National Institute for Health and Care Excellence

Draft for consultation

Stroke rehabilitation in adults (update)

[A] Evidence reviews for early supported discharge

NICE guideline GID-NG10175

Evidence reviews underpinning recommendations 1.1.8 to 1.1.11 in the NICE guideline

April 2023

Draft for Consultation

These evidence reviews were developed by the Guideline Development Team at NICE

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Appendices

Appendix F – Forest plots (effectiveness evidence)

F.1 All studies analysed together

Figure 1: Mortality at the end of scheduled follow-up

	Early supported discharge		Usual care			Risk Ratio	Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Adelaide 2000	2	42	0	44	0.5%	5.23 [0.26, 105.89]	
Adelaide 2016	2	31	0	32	0.5%	5.16 [0.26, 103.27]	
Akershus 1998	20	124	12	127	12.1%	1.71 [0.87, 3.34]	
ATTEND pilot 2015	13	50	7	54	6.8%	2.01 [0.87, 4.62]	
Aveiro 2016	2	95	1	95	1.0%	2.00 [0.18, 21.69]	
Bangkok 2002	1	52	0	50	0.5%	2.89 [0.12, 69.24]	
Belfast 2004	1	59	3	54	3.2%	0.31 [0.03, 2.85]	
CARE4STROKE 2019	0	32	1	29	1.6%	0.30 [0.01, 7.16]	
Copenhagen 2009	0	50	3	50	3.6%	0.14 [0.01, 2.70]	
Gothenburg 2019	1	69	1	71	1.0%	1.03 [0.07, 16.13]	
London 1997	26	167	34	164	34.9%	0.75 [0.47, 1.19]	
Manchester 2001	1	12	2	11	2.1%	0.46 [0.05, 4.38]	
Montreal 2000	2	58	0	56	0.5%	4.83 [0.24, 98.44]	
Newcastle 1997	2	46	4	46	4.1%	0.50 [0.10, 2.60]	
Oslo 2000	2	42	4	40	4.2%	0.48 [0.09, 2.46]	
Stockholm 1998	1	42	3	40	3.1%	0.32 [0.03, 2.93]	
Trondheim 2000	13	160	15	160	15.3%	0.87 [0.43, 1.76]	
Trondheim 2004	8	31	5	31	5.1%	1.60 [0.59, 4.35]	
Total (95% CI)		**1162**		**1154**	**100.0%**	**1.02 [0.79, 1.32]**	
Total events	97		95				

Heterogeneity: Chi² = 17.94, df = 17 (P = 0.39); I² = 5%

Test for overall effect: Z = 0.15 (P = 0.88)

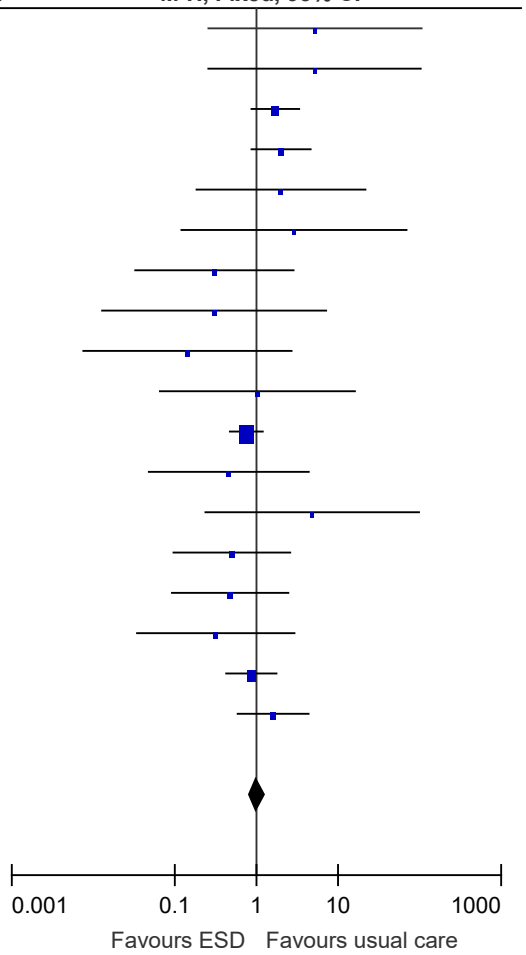

Figure 2: Person/participant generic health-related quality of life (EuroQol, 0-100, higher values are better, final value) at end of scheduled follow-up

	Early supported discharge			Usual care			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Belfast 2004	66.36	18.45	59	68.21	20.31	54	-1.85 [-9.03, 5.33]	

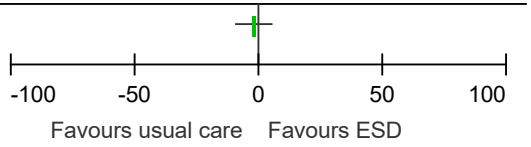

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Figure 3: Person/participant generic health-related quality of life (SF-36 physical component summary, 0-100, higher values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Adelaide 2000	47.4	10	42	41.6	10.6	44	34.5%	5.80 [1.45, 10.15]	
Akershus 1998	48	19	124	47	20	127	28.1%	1.00 [-3.83, 5.83]	
Montreal 2000	42.9	10.1	51	37.9	10.6	44	37.4%	5.00 [0.82, 9.18]	
Total (95% CI)			**217**			**215**	**100.0%**	**4.15 [1.59, 6.71]**	

Heterogeneity: Chi² = 2.35, df = 2 (P = 0.31); I² = 15%

Test for overall effect: Z = 3.18 (P = 0.001)

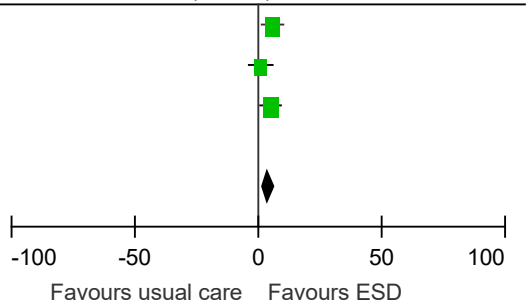

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Figure 4: Person/participant generic health-related quality of life (SF-36 mental component summary, 0-100, higher values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
Adelaide 2000	46.7	11.3	42	52.3	7.8	44	37.3%	-5.60 [-9.72, -1.48]
Akershus 1998	70	17	124	70	19	127	31.9%	0.00 [-4.46, 4.46]
Montreal 2000	46.5	11.7	51	46.7	10.8	44	30.9%	-0.20 [-4.73, 4.33]
Total (95% CI)			**217**			**215**	**100.0%**	**-2.15 [-4.66, 0.37]**

Heterogeneity: Chi² = 4.30, df = 2 (P = 0.12); I² = 53%

Test for overall effect: Z = 1.67 (P = 0.09)

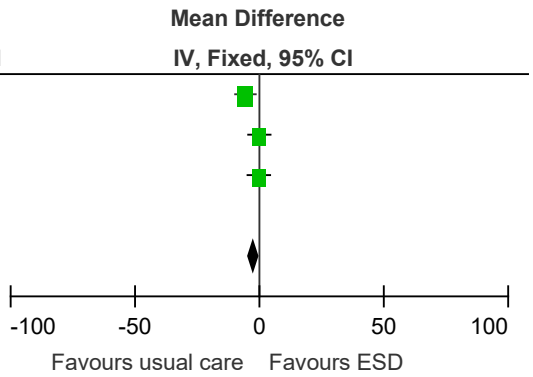

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Figure 5: Carer generic health-related quality of life (carer QoL [different scale ranges], higher values are better, final values) at end of scheduled follow-up

			Early supported discharge	Usual care		Std. Mean Difference
Study or Subgroup	**Std. Mean Difference**	**SE**	**Total**	**Total**	**Weight**	**IV, Fixed, 95% CI**
Adelaide 2016	-0.1084	0.2522	31	32	51.0%	-0.11 [-0.60, 0.39]
CARE4STROKE 2019	-0.2076	0.2571	32	29	49.0%	-0.21 [-0.71, 0.30]
Total (95% CI)			**63**	**61**	**100.0%**	**-0.16 [-0.51, 0.20]**

Heterogeneity: Chi² = 0.08, df = 1 (P = 0.78); I² = 0%

Test for overall effect: Z = 0.87 (P = 0.38)

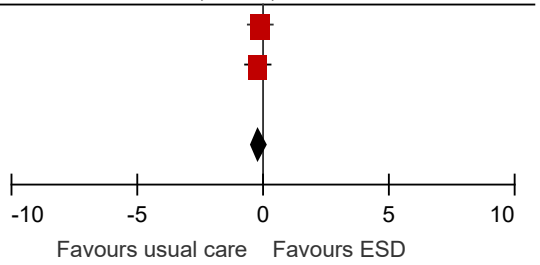

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Figure 6: Physical dependency at the end of scheduled follow-up

	Early supported discharge		Usual care			Risk Ratio	Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Adelaide 2000	13	42	16	44	3.3%	0.85 [0.47, 1.55]	
Akershus 1998	23	92	16	108	3.1%	1.69 [0.95, 3.00]	
ATTEND pilot 2015	25	50	30	54	6.0%	0.90 [0.62, 1.30]	
Aveiro 2016	2	95	5	95	1.0%	0.40 [0.08, 2.01]	
Bangkok 2002	9	52	11	50	2.3%	0.79 [0.36, 1.73]	
Belfast 2004	29	59	32	54	7.0%	0.83 [0.59, 1.17]	
Bergen 2014	73	207	37	99	10.4%	0.94 [0.69, 1.29]	
Copenhagen 2009	17	50	25	50	5.2%	0.68 [0.42, 1.09]	
London 1997	105	167	109	164	22.9%	0.95 [0.81, 1.11]	
Manchester 2001	5	12	7	11	1.5%	0.65 [0.29, 1.46]	
Montreal 2000	17	58	24	56	5.1%	0.68 [0.41, 1.13]	
Newcastle 1997	22	46	28	46	5.8%	0.79 [0.54, 1.15]	
Oslo 2000	16	42	17	40	3.6%	0.90 [0.53, 1.52]	
Stockholm 1998	9	42	12	40	2.6%	0.71 [0.34, 1.51]	
Trondheim 2000	64	160	81	160	16.9%	0.79 [0.62, 1.01]	
Trondheim 2004	19	31	15	31	3.1%	1.27 [0.80, 2.00]	
Total (95% CI)		**1205**		**1102**	**100.0%**	**0.88 [0.80, 0.97]**	
Total events	448		465				

Heterogeneity: Chi² = 13.49, df = 15 (P = 0.56); I² = 0%

Test for overall effect: Z = 2.63 (P = 0.008)

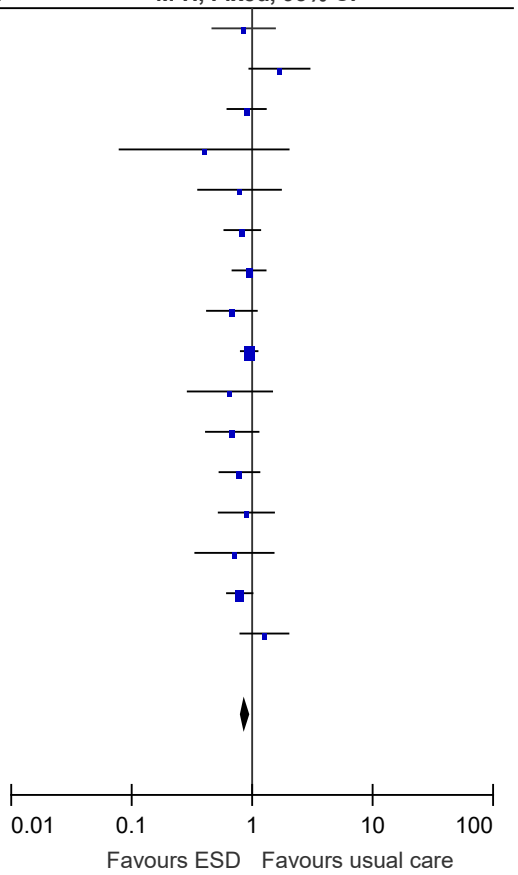

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Figure 7: Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
Adelaide 2000	96	9	42	98	10	44	5.8%	-0.21 [-0.63, 0.22]
Adelaide 2016	84.8	18.5	31	87.3	17.9	32	4.3%	-0.14 [-0.63, 0.36]
Akershus 1998	95	20	124	95	20	127	17.0%	0.00 [-0.25, 0.25]
ATTEND pilot 2015	18	3.4	34	16.5	8.8	41	5.0%	0.22 [-0.24, 0.67]
Aveiro 2016	107.4	19.9	74	106.6	25.5	78	10.3%	0.03 [-0.28, 0.35]
Belfast 2004	17.98	3.1	59	17.15	3.81	54	7.6%	0.24 [-0.13, 0.61]
Bergen 2014	100	8.6	153	100	10.7	60	11.7%	0.00 [-0.30, 0.30]
CARE4STROKE 2019	17.63	3.49	32	16.89	3.47	29	4.1%	0.21 [-0.29, 0.71]
Copenhagen 2009	19.5	5	43	19	3	44	5.9%	0.12 [-0.30, 0.54]
London 1997	16	4	136	16	4	126	17.8%	0.00 [-0.24, 0.24]
Manchester 2001	17	4	9	15	7	8	1.1%	0.34 [-0.62, 1.30]
Montreal 2000	97.1	6.9	48	95.1	10.6	43	6.1%	0.22 [-0.19, 0.64]
Trondheim 2004	71.7	34.7	23	79	28.7	25	3.2%	-0.23 [-0.79, 0.34]
Total (95% CI)			**808**			**711**	**100.0%**	**0.04 [-0.06, 0.14]**

Heterogeneity: Chi² = 6.30, df = 12 (P = 0.90); I² = 0%

Test for overall effect: Z = 0.78 (P = 0.44)

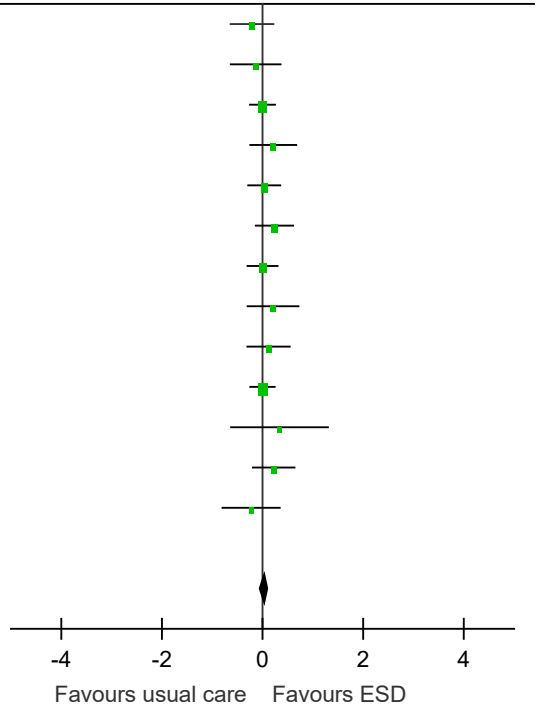

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Figure 8: Extended activities of daily living (Adelaide Activities Profile, Frenchay Activities Index, Nottingham Activities of Daily Living, OARS, Rivermead Activities of Daily Living [different scale ranges], higher values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
Adelaide 2000	39.7	32.5	42	36.4	37.8	44	7.2%	0.09 [-0.33, 0.52]
Aveiro 2016	34.6	17.6	73	32.2	11.4	74	12.2%	0.16 [-0.16, 0.49]
Belfast 2004	12	6.34	59	10.43	5.92	54	9.3%	0.25 [-0.12, 0.62]
London 1997	27	12	136	27	11	126	21.8%	0.00 [-0.24, 0.24]
Manchester 2001	12	6	9	9	6	8	1.4%	0.47 [-0.50, 1.44]
Montreal 2000	11	3.5	51	9.5	3.9	44	7.7%	0.40 [-0.00, 0.81]
Newcastle 1997	10	13	45	7	15	42	7.2%	0.21 [-0.21, 0.63]
Oslo 2000	35.35	13.46	34	35.81	16.51	31	5.4%	-0.03 [-0.52, 0.46]
Stockholm 1998	24	6	40	21.5	8	38	6.4%	0.35 [-0.10, 0.80]
Trondheim 2000	32.2	11.1	133	31.1	11.1	124	21.4%	0.10 [-0.15, 0.34]
Total (95% CI)			**622**			**585**	**100.0%**	**0.14 [0.03, 0.26]**

Heterogeneity: Chi² = 5.31, df = 9 (P = 0.81); I² = 0%

Test for overall effect: Z = 2.51 (P = 0.01)

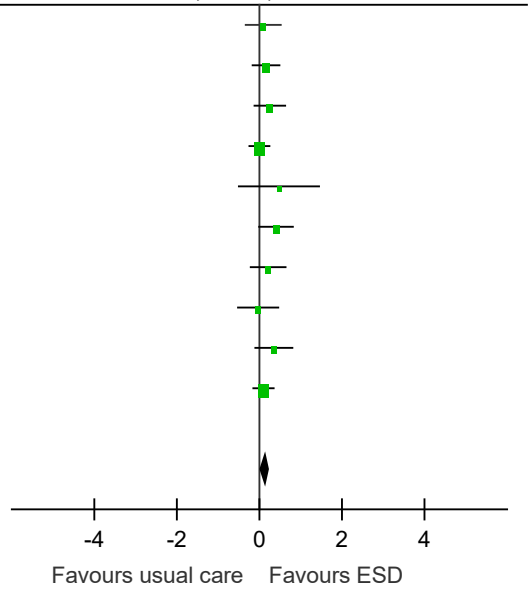

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Figure 9: Length of hospital stay (days, lower values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Adelaide 2000	20.9	20.55	42	36	24.04	44	4.1%	-15.10 [-24.54, -5.66]
Adelaide 2016	25.6	26.1	31	24.7	28.7	32	2.4%	0.90 [-12.64, 14.44]
ATTEND pilot 2015	10	7.1	50	11.5	7.9	54	10.1%	-1.50 [-4.38, 1.38]
Aveiro 2016	9.8	5.3	95	10	5.3	95	11.4%	-0.20 [-1.71, 1.31]
Bangkok 2002	3	3	52	10	5	50	11.3%	-7.00 [-8.61, -5.39]
Belfast 2004	41.9	28.25	59	49.5	46.95	54	2.2%	-7.60 [-22.05, 6.85]
Bergen 2014	36.7	49.4	207	42.2	39.9	99	3.6%	-5.50 [-15.85, 4.85]
CARE4STROKE 2019	117	5	32	117	54	29	1.3%	0.00 [-19.73, 19.73]
Copenhagen 2009	16.5	10	50	15	16	50	7.5%	1.50 [-3.73, 6.73]
Gothenburg 2019	11.8	6.7	69	13.8	8.4	71	10.5%	-2.00 [-4.51, 0.51]
London 1997	32.8	33.05	165	41.3	40.09	163	5.0%	-8.50 [-16.46, -0.54]
Manchester 2001	39.8	35.78	10	46.09	41.17	11	0.5%	-6.29 [-39.21, 26.63]
Montreal 2000	9.8	5.3	58	12	7.07	56	10.7%	-2.20 [-4.50, 0.10]
Newcastle 1997	21.6	24.59	44	33.8	35.22	42	2.6%	-12.20 [-25.09, 0.69]
Oslo 2000	26.4	17.33	42	33.8	21.83	40	4.6%	-7.40 [-15.96, 1.16]
Stockholm 1998	13.6	6.93	42	29.2	26.28	40	4.7%	-15.60 [-24.01, -7.19]
Trondheim 2000	18.6	30	160	31.1	30	160	6.2%	-12.50 [-19.07, -5.93]
Trondheim 2004	23.5	30.5	31	30.5	44.8	31	1.4%	-7.00 [-26.08, 12.08]
Total (95% CI)			**1239**			**1121**	**100.0%**	**-4.98 [-7.34, -2.63]**

Heterogeneity: Tau² = 12.13; Chi² = 70.50, df = 17 (P < 0.00001); I² = 76%

Test for overall effect: Z = 4.14 (P < 0.0001)

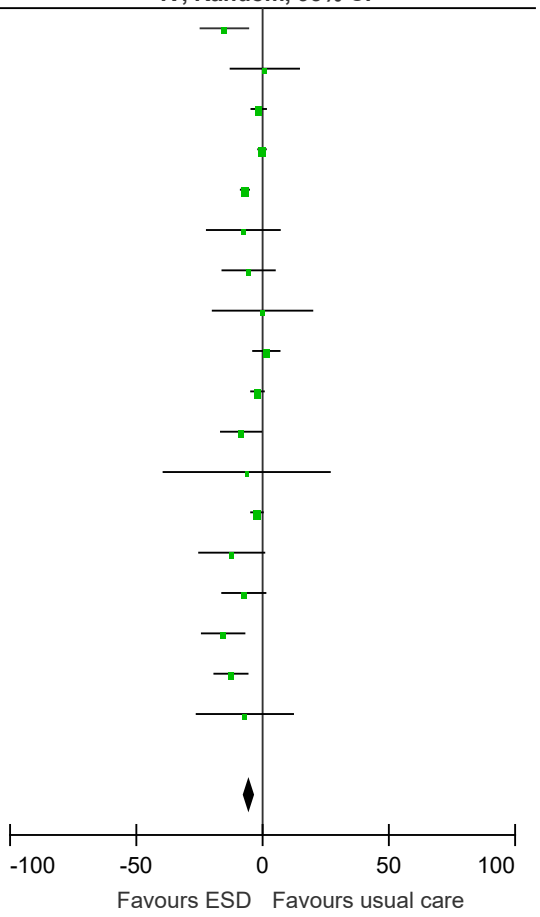

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Figure 10: Caregiver strain index ([different scale ranges], lower values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
Adelaide 2000	0.2	0.4	42	0.2	0.4	44	13.5%	0.00 [-0.42, 0.42]
Adelaide 2016	7.6	2.8	31	8.7	2.9	33	9.8%	-0.38 [-0.88, 0.11]
Belfast 2004	5.92	2.86	27	6	4.23	25	8.1%	-0.02 [-0.57, 0.52]
CARE4STROKE 2019	5.72	3.14	32	5.35	2.95	29	9.5%	0.12 [-0.38, 0.62]
London 1997	5	4	75	4	3	59	20.5%	0.28 [-0.07, 0.62]
Trondheim 2000	23.39	2.7	128	22.58	3.12	121	38.6%	0.28 [0.03, 0.53]
Total (95% CI)			**335**			**311**	**100.0%**	**0.14 [-0.02, 0.29]**

Heterogeneity: Chi² = 6.79, df = 5 (P = 0.24); I² = 26%

Test for overall effect: Z = 1.72 (P = 0.09)

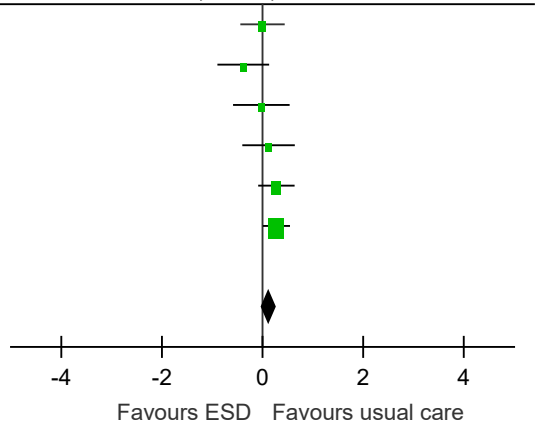

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Figure 11: Falls at end of scheduled follow-up

