Peer Review File

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Review Comments (Round 1)

Reviewer A

Thank you for this really interesting manuscript. This is an important study that I enjoyed reading, but I have some concerns about the conceptual choices. The choice for the term 'intervention' is not really explained; and the terms compassionate communities, and compassionate cities seem to be used interchangeably. Additionally, there is some confusion if the 'compassionate community principles' is another way of referring to the Compassionate Cities Charter.

Major comments:

Line 56- 73, line 91 p. 2:

Comment 1: I am having some difficulties with the term intervention when speaking of compassionate communities. Many compassionate communities are initiated from a community development approach in which the community develops actions that are in line with their own interests regarding serious illness, dying and loss. Consequently, compassionate communities are maybe more difficult to apply the term intervention to, because they are primarily based on community actions and initiatives. Can the choice for using the term intervention be clarified?

Reply 1: Thank you to Reviewer A for encouraging us to reflect upon and make explicit our assumptions and application of the term 'intervention' and justify its use in the paper.

Changes in the text: Text added p. 4; Line 82-92.

Thank you for taking to heart this comment and providing this clarification for the use of 'intervention'. A minor addition: add reference 12 as one of the examples of reviews that also capture naturally occurring networks of support. (p. 5, Line 80)

Author Response: Here we refer to empirical research that investigated how bereavement/illness/end-of-life is currently experienced by people (i.e., with no intervention) as investigating 'naturally occurring networks of support'. At your suggestion we have re-examined the D'Eer paper, and all the included studies appear to be an intervention rather than an examination into 'how things are'. We therefore have not included the reference as you suggested but have clarified our meaning on Page 4: Line 91 & Page 5: Line 100.

Comment 2: There is a difference between community development on the one hand and community engagement on the other hand. Where compassionate communities are based on the principles of community development, community engagement is primarily used in the

context of organisations wanting to improve their services by involving the community. The latter would be best described as community engagement in palliative care. Especially for the included service interventions and the clinical interventions, there needs to be a clarification on their community development aspect. This can be done by adding a column in Table 2 with how the community is involved in each of the initiatives.

Reply 2: The section identified here has been re-written in response to Reviewer A's comment (below) regarding the compassionate communities / compassionate cities and so it no longer refers to community development/engagement.

However, care has been taken throughout the manuscript to apply the terms 'community development' and 'community engagement' differentially.

We are also grateful for Reviewer A's reflections on the differences between community development and community engagement – it has given us pause for thought not only on the usage in our own paper but rather more broadly within the CC intervention literature.

Thank you for reflecting on the difference between community engagement and community development, which is an added value in regard to this paper. I like the general use of the term community involvement that is here used as an umbrella term to capture both community engagement and development. Is it possible to add one sentence, for instance in the background section, that in this paper the term community involvement comprises both community engagement and development.

Author Response: We struggled to find a natural place for such a sentence in the Background/Introduction section. Instead, we have explicated some of the forms 'community involvement' may take (in the methods section on data charting) to signal it has been used as an umbrella term. See Page 8: Lines 194-195.

As suggested, we have added a column to the main table to address community involvement in the intervention. Because different terms are used, and the same terms are used differentially across studies we elected to use the definitions authors proffer within their paper. We felt that this would avoid a further level of interpretation (i.e., our interpretation) when this is clearly already a contradictory part of the movement that warrants more attention than we can provide here.

Changes in text: Text added, p.10; Line 237-247.

See also additional column in Table 1. Main Findings of Included Studies.

I am grateful for the interesting addition on the various kinds of community involvement.

This may offer inspiration for future interventions on the different levels of community-based participatory research.

Author Response: We once again thank Reviewer A for this suggestion, we likewise agree this has enhanced the contribution of this review.

On P. 23, Line 699-701: Please change the term *the community development model"* to a 'community engagement model/approach'. Since, community engagement is used in relation services and educational interventions. In addition, please change *"community activist model",* to a 'community development approach' because this is I think the appropriate term for the community that is actively involved in an intervention.

