsure that the data supports the assertion that 'This study identified the hidden work undertaken by patients and informal carers' since no evidence is provided that it was hidden. The role of carers is well documented (for example https://www.mdpi.com/2077-0383/9/5/1497/htm). The conclusion in the abstract also needs to be adjusted.
Response
Thank you, the discussion has been rephrased to make this clearer. We agree that the intention was never to identify shortcomings in service provision. Clinical attention has been removed. Thank you for the paper.
The PPI group wanted to include people with memory loss to ensure they were involved and their

experience not excluded just because they could not manage an interview. Hidden has been removed however participants did feel that their contributions were hidden from view and they were often not understood. We will reflect on this as it goes beyond this paper.
The conclusion in the abstract has been rephrased.
Despite these limitations, this study highlights that patients and informal carers may benefit from supportive activities in acute care that: i) sustain opportunities for companionship, ii) enable the processing of emotions as a consequence of injury and iii) facilitate caring interactions in relation to pain and intimate bodily care. To enhance support through this challenging transition understanding gained from participants could be used within strategies such as person centred care, education and communication. Involvement of patients and their family underpins person centred care [23] although this aspect can be inconsistent and families may struggle to acquire it. [10 ,24] Opportunities for human connection through being included, being useful and being part of decisions are evident in partnership working.[25] Education and support may facilitate the identification of, expression and processing of strong emotions allowing families to develop skills to live with change and uncertainty. Helping carers to develop an awareness of the burden of caring [26 ,27] and the importance of self-compassion[28 ,29] may help prevent compassion fatigue. Relationships with multidisciplinary staff, patient and family that are open and responsive to knowledge exchange, valuing carer expertise[10 ,30] may help to identify what matters to them. Caring interactions, good bodily care, pain assessment which is often underestimated by professionals[31] may support older people to self-manage their changed bodies. Being aware that organisational care can compound feelings of insignificance and powerlessness[10 ,32], be misaligned with patients' needs,[32] may help to challenge feelings of inevitability and decline.[33] Negotiating a balance between individual autonomy and dependency on others for help, when injured, is challenging and for informal carers this continues after discharge.[12] However, enabling patients to feel comfortable and in control,[34] appreciative caring conversations,[35] valuing their identity, building relationships and involvement[10] may support their negotiation of this challenging life transition.
Conclusion
This study identified the experience of patients and informal carers in sharing the journey of hip fracture, a challenging life transition epitomised by uncertainty and change. Strategies that support wellbeing and enable successful negotiation of the emotional and practical challenges of acute care may help with longer term recovery. Research should focus on developing interventions that promote wellbeing during this transition to help provide the foundation for patients and carers to live fulfilled lives.

Point 13 If the carers interviewed are not the carers of the patients, this should be reflected on somewhere, perhaps the limitations?
Response
This aspect has been added into the methods. It does not feel like a limitation as data were similar from all the carers/patients whether they were part of a dyad or not.
There were 12 dyads of patients with hip fracture and their carer. This has been added in the text and table 1.

Point 14 The second and third bullet points in the Article Summary strengths and limitations should be reviewed since are not strengths and limitations. There is no mention of a 'framework' elsewhere in the paper.
Response
Thank you. This has been rephrased, see top of page 1.

VERSION 2 – REVIEW

REVIEWER	Iain Moppett

	University of Nottingham, UK The authors now include a PPI member. Although we have never met in person, RG is a co-applicant on grant applications I have made (through his work in the Oxford PPI group, not directly linked to this work).
REVIEW RETURNED	04-Nov-2020

GENERAL COMMENTS	The authors have addressed my previous comments. The paper reads much better - thank you.

REVIEWER	Bridie Angela Evans Swansea University Medical School and PRIME Centre Wales Wales UK
REVIEW RETURNED	25-Nov-2020

GENERAL COMMENTS	Thank you for amending your paper to reflect the feedback received. I have no further comments.