	Early supported discharge		Usual care			Risk Difference
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**
Oslo 2000	0	42	0	40	50.0%	0.00 [-0.05, 0.05]
Stockholm 1998	19	42	14	40	50.0%	0.10 [-0.11, 0.31]
Total (95% CI)		**84**		**80**	**100.0%**	**0.05 [-0.06, 0.16]**
Total events	19		14			

Heterogeneity: Chi² = 4.90, df = 1 (P = 0.03); I² = 80%

Test for overall effect: Z = 0.93 (P = 0.35)

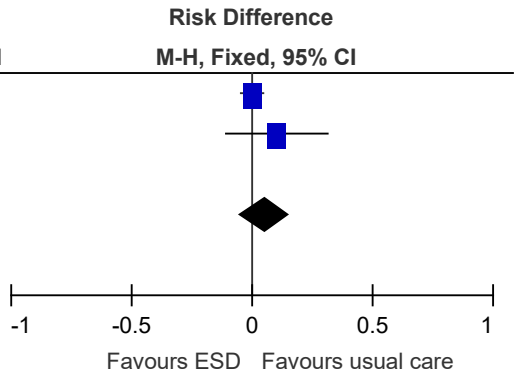

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Figure 12: Readmissions to hospital at end of scheduled follow-up

	Early supported discharge		Usual care			Risk Ratio	Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Adelaide 2000	15	42	11	44	10.9%	1.43 [0.74, 2.75]	
Adelaide 2016	7	31	8	32	8.0%	0.90 [0.37, 2.19]	
Belfast 2004	6	21	6	22	5.9%	1.05 [0.40, 2.74]	
Copenhagen 2009	12	43	13	44	13.0%	0.94 [0.49, 1.83]	
London 1997	44	167	42	164	42.9%	1.03 [0.72, 1.48]	
Newcastle 1997	5	46	5	46	5.1%	1.00 [0.31, 3.22]	
Stockholm 1998	16	41	14	40	14.3%	1.11 [0.63, 1.97]	
Total (95% CI)		**391**		**392**	**100.0%**	**1.06 [0.84, 1.34]**	
Total events	105		99				

Heterogeneity: Chi² = 1.11, df = 6 (P = 0.98); I² = 0%

Test for overall effect: Z = 0.51 (P = 0.61)

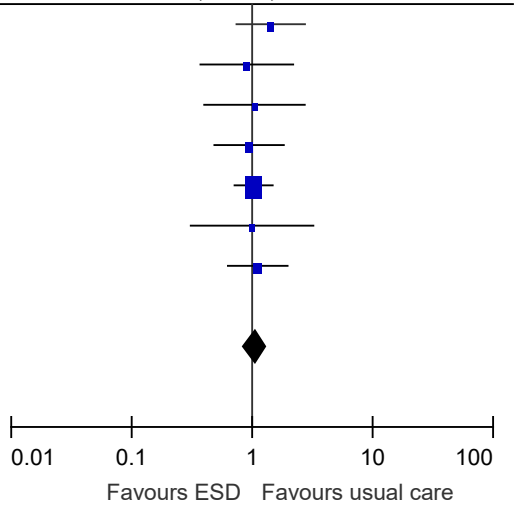

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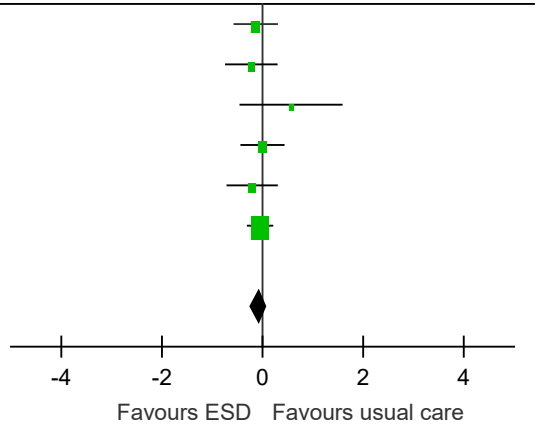
Figure 13: Psychological distress/mood (General Health Questionnaire, HADS, Montgommery Asberg Depression rating scale, Wakefield depression inventory [different scale ranges], lower values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
Adelaide 2000	80.5	17.3	42	82.6	13.6	44	15.0%	-0.13 [-0.56, 0.29]
CARE4STROKE 2019	3.69	3.7	32	4.52	3.66	29	10.6%	-0.22 [-0.73, 0.28]
Manchester 2001	15	5	8	12	5	8	2.7%	0.57 [-0.44, 1.57]
Newcastle 1997	3	2.9	45	3	2.9	42	15.2%	0.00 [-0.42, 0.42]
Oslo 2000	2.73	3.18	33	3.42	3.47	31	11.1%	-0.21 [-0.70, 0.29]
Trondheim 2000	5.52	5.83	134	5.82	6.34	125	45.3%	-0.05 [-0.29, 0.19]
Total (95% CI)			**294**			**279**	**100.0%**	**-0.07 [-0.24, 0.09]**

Heterogeneity: Chi² = 2.40, df = 5 (P = 0.79); I² = 0%

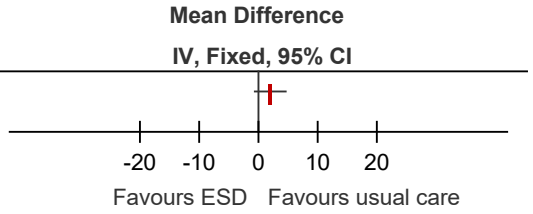
Test for overall effect: Z = 0.88 (P = 0.38)



1

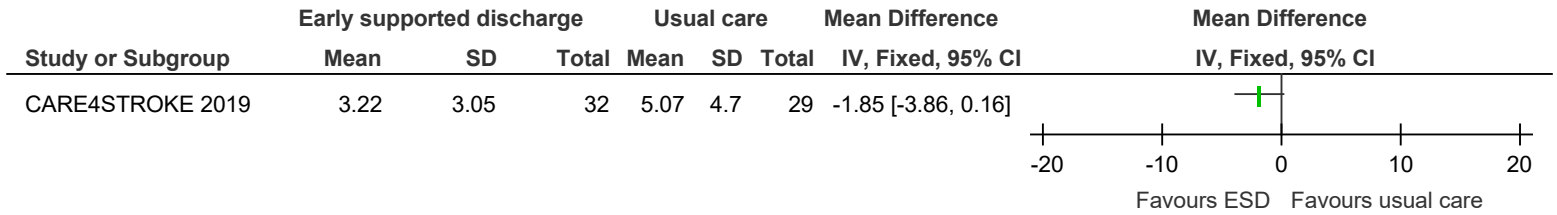
Figure 14: Psychological distress/mood (HADS depression, 0-42, lower values are better, mean difference) at end of scheduled follow-up

			Early supported discharge	Usual care	Mean Difference
Study or Subgroup	**Mean Difference**	**SE**	**Total**	**Total**	**IV, Fixed, 95% CI**
Adelaide 2016	2	1.3266	31	32	2.00 [-0.60, 4.60]



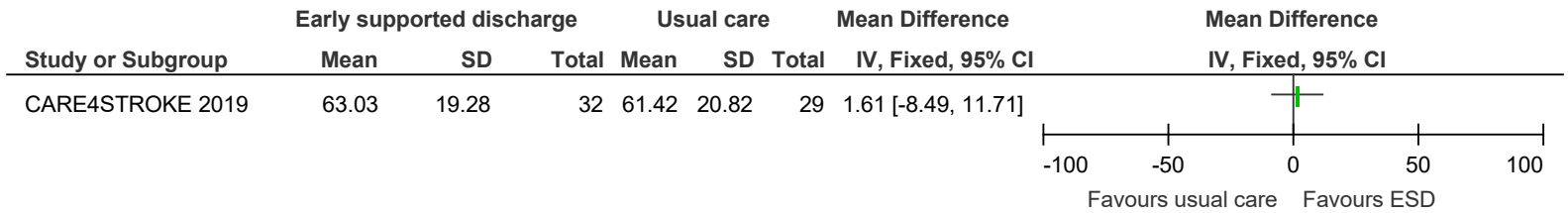
2

Figure 15: Psychological distress/mood (HADS anxiety subscale, 0-21, lower values are better, final value) at end of scheduled follow-up



1

Figure 16: Stroke-specific Patient-Reported Outcome Measures (SIS composite physical scale, 0-100, higher values are better, final value) at end of scheduled follow-up



2

Figure 17: Stroke-specific Patient-Reported Outcome Measures (SIS mobility, 0-100, higher values are better, mean difference) at end of scheduled follow-up

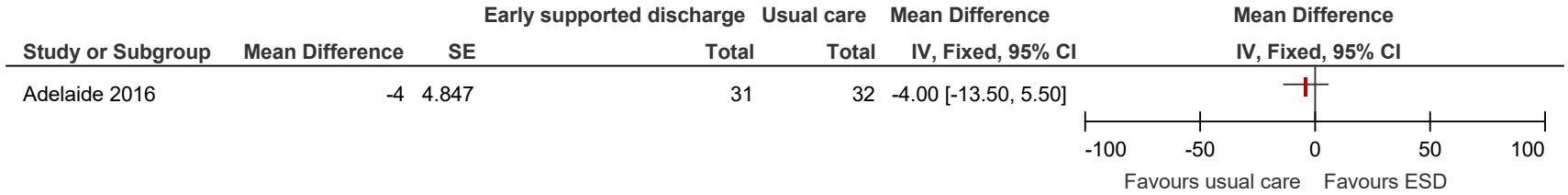


Figure 18: Stroke-specific Patient-Reported Outcome Measures (SIS strength, 0-100, higher values are better, mean difference) at end of scheduled follow-up

Study or Subgroup	Mean Difference	SE	Early supported discharge Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
Adelaide 2016	8.2	3.7756	31	32	8.20 [0.80, 15.60]

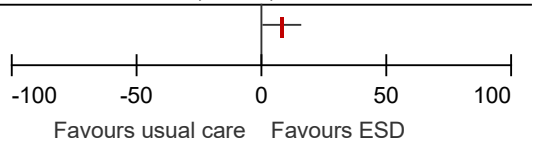


Figure 19: Stroke-specific Patient-Reported Outcome Measures (SIS hand function, 0-100, higher values are better, mean difference) at end of scheduled follow-up

Study or Subgroup	Mean Difference	SE	Early supported discharge Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
Adelaide 2016	2.1	8.4185	31	32	2.10 [-14.40, 18.60]

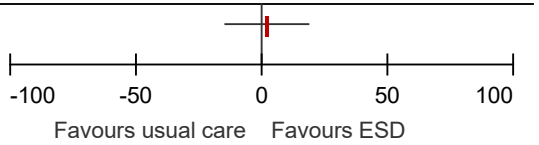
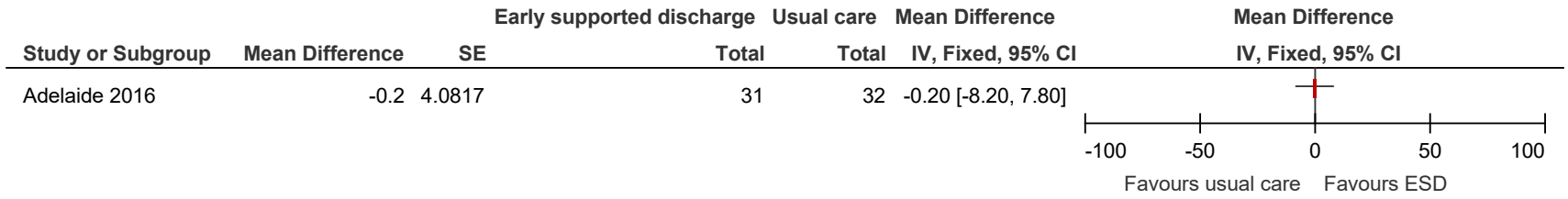


Figure 20: Stroke-specific Patient-Reported Outcome Measures (SIS activities of daily living, 0-100, higher values are better, mean difference) at end of scheduled follow-up



1

Figure 21: Stroke-specific Patient-Reported Outcome Measures (SIS emotion, 0-100, higher values are better, mean difference) at end of scheduled follow-up

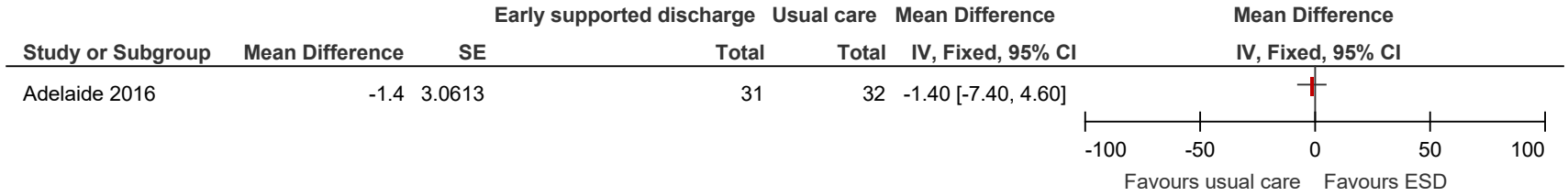


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Figure 22: Stroke-specific Patient-Reported Outcome Measures (SIS memory, 0-100, higher values are better, mean difference) at end of scheduled follow-up

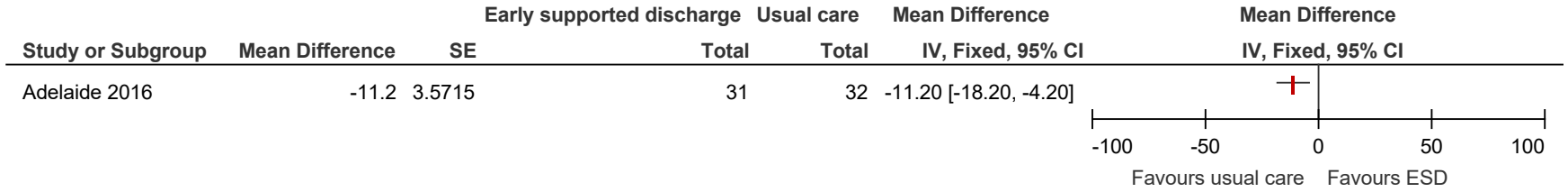


Figure 23: Stroke-specific Patient-Reported Outcome Measures (SIS communication, 0-100, higher values are better, mean difference) at end of scheduled follow-up

Study or Subgroup	Mean Difference	SE	Early supported discharge Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
Adelaide 2016	-5.2	2.8062	31	32	-5.20 [-10.70, 0.30]

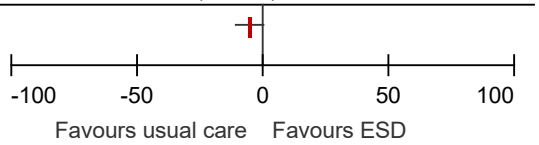


Figure 24: Stroke-specific Patient-Reported Outcome Measures (SIS social participation, 0-100, higher values are better, mean difference) at end of scheduled follow-up

Study or Subgroup	Mean Difference	SE	Early supported discharge Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
Adelaide 2016	5.2	11.2247	31	32	5.20 [-16.80, 27.20]

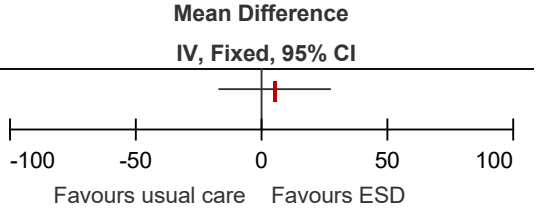
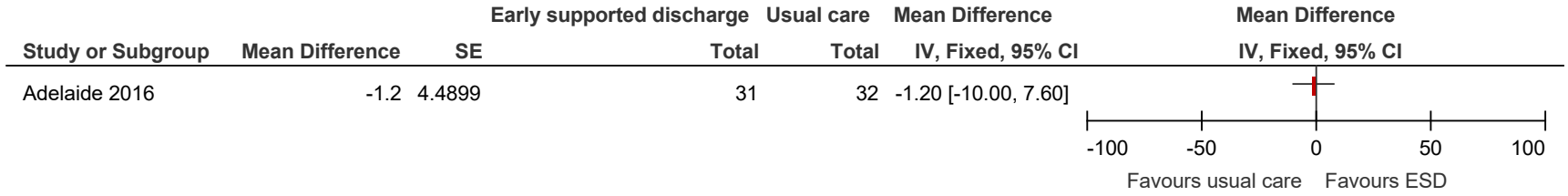


Figure 25: Stroke-specific Patient-Reported Outcome Measures (SIS recovery, 0-100, higher values are better, mean difference) at end of scheduled follow-up



F.2 Stratification of outcomes by the coordination and delivery of early supported discharge

Figure 26: Mortality at end of scheduled follow-up

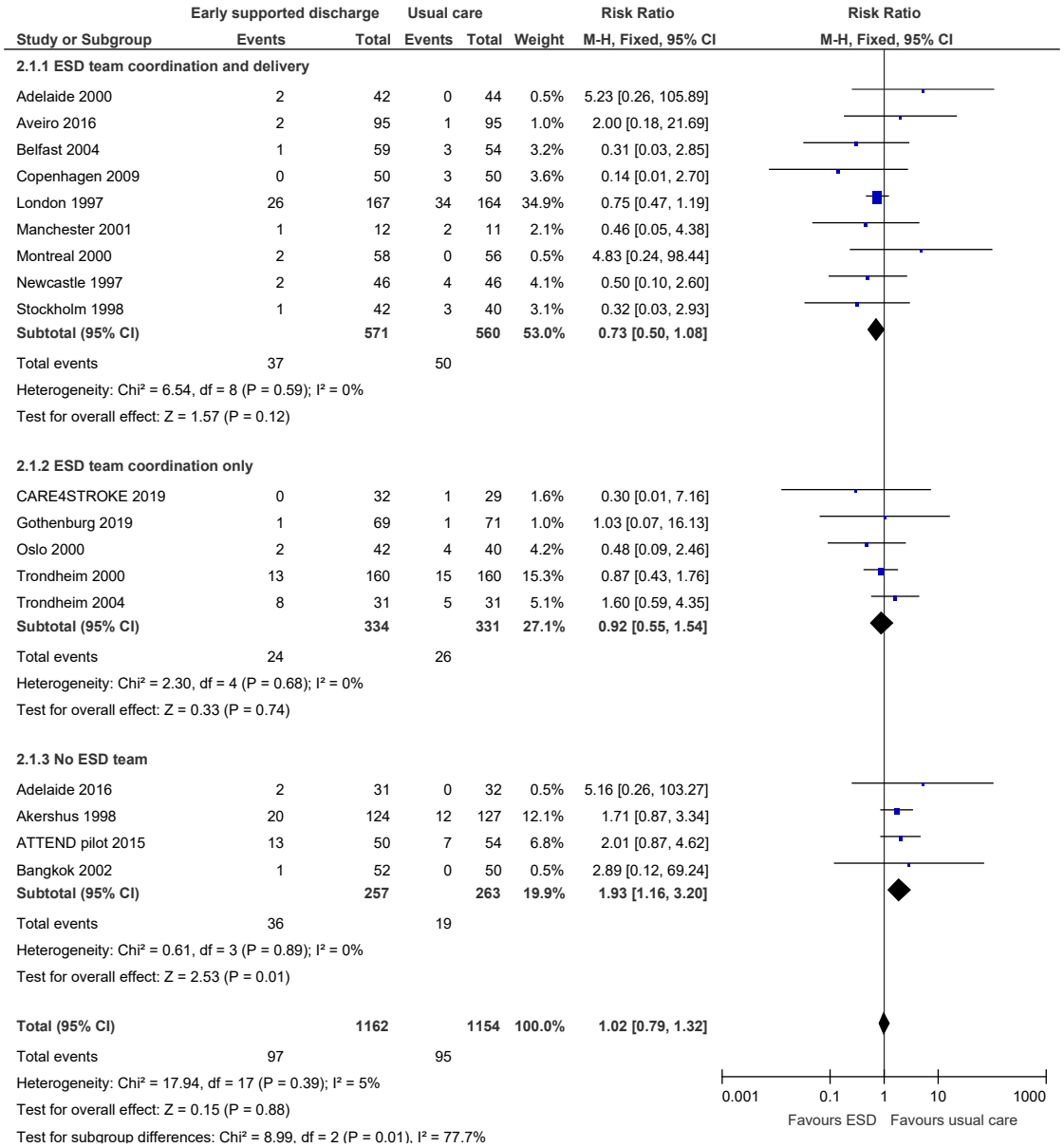

Early supported discharge
Usual care
Risk Ratio
Risk Ratio
Study or Subgroup
Events
Total
Events
Total
Weight
M-H, Fixed, 95% CI
M-H, Fixed, 95% CI
2.1.1 ESD team coordination and delivery
Adelaide 2000 2 42 0 44 0.5% 5.23 [0.26, 105.89]
Aveiro 2016 2 95 1 95 1.0% 2.00 [0.18, 21.69]
Belfast 2004 1 59 3 54 3.2% 0.31 [0.03, 2.85]
Copenhagen 2009 0 50 3 50 3.6% 0.14 [0.01, 2.70]
London 1997 26 167 34 164 34.9% 0.75 [0.47, 1.19]
Manchester 2001 1 12 2 11 2.1% 0.46 [0.05, 4.38]
Montreal 2000 2 58 0 56 0.5% 4.83 [0.24, 98.44]
Newcastle 1997 2 46 4 46 4.1% 0.50 [0.10, 2.60]
Stockholm 1998 1 42 3 40 3.1% 0.32 [0.03, 2.93]
Subtotal (95% CI) 571 560 53.0% 0.73 [0.50, 1.08]
Total events 37 50
Heterogeneity: Chi² = 6.54, df = 8 (P = 0.59); I² = 0%
Test for overall effect: Z = 1.57 (P = 0.12)
2.1.2 ESD team coordination only
CARE4STROKE 2019 0 32 1 29 1.6% 0.30 [0.01, 7.16]
Gothenburg 2019 1 69 1 71 1.0% 1.03 [0.07, 16.13]
Oslo 2000 2 42 4 40 4.2% 0.48 [0.09, 2.46]
Trondheim 2000 13 160 15 160 15.3% 0.87 [0.43, 1.76]
Trondheim 2004 8 31 5 31 5.1% 1.60 [0.59, 4.35]
Subtotal (95% CI) 334 331 27.1% 0.92 [0.55, 1.54]
Total events 24 26
Heterogeneity: Chi² = 2.30, df = 4 (P = 0.68); I² = 0%
Test for overall effect: Z = 0.33 (P = 0.74)
2.1.3 No ESD team
Adelaide 2016 2 31 0 32 0.5% 5.16 [0.26, 103.27]
Akershus 1998 20 124 12 127 12.1% 1.71 [0.87, 3.34]
ATTEND pilot 2015 13 50 7 54 6.8% 2.01 [0.87, 4.62]
Bangkok 2002 1 52 0 50 0.5% 2.89 [0.12, 69.24]
Subtotal (95% CI) 257 263 19.9% 1.93 [1.16, 3.20]
Total events 36 19
Heterogeneity: Chi² = 0.61, df = 3 (P = 0.89); I² = 0%
Test for overall effect: Z = 2.53 (P = 0.01)
Total (95% CI) 1162 1154 100.0% 1.02 [0.79, 1.32]
Total events 97 95
Heterogeneity: Chi² = 17.94, df = 17 (P = 0.39); I² = 5%
Test for overall effect: Z = 0.15 (P = 0.88)
Test for subgroup differences: Chi² = 8.99, df = 2 (P = 0.01), I² = 77.7%
0.001
0.1
1
10
1000
Favours ESD
Favours usual care