Author Response: We used these terms because they are the implementation models outlined by Kellehear in the 'Compassionate Cities' book (Chapter 7; Page 117), but we acknowledge that we had not referenced this/made it sufficiently clear to the reader. We have therefore retained the terms (although we agree they are perhaps not the most sophisticated descriptors for the kind of interventions we have observed/would like to see) but made it clear they are the models outlined by Kellehear rather than our own categories. See Pages 21-22: Lines 520-524.

Line 22, p. 1

Line 56-61, p. 2

Comment 3: Line 115, p. 3: Please provide a clear definition of what is meant with 'the concept of the CC movement as the core factor'.

Reply 3: In response to other reviewer comments (including Reviewer A's comments regarding the application of the Compassionate Cities Charter) we have made changes to this section which also ameliorate this comment.

Changes in the text: Text amended and added p. 6-7; Line 142-152.

p. 8, line 187

"The concept of "compassionate communities" was the primary indicator driving inclusion in this review, specifically, interventions that had been informed by, or inform the CC movement."

Could be added in a short sentence in what way these interventions are informed by the CC movement? (i.e. PC as an indispensable part of society through involvement of local governments, organisations, community groups or people).

Author Response: At your suggestion we have amended the sentence on Page 7: Lines 158-161

Comment 4: Line 85-87: The review states that the is a more explicit focus on compassionate communities than other reviews , because these other reviews focus public health approaches to palliative care more broadly. But then again, the main inclusion criterium is 'papers with a public health approach to death, dying and bereavement'. Please be clearer on the aspect that makes this review different from other compassionate communities reviews.

Reply 4: There was consensus among reviewers that we should dedicate more space to acknowledging the contributions of other reviews in the area and to signal more explicitly how ours adds to this corpus.

We have taken these comments on board.

Changes in the text: Text added p. 4-5; Line 93-114.

Line 225-226, p. :

Comment 5: It seems to me that the concepts ‘compassionate communities’ and ‘compassionate cities’ are used interchangeably throughout the review. A compassionate city is a particular form of a compassionate community. A compassionate community is not necessarily bound by the compassionate city charter or principles. Compassionate communities are based on certain approaches such as a community development approach, a new public health approach in PC, an asset-based approach in the community. In summary, there is rather an idea or philosophy behind compassionate communities, than a listing of principles. Can there be a clarification on the distinctive use between compassionate cities and communities?

Reply 5: We accept that the manuscript insufficiently attended to the differences between compassionate communities and compassionate cities, and perhaps even obfuscated these differences in our application of the terms.

We agree with Reviewer A’s distinction that Compassionate Cities are committed to the Charter and Compassionate Communities are not and have made this clearer in the manuscript.

Changes in the text: Text added p. 3-4; Line 65-79.

Thank you for providing this clear addition to the manuscript. Perhaps ‘buy-in’ (p. 9; Line 391) is not the best word-choice in reference to Compassionate Cities. Please replays this by another word of choice the reflects the meaning (e.g. involvement or facilitation, …).

Author Response: We capitulate to Reviewer A’s comment and have replaced ‘buy-in’ with ‘commitment’ (Page 3: Line 66).

Line 391, p. 9

Comment 6: Additionally, I am a bit confused regarding the use of ‘principles of CC’s’ throughout the article. I think with that you mean the Compassionate City Charter? It does not seem to be an inclusion criterium, but than again in the results section there is reference to the charter. Can you provide clarification on what is the place of the Compassionate City Charter in this review?

Reply 6: Again, we thank Reviewer A for encouraging us to think more deeply about the language we have used.

The Compassionate City Charter did not guide inclusion/exclusion in this review (which we have now clarified in the manuscript).

We have replaced the word ‘principles’, which we accept could be conflated with the Charter, with ‘ethos’.

Changes in the text: Text added, p.7; Line 162-163.

Line 80, p. 2

Line 484 p. 10

Comment 7: I miss some sort of reflection on the fact that the lack of interventions and methodological paucity is also an inherent part of compassionate communities. Some of the compassionate communities are initiated purely from community interests, without any methodological or theoretical background. Because of the unpredictable aspect related to community development character, these actions are also more difficult to capture in a research protocol or intervention.

Reply 7: We thank Reviewer A for sharing this perspective and we certainly hold space that interventions initiated from community interests may not present their programmes in a way that we have come to expect in scientific journals.

