Question	Findings	Evidence	Suggestions for improvement
1. Did the feasibility/pilot study allow a sample size calculation for the main trial?	Sample size of 131 patients per group indicated for main trial.	See Sample Size for main trial	Use longitudinal data for primary outcome.
2. What factors influenced eligibility and what proportion of those approached were eligible?	Clear eligibility criteria enabled prescreening using clinical records. Large number of patients were excluded because they were not currently receiving MDC care. Fewer patients excluded on clinical grounds. Including atypical MND and patients without their carer increased eligibility.	CONSORT diagram and Table 1.	Maintain low burden intervention and study methods and continue to use a broad and pragmatic inclusion criteria that can be applied at pre-screening using notes/clinical database.
3. Was recruitment successful?	Achieved target but took longer than expected due initially to study resources and later due to availability of eligible patients. Patient response rates to invitation good. Participants reflected a published cohort of Sheffield MDC patients, those with severe disabilities and those with little experience using technology.	Target of 40 patients and 37 carers achieved in 13 months. 28 existing patients and 12 newly diagnosed patients were recruited. 42/90 patients interested in participating. See Table 1.	Use face-to-face invitations and use registries to identify more eligible patients in other participating centres.
4. Did eligible participants consent?	Good conversion to consent facilitated by good participant motivation and low study burden.	All eligible participants indicating an interest in the trial were recruited	Maintain good information in the patient invitation processes and participant literature.
5. Were participants successfully randomized and did randomization yield equality in groups?	All patients randomised on the day of recruitment and all received the allocated treatment on the same day except one patient who received it three days later.	Characteristics of groups appeared broadly similar.	
6. Were blinding procedures adequate?	Blinding not possible but follow-up data was collected without the involvement of the study team.	Patient interviews.	
7. Did participants adhere to the intervention?	Good participant adherence. Fewer actions taken by telehealth nurse than expected. See parallel publication.	14 (70%) patients completed a TiM session, on average, fortnightly. 13 (70%) carers completed a TiM session at least three weekly.	Further research to promote the use of the TiM system by staff in different clinical settings.
8. Was the intervention acceptable to the participants?	Intervention acceptable to patients, carers and staff. Main findings described parallel publication. Withdrawal rate low.	See parallel publication. Two patients withdrew.	Further research is required to assess the acceptability of the TiM system by staff in different clinical settings.
9. Was it possible to calculate intervention costs?	Telehealth nurse time was not assessed: diaries unfeasible. Assessment of health economic data limited, see text.	Telehealth nurse time was not assessed: diaries unfeasible.	Automatic assessment of TiM system use collected by the TiM software.

10. Were outcome assessments completed?	PROMs return was good in both treatment arms. Pre-clinic shadow monitoring was not feasible (see text for reasons). Some clinic shadow monitoring forms completed, but it was not clear how many were missed due to lack of records.	Participant questionnaires completed: 6 months 80% patient and 82% carer, 12 months 71% patient, 67% carer. 0 pre-clinic shadow monitoring forms and 38 clinic shadow monitoring forms collected.	Fund administration and clinician time to collect clinical outcomes.
11. Were outcomes measured those that were the most appropriate outcomes?	The MND specific ALSAQ-40 was the preferred QoL measure and captured a trend towards deterioration in the physical QoL of patients during the trial. RAND-36 was less acceptable with more missing data. Collecting informal carer hour requirements using patient estimation was not successful. Health and social care resource use varied widely and did not appear to be related to quality of care. Hospital admissions rates low.	Incomplete questionnaires: RAND-36 2%, ALSAQ-40 0%, HADS 0%, ZBI 0% number of carer hours required 9%. Interview data highlighting participants' preference for the ALSAQ-40, ZBI, HADS. Range of healthcare episodes was very high: 0-120 in three months. 4 emergency MND related admissions.	Continue postal questionnaires and offer participants support to complete outcomes at baseline. Use outcome measures that best reflect participant experiences (ALSAQ-40, ZBI, HADS) and do not measure carer hours using simple recall. Examine whether TiM delivered non-inferior care and/or improves access to MDC care, which is known to improve outcomes.
12. Was retention to the study good?	Dropout was low.	2/40 patients withdrew due to ill health. No loss to follow-up.	
13. Were the logistics of running a multicenter trial assessed?	N/A	N/A	N/A
14. Did all components of the protocol work together?	Components had strong synergy except the components using quantitative outcomes to capture clinician experiences and activities due to lack of administrative time and potential burden on clinical staff.	All those recruited were randomised, received the allocated treatment arm and a good level of data completion. Completion of the Shadow Monitoring forms & Telehealth Nurse diaries was poor.	Use automated systems and qualitative methodologies to capture clinician data.