Figure 27: Person/participant generic health-related quality of life (EuroQol, 0-100, higher values are better, final value) at end of scheduled follow-up

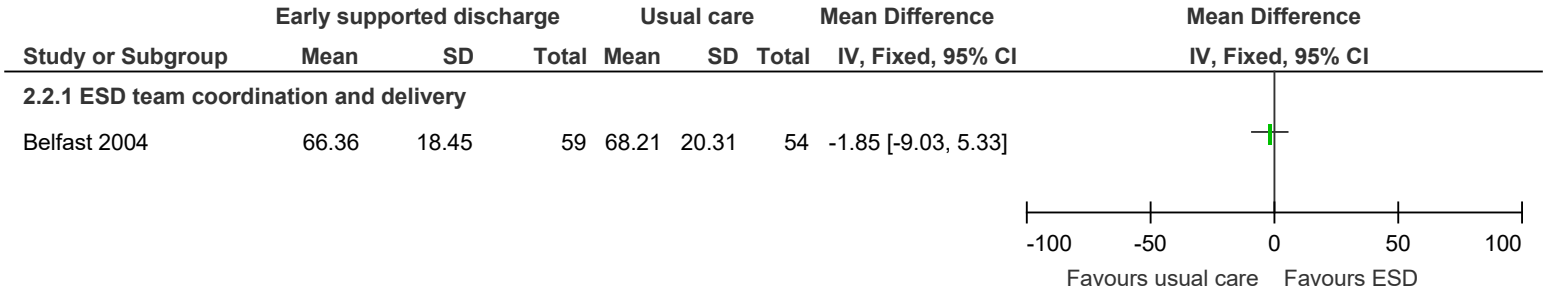


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Figure 28: Person/participant generic health-related quality of life (SF-36 physical component summary, 0-100, higher values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
2.3.1 ESD team coordination and delivery								
Adelaide 2000	47.4	10	42	41.6	10.6	44	34.5%	5.80 [1.45, 10.15]
Montreal 2000	42.9	10.1	51	37.9	10.6	44	37.4%	5.00 [0.82, 9.18]
Subtotal (95% CI)			**93**			**88**	**71.9%**	**5.38 [2.37, 8.40]**
Heterogeneity: Chi² = 0.07, df = 1 (P = 0.80); I² = 0%								
Test for overall effect: Z = 3.50 (P = 0.0005)								
2.3.2 ESD team coordination only								
Akershus 1998	48	19	124	47	20	127	28.1%	1.00 [-3.83, 5.83]
Subtotal (95% CI)			**124**			**127**	**28.1%**	**1.00 [-3.83, 5.83]**
Heterogeneity: Not applicable								
Test for overall effect: Z = 0.41 (P = 0.68)								
Total (95% CI)			**217**			**215**	**100.0%**	**4.15 [1.59, 6.71]**
Heterogeneity: Chi² = 2.35, df = 2 (P = 0.31); I² = 15%								
Test for overall effect: Z = 3.18 (P = 0.001)								
Test for subgroup differences: Chi² = 2.28, df = 1 (P = 0.13), I² = 56.1%								

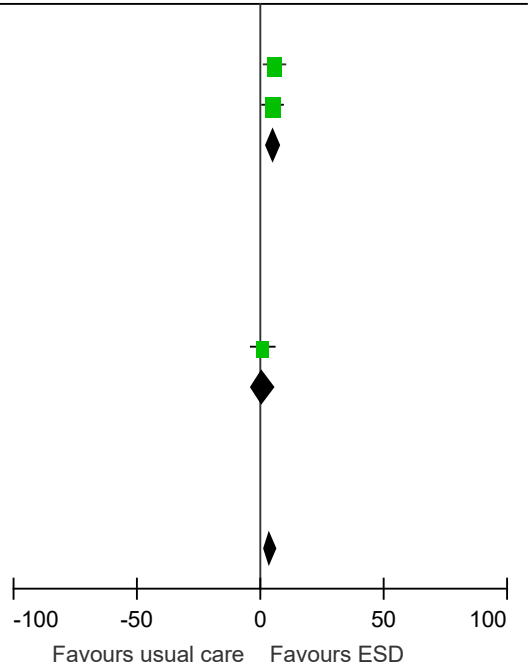

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Figure 29: Person/participant generic health-related quality of life (SF-36 mental component summary, 0-100, higher values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
2.4.1 ESD team coordination and delivery								
Adelaide 2000	46.7	11.3	42	52.3	7.8	44	37.3%	-5.60 [-9.72, -1.48]
Montreal 2000	46.5	11.7	51	46.7	10.8	44	30.9%	-0.20 [-4.73, 4.33]
Subtotal (95% CI)			**93**			**88**	**68.1%**	**-3.15 [-6.20, -0.10]**
Heterogeneity: Chi² = 2.99, df = 1 (P = 0.08); I² = 67%								
Test for overall effect: Z = 2.03 (P = 0.04)								
2.4.2 ESD team coordination only								
Akershus 1998	70	17	124	70	19	127	31.9%	0.00 [-4.46, 4.46]
Subtotal (95% CI)			**124**			**127**	**31.9%**	**0.00 [-4.46, 4.46]**
Heterogeneity: Not applicable								
Test for overall effect: Z = 0.00 (P = 1.00)								
Total (95% CI)			**217**			**215**	**100.0%**	**-2.15 [-4.66, 0.37]**
Heterogeneity: Chi² = 4.30, df = 2 (P = 0.12); I² = 53%								
Test for overall effect: Z = 1.67 (P = 0.09)								
Test for subgroup differences: Chi² = 1.31, df = 1 (P = 0.25), I² = 23.6%								

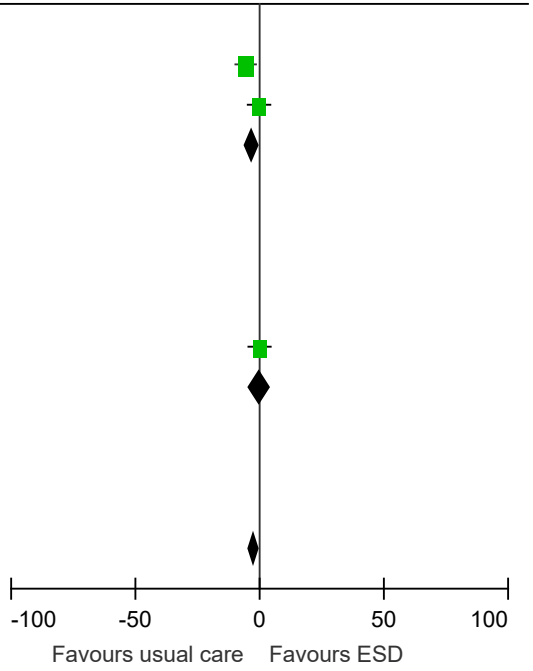

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Figure 30: Carer generic health-related quality of life (carer QoL [different scale ranges], higher values are better, final values) at end of scheduled follow-up

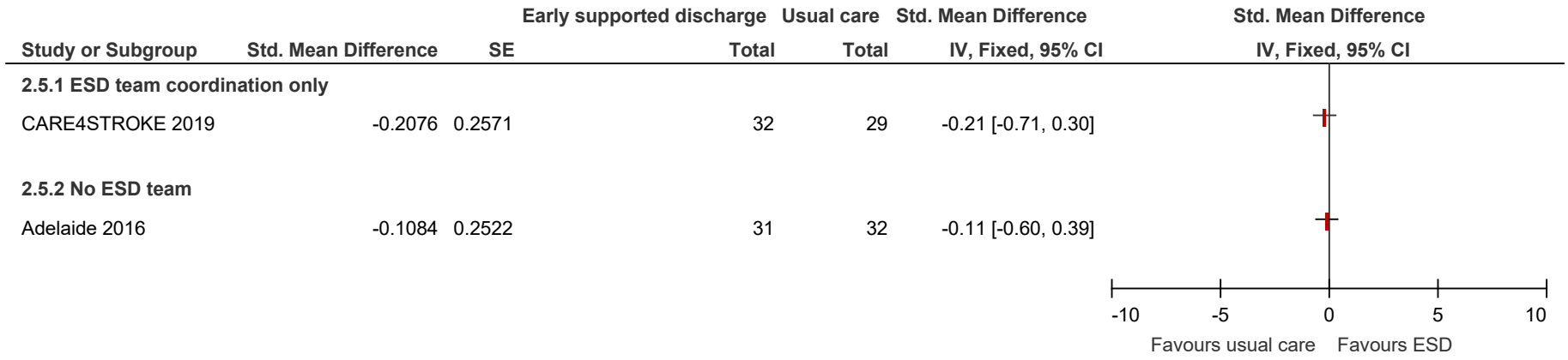

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Figure 31: Physical dependency at the end of scheduled follow-up

Study or Subgroup	Early supported discharge Events	Total	Usual care Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
2.6.1 ESD team coordination and delivery						
Adelaide 2000	13	42	16	44	3.3%	0.85 [0.47, 1.55]
Aveiro 2016	2	95	5	95	1.0%	0.40 [0.08, 2.01]
Belfast 2004	29	59	32	54	7.0%	0.83 [0.59, 1.17]
Copenhagen 2009	17	50	25	50	5.2%	0.68 [0.42, 1.09]
London 1997	105	167	109	164	22.9%	0.95 [0.81, 1.11]
Manchester 2001	5	12	7	11	1.5%	0.65 [0.29, 1.46]
Montreal 2000	17	58	24	56	5.1%	0.68 [0.41, 1.13]
Newcastle 1997	22	46	28	46	5.8%	0.79 [0.54, 1.15]
Stockholm 1998	9	42	12	40	2.6%	0.71 [0.34, 1.51]
Subtotal (95% CI)		**571**		**560**	**54.5%**	**0.83 [0.73, 0.94]**
Total events	219		258			
Heterogeneity: Chi² = 5.22, df = 8 (P = 0.73); I² = 0%						
Test for overall effect: Z = 2.97 (P = 0.003)						
2.6.2 ESD team coordination only						
Bergen 2014	73	207	37	99	10.4%	0.94 [0.69, 1.29]
Oslo 2000	16	42	17	40	3.6%	0.90 [0.53, 1.52]
Trondheim 2000	64	160	81	160	16.9%	0.79 [0.62, 1.01]
Trondheim 2004	19	31	15	31	3.1%	1.27 [0.80, 2.00]
Subtotal (95% CI)		**440**		**330**	**34.1%**	**0.89 [0.75, 1.06]**
Total events	172		150			
Heterogeneity: Chi² = 3.32, df = 3 (P = 0.35); I² = 10%						
Test for overall effect: Z = 1.33 (P = 0.18)						
2.6.3 No ESD team						
Akershus 1998	23	92	16	108	3.1%	1.69 [0.95, 3.00]
ATTEND pilot 2015	25	50	30	54	6.0%	0.90 [0.62, 1.30]
Bangkok 2002	9	52	11	50	2.3%	0.79 [0.36, 1.73]
Subtotal (95% CI)		**194**		**212**	**11.4%**	**1.09 [0.81, 1.46]**
Total events	57		57			
Heterogeneity: Chi² = 3.93, df = 2 (P = 0.14); I² = 49%						
Test for overall effect: Z = 0.56 (P = 0.57)						
Total (95% CI)		**1205**		**1102**	**100.0%**	**0.88 [0.80, 0.97]**
Total events	448		465			
Heterogeneity: Chi² = 13.49, df = 15 (P = 0.56); I² = 0%						
Test for overall effect: Z = 2.63 (P = 0.008)						
Test for subgroup differences: Chi² = 2.90, df = 2 (P = 0.23), I² = 31.0%						

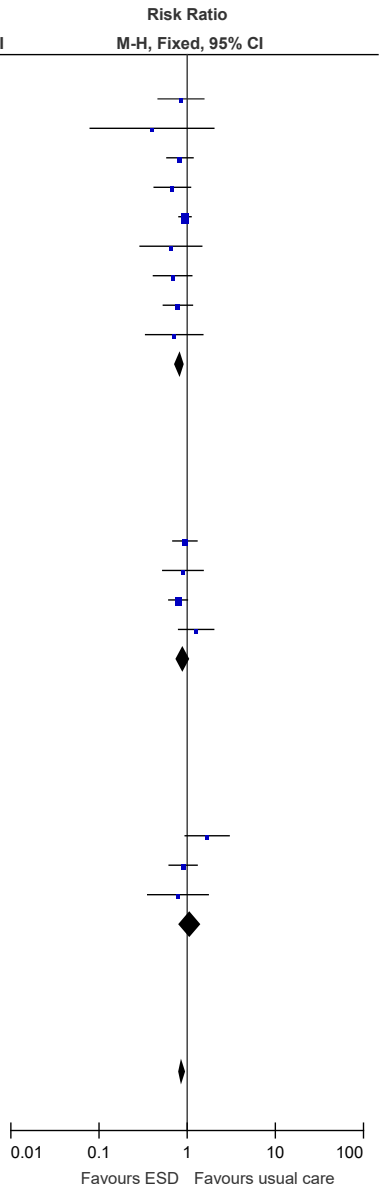

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Figure 32: Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at end of scheduled follow-up

Study or Subgroup	Early supported discharge Mean	SD	Total	Usual care Mean	SD	Total	Weight	Std. Mean Difference IV, Fixed, 95% CI
2.7.1 ESD team coordination and delivery								
Adelaide 2000	96	9	42	98	10	44	5.8%	-0.21 [-0.63, 0.22]
Aveiro 2016	107.4	19.9	74	106.6	25.5	78	10.3%	0.03 [-0.28, 0.35]
Belfast 2004	17.98	3.1	59	17.15	3.81	54	7.6%	0.24 [-0.13, 0.61]
Copenhagen 2009	19.5	5	43	19	3	44	5.9%	0.12 [-0.30, 0.54]
London 1997	16	4	136	16	4	126	17.8%	0.00 [-0.24, 0.24]
Manchester 2001	17	4	9	15	7	8	1.1%	0.34 [-0.62, 1.30]
Montreal 2000	97.1	6.9	48	95.1	10.6	43	6.1%	0.22 [-0.19, 0.64]
Subtotal (95% CI)			**411**			**397**	**54.6%**	**0.06 [-0.08, 0.20]**
Heterogeneity: Chi² = 3.70, df = 6 (P = 0.72); I² = 0%								
Test for overall effect: Z = 0.89 (P = 0.37)								
2.7.2 ESD team coordination only								
Bergen 2014	100	8.6	153	100	10.7	60	11.7%	0.00 [-0.30, 0.30]
CARE4STROKE 2019	17.63	3.49	32	16.89	3.47	29	4.1%	0.21 [-0.29, 0.71]
Trondheim 2004	71.7	34.7	23	79	28.7	25	3.2%	-0.23 [-0.79, 0.34]
Subtotal (95% CI)			**208**			**114**	**19.0%**	**0.01 [-0.23, 0.24]**
Heterogeneity: Chi² = 1.27, df = 2 (P = 0.53); I² = 0%								
Test for overall effect: Z = 0.06 (P = 0.95)								
2.7.3 No ESD team								
Adelaide 2016	84.8	18.5	31	87.3	17.9	32	4.3%	-0.14 [-0.63, 0.36]
Akershus 1998	95	20	124	95	20	127	17.0%	0.00 [-0.25, 0.25]
ATTEND pilot 2015	18	3.4	34	16.5	8.8	41	5.0%	0.22 [-0.24, 0.67]
Subtotal (95% CI)			**189**			**200**	**26.3%**	**0.02 [-0.18, 0.22]**
Heterogeneity: Chi² = 1.11, df = 2 (P = 0.57); I² = 0%								
Test for overall effect: Z = 0.19 (P = 0.85)								
Total (95% CI)			**808**			**711**	**100.0%**	**0.04 [-0.06, 0.14]**
Heterogeneity: Chi² = 6.30, df = 12 (P = 0.90); I² = 0%								
Test for overall effect: Z = 0.78 (P = 0.44)								
Test for subgroup differences: Chi² = 0.22, df = 2 (P = 0.89), I² = 0%								

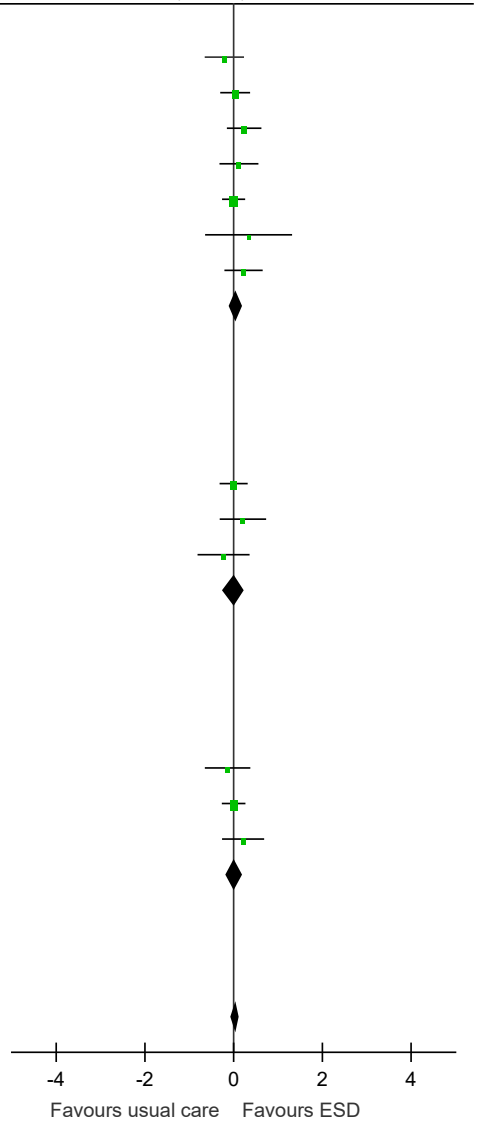

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Figure 33: Extended activities of daily living (Adelaide Activities Profile, Frenchay Activities Index, Nottingham Activities of Daily Living, OARS, Rivermead Activities of Daily Living [different scale ranges], higher values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
2.8.1 ESD tema coordination and delivery								
Adelaide 2000	39.7	32.5	42	36.4	37.8	44	7.2%	0.09 [-0.33, 0.52]
Aveiro 2016	34.6	17.6	73	32.2	11.4	74	12.2%	0.16 [-0.16, 0.49]
Belfast 2004	12	6.34	59	10.43	5.92	54	9.3%	0.25 [-0.12, 0.62]
London 1997	27	12	136	27	11	126	21.8%	0.00 [-0.24, 0.24]
Manchester 2001	12	6	9	9	6	8	1.4%	0.47 [-0.50, 1.44]
Montreal 2000	11	3.5	51	9.5	3.9	44	7.7%	0.40 [-0.00, 0.81]
Newcastle 1997	10	13	45	7	15	42	7.2%	0.21 [-0.21, 0.63]
Stockholm 1998	24	6	40	21.5	8	38	6.4%	0.35 [-0.10, 0.80]
Subtotal (95% CI)			**455**			**430**	**73.2%**	**0.17 [0.04, 0.30]**
Heterogeneity: Chi² = 4.52, df = 7 (P = 0.72); I² = 0%								
Test for overall effect: Z = 2.54 (P = 0.01)								
2.8.2 ESD team coordination only								
Oslo 2000	35.35	13.46	34	35.81	16.51	31	5.4%	-0.03 [-0.52, 0.46]
Trondheim 2000	32.2	11.1	133	31.1	11.1	124	21.4%	0.10 [-0.15, 0.34]
Subtotal (95% CI)			**167**			**155**	**26.8%**	**0.07 [-0.15, 0.29]**
Heterogeneity: Chi² = 0.22, df = 1 (P = 0.64); I² = 0%								
Test for overall effect: Z = 0.65 (P = 0.51)								
Total (95% CI)			**622**			**585**	**100.0%**	**0.14 [0.03, 0.26]**
Heterogeneity: Chi² = 5.31, df = 9 (P = 0.81); I² = 0%								
Test for overall effect: Z = 2.51 (P = 0.01)								
Test for subgroup differences: Chi² = 0.57, df = 1 (P = 0.45), I² = 0%								

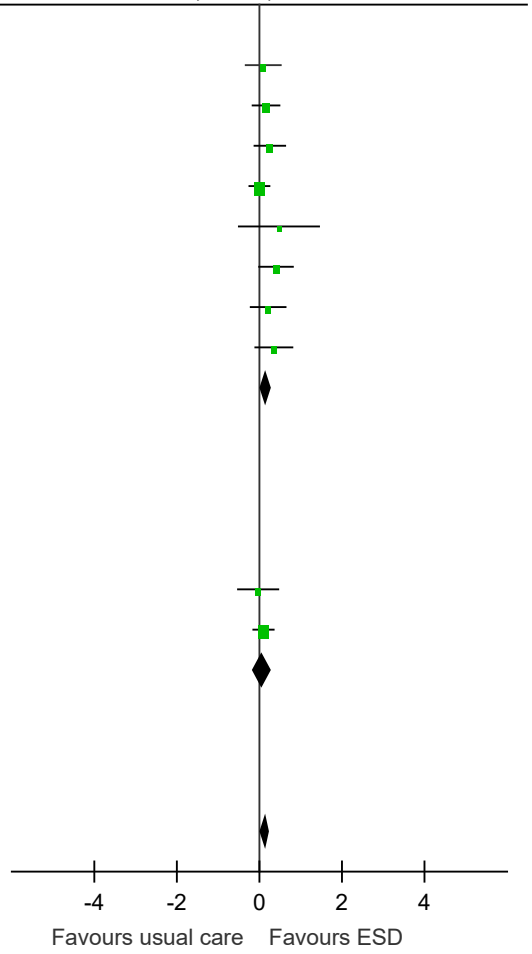

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Figure 34: Length of hospital stay (days, lower values are better, final values) at end of scheduled follow-up