Nevertheless, we argue that research of all kinds can, and should, be reported transparently.

Changes in the text: Text added, p. 22; Line 536-539.

Thank you for this valuable addition to the manuscript.

Minor comments:

Comment 8: Line 22, p. 1: I am missing something here: an emergent health promotion approach to palliative care that …. Please provide some clarification on what a compassionate community aims to do.

Reply 8: We were perhaps too effusive in our efforts to be succinct here!

As you suggest, we have added clarification on what CC aims to do.

Changes in text: Text added, p. 1; Line 22-24.

Line 23, p. 1:

Comment 9: What is meant with the evidence? The intervention efficacy? Maybe clarify this by stating the evidence in terms of e.g. efficacy, impact,…?

Reply 9: Likewise, we had used evidence here as a catch-all term to conserve words.

As you suggest, we have clarified specifically what we synthesised in the review.

Changes in text: Text added, p. 1; Line 26.

Line 103, p. 3:

Comment 10: What is meant with the extent and range? Needs some further clarification.

Reply 10: The phrase "extent, range, and nature" is used ubiquitously within the scoping review literature, and we have applied it here uncritically. We are therefore grateful to Reviewer A for surfacing this and encouraging us to reflect more deeply on this research aim.

Changes in text: We have amended the text on p.6; Line 144.

- Line 188, p. 5

Comment 11: Ingredients is a non-scientific term: what is the focus/aim of these interventions? What are their core components?

Reply 11: We acquiesce that 'ingredients' is a non-scientific time and have amended.

Changes in text: We have amended the text on p.6; Line 145.

Line 108, p. 3

Comment 12: Was there a time-limit on the search? In the abstract is mentioned that compassionate communities emerged in the last decade. Is this a search limitation as well?

Reply 12: No time-limits were applied to the search, and we have now been more explicit in the text.

Changes in text: We have added a sentence on p.7; Line 152-153.

Line 189-190, p. 5

Comment 13: It is more an interpretation than a result, and can therefore be moved to the discussion part.

Reply 13: The idea that the taxonomy should not be viewed as discrete categories stems from the developers (Clark et al, 2017) – an interpretation that we agree with.

Rather than move this sentence to the discussion, we have adapted the sentence to be more explicit.

Changes in text: Text amended, p.11-12; Line 272-274.

Line 115, p. 3

Line 225-226, p. 5

Comment 14: Is the CC movement here the compassionate city or the compassionate community movement? Please clarify. Education is a core element of the compassionate city (as explicitly mentioned on the charter), and can be chosen as a focus within compassionate communities as well, although it is not a necessity.

Reply 14: Upon reflection we were dissatisfied with the flow of this section of the review. We have therefore streamlined the arguments made which resulted in the exclusion of the sentence identified here by Reviewer A.

Changes in text: Text edited and removed, p.13; Line 303-319.

Line 384-388, p.9

Comment 15: This is an interesting reflection, but is perhaps better placed in the discussion section, hence it is an interpretation rather than a result. Can be included in the beginning of paragraph 2.

Reply 15: At Reviewer A's suggestion we attempted to adapt this reflection into paragraph 2 of the discussion. However, we felt that it did not really belong there and disrupted the flow

of what we were trying to communicate in that section. Instead, it has been moved to the conclusion.

Changes in text: Text added, p. 23; Line 561-566.

Reviewer B

It is well written and addresses a rapidly emerging topic in palliative care. I have recommended some major revisions but unless my questions with the methodology are difficult to address, these revisions should be fairly straightforward.

Comment 16: Background to the study: This was well written and informative. I don't think you necessarily have to defend why this scoping review was necessary. You are mapping the landscape which is different than what some of the others did. So, I would simply give a nod to the good work being done in other reviews and be more explicit about the methodological advantages of a scoping review in emerging concepts. You also need to differentiate between the Compassionate Community and Public Health Movement if you are making a claim that your review is different than those that focused on public health.

Reply 16: There was consensus among reviewers that we should dedicate more space to acknowledging the contributions of other reviews in the area and to signal more explicitly how ours adds to this corpus.

We have taken these comments on board.

Changes in text: Text added p. 4-5; Line 93-114.

