Dear Reviewer 3,

Thank you so much for your time in reviewing this manuscript and for your thoughtful comments. I have copied your comments below, with my responses in red.

Thank you for the opportunity to review this interesting paper. I think this is a subject that is worthy of exploration, and necessary for psychological recovery of burn patients. Overall, I think this paper can be accepted for publication and is well written. Well done so far. I have added my thoughts below about the themes for you all to consider, and to make changes or not following your internal discussion within the team of authors.

Result section:

Overall themes look reasonable. Here are some thoughts to consider about the themes.

3.1.1. Communication between patient and service

missed opportunities:

the quote about being 'just normal for the hospital' (lines 157-8) seems to be that this patient is asking for the need for psych support to be destigmatised

Poor communication:

what does they *'have to go through stress'* actually refer to within the text? Is this about 1) the process of accessing support being stressful or 2) that the patient sees this as a necessary criteria for seeking support?

Thus, are the above two quotes. about communication (3.1.1) or about beliefs (3.1.2)?

Thank you for these comments, both these quotes refer to communication as the first participant felt that psychologists were not 'present' enough on wards, and therefore not part of normal process. The second found communication too stressful as reported waiting for calls. As such, we have left these quotes in communication section, however, we have amended the wording slightly to make this clearer to the reader:

Some participants perceived they would '*have to go through stress'* (P11) to contact the Psychology team due to past experience with ward communication.

Most of the participants described that patients should be made familiar with the Psychology team, *'So that the patient doesn't even think about it. They just think this is normal for the hospital'* (P10).

3.1.4 Fostering hope:

encouraging positivity (lines 305-6) and inner strength (lines 325-340)

These themes/sub-themes reflect the principles of posttraumatic growth after burn – of which hope is an important part.

However, I am not sure about the inclusion of *Clinician Care* as a subtheme under the *Fostering Hope* theme. The interactions of patients with the HCPs are important to foster hope, but also not to create shame (lines 300-302). I feel that perhaps the 'clinician care' subtheme could be more of an overarching theme instead to prioritise their role in psychosocial care. The MDT as a whole could be encouraged to take a more holistic approach to burn recovery, so they can normalise the impact of the burn on mental wellbeing, destigmatise the use of supportive psychosocial services, and encourage patients to access these at all stages of the patients' postburn journey. It can be hard to predict at what stage an individual will need help, therefore specifying a fixed timepoint post-burn to screen patients can easily miss those who require support.

Thank you for this really thoughtful comment. We agree that the role of MDT is integral to normalise and destigmatise psychological services. However, in the context of this data, clinician care subtheme was specific to clinicians facilitating hope through reassurance and empathy. Participants felt that clinician care was important to their level of hope and suggestions were made that using hopeful or reassuring language would improve psychology access. There were not enough codes to make this a full theme in and of itself. As such we felt in this context that it would be helpful to keep this as a subtheme.

Discussion

line 392 – is this a definition of cultural humility? if not please state a definition or, if yes, clarify it is one

Thank you for highlighting, I have changed this sentence to clarify it is a definition:

'Cultural humility' is the process of developing awareness of one's own implicit biases, as well as, of the cultural diversity of others [34].

lines 410-413 these patient characteristics are all aspects of posttraumatic growth after burn – please add comment in text

Thank you, we agree. We have included this in the text:

Most participants reflected on personal characteristics required to cope with their injury, including hope, positive mindset, and inner strength. Such characteristics are in line with the concept of Posttraumatic growth (PTG), which indicates positive psychological change beyond pre-trauma functioning, beliefs, and values [39].

line 414 – emphasises the importance of clinician's care as well – should this be a theme?

Thank you for highlighting, due to the amount of data and the specific nature of which clinician care was discussed, we agreed to keep this as a sub theme.

4.1 Service recommendations and rationale

Table 3

- if the recommendations are based on the literature as well as these study findings then please add references.

Thank you – we have amended the language used

- Resources supplied should be developed with patients so that they address the patients' needs such as the use of language, acceptable layout and presentation, patient stories, quotes and anecdotes.