Study or Subgroup	Early supported discharge Mean	SD	Total	Usual care Mean	SD	Total	Weight	Mean Difference IV, Random, 95% CI
2.9.1 ESD team coordination and delivery								
Adelaide 2000	20.9	20.55	42	36	24.04	44	4.1%	-15.10 [-24.54, -5.66]
Aveiro 2016	9.8	5.3	95	10	5.3	95	11.4%	-0.20 [-1.71, 1.31]
Belfast 2004	41.9	28.25	59	49.5	46.95	54	2.2%	-7.60 [-22.05, 6.85]
Copenhagen 2009	16.5	10	50	15	16	50	7.5%	1.50 [-3.73, 6.73]
London 1997	32.8	33.05	165	41.3	40.09	163	5.0%	-8.50 [-16.46, -0.54]
Manchester 2001	39.8	35.78	10	46.09	41.17	11	0.5%	-6.29 [-39.21, 26.63]
Montreal 2000	9.8	5.3	58	12	7.07	56	10.7%	-2.20 [-4.50, 0.10]
Newcastle 1997	21.6	24.59	44	33.8	35.22	42	2.6%	-12.20 [-25.09, 0.69]
Stockholm 1998	13.6	6.93	42	29.2	26.28	40	4.7%	-15.60 [-24.01, -7.19]
Subtotal (95% CI)			**565**			**555**	**48.7%**	**-5.22 [-8.78, -1.67]**
Heterogeneity: Tau² = 14.20; Chi² = 29.64, df = 8 (P = 0.0002); I² = 73%								
Test for overall effect: Z = 2.88 (P = 0.004)								
2.9.2 ESD team coordination only								
Bergen 2014	36.7	49.4	207	42.2	39.9	99	3.6%	-5.50 [-15.85, 4.85]
CARE4STROKE 2019	117	5	32	117	54	29	1.3%	0.00 [-19.73, 19.73]
Gothenburg 2019	11.8	6.7	69	13.8	8.4	71	10.5%	-2.00 [-4.51, 0.51]
Oslo 2000	26.4	17.33	42	33.8	21.83	40	4.6%	-7.40 [-15.96, 1.16]
Trondheim 2000	18.6	30	160	31.1	30	160	6.2%	-12.50 [-19.07, -5.93]
Trondheim 2004	23.5	30.5	31	30.5	44.8	31	1.4%	-7.00 [-26.08, 12.08]
Subtotal (95% CI)			**541**			**430**	**27.5%**	**-5.95 [-10.65, -1.24]**
Heterogeneity: Tau² = 14.24; Chi² = 9.73, df = 5 (P = 0.08); I² = 49%								
Test for overall effect: Z = 2.48 (P = 0.01)								
2.9.3 No ESD team								
Adelaide 2016	25.6	26.1	31	24.7	28.7	32	2.4%	0.90 [-12.64, 14.44]
ATTEND pilot 2015	10	7.1	50	11.5	7.9	54	10.1%	-1.50 [-4.38, 1.38]
Bangkok 2002	3	3	52	10	5	50	11.3%	-7.00 [-8.61, -5.39]
Subtotal (95% CI)			**133**			**136**	**23.8%**	**-3.83 [-8.79, 1.13]**
Heterogeneity: Tau² = 12.94; Chi² = 11.56, df = 2 (P = 0.003); I² = 83%								
Test for overall effect: Z = 1.51 (P = 0.13)								
Total (95% CI)			**1239**			**1121**	**100.0%**	**-4.98 [-7.34, -2.63]**
Heterogeneity: Tau² = 12.13; Chi² = 70.50, df = 17 (P < 0.00001); I² = 76%								
Test for overall effect: Z = 4.14 (P < 0.0001)								
Test for subgroup differences: Chi² = 0.38, df = 2 (P = 0.83), I² = 0%								

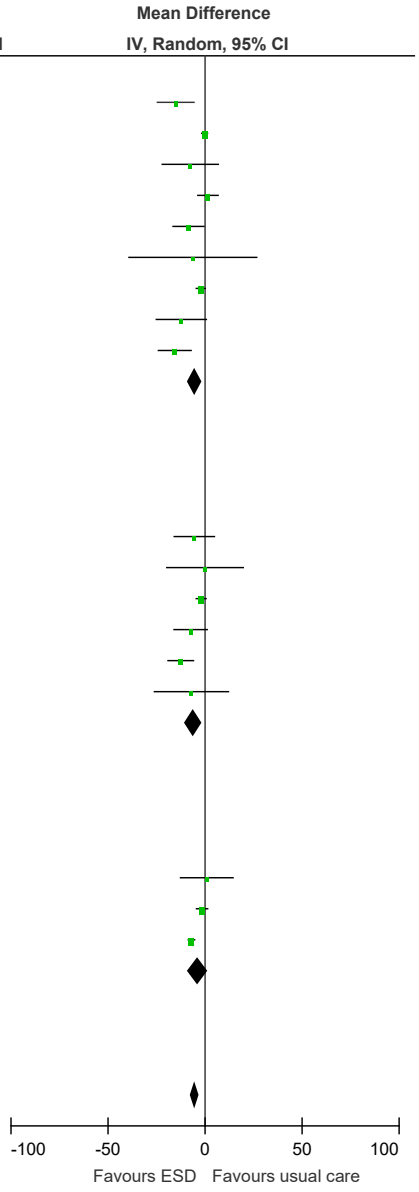

Figure 35: Caregiver strain index ([different scale ranges], lower values are better, final values) at end of scheduled follow-up

Study or Subgroup	Early supported discharge Mean	SD	Total	Usual care Mean	SD	Total	Weight	Std. Mean Difference IV, Fixed, 95% CI
2.10.1 ESD team coordination and delivery								
Adelaide 2000	0.2	0.4	42	0.2	0.4	44	14.9%	0.00 [-0.42, 0.42]
Belfast 2004	5.92	2.86	27	6	4.23	25	9.0%	-0.02 [-0.57, 0.52]
London 1997	5	4	75	4	3	59	22.6%	0.28 [-0.07, 0.62]
Subtotal (95% CI)			**144**			**128**	**46.5%**	**0.13 [-0.11, 0.37]**
Heterogeneity: Chi² = 1.37, df = 2 (P = 0.51); I² = 0%								
Test for overall effect: Z = 1.07 (P = 0.29)								
2.10.2 ESD team coordination only								
Trondheim 2000	23.39	2.7	128	22.58	3.12	121	42.6%	0.28 [0.03, 0.53]
Subtotal (95% CI)			**128**			**121**	**42.6%**	**0.28 [0.03, 0.53]**
Heterogeneity: Not applicable								
Test for overall effect: Z = 2.18 (P = 0.03)								
2.10.3 No ESD team								
Adelaide 2016	7.6	2.8	31	8.7	2.9	33	10.9%	-0.38 [-0.88, 0.11]
Subtotal (95% CI)			**31**			**33**	**10.9%**	**-0.38 [-0.88, 0.11]**
Heterogeneity: Not applicable								
Test for overall effect: Z = 1.51 (P = 0.13)								
Total (95% CI)			**303**			**282**	**100.0%**	**0.14 [-0.03, 0.30]**
Heterogeneity: Chi² = 6.79, df = 4 (P = 0.15); I² = 41%								
Test for overall effect: Z = 1.65 (P = 0.10)								
Test for subgroup differences: Chi² = 5.42, df = 2 (P = 0.07), I² = 63.1%								

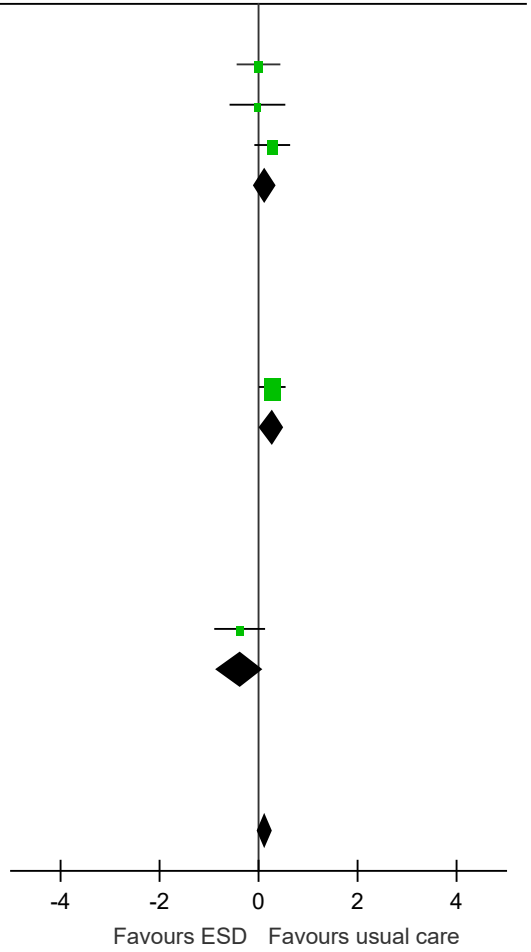

Figure 36: Falls at end of scheduled follow-up

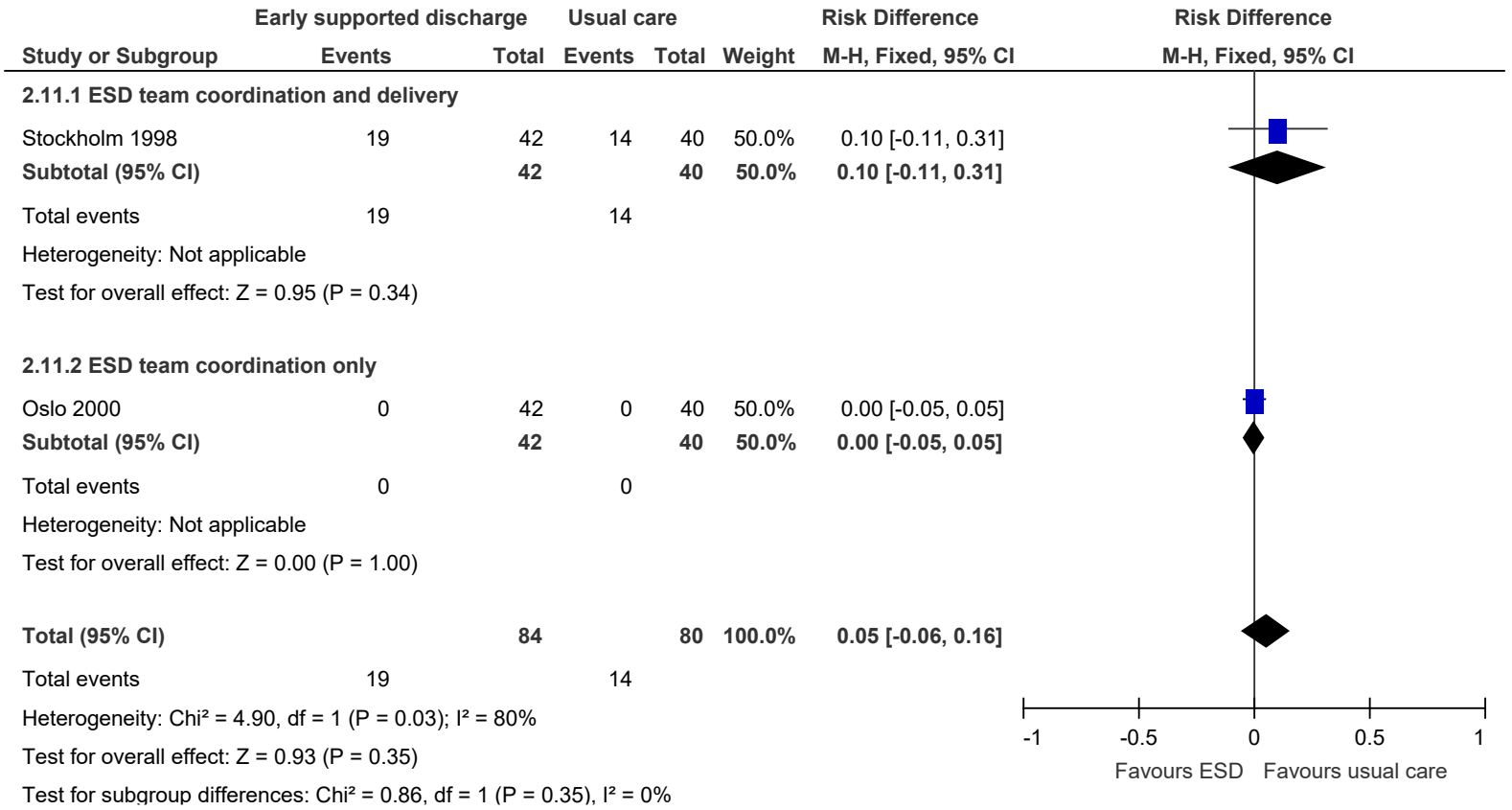

Figure 37: Readmissions to hospital at end of scheduled follow-up

Study or Subgroup	Early supported discharge Events	Total	Usual care Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
2.12.1 ESD team coordination and delivery						
Adelaide 2000	15	42	11	44	10.9%	1.43 [0.74, 2.75]
Belfast 2004	6	21	6	22	5.9%	1.05 [0.40, 2.74]
Copenhagen 2009	12	43	13	44	13.0%	0.94 [0.49, 1.83]
London 1997	44	167	42	164	42.9%	1.03 [0.72, 1.48]
Newcastle 1997	5	46	5	46	5.1%	1.00 [0.31, 3.22]
Stockholm 1998	16	41	14	40	14.3%	1.11 [0.63, 1.97]
Subtotal (95% CI)		**360**		**360**	**92.0%**	**1.08 [0.85, 1.37]**
Total events	98		91			
Heterogeneity: Chi² = 0.96, df = 5 (P = 0.97); I² = 0%						
Test for overall effect: Z = 0.60 (P = 0.55)						
2.12.2 No ESD team						
Adelaide 2016	7	31	8	32	8.0%	0.90 [0.37, 2.19]
Subtotal (95% CI)		**31**		**32**	**8.0%**	**0.90 [0.37, 2.19]**
Total events	7		8			
Heterogeneity: Not applicable						
Test for overall effect: Z = 0.23 (P = 0.82)						
Total (95% CI)		**391**		**392**	**100.0%**	**1.06 [0.84, 1.34]**
Total events	105		99			
Heterogeneity: Chi² = 1.11, df = 6 (P = 0.98); I² = 0%						
Test for overall effect: Z = 0.51 (P = 0.61)						
Test for subgroup differences: Chi² = 0.14, df = 1 (P = 0.71), I² = 0%						

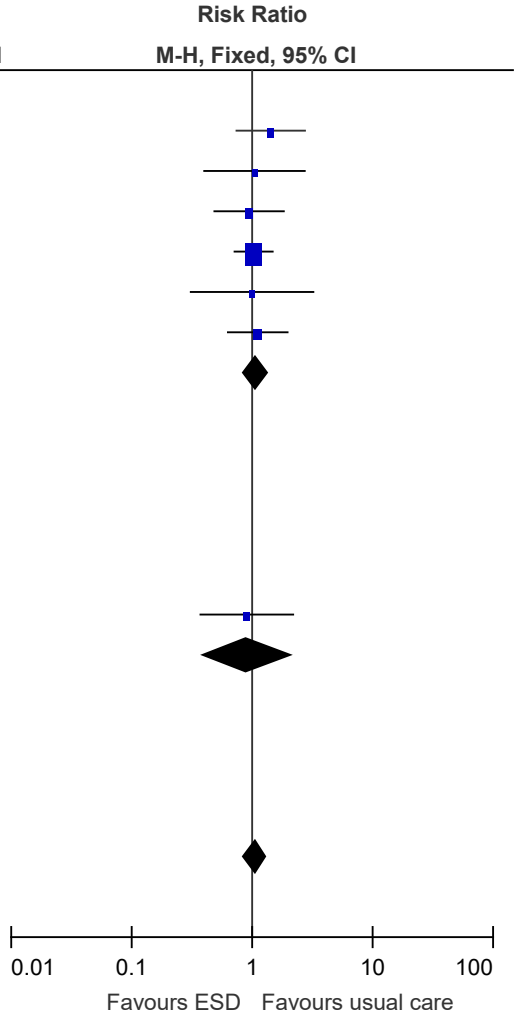

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Figure 38: Psychological distress/mood (General Health Questionnaire, HADS, Montgommery Asberg Depression rating scale, Wakefield depression inventory [different scale ranges], lower values are better, final values) at end of scheduled follow-up

	Early supported discharge			Usual care				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Fixed, 95% CI**
2.13.1 ESD team coordination and delivery								
Adelaide 2000	80.5	17.3	42	82.6	13.6	44	15.0%	-0.13 [-0.56, 0.29]
Manchester 2001	15	5	8	12	5	8	2.7%	0.57 [-0.44, 1.57]
Newcastle 1997	3	2.9	45	3	2.9	42	15.2%	0.00 [-0.42, 0.42]
Subtotal (95% CI)			**95**			**94**	**32.9%**	**-0.02 [-0.30, 0.27]**
Heterogeneity: Chi² = 1.60, df = 2 (P = 0.45); I² = 0%								
Test for overall effect: Z = 0.11 (P = 0.92)								
2.13.2 ESD team coordination only								
CARE4STROKE 2019	3.69	3.7	32	4.52	3.66	29	10.6%	-0.22 [-0.73, 0.28]
Oslo 2000	2.73	3.18	33	3.42	3.47	31	11.1%	-0.21 [-0.70, 0.29]
Trondheim 2000	5.52	5.83	134	5.82	6.34	125	45.3%	-0.05 [-0.29, 0.19]
Subtotal (95% CI)			**199**			**185**	**67.1%**	**-0.10 [-0.30, 0.10]**
Heterogeneity: Chi² = 0.57, df = 2 (P = 0.75); I² = 0%								
Test for overall effect: Z = 1.00 (P = 0.32)								
Total (95% CI)			**294**			**279**	**100.0%**	**-0.07 [-0.24, 0.09]**
Heterogeneity: Chi² = 2.40, df = 5 (P = 0.79); I² = 0%								
Test for overall effect: Z = 0.88 (P = 0.38)								
Test for subgroup differences: Chi² = 0.24, df = 1 (P = 0.62), I² = 0%								

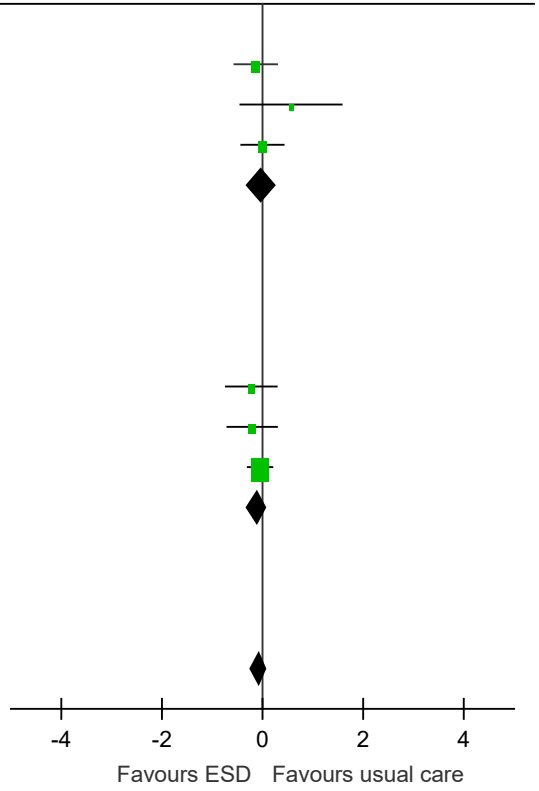

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Figure 39: Psychological distress/mood (HADS depression, 0-42, lower values are better, mean difference) at end of scheduled follow-up

Study or Subgroup	Mean Difference	SE	Early supported discharge Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
2.14.1 No ESD team					
Adelaide 2016	2	1.3266	31	32	2.00 [-0.60, 4.60]

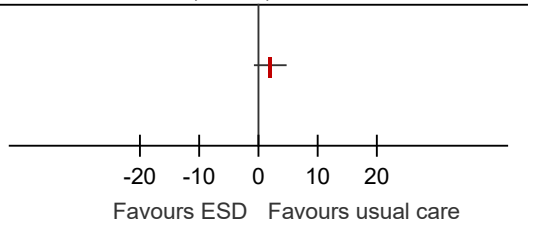

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Figure 40: Psychological distress/mood (HADS anxiety subscale, 0-21, lower values are better, final value) at end of scheduled follow-up

Study or Subgroup	Early supported discharge Mean	SD	Total	Usual care Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
2.15.1 ESD team coordination only							
CARE4STROKE 2019	3.22	3.05	32	5.07	4.7	29	-1.85 [-3.86, 0.16]

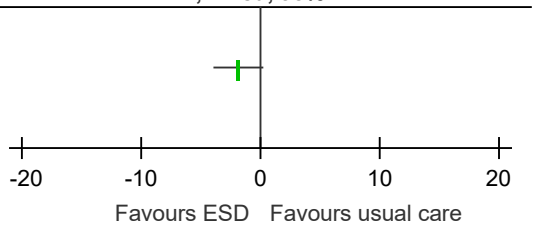

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Figure 41: Stroke-specific Patient-Reported Outcome Measures (SIS composite physical scale, 0-100, higher values are better, final value) at end of scheduled follow-up

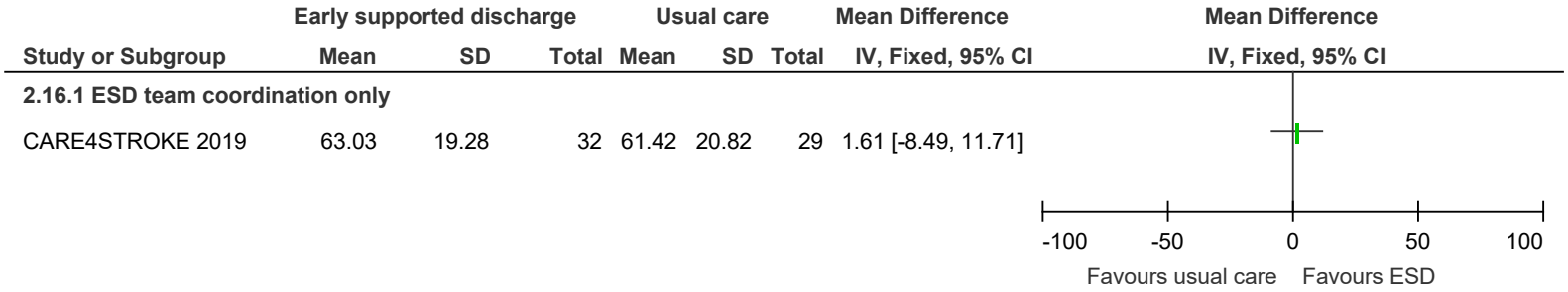

Figure 42: Stroke-specific Patient-Reported Outcome Measures (SIS mobility, 0-100, higher values are better, mean difference) at end of scheduled follow-up

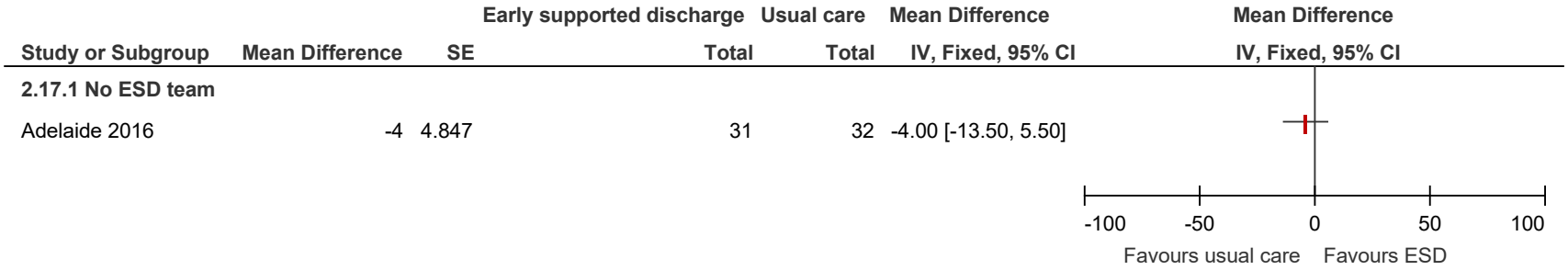

Figure 43: Stroke-specific Patient-Reported Outcome Measures (SIS strength, 0-100, higher values are better, mean difference) at end of scheduled follow-up