Comment 17: Methods: I am a bit confused by the search strategy and how many records were screened. These numbers are different throughout the manuscript and I think it is because so many were found outside of data bases? Which raises the question of why that happened? Were there perhaps some difficulties in how the search terms were applied? This could be resolved by explaining in more detail the two branches of the search that you show in the PRISMA diagram. This will help the reader to have more confidence in your findings. You may also want to say a bit more about your inclusion and exclusion criteria. I assume that these were all studies but I am not sure how you would determine that if there were no methods outlined? Perhaps explain how you chose to include or exclude what you found. I am making the assumption that you included all interventions whether they were evaluated or not?

Reply 17: We acknowledge that there were omissions in how we first presented the screening results of the review - this was merely an effort to keep within the word limit as the flow chart outlined the process in more depth.

We do however echo Reviewer B's position that this may be confusing for the reader, and we have therefore expanded our in-text screening process.

Changes in text: Added text p. 9; Line 205-217.

Comment 18: Findings: These were well written and organized. The use of the taxonomy was helpful but at the end of the day I was still not sure about what these interventions were? A statement is made near the end that 62 interventions were found but it seems that many of these were actually quite similar. So I think you mean 62 empirical papers but they probably represent less actual interventions? One way to fix this might be to modify your tables. With the two tables split it was almost impossible to understand a particular intervention without going back and forth between the tables – which was quite awkward. I think the two tables could be combined by deleting some of the less pertinent information that the reader can look up on their own if they are interested. In my opinion the most important categories were: context, sample, intervention and findings. Also, sometimes the intervention was explained more clearly than at other times. I would devote space to describing each intervention well because it forms the essence of your paper. You may also want to arrange this table under your findings categories rather than alphabetically. The reader can then look at all the studies that do a particular thing (e.g., education, use of volunteers) together. I think this will make it easier for the reader to understand the scope of what is being done. Also, I saw some highlighting in the table using different colors. I was not sure what this signified?

Reply 18: We were cognisant of the size and number of tables we had included and were concerned about their readability. We are therefore grateful to Reviewer B for their comments and recommendations to streamline the tables and in so doing present our findings more succinctly and effectively.

Your assumption that the 62 included studies do not translate to 62 unique interventions was correct. In an effort to make this clearer we have added a short section in the results section in addition to your suggestions regarding the tables (more detail below).

In response to your specific recommendations:

1. We have merged the two findings tables as you suggest – removing some of the columns (e.g., methods for data collection and analysis, country of origin) and instead articulating these findings in the text as recommended by Reviewer C (see below).
2. We agree that some interventions are expressed more clearly than others – this in part is due to insufficient detail in the included articles, but we have reviewed and expanded the details wherever possible.
3. At your suggestion, we have reorganised the table thematically.

Apologies that the submitted table(s) contained highlighting; this was an error and has since been removed.

Changes in text: Text added p. 9-10; Line 220-225 to clarify that the 62 included studies do not translate to 62 unique interventions.

We have also radically changed our results tables – Tables 2 (profile) and 4 (main findings) have been merged to form a new table (named Table 1).

Comment 19: Nice work. As I mentioned previously, I think this makes an important contribution.

Reply 19: Thank you very much, we appreciate this.

Reviewer C

In this manuscript, the researchers present a thorough scoping review of the current state of the compassionate communities movement. While the manuscript describes the evolution of the CC concept and its current and diverse applicability, there are a few suggestions I would like the authors to address before it is accepted for publication.

Comment 20. Introduction, first paragraph, lines 42 to 55:

While end-of-life care is part of the compassionate communities approach (and palliative care), it is not its sole focus. Palliative care is a field that has evolved dramatically in the last couple of decades. Part of this evolution includes expanding beyond the end-of-life phase and offering palliative care throughout the disease trajectory (in some cases throughout the life span, i.e. pediatric palliative care). People who live with life-limiting conditions benefit from a palliative care approach way before their end-of-life. As you highlight, Kellehear's point: "living with a life-threatening illness"(although the preferred terminology is life-limiting) means that people continue to do life while being sick. They would immensely benefit from the CC movement where the care provided happens while the patients are alive, during death and continue beyond the end with grief and bereavement support. I suggest the authors consider using a broader inclusion of who the CC movement helps by not limiting the definition of CC and palliative care to end-of-life exclusively. Kellehear was the first to describe the CC idea, emphasizing End-of-Life. However the CC idea has been expanded since (see Tompkins 2018. doi:10.21037/apm.2018.03.16 and Mills 2019. DOI: 10.12968/ijpn.2019.25.3.107).

