1. Use mixed methods to establish local need, consult with user groups and professionals, and to model the service, and pilot measures;
2. Consider a fast track design, where those refusing the trial receive the control arm as default;
3. Train staff within the service, and researchers/interviewers in the need for the trial, data collection tools, interviewing;
4. Publicise the service widely throughout the operation, with local training to raise awareness and prompt referral;
5. Agree referral criteria and definitions of “Urgent” and review appropriateness of referrals during trial.
6. Separate the clinical team and staff delivering the intervention from any possible contact with the control arm, or possible access to their records.
7. Employ sufficient interviewers to be able to manage a sudden influx of referrals and train, supervise and monitor these carefully;
8. Use experienced independent consultants in palliative medicine to screen referrals;
9. Be cautious about allowing suggested ‘urgent’ referrals to directly receive the service outside of the trial, and when this attempt to recruit them and collect data
10. Conduct home interviews, and allow for travel time; if necessary with a break
11. Develop effective systems to monitor interviews and missing data carefully, and intervene early if this is apparent;
12. Work in close collaboration with user groups and other clinical experts – e.g. in our case with neurology and rehabilitation staff.