			Early supported discharge	Usual care	Mean Difference	Mean Difference
Study or Subgroup	Mean Difference	SE	Total	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
2.18.1 No ESD team						
Adelaide 2016	8.2	3.7756	31	32	8.20 [0.80, 15.60]	

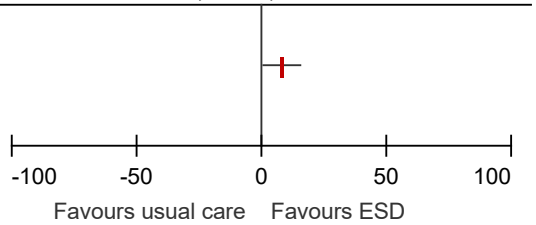

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Figure 44: Stroke-specific Patient-Reported Outcome Measures (SIS hand function, 0-100, higher values are better, mean difference) at end of scheduled follow-up

			Early supported discharge	Usual care	Mean Difference	Mean Difference
Study or Subgroup	Mean Difference	SE	Total	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
2.19.1 No ESD team						
Adelaide 2016	2.1	8.4185	31	32	2.10 [-14.40, 18.60]	

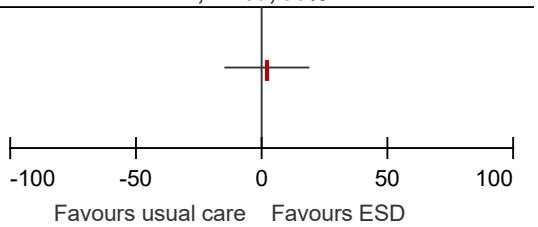

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Figure 45: Stroke-specific Patient-Reported Outcome Measures (SIS activities of daily living, 0-100, higher values are better, mean difference) at end of scheduled follow-up

			Early supported discharge	Usual care	Mean Difference	Mean Difference
Study or Subgroup	Mean Difference	SE	Total	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
2.20.1 No ESD team						
Adelaide 2016	-0.2	4.0817	31	32	-0.20 [-8.20, 7.80]	

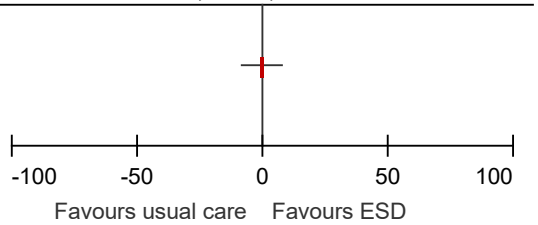

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Figure 46: Stroke-specific Patient-Reported Outcome Measures (SIS emotion, 0-100, higher values are better, mean difference) at end of scheduled follow-up

			Early supported discharge	Usual care	Mean Difference	Mean Difference
Study or Subgroup	Mean Difference	SE	Total	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
2.21.1 No ESD team						
Adelaide 2016	-1.4	3.0613	31	32	-1.40 [-7.40, 4.60]	

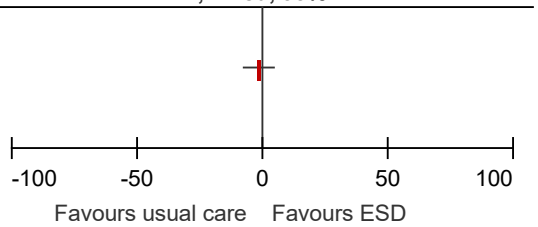

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Figure 47: Stroke-specific Patient-Reported Outcome Measures (SIS memory, 0-100, higher values are better, mean difference) at end of scheduled follow-up

			Early supported discharge	Usual care	Mean Difference	Mean Difference
Study or Subgroup	Mean Difference	SE	Total	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
2.22.1 No ESD team						
Adelaide 2016	-11.2	3.5715	31	32	-11.20 [-18.20, -4.20]	

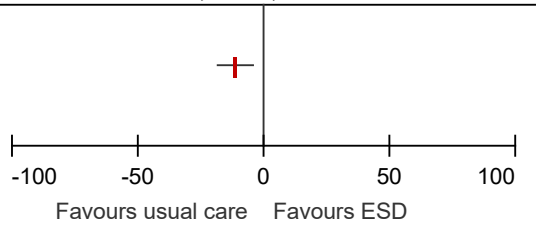


Figure 48: Stroke-specific Patient-Reported Outcome Measures (SIS communication, 0-100, higher values are better, mean difference) at end of scheduled follow-up

			Early supported discharge	Usual care	Mean Difference	Mean Difference
Study or Subgroup	Mean Difference	SE	Total	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
2.23.1 No ESD team						
Adelaide 2016	-5.2	2.8062	31	32	-5.20 [-10.70, 0.30]	

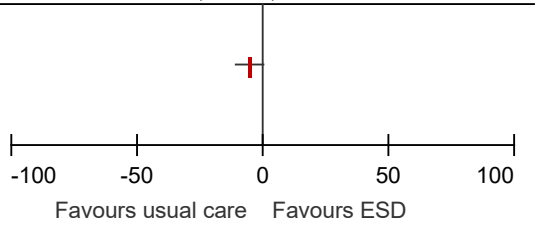


Figure 49: Stroke-specific Patient-Reported Outcome Measures (SIS social participation, 0-100, higher values are better, mean difference) at end of scheduled follow-up

Study or Subgroup	Mean Difference	SE	Early supported discharge Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
2.24.1 No ESD team					
Adelaide 2016	5.2	11.2247	31	32	5.20 [-16.80, 27.20]

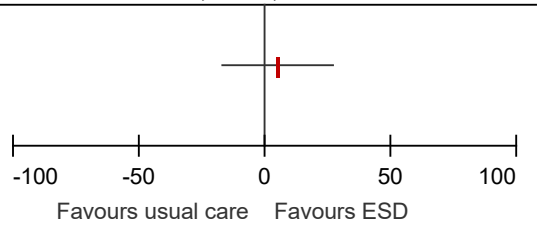
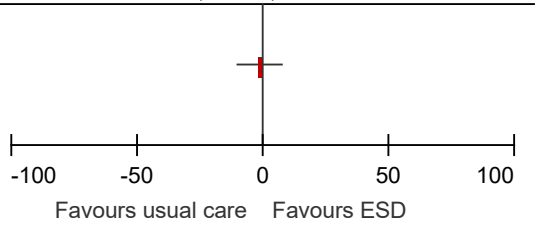


Figure 50: Stroke-specific Patient-Reported Outcome Measures (SIS recovery, 0-100, higher values are better, mean difference) at end of scheduled follow-up

Study or Subgroup	Mean Difference	SE	Early supported discharge Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
2.25.1 No ESD team					
Adelaide 2016	-1.2	4.4899	31	32	-1.20 [-10.00, 7.60]



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Appendix G – GRADE tables

Table 1: Clinical evidence profile: Early supported discharge compared to usual care (all studies analysed together)

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (all types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Mortality at the end of scheduled follow-up (follow-up: mean 33 weeks)												
18	randomised trials	not serious	serious[a]	not serious	very serious[b]	none	97/1162 (8.3%)	95/1154 (8.2%)	**RR 1.02** (0.79 to 1.32)	**2 more per 1,000** (from 17 fewer to 26 more)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (EuroQol, 0-100, higher values are better, final value) at end of scheduled follow-up (follow-up: mean 1 years; Scale from: 0 to 100)												
1	randomised trials	not serious	not serious	not serious	serious[b]	none	59	54	-	MD **1.85 lower** (9.03 lower to 5.33 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Person/participant generic health-related quality of life (SF-36 physical component summary, 0-100, higher values are better, final values) at end of scheduled follow-up (follow-up: mean 5.3 months; Scale from: 0 to 100)												
3	randomised trials	serious[c]	not serious	not serious	serious[b]	none	217	215	-	MD **4.15 higher** (1.59 higher to 6.71 higher)	⨁⨁◯◯ Low	CRITICAL
Person/participant generic health-related quality of life (SF-36 mental component summary, 0-100, higher values are better, final values) at end of scheduled follow-up (follow-up: mean 5.3 months; Scale from: 0 to 100)												
3	randomised trials	serious[c]	serious[d]	not serious	serious[b]	none	217	215	-	MD **2.15 lower** (4.66 lower to 0.37 higher)	⨁◯◯◯ Very low	CRITICAL
Carer generic health-related quality of life (carer QoL [different scale ranges], higher values are better, final values) at end of scheduled follow-up (follow-up: mean 12 weeks; assessed with: MID = 0.5 SMD)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (all types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
2	randomised trials	serious[e]	not serious	not serious	serious[b]	none	63	61	-	SMD **0.16 SD lower** (0.51 lower to 0.2 higher)	⨁⨁◯◯ Low	CRITICAL
Physical dependency at the end of scheduled follow-up (follow-up: mean 36 weeks)												
16	randomised trials	not serious	not serious	serious[f]	not serious	none	448/1205 (37.2%)	465/1102 (42.2%)	**RR 0.88** (0.80 to 0.97)	**51 fewer per 1,000** (from 84 fewer to 13 fewer)	⨁⨁⨁◯ Moderate	CRITICAL
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at end of scheduled follow-up (follow-up: mean 28 weeks)												
13	randomised trials	very serious[g]	not serious	not serious	not serious	none	808	711	-	SMD **0.04 SD higher** (0.06 lower to 0.14 higher)	⨁⨁◯◯ Low	CRITICAL
Extended activities of daily living (Adelaide Activities Profile, Frenchay Activities Index, Nottingham Activities of Daily Living, OARS, Rivermead Activities of Daily Living [different scale ranges], higher values are better, final values) at end of scheduled follow-up (follow-up: mean 30 weeks)												
10	randomised trials	very serious[h]	not serious	not serious	not serious	none	622	585	-	SMD **0.14 SD higher** (0.03 higher to 0.26 higher)	⨁⨁◯◯ Low	CRITICAL
Length of hospital stay (days, lower values are better, final values) at end of scheduled follow-up (follow-up: mean 32 weeks)												
18	randomised trials	not serious	very serious[d]	not serious	not serious	none	1239	1121	-	MD **4.98 lower** (7.34 lower to 2.63 lower)	⨁⨁◯◯ Low	CRITICAL
Caregiver strain index ([different scale ranges], lower values are better, final values) at end of scheduled follow-up (follow-up: mean 34 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (all types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
6	randomised trials	very serious[i]	not serious	not serious	not serious	none	335	311	-	SMD **0.14 SD higher** (0.02 lower to 0.29 higher)	⨁⨁◯◯ Low	CRITICAL
Falls at end of scheduled follow-up (follow-up: mean 2.75 years)												
2	randomised trials	not serious	very serious[d]	not serious	very serious[i]	none	19/84 (22.6%)	14/80 (17.5%)	**RD 0.05** (-0.06 to 0.16)	**50 more per 1,000** (from 60 fewer to 160 more)[k]	⨁◯◯◯ Very low	CRITICAL
Readmissions to hospital at end of scheduled follow-up (follow-up: mean 31 weeks)												
7	randomised trials	not serious	not serious	not serious	serious[b]	none	105/391 (26.9%)	99/392 (25.3%)	**RR 1.06** (0.84 to 1.34)	**15 more per 1,000** (from 40 fewer to 86 more)	⨁⨁⨁◯ Moderate	CRITICAL
Psychological distress/mood (General Health Questionnaire, HADS, Montgommery Asberg Depression rating scale, Wakefield depression inventory [different scale ranges], lower values are better, final values) at end of scheduled follow-up (follow-up: mean 37 weeks)												
6	randomised trials	very serious[h]	not serious	not serious	not serious	none	294	279	-	SMD **0.07 SD lower** (0.24 lower to 0.09 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (HADS depression, 0-42, lower values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 42)												
1	randomised trials	serious[i]	not serious	not serious	serious[b]	none	31	32	-	MD **2 higher** (0.6 lower to 4.6 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (HADS anxiety subscale, 0-21, lower values are better, final value) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 21)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	32	29	-	MD **1.85 lower** (3.86 lower to 0.16 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (all types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Stroke-specific Patient-Reported Outcome Measures (SIS composite physical scale, 0-100, higher values are better, final value) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	32	29	-	MD **1.61 higher** (8.49 lower to 11.71 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS mobility, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	31	32	-	MD **4 lower** (13.5 lower to 5.5 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS strength, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	31	32	-	MD **8.2 higher** (0.8 higher to 15.6 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS hand function, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	very serious[b]	none	31	32	-	MD **2.1 higher** (14.4 lower to 18.6 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS activities of daily living, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	very serious[b]	none	31	32	-	MD **0.2 lower** (8.2 lower to 7.8 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS emotion, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	31	32	-	MD **1.4 lower** (7.4 lower to 4.6 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (all types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Stroke-specific Patient-Reported Outcome Measures (SIS memory, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	31	32	-	MD **11.2 lower** (18.2 lower to 4.2 lower)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS communication, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	31	32	-	MD **5.2 lower** (10.7 lower to 0.3 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS social participation, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	very serious[b]	none	31	32	-	MD **5.2 higher** (16.8 lower to 27.2 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS recovery, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	31	32	-	MD **1.2 lower** (10 lower to 7.6 higher)	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference; **RR:** risk ratio; **SMD:** standardised mean difference

Explanations

a. Downgraded for heterogeneity due to conflicting number of events in different studies (zero events in one or more studies)

b. Downgraded by 1 increment if the confidence interval crossed one MID or by 2 increments if the confidence interval crossed both MIDs

c. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions and bias due to missing outcome data)

d. Downgraded by 1 or 2 increments because heterogeneity, unexplained by subgroup analysis

e. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias in measurement of the outcome)

f. Downgraded by 1 increment due to outcome indirectness (for including mortality in the outcome rather than only physical dependency)

g. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, bias due to missing outcome data, bias in measurement of the outcome, and bias in selection of the reported result)

h. Downgraded by 2 increments as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, bias due to missing outcome data, bias in measurement of the outcome, and bias in selection of the reported result)

i. Downgraded by 2 increments as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, bias due to missing outcome data and bias in measurement of the outcome)

j. Downgraded by 2 increments for imprecision due to zero events and small sample size

k. Absolute effect calculated by risk difference due to zero events in at least one study arm

l. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias arising from the measurement of the outcome)

Table 2: Clinical evidence profile: Early supported discharge compared to usual care (stratification of outcomes by the coordination and delivery of early supported discharge)

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Mortality at the end of scheduled follow-up (follow-up: 33 weeks)												
18	randomised trials	not serious	serious[a]	not serious	very serious[b]	none	97/1162 (8.3%)	95/1154 (8.2%)	**RR 1.02** (0.79 to 1.32)	**2 more per 1,000** (from 17 fewer to 26 more)	⨁◯◯◯ Very low	CRITICAL
Mortality at the end of scheduled follow-up - ESD team coordination and delivery (follow-up: mean 29 weeks)												
9	randomised trials	not serious	serious[a]	not serious	serious[b]	none	37/571 (6.5%)	50/560 (8.9%)	**RR 0.73** (0.50 to 1.08)	**24 fewer per 1,000** (from 45 fewer to 7 more)	⨁⨁◯◯ Low	CRITICAL
Mortality at the end of scheduled follow-up - ESD team coordination only (follow-up: 33 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
5	randomised trials	not serious	serious[a]	not serious	very serious[b]	none	24/334 (7.2%)	26/331 (7.9%)	**RR 0.92** (0.55 to 1.54)	**6 fewer per 1,000** (from 35 fewer to 42 more)	⨁◯◯◯ Very low	CRITICAL
Mortality at the end of scheduled follow-up - No ESD team (follow-up: 5.5 months)												
4	randomised trials	very serious[c]	serious[a]	not serious	serious[b]	none	36/257 (14.0%)	19/263 (7.2%)	**RR 1.93** (1.16 to 3.20)	**67 more per 1,000** (from 12 more to 159 more)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (EuroQol, 0-100, higher values are better, final value) at end of scheduled follow-up (follow-up: 12 months; Scale from: 0 to 100)												
1	randomised trials	not serious	not serious	not serious	serious[b]	none	59	54	-	MD **1.85 lower** (9.03 lower to 5.33 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Person/participant generic health-related quality of life (EuroQol, 0-100, higher values are better, final value) at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 12 months; Scale from: 0 to 100)												
1	randomised trials	not serious	not serious	not serious	serious[b]	none	59	54	-	MD **1.85 lower** (9.03 lower to 5.33 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Person/participant generic health-related quality of life (SF-36 physical component summary, 0-100, higher values are better, final values) at end of scheduled follow-up (follow-up: 5.3 weeks; Scale from: 0 to 100)												
3	randomised trials	serious[d]	not serious	not serious	serious[b]	none	217	215	-	MD **4.15 higher** (1.59 higher to 6.71 higher)	⨁⨁◯◯ Low	CRITICAL
Person/participant generic health-related quality of life (SF-36 physical component summary, 0-100, higher values are better, final values) at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 12 weeks; Scale from: 0 to 100)												
2	randomised trials	serious[e]	not serious	not serious	very serious[b]	none	93	88	-	MD **5.38 higher** (2.37 higher to 8.4 higher)	⨁◯◯◯ Very low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (SF-36 physical component summary, 0-100, higher values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 7 months; Scale from: 0 to 100)												
1	randomised trials	very serious[c]	not serious	not serious	very serious[b]	none	124	127	-	MD **1 higher** (3.83 lower to 5.83 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (SF-36 mental component summary, 0-100, higher values are better, final values) at end of scheduled follow-up (follow-up: 5.3 weeks; Scale from: 0 to 100)												
3	randomised trials	serious[d]	serious[f]	not serious	serious[b]	none	217	215	-	MD **2.15 lower** (4.66 lower to 0.37 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (SF-36 mental component summary, 0-100, higher values are better, final values) at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 12 weeks; Scale from: 0 to 100)												
2	randomised trials	serious[e]	serious[f]	not serious	serious[b]	none	93	88	-	MD **3.15 lower** (6.2 lower to 0.1 lower)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (SF-36 mental component summary, 0-100, higher values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 7 months; Scale from: 0 to 100)												
1	randomised trials	very serious[c]	not serious	not serious	very serious[b]	none	124	127	-	MD **0** (4.46 lower to 4.46 higher)	⨁◯◯◯ Very low	CRITICAL
Carer generic health-related quality of life (carer QoL, scale range unclear, higher values are better, final values) at end of scheduled follow-up (follow-up: 12 weeks)												
2	randomised trials	serious[g]	not serious	not serious	serious[b]	none	63	61	-	SMD **0.16 SD lower** (0.51 lower to 0.2 higher)	⨁⨁◯◯ Low	CRITICAL
Carer generic health-related quality of life (carer QoL, scale range unclear, higher values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 12 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	32	29	-	SMD **0.21 SD lower** (0.71 lower to 0.3 higher)	⨁⨁◯◯ Low	CRITICAL
Carer generic health-related quality of life (carer QoL, scale range unclear, higher values are better, final values) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	SMD **0.11 SD lower** (0.6 lower to 0.39 higher)	⨁⨁◯◯ Low	CRITICAL
Physical dependency at the end of scheduled follow-up (follow-up: 36 weeks)												
16	randomised trials	not serious	not serious	serious[h]	not serious	none	448/1205 (37.2%)	465/1102 (42.2%)	**RR 0.88** (0.80 to 0.97)	**51 fewer per 1,000** (from 84 fewer to 13 fewer)	⨁⨁⨁◯ Moderate	CRITICAL
Physical dependency at the end of scheduled follow-up - ESD team coordination and delivery (follow-up: 8 months)												
9	randomised trials	not serious	not serious	serious[h]	serious[b]	none	219/571 (38.4%)	258/560 (46.1%)	**RR 0.83** (0.73 to 0.94)	**78 fewer per 1,000** (from 124 fewer to 28 fewer)	⨁⨁◯◯ Low	CRITICAL
Physical dependency at the end of scheduled follow-up - ESD team coordination only (follow-up: 9 months)												
4	randomised trials	serious[i]	not serious	serious[h]	serious[b]	none	172/440 (39.1%)	150/330 (45.5%)	**RR 0.89** (0.75 to 1.06)	**50 fewer per 1,000** (from 114 fewer to 27 more)	⨁◯◯◯ Very low	CRITICAL
Physical dependency at the end of scheduled follow-up - No ESD team (follow-up: 6 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
3	randomised trials	very serious[i]	not serious	serious[h]	serious[b]	none	57/194 (29.4%)	57/212 (26.9%)	**RR 1.09** (0.81 to 1.46)	**24 more per 1,000** (from 51 fewer to 124 more)	⨁◯◯◯ Very low	CRITICAL
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at end of scheduled follow-up (follow-up: 28 weeks)												
13	randomised trials	very serious[k]	not serious	not serious	not serious	none	808	711	-	SMD **0.04 SD higher** (0.06 lower to 0.14 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 8 months)												
7	randomised trials	very serious[l]	not serious	not serious	not serious	none	411	397	-	SMD **0.06 SD higher** (0.08 lower to 0.2 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 3 months)												
3	randomised trials	very serious[m]	not serious	not serious	not serious	none	208	114	-	SMD **0.01 SD higher** (0.23 lower to 0.24 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at end of scheduled follow-up - No ESD team (follow-up: 5.3 months)												
3	randomised trials	very serious[n]	not serious	not serious	not serious	none	189	200	-	SMD **0.02 SD higher** (0.18 lower to 0.22 higher)	⨁⨁◯◯ Low	CRITICAL
Extended activities of daily living (Adelaide Activities Profile, Frenchay Activities Index, Nottingham Activities of Daily Living, OARS, Rivermead Activities of Daily Living [different scale ranges], higher values are better, final values) at end of scheduled follow-up (follow-up: 30 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
10	randomised trials	very serious[o]	not serious	not serious	not serious	none	622	585	-	SMD **0.14 SD higher** (0.03 higher to 0.26 higher)	⨁⨁◯◯ Low	CRITICAL

Extended activities of daily living (Adelaide Activities Profile, Frenchay Activities Index, Nottingham Activities of Daily Living, OARS, Rivermead Activities of Daily Living [different scale ranges], higher values are better, final values) at end of scheduled follow-up - ESD tema coordination and delivery (follow-up: 7 months)

8	randomised trials	very serious[p]	not serious	not serious	not serious	none	455	430	-	SMD **0.17 SD higher** (0.04 higher to 0.3 higher)	⨁⨁◯◯ Low	CRITICAL

Extended activities of daily living (Adelaide Activities Profile, Frenchay Activities Index, Nottingham Activities of Daily Living, OARS, Rivermead Activities of Daily Living [different scale ranges], higher values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 9 months)

2	randomised trials	very serious[q]	not serious	not serious	not serious	none	167	155	-	SMD **0.07 SD higher** (0.15 lower to 0.29 higher)	⨁⨁◯◯ Low	CRITICAL

Length of hospital stay (days, lower values are better, final values) at end of scheduled follow-up (follow-up: 32 weeks)