Reply 20: Thank you bringing this nuance to the fore – we are in complete agreement.

We accept that we did not do justice to the expansion of the definition and remit of palliative care in our original piece – compounded by poor word choice in our introductory sentence (i.e., end-of-life care) – although as you note, we did acknowledge, in part, this trajectory.

We have taken more care in our word choices throughout the manuscript and made more explicit reference to the expansion of our understanding of palliative care and its implication for CC.

Changes in text: Text edited p. 3; Line 45

Text added p. 3; Line 60-63.

Comment 21. Methods, first paragraph, lines 95 to 100:

Traditionally, scoping and systematic reviews use Table 1 to describe the included studies (currently as Table 2). While the information in table 1 is helpful, it is not essential to the manuscript's purpose. I suggest moving table 1 to the supplementary data, which those interested can still access and using the current Table 2 as Table 1.

Reply 21: Thank you for this suggestion.

Changes in text: We have edited the sentence on p.6; Line 141 to signpost the reader to the supplementary file rather than an in-document table.

Comment 22. Results, first paragraph, lines 157 to 164:

The abstract mentions that 1882 records were screened, yet the results mention that only 310 titles were found on the search. It is only when you see the PRISMA flowchart and add the numbers that the 1882 number makes sense. I suggest the authors mention in the results section where the other 1572 records were screened from. Otherwise, it creates a discrepancy at first glance, and readers might be confused by how the data is currently being presented.

Reply 22: We acknowledge that there were omissions in how we first presented the screening results of the review - this was merely an effort to keep within the word limit as the flow chart outlined the process in more depth.

We do however echo Review C's position that this may be confusing for the reader, and we have therefore expanded our in-text screening process.

Changes in text: Added text p. 9; Line 205-217.

Comment 23. Results lines 166 to 183:

Please add references to this paragraph to identify the studies with the mentioned characteristics, mainly if this information is not included in the table.

Reply 23: We had included references in this section in an earlier iteration of the manuscript, but we were concerned that long chains of references would be difficult to read and so omitted them.

However, at your request we have added the references.

Changes in text: References added throughout p.9-12; Line 220-265

Comment 24. Results, lines 186 to 194:

Table 3 should also be sent to the supplements. The article is long enough, and the focus should be on the Tables that offer the results of your review. Interested readers would still have access to this information if needed.

Reply 24: We have implemented this as suggested.

Changes in text: text amended, p. 11; Line 271

Comment 25. Results lines 348 to 350 and Discussion, lines 457 and 460:

It is still very common in many centres that referrals to PC happen until the patient is actively dying (they are called in very late in the patient's trajectory). This limits the time and interventions that PC providers can offer. The authors might consider adding to the discussion that CC programs might experience a low referral due to the late recognition of the end-of-life phase by non-palliative care physicians, precluding CC services from being offered in time. A solution to this problem and a suggestion for future CC studies/programs is that they might receive a more considerable uptake when CC services are provided before the end-of-life phase,

and the transition becomes seamless. Aligning with the goal of PC where people are familiar with the team, philosophy and resources before the active end-of-life makes it less work in the transition or the start of new programs.

Reply 25: This is an interesting point and the study by Abel & Townsend identified this as a possible barrier to intervention efficacy.

The concern with referrals is most acute within what we have categorised here as 'service interventions'. These are often delivered by palliative care organisations or in collaboration with primary care. As such they tended to have quite generous eligibility criteria - for example in Abel et al's study the criteria was any GP patient giving "cause for concern" – and so perhaps late referral in this context is less salient? As more CC publications reflect their experiences of implementing their programme it will be interesting to see whether this problem is more widely endorsed.

Changes in text: Text added, p. 17; Line 414-416.

Comment 26. Discussion lines 496 to 498

It was unclear from the methods section that a single researcher did the review. While this is acknowledged in the limitations section, it should be added to the methodology section.