Very helpful point. We have included this in the text

- Staff education around patient experiences, psychosocial support, how to encourage and motivate patients.

- It reads as thought the recommendations made are all about written materials placed in the vicinity of the patient without personal face-to-face interaction of the clinical psychology team, and without the clinical psychology team being a present and integrated part of the burns MDT. Is it possible for the clinical psychologist to have a physical presence on ward rounds, in the ward, MDT meetings as well as in the outpatient clinic etc?

Unfortunately, as the service is limited in resource, we tried to make the recommendations as feasible as possible. We have therefore tried to include recommendations which facilitate referrals (e.g. designing materials for distribution, psychologists training and supporting MDT staff to screen for distress) without a psychologist always being present. We have now included more information about this in service context:

This project took place within a specialist NHS Burns unit in South-East England. The unit treats adult patients who have experienced burn injury below the level of 40% total body surface area. The multi-disciplinary team (MDT) consists of surgeons, nurses, occupational therapists, physiotherapists, psychologists, and dieticians. Within the Psychology team, there are two part-time Clinical Psychologists and one full-time Assistant Psychologist. In line with National Burns Care Standards (NBCS), the Psychology team aim to screen all inpatients who are admitted for more than 24 hours as soon as clinically appropriate and prior to discharge [BBA; 19]. Across the UK, it is predominantly accepted that screening during a patient's admission should consider the following domains: depression, anxiety, acute stress symptoms, PTSD, distress related to pain or appearance, and, risk of self-harm and suicidality [20]. Patients who are identified as experiencing psychological difficulties during screening, are then offered further psychological assessment with a Clinical Psychologist, and psychological interventions are provided if appropriate. Should screenings highlight manageable levels of distress, patients and their families are provided with the Burns unit contact details and informed they can self-refer for psychological support (e.g., psychological assessment, signposting to relevant services, and/or psychological therapy) at any point following discharge.
In 2021, available data suggests that approximately 127 adult patients were admitted to the ward. The Psychology team received approximately 13 referrals for follow up support via the MDT, 19 via outpatient scar clinics, and 4 self-referrals. The low level of adult self-referrals is interesting as mental-health difficulties are prevalent and enduring following a burn injury[8].

It is unclear how many, and why, patients are not self-referring. Given that untreated psychological distress in this population can influence physical recovery [2], it important to ensure patients have access to appropriate psychological care. Therefore, there is a need to understand patient perspectives of psychological support at the Burn's unit, especially in the context of healthcare received from admission to outpatient rehabilitation support. This will help the Psychology team to make feasible changes to improve patient experience and facilitate access to appropriate care in line with psychological needs.

This is then revisited in the conclusion:

Given service context, it is not feasible for a psychologist to be present in every patient medical appointment. However, if every intervention a patient receives from the point of burn injury 'influences their scar worn for life' then focus must be on ensuring a psychologically informed, empathic workforce[43], [44].

Limitations

please comment about not reaching saturation (unless you did – in which case please state in the methods section)

Agreed, this is now included in methods section.

This study employed phenomenological qualitative methodology to gain an understanding of the lived experiences of burn patients. Thematic analysis was used to identify patterns of meaning in the data [20]. Purposive sampling was used to recruit participants who had previously experienced a burn injury to limit sample heterogeneity. Participants were required to be 18+ years old, not receiving psychological support, and under the care of the Burns team. Patients attending outpatient clinics in the service were screened for eligibility by AC and LM and were contacted via phone to participate. An information sheet and consent form were sent to a participant's email. Recruitment commenced in October 2022 and demonstrated 28% uptake (n= 11/39). To reach saturation, the authors aimed to conduct 9-17 interviews [21]. All participants were required to give verbal or written consent.

Conclusion

Please, add a statement that captures the main themes as being important from a patient perspective.

Thank you, the conclusion states:

This qualitative study aimed to explore the barriers and facilitators to psychological support in a Burns unit from a patient perspective.

We have also included this in discussion: Four main themes highlighted how patients perceive access to Psychology was influenced by patient and service communication, beliefs about mental health, environmental challenges, and fostering patient hope.

Many thanks once again for your comments and taking the time to read our manuscript.