18	randomised trials	not serious	very serious[r]	not serious	not serious	none	1239	1121	-	MD **4.98 lower** (7.34 lower to 2.63 lower)	⨁⨁◯◯ Low	CRITICAL

Length of hospital stay (days, lower values are better, final values) at end of scheduled follow-up - ESD team coordination and delivery

9	randomised trials	not serious	very serious[r]	not serious	not serious	none	565	555	-	MD **5.22 lower** (8.78 lower to 1.67 lower)	⨁⨁◯◯ Low	CRITICAL

Length of hospital stay (days, lower values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 9.5 months)

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
6	randomised trials	serious[d]	not serious	not serious	serious[b]	none	541	430	-	MD **5.95 lower** (10.65 lower to 1.24 lower)	⨁⨁◯◯ Low	CRITICAL
Length of hospital stay (days, lower values are better, final values) at end of scheduled follow-up - No ESD team (follow-up: 4 months)												
3	randomised trials	very serious[i]	very serious[f]	not serious	serious[b]	none	133	136	-	MD **3.83 lower** (8.79 lower to 1.13 higher)	⨁◯◯◯ Very low	CRITICAL
Caregiver strain index ([different scale ranges], lower values are better, final values) at end of scheduled follow-up (follow-up: 34 weeks)												
5	randomised trials	very serious[r]	not serious	not serious	not serious	none	303	282	-	SMD **0.14 SD higher** (0.03 lower to 0.3 higher)	⨁⨁◯◯ Low	CRITICAL
Caregiver strain index ([different scale ranges], lower values are better, final values) at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 10 months)												
3	randomised trials	serious[d]	not serious	not serious	not serious	none	144	128	-	SMD **0.13 SD higher** (0.11 lower to 0.37 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Caregiver strain index ([different scale ranges], lower values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 12 months)												
1	randomised trials	very serious[q]	not serious	not serious	serious[b]	none	128	121	-	SMD **0.28 SD higher** (0.03 higher to 0.53 higher)	⨁◯◯◯ Very low	CRITICAL
Caregiver strain index ([different scale ranges], lower values are better, final values) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	33	-	SMD **0.38 SD lower** (0.88 lower to 0.11 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Falls at end of scheduled follow-up												
2	randomised trials	not serious	very serious[f]	not serious	very serious[b]	none	19/84 (22.6%)	14/80 (17.5%)	**RD 0.05** (-0.06 to 0.16)	**50 more per 1,000** (from 60 fewer to 160 more)[s]	⨁◯◯◯ Very low	CRITICAL
Falls at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 5 years)												
1	randomised trials	serious[t]	not serious	not serious	very serious[b,s]	none	19/42 (45.2%)	14/40 (35.0%)	**RD 0.10** (-0.11 to 0.31)	**100 more per 1,000** (from 110 fewer to 310 more)[s]	⨁◯◯◯ Very low	CRITICAL
Falls at end of scheduled follow-up - ESD team coordination only (follow-up: 6 months)												
1	randomised trials	serious[t]	not serious	not serious	very serious[b]	none	0/42 (0.0%)	0/40 (0.0%)	**RD 0.00** (-0.05 to 0.05)	**0 fewer per 1,000** (from 50 fewer to 50 more)[s]	⨁◯◯◯ Very low	CRITICAL
Readmissions to hospital at end of scheduled follow-up (follow-up: 31 weeks)												
7	randomised trials	very serious[r]	not serious	not serious	serious[b]	none	105/391 (26.9%)	99/392 (25.3%)	**RR 1.06** (0.84 to 1.34)	**15 more per 1,000** (from 40 fewer to 86 more)	⨁◯◯◯ Very low	CRITICAL
Readmissions to hospital at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 7 months)												
6	randomised trials	not serious	not serious	not serious	serious[b]	none	98/360 (27.2%)	91/360 (25.3%)	**RR 1.08** (0.85 to 1.37)	**20 more per 1,000** (from 38 fewer to 94 more)	⨁⨁⨁◯ Moderate	CRITICAL
Readmissions to hospital at end of scheduled follow-up - No ESD team (follow-up: 3 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	7/31 (22.6%)	8/32 (25.0%)	**RR 0.90** (0.37 to 2.19)	**25 fewer per 1,000** (from 158 fewer to 298 more)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (General Health Questionnaire, HADS, Montgommery Asberg Depression rating scale, Wakefield depression inventory [different scale ranges], lower values are better, final values) at end of scheduled follow-up (follow-up: 37 weeks)												
6	randomised trials	very serious[o]	not serious	not serious	not serious	none	294	279	-	SMD **0.07 SD lower** (0.24 lower to 0.09 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (General Health Questionnaire, HADS, Montgommery Asberg Depression rating scale, Wakefield depression inventory [different scale ranges], lower values are better, final values) at end of scheduled follow-up - ESD team coordination and delivery (follow-up: 9 months)												
3	randomised trials	very serious[u]	not serious	not serious	not serious	none	95	94	-	SMD **0.02 SD lower** (0.3 lower to 0.27 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (General Health Questionnaire, HADS, Montgommery Asberg Depression rating scale, Wakefield depression inventory [different scale ranges], lower values are better, final values) at end of scheduled follow-up - ESD team coordination only (follow-up: 6 months)												
3	randomised trials	very serious[q]	not serious	not serious	not serious	none	199	185	-	SMD **0.1 SD lower** (0.3 lower to 0.1 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (HADS depression, 0-42, lower values are better, mean difference) at end of scheduled follow-up (follow-up: mean 12 weeks; Scale from: 0 to 42)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **2 higher** (0.6 lower to 4.6 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (HADS depression, 0-42, lower values are better, mean difference) at end of scheduled follow-up - No ESD team												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **2 higher** (0.6 lower to 4.6 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (HADS anxiety subscale, 0-21, lower values are better, final value) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 21)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	32	29	-	MD **1.85 lower** (3.86 lower to 0.16 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress/mood (HADS anxiety subscale, 0-21, lower values are better, final value) at end of scheduled follow-up - ESD team coordination only												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	32	29	-	MD **1.85 lower** (3.86 lower to 0.16 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS composite physical scale, 0-100, higher values are better, final value) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	32	29	-	MD **1.61 higher** (8.49 lower to 11.71 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS composite physical scale, 0-100, higher values are better, final value) at end of scheduled follow-up - ESD team coordination only												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	32	29	-	MD **1.61 higher** (8.49 lower to 11.71 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS mobility, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **4 lower** (13.5 lower to 5.5 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Stroke-specific Patient-Reported Outcome Measures (SIS mobility, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **4 lower** (13.5 lower to 5.5 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS strength, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **8.2 higher** (0.8 higher to 15.6 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS strength, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **8.2 higher** (0.8 higher to 15.6 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS hand function, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	very serious[b]	none	31	32	-	MD **2.1 higher** (14.4 lower to 18.6 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS hand function, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	very serious[b]	none	31	32	-	MD **2.1 higher** (14.4 lower to 18.6 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS activities of daily living, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	very serious[b]	none	31	32	-	MD **0.2 lower** (8.2 lower to 7.8 higher)	⨁◯◯◯ Very low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Stroke-specific Patient-Reported Outcome Measures (SIS activities of daily living, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	very serious[b]	none	31	32	-	MD **0.2 lower** (8.2 lower to 7.8 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS emotion, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **1.4 lower** (7.4 lower to 4.6 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS emotion, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **1.4 higher** (7.4 lower to 4.6 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS memory, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **11.2 lower** (18.2 lower to 4.2 lower)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS memory, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **11.2 lower** (18.2 lower to 4.2 lower)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS communication, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **5.2 lower** (10.7 lower to 0.3 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early supported discharge (stratified into types) compared to usual care	placebo	Relative (95% CI)	Absolute (95% CI)		
Stroke-specific Patient-Reported Outcome Measures (SIS communication, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **5.2 lower** (10.7 lower to 0.3 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS social participation, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	very serious[b]	none	31	32	-	MD **5.2 higher** (16.8 lower to 27.2 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS social participation, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	very serious[b]	none	31	32	-	MD **5.2 higher** (16.8 lower to 27.2 higher)	⨁◯◯◯ Very low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS recovery, 0-100, higher values are better, mean difference) at end of scheduled follow-up (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **1.2 lower** (10 lower to 7.6 higher)	⨁⨁◯◯ Low	CRITICAL
Stroke-specific Patient-Reported Outcome Measures (SIS recovery, 0-100, higher values are better, mean difference) at end of scheduled follow-up - No ESD team (follow-up: 12 weeks; Scale from: 0 to 100)												
1	randomised trials	serious[g]	not serious	not serious	serious[b]	none	31	32	-	MD **1.2 lower** (10 lower to 7.6 higher)	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference; **RR:** risk ratio; **SMD:** standardised mean difference

Explanations

a. Downgraded for heterogeneity due to conflicting number of events in different studies (zero events in one or more studies)

b. Downgraded by 1 increment if the confidence interval crossed one MID or by 2 increments if the confidence interval crossed both MIDs

c. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias arising from the randomisation process, and bias due to missing outcome data)

d. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, and bias due to missing outcome data)

e. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias arising from deviations from the intended intervention)

f. Downgraded by 1 or 2 increments because heterogeneity, unexplained by subgroup analysis

g. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias in measurement of the outcome)

h. Downgraded by 1 increment due to outcome indirectness (for including mortality in the outcome rather than only physical dependency)

i. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions and bias due to missing outcome data)

j. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, and bias due to missing outcome data)

k. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, bias due to missing outcome data and bias in measurement of the outcome)

l. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, bias due to missing outcome data, bias in measurement of the outcome and bias in selection of the reported result)

m. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to deviations from the intended interventions, and bias due to missing outcome data)

n. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias arising from the randomisation process, and bias due to missing outcome data)

o. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, bias due to missing outcome data bias in measurement of the outcome and bias in selection of the reported result)

p. Downgraded by 2 increments as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, and bias in measurement of the outcome)

q. Downgraded by 2 increments as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process, and bias due to deviations from the intended interventions)

r. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias arising from the randomisation process, bias due to deviations from the intended interventions, bias due to missing outcome data and bias in measurement of the outcome)

s. Absolute effect calculated by risk difference due to zero events in at least one study arm

t. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to bias arising from the randomisation process)

u. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias due to deviations from the intended interventions, bias due to missing outcome data, bias in measurement of the outcome and bias in selection of the reported result)

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Appendix H – GRADE-CERQual tables

Table 3: Summary of review finding 1

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person-centred care: the underpinning principle of early supported discharge success[4, 6, 13, 18, 31, 36, 40, 42, 46]					
9	Interviews (n=6) Focus groups (n=1) Qualitative survey data (n=1) Qualitative survey data, nterviews and focus groups (n=1)	Stroke survivors, family members and carers and healthcare professionals all agreed that the main benefit of early supported discharge was the ability to provide person-centred care in a way that was possible in a person's home and not possible in a hospital.	Limitations	Minor concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No concerns about adequacy	

(a) Minor methodological limitations in the contributing studies (due to a lack of clarity in whether the relationship between researcher and participants had been considered and whether data analysis was sufficiently rigorous in some studies)

(b) Minor concerns about relevance due to the majority of contributing studies representing the views from countries that were not in the United Kingdom (such as Sweden, Denmark, Australia and Canada) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding

Table 4: Summary of review finding 2a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Clear and fair eligibility criteria[4, 9, 17, 18, 29]					

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
5	Interviews (n=4) Delphi approach (n=1)	Healthcare professionals all appreciated the presence of clear and fair eligibility criteria that are sufficiently flexible to allow the correct people to access early supported discharge. Stroke survivors and family members and carers were generally unaware of the criteria for early supported discharge.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	Minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	No concerns about adequacy	

(a) Moderate methodological limitations (due to a combination of problems with the recruitment process in one study, a lack of clarity in whether the relationship between researcher and participants had been considered, a lack of information about whether ethical concerns were addressed and whether data analysis was sufficiently rigorous in one study)
(b) Minor concerns about the coherence of the finding due to disagreement between professionals regarding the use of ability to make meaningful goals as a criteria
(c) Minor concerns about relevance due to the majority of contributing studies representing the views from countries that were not in the United Kingdom (such as Sweden, Denmark and Australia)

Table 5: Summary of review finding 2b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Lack of clarity regarding the referral decision making process[4, 9, 21]					
3	Interviews (n=2) Delphi approach (n=1)	Healthcare professionals raised that there can be a lack of clarity regarding the referral decision making process for early supported discharge, and how the different services after discharge interact.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	Minor concerns about coherence[b]	
			Relevance	No or very minor	

Study design and sample size		Finding	Quality assessment		
Number of studies contributing to the finding	Design		Criteria	Rating	Overall assessment of confidence
				concerns about relevance	
			Adequacy	Minor concerns about adequacy[c]	

(a) Moderate methodological limitations (due to a combination of problems with the recruitment process in one study, a lack of clarity in whether the relationship between researcher and participants had been considered and a lack of information about whether ethical concerns were addressed)
(b) Minor concerns about the coherence of the findings due to debate on when early supported discharge should be considered and the differences in knowledge between different types of healthcare professionals
(c) Minor concerns about inadequacy as the evidence was gathered from three studies and there appeared to be gaps in knowledge that could provide additional information discussing this subtheme

Table 6: Summary of review finding 2c

Study design and sample size		Finding	Quality assessment		
Number of studies contributing to the finding	Design		Criteria	Rating	Overall assessment of confidence
Delays from starting care due to paperwork/bureaucracy[4, 16, 36, 46]					
4	Interviews (n=3) Focus groups (n=1)	Some stroke survivors and family members and carers believed that their care was delayed due to the process of transferring care between services. However, some participants had a different experience and found that the care they needed was less likely to be delayed than if they had not received early supported discharge.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	Minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a combination of problems with a lack of clarity in whether the relationship between researcher and participants had been considered and a lack of information about whether ethical concerns were addressed)

(b) Minor concerns about the coherence of the findings due to variations in whether delays were experienced or not
(c) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway and Australia) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding

Table 7: Summary of review finding 3a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Stroke survivor/family member expectation of what will happen in early supported discharge[5, 6, 9, 18, 26, 29, 31, 36]					
8	Interviews (n=6) Qualitative survey data (n=1) Delphi approach (n=1)	Stroke survivors and family members were unclear about what to expect from early supported discharge and felt like they had inadequate information provided to understand this ahead of time.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns about adequacy[c]	

(a) Moderate methodological limitations (due to a combination of problems including a lack of clarity in whether the relationship between researcher and participants had been considered, two studies where the rigor of the data analysis was unclear, one study where it was unclear if the recruitment strategy was appropriate and one study where it was unclear if ethical issues have been considered)
(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Denmark, Norway and Canada) and so may have had a different cultural experience of healthcare
(c) Minor concerns about adequacy as the evidence as the expectations of stroke survivors and family members are only explained in one study, with the majority of studies supporting the lack of information instead

Table 8: Summary of review finding 3b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Stroke survivor/family member/healthcare professional expectation of challenge: physical, psychological and social[6, 26, 40]					
3	Interviews (n=2) Focus groups (n=1)	Stroke survivors, family members and healthcare professionals expected that there would be challenges when the person went home.	Limitations	Minor concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns about adequacy[c]	

(a) Minor methodological limitations (due to a lack of clarity in whether the relationship between researcher and participants had been considered in one study)

(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden and the Netherlands) and so may have had a different cultural experience of healthcare

(c) Minor concerns about adequacy as the evidence was limited to very few studies presenting each perspective of the finding

Table 9: Summary of review finding 3c

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Stroke survivor/family member expectation to return to 'normal' after early supported discharge[4, 6, 8, 13, 16, 18, 26, 29, 35, 36, 40, 46]					
12	Interviews (n=9) Focus groups (n=2)	Initially after stroke, motivation to return to how their life was before the stroke was high. This understanding was moderated by the amount of recovery the person was experiencing. This idea was often at the forefront of stroke	Limitations	Minor concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
	Qualitative survey data, interviews and focus groups (n=1)	survivors' thoughts, but behind this was anxiety at whether this was possible or not which was coupled with frustration when the evidence indicated they were not returning to the normality that they wished for.		concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Minor methodological limitations (due to a combination of problems with a lack of clarity in whether the relationship between researcher and participants had been considered, one study with a lack of information about whether ethical concerns were addressed and one study where it was unclear if the data analysis was sufficiently rigorous)

(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Denmark, Norway, the Netherlands and Australia) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding

Table 10: Summary of review finding 3d

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Stroke survivor/family member/healthcare professional expectation that the family member will help[4, 8, 17, 29]					
4	Interviews (n=4)	Where family members were involved in the life of the stroke survivor, there appeared to be an assumption by everyone that they would be supporting the stroke survivor once they got home.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
				about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a combination of problems including a lack of clarity in whether the relationship between researcher and participants had been considered, one study where it was unclear if ethical issues have been considered and one study where the rigor of the data analysis was unclear)
(b) Minor concerns regarding relevance due to some studies discussing home rehabilitation rather than specifically early supported discharge

Table 11: Summary of review finding 3e

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Stroke survivor/family member expectation that they will work with professionals experienced in stroke[9, 16, 26, 36, 40]					
5	Interviews (n=2) Focus groups (n=2) Delphi approach (n=1)	Stroke survivors and family members expected that the healthcare professionals working with them would have a significant amount of experience with stroke and would be able to provide them with information and guide their care effectively.	Limitations	Minor concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Minor methodological limitations (due to a combination of problems with a lack of clarity in whether the relationship between researcher and participants had been considered, one study where it was unclear if the

recruitment strategy was appropriate and one study where it was unclear if ethical issues have been considered)

(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway and the Netherlands) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding

Table 12: Summary of review finding 3f

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Beliefs about intensity of therapy[4, 5, 9, 13, 17, 29, 36, 40, 42]					
9	Interviews (n=6) Focus groups (n=1) Delphi approach (n=1) Qualitative survey data, interview and focus group (n=1)	There was inconsistency in people's beliefs and experiences regarding the intensity of therapy that would be provided during early supported discharge with the majority believing it increases intensity while others believed it reduced this.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence[b]	
			Relevance	No or very minor concerns about relevance	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a combination of problems including a lack of clarity in whether the relationship between researcher and participants had been considered, one study where it was unclear if ethical issues have been considered and one study where the rigor of the data analysis was unclear)

(b) No or very minor concerns about the coherence of the findings due to the theme of the finding being that inconsistency is present in the finding and highlighting the need to consider this

Table 13: Summary of review finding 3g

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Beliefs about the cost of early supported discharge[9, 13, 21]					
3	Interviews (n=1) Delphi approach (n=1) Qualitative survey data, interview and focus group (n=1)	The thoughts on the cost of early supported discharge was a moderator for whether people consider the service appropriate to use or not.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	Minor concerns about coherence[b]	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[c]	

(a) Moderate methodological limitations (due to a combination of problems including a lack of clarity in whether the relationship between researcher and participants had been considered, one study where it was unclear if ethical issues have been considered and one study where it was unclear how appropriate the recruitment strategy was for answering the question)

(b) Minor concerns regarding coherence due to variety in understanding about cost between different healthcare professionals

(c) Minor concerns regarding adequacy due to there being few studies that explored this factor in the depth required for a more complete understanding

Table 14: Summary of review finding 4a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Loss of independence – sometimes needing support[26, 29, 35]					
3	Interviews (n=3)	Discharge after stroke was often associated with a realisation of a loss of independence and requiring support from family members or friends and healthcare professionals that they would not have required	Limitations	Minor concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
		previously. This was often associated with feelings of loss.		concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy[c]	

(a) *Minor methodological limitations (the majority of studies had no concerns with risk of bias, with one having limitations with a lack of clarity regarding the exploration of the relationship between the interviewer and the participants and whether the data analysis was sufficiently rigorous)*
(b) *Minor concerns about relevance due to all of the contributing studies representing the views of people from countries that were not in the United Kingdom (Sweden and Norway) and so may have had a different cultural experience of healthcare*
(c) *No or very minor concerns regarding the adequacy (while the number of studies were low, the data was considered sufficiently rich to explore the issue)*

Table 15: Summary of review finding 4b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Changing relationships with their partners[5, 8, 16, 18, 29, 36], friends[8, 29, 35, 36] and children/grandchildren[8, 17, 18, 26, 35, 36]					
9	Interviews (n=8) Focus groups (n=1)	Stroke survivors and people they are in relationships with (from the views explored in these studies, either married or long term partner) can experience significant changes in their roles after the stroke, with the partner becoming a caregiver and the stroke survivor becoming a patient who needs support. The stroke survivor's relationship with their friends often changes. This is due to a mixture of factors including the stroke survivor's ability	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
		to interact with the outside world due to a mixture of less physical and emotional access, reduced ability to withstand conflicts and reduced ability to manage familiar activities with others. For parents and grandparents, they found that their relationships with their children and grandchildren changed after their stroke. For some their children and grandchildren may become carers to support them and so undergo a similar transition to partners in this regard and gain the challenges associated with this. For parents and grandparents who are still caring for their children, the challenges of adapting to their life after stroke and providing the care required were significant.	Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to it being unclear whether the study considered the relationship between the interviewer and the participant)
(b) No or very minor concerns regarding coherence (while variations were seen, these are likely reflective of the varied relationships that partners can have and still support the theme that changes occur)
(c) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway, Denmark and Australia) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding

Table 16: Summary of review finding 4c

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
The future – What is life going to look like? Will I have another stroke? [5, 6, 8, 15, 16, 18, 29, 35, 36]					
9	Interviews (n=8)	Stroke survivors were commonly concerned about what the future would be like after their stroke including future plans and the	Limitations	Moderate concerns about methodological limitations[a]	MODERATE

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
	Focus groups (n=1)	possibility of having another stroke in the future.	Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of unclear reporting of exploration of the relationship between the interviewer and the participant and whether the data analysis was sufficiently rigorous)

(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway and Denmark) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding

Table 17: Summary of review finding 5a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
From family member to carer[17, 18, 26, 29, 40]					
5	Interviews (n=4) Focus groups (n=1)	Family members who are involved in the care of a stroke survivor can experience a large change in their life where they transition from being a family member to helping to provide care and support to their family member who has had a stroke.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
			Adequacy	No or very minor concerns about adequacy	

(a) *Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant and about the rigour of the data analysis in one study)*
(b) *Minor concerns about relevance due to all of the studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Denmark, the Netherlands and Australia) and so may have had a different cultural experience of healthcare*

Table 18: Summary of review finding 5b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Not involved in decision making[17, 29, 31, 40]					
4	Interviews (n=2) Focus groups (n=1) Qualitative survey data (n=1)	Even though family members were seen to be important in deciding whether someone could use the early supported discharge services, family members often found that they were not included in the decision making process.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) *Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant and about the rigour of the data analysis in one study, lack of information about the ethical considerations in one study and no clear statement of findings in one study)*

(b) Minor concerns about relevance due to all of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, the Netherlands, Canada and Australia) and so may have had a different cultural experience of healthcare