Reply 26: Thank you for bringing this to our attention, this omission was an oversight.

Changes in text: p.6; Line 136

Comment 27. Conclusion lines 511 to 513:

Improving the quality of life for people with a life-limiting illness is a common goal CC has with PC. I suggest the authors emphasize how these two philosophies can work together to help patients and families during illness trajectories, at the end of life and beyond death.

Reply 27: We have incorporated this recommendation as suggested.

Changes in text: Text added p. 23; Line 562-567.

Reviewer D

Comment 28: I have no problems with the careful and systematic way in which the review itself has been conducted, but remain unconvinced about the utility or application of the findings. The review appears to be designed to be a study of taxonomy – identifying articles that make explicit use of compassionate community/communities terminology. But in practice this does not capture all the interventions that adopt or are informed by compassionate communities approaches. Thus I am concerned not so much about what this scoping review has identified as what has not come into scope.

Speaking as someone who works in the field of community engagement in end-of-life care (even before compassionate communities terminology became more prominent), this review has failed to locate a number of seminal articles in the compassionate communities field, including all of the Calicut Centre of Excellence material (Kumar et al), most of the Western

Sydney University social networks material (Horsfield et al), Libby Sallnow's Good Neighbours project, and more. (These articles do appear in other reviews cited here, Quintiens et al in particular). A review of compassionate community (CC) interventions that misses these studies is not adequate to serve as an introduction to or overview of the field. Conversely, the scoping review does capture some interventions that are only casually related to a compassionate communities approach, but appear in the review because for some reason the authors chose to use CC as a key word.

Reply 28: We are grateful for Reviewer D's time and consideration of our manuscript. We respect that they remain unconvinced of the utility of this research and as they offer us no concrete ways to respond or improve the submission, we have not implemented any changes to this comment directly. We are hopeful that the improvement undertaken in response to other reviewer comments goes some way to ameliorating Reviewer D's concerns.

Comment 29: The introduction to this article acknowledges other reviews already published and suggests how this scoping review might complement them. I think the discussion and conclusion needs to return to this claim and spell out in some detail how these findings complement those of these other reviews. Without such discussion I struggle to identify the contribution being made here. While some limitations have been noted, a key issue that remains to be addressed is how this review relates to other reviews, such as Quintiens et al, that scope the conceptual approach of compassionate communities, not just the term 'compassionate communities'. That is, as I've already said, searching the terms "compassionate community/ communities" seems to me an enquiry into taxonomy more than a review of practice driven by a compassionate communities approach. I think it essential to address this in the discussion and conclusions of this article, indicating how this particular scoping review contributes to the field, taking into account that in practice 'compassionate communities' is not necessarily a preferred term for people carrying out community engagement in end-of-life care (presumably the major reason why this review misses so many articles/ interventions that are key resources in the field).

Reply 29: There was consensus among reviewers that we should dedicate more space to acknowledging the contributions of other reviews in the area and to signal more explicitly how ours adds to this corpus.

We have taken these comments on board.

Changes in text: Text added p. 4-5; Line 93-114.

I'd offer two further comments for consideration.

Comment 30: First, why not hand-search Palliative Care and Social Practice? This is after all the home journal for public health palliative care international network. It is, with due respect to the editors of APM, a more likely source of further relevant material than the three journals nominated for hand searching.

Reply 30: Unfortunately, finite resources precluded hand-searching all potentially relevant journals. The journals selected were most frequently endorsed by the articles identified through

our search, as we justify in the manuscript. If it is warranted perhaps future researchers can search PCSP.

Changes in the text: None.

Comment 31: Second, I wonder why the original terminology used by Kellehear, compassionate city/cities, was not included in the scoping search. This term captures not only material from the public health palliative care (PHPC) literature but also from the Karen Armstrong Charter for Compassion movement. This latter source is more likely to contribute to grey literature, but it is an influence, along with the compassionate care movement, in the wider use of compassion terminology in recent years.