Table 19: Summary of review finding 5c

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Lack of training for carers[5, 29, 42]					
3	Interviews (n=3)	Family members who were supporting with care also reported that they did not receive enough training and information for the role they would need to place. Family members may need to provide support with problem-solving that they may not know how to do in a way that manages the complex interaction of encouraging the person's autonomy while also providing the support they need.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	Minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant and about the rigour of the data analysis in one study, lack of information about the ethical considerations in one study and no clear statement of findings in one study)
(b) Minor concerns regarding coherence (due to one report that the training was adequate)
(c) Minor concerns about relevance due to the majority of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden) and so may have had a different cultural experience of healthcare

Table 20: Summary of review finding 5d

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Limited support for carers[5, 13, 18, 29, 31]					

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
5	Interviews (n=3) Qualitative survey data (n=1) Qualitative survey data, interview and focus group (n=1)	In addition, family members agreed that there was limited support available for carers. Carers were often left exhausted and physically strained, having to undertake tasks that the other person may have done initially on top of their usual responsibilities.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	Minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant and about the rigour of the data analysis in one study, lack of information about the ethical considerations in one study and no clear statement of findings in one study)
(b) Minor concerns regarding coherence (due to one report that the training was adequate)
(c) Minor concerns about relevance due to the majority of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Denmark, Canada and Australia) and so may have had a different cultural experience of healthcare

Table 21: Summary of review finding 6a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Wanting to return home as soon as possible balanced against feeling safe in hospital[5, 6, 13, 17, 18, 21, 26, 29, 42, 46]					
10	Interviews (n=9) Qualitative survey data, intervie	The people in the studies reported a mixture of feelings regarding returning home that varied from wanting to return home as soon as possible to feeling safe in hospital and so not wanting to return home too early.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
	w and focus group (n=1)			about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of unclear reporting of exploration of the relationship between the interviewer and the participant, whether the data analysis was sufficiently rigorous and a lack of clear statement of findings)

(b) No or very minor concerns regarding coherence (while variations were seen, these are likely reflective of the balance of feelings people could have after stroke and represented a dichotomy of thoughts that are present at different weightings, rather than separate concepts)

(c) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Denmark and Australia) and so may have had a different cultural experience of healthcare

Table 22: Summary of review finding 6b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Home as a place of familiarity[6, 8, 17, 26, 36, 46]					
6	Interviews (n=6)	People after stroke referred to home as a place of familiarity where, once they returned, they would start to feel more like themselves again. Returning home would allow them to have access to their own things and see the people they wanted to see. However, there was a thought from some that while being home in a familiar situation was initially exclusively positive, as time passed it became more of a hindrance.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns	

Study design and sample size		Finding	Quality assessment		
Number of studies contributing to the finding	Design		Criteria	Rating	Overall assessment of confidence
				about adequacy[c]	

(a) Moderate methodological limitations (due to unclear reporting of exploration of the relationship between the interviewer and the participant)
(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway, the Netherlands and Australia) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding
(c) Minor concerns regarding adequacy due to the limited information available at the changes in the long term after early supported discharge

Table 23: Summary of review finding 6c

Study design and sample size		Finding	Quality assessment		
Number of studies contributing to the finding	Design		Criteria	Rating	Overall assessment of confidence
Home as a new training ground/workplace[18, 26, 29, 40, 46]					
5	Interviews (n=4) Focus groups (n=1)	Returning home for early supported discharge created a new place full of challenges that required solutions. This meant that people sometimes felt like home was a new training ground or workplace.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE[d]
			Coherence	Minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of unclear reporting of exploration of the relationship between the interviewer and the participant and whether the data analysis was sufficiently rigorous)
(b) Minor concerns regarding coherence (due to the view that home may be a barrier to rehabilitation rather than a training ground that encourages it)

(c) Minor concerns about relevance due to all of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Denmark and the Netherlands) and so may have had a different cultural experience of healthcare
(d) There was a judgement of moderate confidence in this finding due to concerns with methodological limitations, coherence and the relevance of this finding (with the limitations due to coherence being seen as a minor difference and not sufficient enough to reduce the overall quality rating)

Table 24: Summary of review finding 6d

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Suitability of home/equipment[5, 17, 26, 29, 46]					
5	Interviews (n=5)	As early supported discharge is prepared for, discussions need to be had on the suitability of the home and whether additional equipment is required. While home can provide additional challenges that may help rehabilitation, it was noted that homes may not always be suitable and may be a problem that hinders rehabilitation instead.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of unclear reporting of exploration of the relationship between the interviewer and the participant and whether the data analysis was sufficiently rigorous)
(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden and Australia) and so may have had a different cultural experience of healthcare

Table 25: Summary of review finding 6e

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Returning to work[15, 35]					

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
2	Interviews (n=2)	The experiences of returning to work varied from seeing a lot of benefit from returning to normality but also that, due to the changing pace of life that is seen with people during early supported discharge anyway, that this can lead them feeling like they may be less able to do their job.	Limitations	No or very minor concerns about methodological limitations	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[a]	
			Adequacy	Minor concerns about adequacy[b]	

(a) Minor concerns about relevance due to the contributing study reflecting the views of people from Norway instead of the United Kingdom and so may have had a different cultural experience
(b) Minor concerns regarding adequacy due to the limited number of studies exploring this theme

Table 26: Summary of review finding 7a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Motivation[6, 15, 18, 26, 35, 36, 42]					
7	Interviews (n=7)	Motivation and how to maintain this was commonly discussed. A common experience discussed was an initial hope filled period where people were seeing significant improvements with rehabilitation that motivated them to do more. However, if these improvements are not as apparent, start to slow down or are not to the amount that the person would want in their journey	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
		to return to 'normal', then this will reduce motivation.		about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) *Moderate methodological limitations (due to a mixture of lack of information exploring the relationship between the interviewer and the participant, whether the data analysis was sufficiently rigorous and there being no clear statement about the findings from one study)*
(b) *Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway and Denmark) and so may have had a different cultural experience of healthcare*

Table 27: Summary of review finding 7b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Control[6, 15, 18, 26, 35, 36, 46]					
7	Interviews (n=7)	After a stroke, the experience of control starts to change. Early supported discharge is an opportunity to restore control by being in their home and their own environment. However, recovering from a stroke is associated with a wish to gain more control of their body and their life. Some parts of their life after a stroke are not controllable and can lead to more distress.	Limitations	Minor concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	No or very minor concerns about adequacy	

(a) *Minor methodological limitations (due to half of the studies having minor limitations and half where the information regarding whether the relationship between the interviewer and participant were considered was unclear)*
(b) *No or very minor concerns regarding coherence (as the findings were different parts of the same experience)*

(c) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway and Denmark) and so may have had a different cultural experience of healthcare

Table 28: Summary of review finding 7c

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Loss[29, 35]					
2	Interviews (n=2)	As life has changed significantly there is a loss associated with what has changed. This is coupled with changes in emotionality that can come after a stroke, which becomes more apparent as time passes.	Limitations	Minor concerns about methodological limitations[a]	MODERATE[d]
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns about adequacy[c]	

(a) Minor methodological limitations (due to one study having minor limitations and one where the exploration of the relationship between the interviewer and participant was not clearly stated and the rigour in the analysis was unclear)
(b) Minor concerns about relevance as all of the studies represent the views of people from countries that were not in the United Kingdom (Sweden and Norway) and so may have had a different cultural experience of healthcare
(c) Minor concerns regarding adequacy due to information being obtained from two studies
(d) There was a judgement of moderate confidence in this finding due to minor concerns with methodological limitations, relevance and adequacy (that were deemed to each have minimal impact on the overall quality of the finding)

Table 29: Summary of review finding 7d

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Mild stroke and feelings associated with invisible disability[18, 35]					

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
2	Interviews (n=2)	People after mild stroke, who may be eligible for early supported discharge, may experience feelings associated with having an invisible disability, where their experience of life has changed a lot and makes life more difficult in ways that other people may not notice or realise.	Limitations	Minor concerns about methodological limitations[a]	MODERATE[d]
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns about adequacy[c]	

(a) *Minor methodological limitations (due to one study having minor limitations and one where the exploration of the relationship between the interviewer and participant was not clearly stated)*
(b) *Minor concerns about relevance as all of the studies represent the views of people from countries that were not in the United Kingdom (Denmark and Norway) and so may have had a different cultural experience of healthcare*
(c) *Minor concerns regarding adequacy due to information being obtained from two studies*
(d) *There was a judgement of moderate confidence in this finding due to minor concerns with methodological limitations, relevance and adequacy (that were deemed to each have minimal impact on the overall quality of the finding)*

Table 30: Summary of review finding 7e

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Adapting to life being different[6, 8, 15, 17, 18, 26, 29, 35, 46]					
9	Interviews (n=9)	After a stroke people have to adapt to their new experience of life, but how they do this varies between different people. This adaptation includes physical adaptations to the home as well as changes in their behaviour.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
				about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant and about the rigour of the data analysis in one study)

(b) Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway, Denmark and Australia) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding

Table 31: Summary of review finding 7f

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
The need for psychological support[4, 5, 35, 36, 42, 46]					
6	Interviews (n=6)	With all of these factors taken into account, there is a need expressed by some stroke survivors for psychological support. Early supported discharge provided to key opportunity for addressing the emotional and cognitive challenges that stroke survivors experience, that may become more apparent when they return home.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
				concerns about adequacy	

(a) *Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant and about the rigour of the data analysis in one study, lack of information about the ethical considerations in one study and no clear statement of findings in one study)*
(b) *Minor concerns about relevance due to the majority of contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden and Norway) and so may have had a different cultural experience of healthcare*

Table 32: Summary of review finding 8a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Collaborative work between different professions and the stroke survivor[4, 21, 36, 40, 42, 46]					
6	Interviews (n=5) Focus groups (n=1)	The early supported discharge team worked at its best when there was a collaboration between different professions, the stroke survivor and others involved in their care.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) *Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about the rigour of the data analysis in one study, lack of information about the ethical considerations in one study and no clear statement of findings in one study)*

(b) Minor concerns about relevance due to the majority of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, the Netherlands and Norway) and so may have had a different cultural experience of healthcare

Table 33: Summary of review finding 8b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
The need for early supported discharge coordination[13, 18, 31, 40]					
4	Interviews (n=1) Focus groups (n=1) Qualitative survey data (n=1) Qualitative survey data, interview and focus group (n=1)	One part noted to be important to the success of early supported discharge was to have a staff member who was responsible for coordinating the care received by the person.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about the rigour of the data analysis in one study and no clear statement of findings in one study)

(b) Minor concerns about relevance due to all of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as the Netherlands, Denmark, Canada and Australia) and so may have had a different cultural experience of healthcare

Table 34: Summary of review finding 8c

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Who is in the team? Staff requirements[4, 9, 21]					

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
3	Interviews (n=2) Delphi approach (n=1)	The staff members who make up the early supported discharge team were discussed. While some members were taken as obviously included (for example: allied health professionals, physicians) a few members were emphasised. The first were rehabilitation assistants, the second were social care professionals.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about the rigour of the data analysis and it being unclear if the recruitment strategy was appropriate for the aims of the research in one study)

Table 35: Summary of review finding 8d

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Relationship between the stroke survivor and early supported discharge professionals: encouraging their journey[6, 15, 18, 36, 42, 46]					
6	Interviews (n=6)	The relationship between the stroke survivor and the healthcare professionals and the role that healthcare professionals play in their rehabilitation was raised. Healthcare professionals were initially 'strangers' who stroke survivors were forced to be together	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
		to restore them to their pre-stroke self who they may not want to come into their home. However, as time passes and they journey together the stroke survivor may find the healthcare professionals progressing towards friendship. Healthcare professionals saw their role to encourage the person to identify the challenges in their life and to work together while encouraging the person to find their problem-solving skills.		about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about the rigour of the data analysis and it being unclear if the recruitment strategy was appropriate for the aims of the research in one study)
(b) Minor concerns about relevance due to the majority of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway and Denmark) and so may have had a different cultural experience of healthcare

Table 36: Summary of review finding 8e

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Trust[17, 29, 36, 42]					
4	Interviews (n=4)	Stroke survivors and family members reflected that they trusted healthcare professionals to be experts and provide knowledge that they otherwise would not have.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about the rigour of the data analysis and it being unclear if the recruitment strategy was appropriate for the aims of the research in one study)
(b) Minor concerns about relevance due to all of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway and Australia) and so may have had a different cultural experience of healthcare

Table 37: Summary of review finding 8f

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Access to professionals when you need them[8, 26, 31]					
3	Interviews (n=2) Qualitative survey data (n=1)	Stroke survivors and family members found that during early supported discharge they could have access to support from healthcare professionals whenever they need it.	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence[b]	
			Relevance	Minor concerns about relevance[c]	
			Adequacy	Minor concerns about adequacy[d]	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about the rigour of the data analysis and, for one study, the research design not being appropriate to address the aims of the research and the data was collected in a way that did not address the research issue)
(b) No or very minor concerns regarding coherence (while there are different perspectives, these appear to be referring to different times in the process)

(c) Minor concerns about relevance due to all of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden and Canada) and so may have had a different cultural experience of healthcare and for some studies discussing home rehabilitation rather than specifically early supported discharge, which were both deemed unlikely to have a large effect on the finding
(d) Minor concerns regarding adequacy (as the different perspectives of this theme have been found to have limited information supporting them)

Table 38: Summary of review finding 9a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Fragmented and inconsistent stroke care pathway[4, 9, 21, 36, 40]					
5	Interviews (n=3) Focus groups (n=1) Delphi approach (n=1)	Healthcare professionals and stroke survivors reported that the stroke care pathway and where early supported discharge sat in that was confusing, in particular where it sits among other community services.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about whether ethical issues were considered and whether the recruitment strategy was appropriate in one study)

Table 39: Summary of review finding 9b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Methods for increasing collaboration[4]					

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
1	Interviews (n=1)	Healthcare professionals discussed methods that could be used to increase collaboration between different services. This included allowing staff to experience the approach by introducing a rotational element between people who could be involved with the team and participation in meetings and common training events.	Limitations	Moderate concerns about methodological limitations[a]	VERY LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Major concerns about adequacy[b]	

(a) *Moderate methodological limitations (due to the study providing limited information about the exploration of the relationship between the interviewer and participant and about whether ethical issues were considered)*
(b) *Major concerns regarding adequacy (due to information only being provided by participants in one study and not achieving the richness needed to explore this theme)*

Table 40: Summary of review finding 10a

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Providing therapy for as long as it is needed[4, 5, 9, 13, 29, 31, 36, 42, 46]					
9	Interviews (n=6) Qualitative survey data (n=1) Delphi approach (n=1)	A discussion between participants took place as to how long therapy should be provided. Noting the person-centred nature of early supported discharge, some healthcare professionals believed that supported should not be provided for an arbitrary amount of time and instead for as long as the person needed it. However, early supported discharge services were	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	Minor concerns about coherence[b]	
			Relevance	Minor concerns	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
	Qualitative survey data, interview and focus group (n=1)	often provided for a set amount of time, with the understanding that some people may need less or more support.		about relevance[b]	
			Adequacy	No or very minor concerns about adequacy	

(a) Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about whether ethical issues were considered, if the data analysis was sufficiently rigorous and whether the recruitment strategy was appropriate in one study)

(b) Minor concerns about coherence (due to disagreements within the same population of healthcare professionals, while differences with stroke survivors may represent different perspectives rather than contradiction)

(c) Minor concerns about relevance due to the majority of the contributing studies representing the views of people from countries that were not in the United Kingdom (such as Sweden, Norway, Canada and Australia) and so may have had a different cultural experience of healthcare

Table 41: Summary of review finding 10b

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Early supported discharge bridging the gap between inpatient and community services[4, 5, 9, 21, 26, 46]					
6	Interviews (n=5) Delphi approach (n=1)	Early supported discharge is an important opportunity to try and support the transition from inpatient to community services, which can be a problem experienced by stroke survivors whether they are taking part in early supported discharge or not.	Limitations	Moderate concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	

Study design and sample size			Quality assessment		
Number of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
			Adequacy	No or very minor concerns about adequacy	

(a) *Moderate methodological limitations (due to a mixture of studies providing limited information about the exploration of the relationship between the interviewer and participant, about whether ethical issues were considered and whether the recruitment strategy was appropriate in one study)*

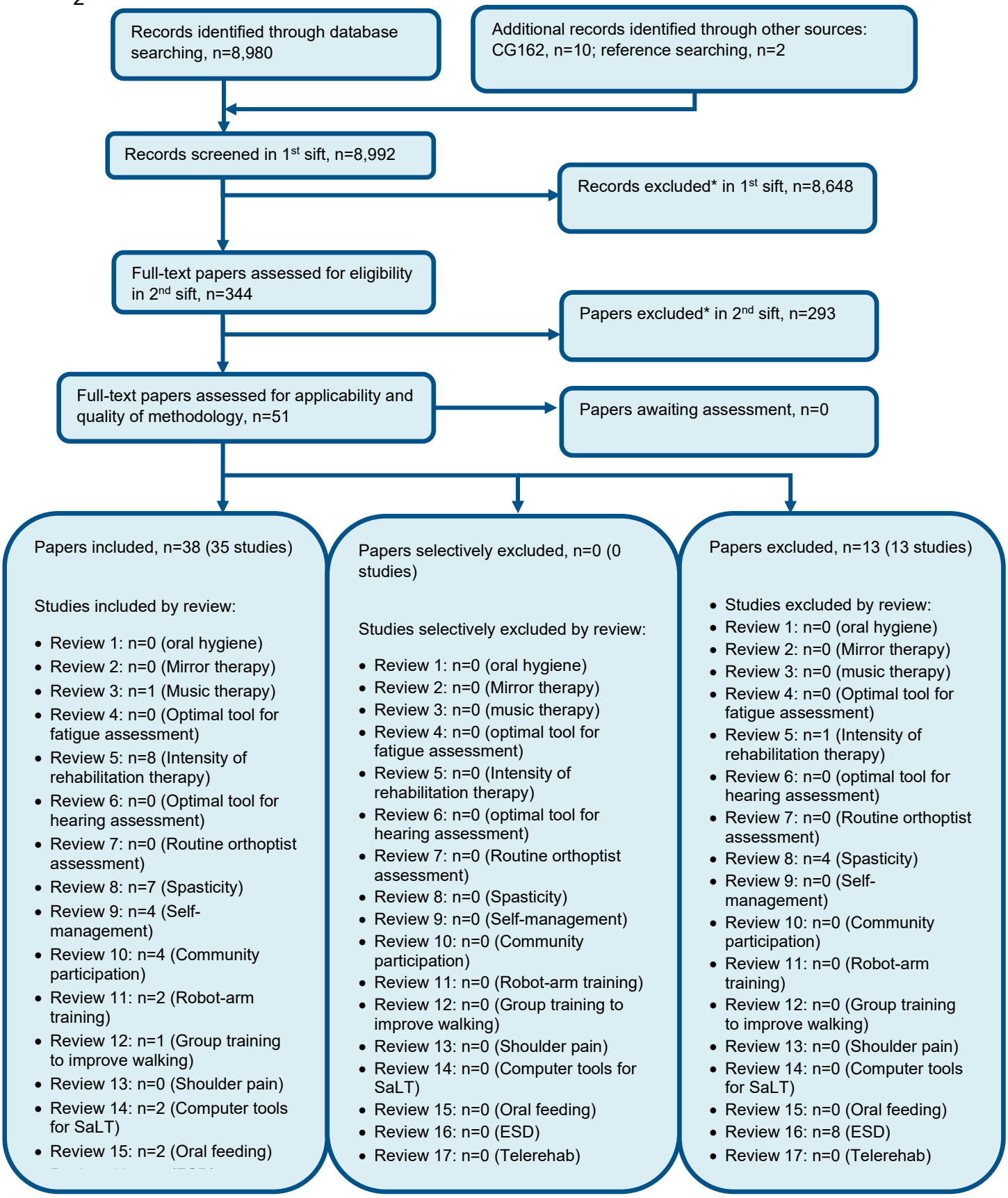
1

2

3

Appendix I – Economic evidence study selection

Figure 51: Flow chart of health economic study selection for the guideline



* Non-relevant population, intervention, comparison, design or setting; non-English language

Appendix J – Economic evidence tables

Study	Rasmussen, 2016[28]			
Study details	**Population & interventions**	**Costs**	**Health outcomes**	**Cost effectiveness**
Economic analysis: CCA (various health outcomes) **Study design:** Within trial analysis (RCT – same paper) without any modelled extrapolation. **Approach to analysis:** Cost analysis was a short-term, within-trial analysis that assessed differences in disability and quality of life outcomes associated with ESD (90 days post-stroke) and the subsequent impact on resource utilisation compared to those receiving usual care at 150 days from baseline. **Perspective:** Danish healthcare system	**Population:** Adults with post-stroke focal neurological deficits, hospitalised for a minimum of three days with a premorbid mRS 0-3 and ability to live at home. **Patient characteristics:** N=71 Start age: 79 years Male: 42% **Intervention 1:** Usual care (n=33). Conventional discharge planning from combined acute/ rehabilitation stroke unit and conventional after discharge care. Control patients were treated following standard care procedures in the Stroke Unit. Post-discharge, all control patients were treated according to standard procedures by	**Total costs (mean per patient at 5 months):** Intervention 1: £37,885 Intervention 2: £37,798 Incremental (2−1): saves £87 (95% CI: NR; p=NR) **Cost of Intervention (including transport):** Intervention 1: £0 Intervention 2: £876 (95% CI: NR; p=NR) **Currency & cost year:** 2014 USD ($) converted to UK pounds (£)[(b)] **Cost components incorporated:** Medicine, transportation for staff (including waiting time and rental of low-budget car) personnel salaries, costs paid by different health insurance sections, costs of hospital	**90-day EQ-5D gain (median per patient):** Intervention 1: 0.27 (IQR=0-0.49; p>0.05) Intervention 2: 0.19 (IQR=0.05-0.51; p=<0.05) Incremental (2−1): -0.08[(c)] (95% CI: NR; p=NR) **mRS ≥3 months (median):** Intervention 1: 3 (IQR= 2-4) Intervention 2: 2 (IQR= 2-3) Incremental (2−1): -1 (95% CI: NR; p=0.04) **BI improvement ≥3 months (median):** Intervention 1: 20 (IQR=13–37) Intervention 2: 29 (IQR=17–38) Incremental (2−1): 9	**ICER (Intervention 2 versus Intervention 1): NA** Probability Intervention 2 cost effective (£20K/30K threshold): NA • Results suggest when compared to usual care, ESD saves on total costs at five months. A decrease in median utility was reported at 3 months post-intervention, however the EQ-5D improvement for usual care was not statistically significant (p>0.05). • Improvements were seen in the degree of disability (mRS) and for activities of daily living (BI) for ESD compared to usual care at 3 months, however these outcomes were reported as median values. **Analysis of uncertainty:** None reported.

Follow-up: 3 months after stroke (150 days for average expenditure) **Treatment effect duration:**[(a)] 3 months after stroke (150 days for average expenditure) **Discounting:** NA	municipality health care professionals. **Intervention 2:** Early supported discharge (n=38)**.** Hospital out-reach multidisciplinary team (MDT), based within stroke unit. Home-based rehabilitation was given during hospitalization and for up to four weeks after discharge. Inpatients were transported to their homes, trained at home by the team and then returned to the hospital. Post-discharge patients received individual rehabilitation training at home for 1-5 days per week by the MDT.	admission and costs of supporting patients at home before and after hospital discharge.	(95% CI: NR; p>0.05)	

Data sources

Health outcomes: Within-trial analysis of an RCT (same paper) included in the clinical review. EQ-5D-3L (Danish population tariff) was reported at baseline and 90-days after stroke onset alongside other clinical outcomes (e.g., mRS, Barthel Index). **Quality-of-life weights:** NA. **Cost sources:** Cost year and references were not stated, assumed to be 2014 based on manuscript submission. Study costs were presented in USD, with 1 US$ being equal to 5.41 DKK. Intervention costs and resource use estimates were collected using case report forms by members of the multi-disciplinary team.