Reply 31: In hindsight our review would perhaps have been stronger if we had included compassionate city/cities as a search term. Our primary explanation / justification for not doing so is that our engagement with the literature during the early phase of searching indicated that compassionate communities had become the preferred term to describe more localised interventions that were not bound by the charter which is where our interest lay. Since performing the review, and after reflecting upon reviewer comments, it seems that 'compassionate communities' has become a shorthand for aligning with Kellehear's approach irrespective of whether the intervention is a compassionate community or a compassionate city (as evidenced in the volume of 'multi-dimensional interventions' included in this review).

Changes in the text: None.

Review Comments (Round 2)

Reviewer A

Thank you for taking to heart the comments, providing the space in this manuscript to reflect on the difference between Compassionate Cities and Communities, and for including the different kinds of community involvement in the interventions.

The latter is a much-added value in regard to Compassionate Community initiatives and interventions which often reflect on how to mobilise the community around the topics of illness, dying and loss. I added some minor suggestions in red that, if you agree, would further optimise the manuscript before publication.

I have still some minor suggestions (see attachment) that I think would further optimise the manuscript before publication.

Author Reply: We would like to thank Reviewer A once again for their thoughtful and constructive feedback on our manuscript. We have provided specific responses to their additional suggestions on the other document provided.

Reviewer B

I do have some concerns about the way in which this review was conducted. Very few articles were identified through data-base searching whereas Author large numbers of articles were found through reference checking. This often indicates that there were problems with the original search strategy. Further, the authors chose to include book chapters but there was no systematic method of searching for book chapters. So although the findings are interesting, I am concerned that relevant and important articles may have been missed. I understand that this is not a systematic review in the traditional sense but I do think that even scoping reviews should have a fairly rigorous method of locating sources. In this case there was too much reliance upon what other authors chose to cite rather than what was actually available.

Author Reply: We would like to thank Reviewer B for once again taking the time to review our manuscript. We have learned a great deal from all of the reviewers, and the revisions based on their comments have, in our view, enhanced the quality of the manuscript. Additionally, this process will invariably improve our future research, and in particular how we conduct and report scoping reviews.

We accept that expanding our original search terms may have yielded additional papers (a limitation we acknowledge on Page 23: Lines 557-559), however we disagree that our database search identified "very few articles" as Reviewer B suggests. We also contest Reviewer B's assertion that the volume of papers identified through hand searching is indicative of "problems with the original search strategy". Unlike many published scoping review studies (including those published in APM: doi: 10.21037/apm.2017.06.13 / doi: 10.21037/apm.2018.07.03) we not only performed comprehensive and rigorous hand searches (of key journals, and reference lists and citations of included papers), but we reported their contribution to the review transparently. We therefore agree with Reviewer B that while Scoping Reviews have different aims and procedures to Systematic Reviews they nevertheless need to perform and present robust methods.

In saying that, we capitulate to Reviewer B's concerns over the book chapters we included in the review. The book (Kellehear's 'Case Studies from Britain and Europe') was identified in the original search as opposed to have been purposively selected by us. We accept that by locating the book under "identification of studies via other methods" (a product of our iterative approach to conducting the scoping review) the provenance of this citation was obscured and Reviewer B's critique justifiable. We have made explicit that this book was identified through the original search on Page 9: Line 215.

Reviewer C

The major amendments made to the article cover most of the concerns I had with the initial submission. In particular the work done to clarify the relationship of this review with other published reviews makes its contribution clearer and improves its utility for the field.

I still have some reservations about the simple distinction (pp 3-4) that compassionate cities are committed to the Kellehear charter and compassionate communities are not. There is also a literature on compassionate cities/communities that comes out of the Karen Armstrong Charter for Compassion and even more widely the compassionate care movement. Admittedly literature from the Armstrong charter is more often found in leadership and planning journals but it does intersect healthcare at times. Without going through all articles scoped I can't tell if there are interventions that come from outside the Kellehear stable, as it were. But I think there needs to be acknowledgment that scoping 'compassionate community' may identify articles from outside the public health palliative care 'tradition'.

Author Reply:

We are grateful for Reviewer C's continued engagement with our manuscript. We are gratified that our revisions have ameliorated most of the concerns they had with our initial submission and thank them for their previous comments which certainly improved the quality of our manuscript.

We accept that there is literature on compassionate communities/cities outside the "Kellehear stable" but this literature was not the focus of this scoping review, as we explicate on Pages 5-6: Lines 117-123.