Comments

Source of funding: The Danish Ministry of Health and the Ministry of Economic Affairs and the Interior. **Limitations:** Study does not present QALYs; only median EQ-5D scores were reported, therefore an ICER could not be estimated. Danish setting (including the use of the Danish population EQ-5D tariff) and 2008 resource use estimates may not reflect UK NHS context. Baseline outcomes and resource use estimates were obtained from the current trial. Outcomes therefore only reflect this study and not the wider evidence base identified in the clinical review. Median (not mean) outcomes reported. 3-month follow-up for clinical outcomes and 150 days for average total expenditure may not be sufficient to capture long-term costs and outcomes of ESD. References for unit costs (including cost year) were not reported and were converted to UK pounds from USD ($) that was converted from Danish krone (DKK), which limits the interpretation of results for UK context. ESD intervention included the cost of transporting inpatients to their homes and back to the

hospital, which may overestimate costs as not all ESD services would provide home-training before discharge. No sensitivity analyses were performed on parameters of uncertainty.	
Overall applicability:[e] Partially applicable	**Overall quality:**[f] Potentially serious limitations

Abbreviations: 95% CI= 95% confidence interval; BI= modified Barthel Index (scale 0-100, higher values are better); CCA= cost-consequence analysis; EQ-5D= Euroqol 5 dimensions (scale: 0.0 [death] to 1.0 [full health], negative values mean worse than death); ESD= early supported discharge; ICER= incremental cost-effectiveness ratio; IQR= Interquartile range; mRS= modified Rankin Scale (0-6, lower values are better); NA= not applicable; NR= not reported; QALYs= quality-adjusted life years

(a) For studies where the time horizon is longer than the treatment duration, an assumption needs to be made about the continuation of the study effect. For example, does a difference in utility between groups during treatment continue beyond the end of treatment and if so for how long.

(b) Converted using 2014 purchasing power parities[27]}. Cost year was assumed to be 2014 based on year of study submission as this was not reported.

(c) Although the mean difference suggests that the usual care group had improved EQ-5D scores compared to ESD, only the change from baseline for the ESD group was statistically significant (p>0.05).

(d) Directly applicable / Partially applicable / Not applicable

(e) Minor limitations / Potentially serious Limitations / Very serious limitations

Study	**Neale, 2020[25]**			
Study details	**Population & interventions**	**Costs**	**Health outcomes**	**Cost effectiveness**
Economic analysis: CCA (health outcome: Length of stay) **Study design:** Within trial analysis (trial by Leach et al. (2020)[44] without any modelled extrapolation. **Approach to analysis:** Cost analysis where treatment effect was measured in terms of length of stay. Cost savings were associated with a reduction in service costs and the number of hospital days	**Population:** Post-stroke adults with all levels of severity, who were assessed to be safe for discharge home (either with or without a carer and services) and required intensive rehabilitation from at least two disciplines. **Patient characteristics:** N=41 Start age: 67 years Male: 76% **Intervention 1:** Control group (n=13) received standard care via acute admission and inpatient rehabilitation and were followed up	**Total costs (mean (SD) per patient):** Intervention 1: £5,792 (£2,978) Intervention 2: £2,896 (£1,092) Incremental (2−1): Saves £2,896[b] (95% CI: NR; p=0.99) **Currency & cost year:** 2017 Australian Dollars (AUD) converted UK pounds (£)[c] **Cost components incorporated:**	**LOS inpatient rehabilitation (mean (SD) per days patient):** Intervention 1: 15 (5.79) Intervention 2: 9 (8.79) Incremental (2−1): Saves 6 days. (95% CI: NR; p<0.00) **LOS Intensive rehabilitation (mean (SD) days per patient):** Intervention 1: 12.15 (6.25) (ward-based inpatient rehabilitation) Intervention 2: 19.74 (7.44) (ESD in the community) Incremental (2−1): 7.6 days	**ICER (Intervention 2 versus Intervention 1):** NA ESD group spent fewer days in hospital, but standard care group spent fewer days in intensive rehab. There were cost savings for the ESD group, however these were not statistically significant. Probability Intervention 2 cost effective (£20K/30K threshold): NA **Analysis of uncertainty:**

for the ESD program compared to standard care. **Perspective:** Australian healthcare system **Follow-up:** 8 weeks **Treatment effect duration:**[(a)] 8 weeks **Discounting:** NA	with usual community rehabilitation services. **Intervention 2:** 8-week ESD program (n=28) (including an ESD coordinator) where participants received assessment and rehabilitation for up to 5 days per week from MDT therapists. This group also had access to subsidised taxi transportation, for appointments, and personal care assistance, respite and access to paid carers as required.	LOS and inpatient rehabilitation for both groups. For the ESD group, intervention costs included therapy, administration, interpreters, transport, and community service costs.	(95% CI: NR; p<0.00)	None reported.
Data sources				
Health outcomes: Only length of stay was reported and this was based on single trial by Leach et al. (2020)[44]. **Quality-of-life weights:** NA **Cost sources:** Cost year and references were not stated, assumed to be 2017 based on manuscript submission. Staff-recorded logs of the frequency and duration of sessions, travel time and non-clinical time were used to estimate intervention costs for the ESD group (£147 per day). Inpatient rehabilitation was reported to cost £477 per day. Resource use was collected retrospectively using 3-month post-stroke medical records on hospital readmissions and complications. Saved days were calculated as the number of days between the date inpatients in both groups were assessed to be safe for early support discharge and the day of discharge from hospital.				
Comments				
Source of funding: Victorian Stroke Clinical Network, as part of the Subacute Stroke Initiative. **Limitations:** Australian healthcare system may not reflect UK NHS context. QALYs (and cost per QALY) not reported as EQ-5D was not collected. Within-trial analysis that applied baseline outcomes and estimates of resource use from single non-randomised study (with a small sample size (n=41)) that was excluded from the clinical review. 8-week follow-up may not be sufficient to capture long-term costs and outcomes of ESD. References for unit costs (including cost year) were not reported which limits interpretation of results for UK context. No sensitivity analyses were performed on parameters of uncertainty. **Other:** Leach et al. (2020)[44] was excluded from the clinical review as it is non-randomised study when sufficient randomised evidence was identified.				
Overall applicability:[(d)] Partially applicable **Overall quality:**[(e)] Potentially serious limitations				

Abbreviations: 95% CI= 95% confidence interval; CCA= cost-consequence analysis; EQ-5D= Euroqol 5 dimensions (scale: 0.0 [death] to 1.0 [full health], negative values mean worse than death); ESD= Early supported discharge; ICER= incremental cost-effectiveness ratio; LOS=Length of stay; MDT= multi-disciplinary team; NA= not applicable; NR= not reported; QALYs= quality-adjusted life years

(a) For studies where the time horizon is longer than the treatment duration, an assumption needs to be made about the continuation of the study effect. For example, does a difference in utility between groups during treatment continue beyond the end of treatment and if so for how long.

(b) Total cost of standard care was not significantly different to ESD (p>0.05).

(c) Converted using 2017 purchasing power parities[27]. Cost year was assumed to be 2017 based on year of study submission as this was not reported.

(d) Directly applicable / Partially applicable / Not applicable

(e) Minor limitations / Potentially serious Limitations / Very serious limitations

Study	Tistad 2015[39]			
Study details	**Population & interventions**	**Costs**	**Health outcomes**	**Cost effectiveness**
Economic analysis: CCA (health outcome: LOS). **Study design:** Within-trial subgroup analysis of the LAS-1 by Tham 2012[38], without any modelled extrapolation. **Approach to analysis:** Cost analysis where the costs for days spent using different types of inpatient services (including LOS) or for contacts with outpatient services were calculated for each group. **Perspective:** Swedish healthcare system **Follow-up:** 12 months **Treatment effect duration:**[(a)] 12 months **Discounting:** NA	**Population:** Post-stroke adults discharged from hospital but are still in need of rehabilitation, with a BI score ≥50 and have the ability to transfer without assistance between a chair and a bed at baseline. **Patient characteristics:** N= 150 Mean age: 68 years Male: 57% **Intervention 1:** Usual care (n=110). Conventional rehabilitation services included inpatient rehabilitation, rehabilitation at a specialised day hospital or an outpatient clinic, outpatient rehabilitation at a primary healthcare centre and home-based rehabilitation.	**Total costs (mean per patient):** Intervention 1: £23,345 (95% CI= NR; p=NR) Intervention 2: £21,112 (95% CI= NR; p=NR) **Incremental (2-1):** Saves £2,233[(b)] (95% CI= NR; p= 0.52) **Currency & cost year:** 2012 Swedish Krona converted to UK pounds (£)[(c)] **Cost components incorporated:** Rehabilitation costs in primary, home-based, inpatient and outpatient specialist care settings. Both groups received care by MDT staff.	**LOS 3 months post-stroke (mean days)** Intervention 1: 17.6 Intervention 2: 21 Incremental (2-1): Saves 3 days (95% CI= NR; p=0.02) **LOS 12 months post-stroke (mean days):** Intervention 1: 31 Intervention 2: 25 Incremental (2-1): Saves 6 days[(b)] (95% CI= NR; p=0.13)	**ICER (Intervention 2 versus Intervention 1):** NA Total inpatient stay in the first three months after stroke onset was shorter for the ESD group compared to usual care. There was no statistically significant difference between the groups with regards to 12-month LOS outcomes or overall healthcare costs. Probability Intervention 2 cost effective (£20K/30K threshold): NA **Analysis of uncertainty:** None reported.

	Intervention 2: ESD (n=40) Patients were retrospectively classified as ESD group if the interdisciplinary stroke team provided them with rehabilitation in their homes and if the team's first visit occurred before discharge or within the first seven days after discharge from the stroke unit or inpatient rehabilitation. (Mean of 25 visits over 12 months).			
Data sources				
Health outcomes: Outcomes were based on within-trial subgroup analysis (same study) as conducted as part of the Life After Stroke 1 (LAS-1)[38] prospective observational study which was excluded from the clinical review. **Quality-of-life weights:** NA **Cost sources:** Resource use for healthcare services was collected from within the trial sample using the Stockholm County Council's computerised database. Services costs were based on data from the Swedish Case Costing Database (SCCD)[34] and primary care costs were based on figures from Statistics Sweden (SS)[33]				
Comments				
Source of funding: The Stockholm County Council, Karolinska Institute (ALF), the Swedish Research Council (Vetenskapsrådet), the Swedish Brain Foundation (Hjärnfonden) and the Swedish Stroke Association (STROKE-Riksförbundet) **Limitations:** QALYs (and cost per QALY gained) were not presented. Swedish healthcare system with 2012 costs and 2006-2007 resource use estimates may not reflect UK NHS context. Intervention effects and resource use were based on single non-randomised observational study excluded from clinical review. No sensitivity analyses were performed on parameters of uncertainty. **Other:** The analysis was excluded from the clinical review as it is based on a non-randomised study when sufficient randomised evidence was identified.				
Overall applicability:(d) Partially applicable **Overall quality:**(e) Potentially serious limitations				

Abbreviations: 95% CI= 95% confidence interval; CCA= cost-consequence analysis; EQ-5D= Euroqol 5 dimensions (scale: 0.0 [death] to 1.0 [full health], negative values mean worse than death); ESD= Early supported discharge; ICER= incremental cost-effectiveness ratio; LOS=Length of stay; MDT= multi-disciplinary team; NA= not applicable; NR= not reported; QALYs= quality-adjusted life years

a) For studies where the time horizon is longer than the treatment duration, an assumption needs to be made about the continuation of the study effect. For example, does a difference in utility between groups during treatment continue beyond the end of treatment and if so for how long.

b) Differences in outcomes between ESD and usual care groups were not statistically significant at one year after stroke onset (p>0.05).

c) Converted using 2012 purchasing power parities[27].

d) Directly applicable / Partially applicable / Not applicable

e) Minor limitations / Potentially serious Limitations / Very serious limitations

1

Study	Xu 2018[47]			
Study details	**Population & interventions**	**Costs**	**Health outcomes**	**Cost effectiveness**
Economic analysis: CUA (health outcome: QALYs) **Study design:** Time-to-event individual patient simulation model (full details in NGC and SSNAP Technical report[23]) **Approach to analysis:** Health economic simulation was built to estimate patient-level health and social care costs at one and five years after stroke. These estimates were primarily based on SSNAP data. The model was used to estimate the cost savings and QALYs gained from increasing access to ESD. **Perspective:** UK NHS and PSS **Time horizon:** 1 and 5 years	**Population:** Adults who have had a recent stroke and were admitted for acute stroke care in England. **Cohort settings:** Age: Patients were grouped into four age groups (40-64; 65-74: 75-84 and 85-100) Male: 49.6% **Intervention 1:** Extended stroke unit rehabilitation and/or community rehabilitation **Intervention 2:** ESD team with coordination and delivery (mean LOS was 17.01 days within the first year). ESD team consisted of MDT therapists. Only patients who were discharged to and treated by an ESD are included, as SSNAP data reported that some CRT teams do both ESD and CRT treatments.	**Baseline results (mean NHS cost per person):** Intervention 1: NR Intervention 2: NR All patients: 1-year: £13,272 5-years: £17,678 **Mean NHS cost per additional patient discharged to ESD:** 1-year: ESD saves £1,614 5-years: ESD saves £1,571 **Currency & cost year:** 2014 UK pounds (£) **Cost components incorporated:** Pre-hospital care, acute care, diagnostics, prescribing, inpatient rehabilitation, community rehabilitation, early supported discharge, primary care, secondary prevention, and stroke recurrence. Social care included nursing home care, formal care at home,	**QALYs (mean per person):** Intervention 1: NR Intervention 2: NR All patients: 1-year: 0.490 5-years: 1.648 **QALY gain per additional patient discharged to ESD:** 1-year: 0.0391 5-years: 0.1139	**ICER (Intervention 2 versus Intervention 1):** NA Early supported discharge dominated conventional discharge at 1 year and 5 years (lower costs and higher QALYs). Probability Intervention 2 cost effective (£20K/30K threshold): NR **Analysis of uncertainty:** Results from scenario analyses demonstrated that with more ESD, both the NHS and social care costs were reduced, and higher QALY were generated by scenarios with higher proportion of ESD. See Table 42 for details. In additional analysis (not reported), the scenario where only patients with mRS 0-2 were redirected, significant savings in costs or QALYs as ESD use increased were not observed, which implies that patients with moderate to severe disability gain the most from ESD.

Treatment effect duration:[a] 5 years **Discounting:** Costs were not discounted. Stroke recurrence data was collected by SLSR at 3 months then yearly for 5 years.		supported meals and day services.		
Data sources				
Health outcomes: Barthel Index results for each strategy were stratified by age, sex, stroke type and stroke severity and were from SSNAP, which included all patients aged 40-100 admitted for acute stroke from April 2013 to 2015 (n=111,846)[32]. Barthel Index was mapped to mRS. Survival and stroke recurrence were modelled by mRS group using data from the South London Stroke Register (SLSR), which is a population-based register with prospective long-term follow-up of all adults with first ever stroke in South London, including data on 6000 patients[45]. mRS scores were assigned EQ-5D values to estimate QALYs. **Quality-of-life weights:** EQ-5D scores (UK tariff) were mapped from mRS using an algorithm by Whynes and colleagues[43] **Cost sources:** Costs were stratified according to age, sex, stroke type and stroke severity. Health and social care utilisation after stroke were collected from SSNAP and SLSR data. UK national unit costs applied.				
Comments				
Source of funding: NHS England **Limitations:** EQ-5D was not collected so QALY gain was estimated using a mapping algorithm. The main treatment effect (Barthel index) was based on observational data (controlling for age, sex, stroke type and stroke severity). The authors did not attempt further calibration of the model because the relative treatment effects in terms of mRS 3-6 (RR=0.67) and mortality (RR=0.91) were deemed comparable to the results for an ESD team in the Cochrane review of RCTs. One author declared a potential conflict of interest with respect to the research, authorship, and/or publication of this article. **Other:** NA				
Overall applicability:[b] Directly applicable		**Overall quality:**[c] Potentially serious limitations		

Abbreviations: 95% CI= 95% confidence interval; CRT= Community rehabilitation; CUA= cost-utility analysis; DSA= deterministic sensitivity analysis; EQ-5D= Euroqol 5 dimensions (scale: 0.0 [death] to 1.0 [full health], negative values mean worse than death); ESD= Early supported discharge; ICER= incremental cost-effectiveness ratio; LOS=Length of stay; MDT= multi-disciplinary team; NA= not applicable; NR= not reported; PSA= probabilistic sensitivity analysis; QALYs= quality-adjusted life years; RCT= randomised controlled trial; SSNAP= The Sentinel Stroke National Audit Programme

a) For studies where the time horizon is longer than the treatment duration, an assumption needs to be made about the continuation of the study effect. For example, does a difference in utility between groups during treatment continue beyond the end of treatment and if so for how long.

b) Directly applicable / Partially applicable / Not applicable

c) Minor limitations / Potentially serious Limitations / Very serious limitations

Table 42: Baseline and scenario analyses results from Xu 2018[47] (mean costs and QALYs for different levels of ESD use)

Analysis	1-year		5-year		
	Mean NHS cost (£)	Mean QALYs	Mean NHS cost (£)	Mean QALYs	Mean Bed days
Baseline	13,272	0.490	17,678	1.648	22.2
ESD scenarios which increased the proportion of patients from all groups who did not discharge to ESD now discharge to ESD					
Scenario 1 – 20%	12,972	0.496	17,423	1.674	20.0
Scenario 2 – 35%	12,783	0.498	17,220	1.678	19.0
Scenario 3 – 50%	12,562	0.500	16,978	1.685	17.8
Scenario 4 – 80%	12,121	0.504	16,542	1.703	15.7
PSA results					
Baseline PSA sampled input around original inputs from SSNAP	13,528 (95%CI= 12,622-14,434)	0.486 (95% CI= 0.472-0.500)	£18,009 (95%CI =16,955-19,063)	1.636 (95%CI= 1.587-1.685)	NR
Scenario 2 35% of non-ESD discharged patients now redirected to ESD	12,859(95% CI= 11,920-13,798)	0.501 (95% CI= 0.479-0.523)	17,346 (95%CI=15,882-18,810)	1.682 (95% CI= 1.457-1.907)	NR

Abbreviations: ESD= Early support discharge; NR= not reported; PSA= Probabilistic sensitivity analysis; SSNAP= The Sentinel Stroke National Audit Programme; QALYs= quality-adjusted life-years

Study	Candio 2022[3]			
Study details	**Population & interventions**	**Costs**	**Health outcomes**	**Cost effectiveness**
Economic analysis: CUA (health outcome: QALYs). **Study design:** Decision-analytic Markov model with embedded decision tree which determined mRS scores associated	**Population:** Adults (≥20 years old) who survived the acute stroke phase (between 24 hours and two weeks from symptoms onset) and were admitted to hospital.	**Total costs (mean per patient):** Intervention 1: NR Intervention 2: NR Incremental (2−1): Saves £25.28[(c)] (95% CI: -£2022, £657; p=NR)	**QALYs (mean per patient):** Intervention 1: NR Intervention 2: NR Incremental (2−1): 0.07[(c)] (95% CI: -0.01, 0.14; p=NR)	**ICER (Intervention 2 versus Intervention 1):** Home-based rehabilitation dominates centre-based rehabilitation (lower costs and higher QALYs). Probability Intervention 2 cost effective (£20K): 93%

with home-based and centre-based rehabilitation at 3 months post-stroke. **Approach to analysis:** A cohort-level Markov model with 12-month cycles, in which risk of death, costs, and utilities over a 5-year time horizon were conditional on the 3-month mRS score, age and gender for both groups. Home-based rehabilitation was linked to a 1-point upward shift in the Barthel index, which was then linked to 3-month mRS scores. Utility weights were assigned to mRS scores to estimate QALYs. **Perspective:** UK NHS and PSS[(a)] **Time horizon:** 5 years **Treatment effect duration:**[(b)] 5 years **Discounting:** 3.5% for costs and outcomes.	**Cohort settings:** The model was run for 28 age and gender combinations (2 gender and 14 5-year age groups (from 20- to 90-years-old)). **Intervention 1:** Centre-based rehabilitation. Patients would only receive conventional hospital-based care (inpatient and outpatient). **Intervention 2:** Home-based rehabilitation was defined as a package of care whereby a stroke patient would receive physiotherapy, occupational therapy, and speech therapy at their home.	**Currency & cost year:** 2017 UK pounds (£) **Cost components incorporated:** Hospital stay and day cases (inpatient costs), outpatient visits, accident and emergency (A&E) visits and nursing/residential care.		**Analysis of uncertainty:** The primary analysis results were based on a societal perspective; therefore, the results of the one-way sensitivity analyses do not assess the level of uncertainty of the intervention's cost-effectiveness for a healthcare perspective. Results from the societal perspective also suggested that home-based rehabilitation dominates centre-based rehabilitation.
Data sources				
Health outcomes: Country, age, and gender-specific numbers of incident stroke cases were derived from the Global Burden of Disease[14] (n=79,122 for the eligible UK stroke population). Five-year survival and the distribution of mRS scores at 3-months following centre-based rehabilitation was assumed to be the same as that observed in a UK-based population-based cohort study assessing stroke incidence, namely the Oxford Vascular Study (OXVASC).[19] 3-month mRS scores were assigned then to EQ-5D-3L values, which were collected 1, 3, 6, 12, and 60 months from OXVASC[11, 19] to estimate QALYs. BI				

scores were linked to the observed 0–5 mRS distribution in stroke survivors. The intervention effect of home-based rehabilitation was estimated by shifting the BI score up by 1 point, as per the identified meta-analysis,[12] which allowed for the adjustment of the 3-month 0–5 mRS distribution accordingly. **Quality-of-life weights:** EQ-5D-3L scores (UK tariff) were mapped from mRS using an algorithm by Rivero-Arias 2010.[30] **Cost sources:** Evidence from OXVASC (from 2007-2012) was used to derive health and social care resource use following stroke dependent on 3-month mRS score, age and gender up to 5 years. Intervention costs were calculated by multiplying the mean number of therapy sessions by their respective unit costs. The unit costs for each type of therapy session (physiotherapy, occupational and speech therapy) were based on national UK reference costs.
Comments
Source of funding: The study was funded by an unrestricted grant from the Stroke Alliance for Europe. **Limitations:** 2007-2012 UK resource use estimates may not reflect current NHS context. EQ-5D was not collected so QALY gain was estimated using a mapping algorithm. Indirectness of treatment effect as mRS scores were adjusted from associated Barthel Index scores before being assigned utility weights. One-way sensitivity analyses were performed for the societal perspective only and so are not available for the ICER of interest presented here. **Other:** Base case analysis was performed from a societal perspective, but healthcare perspective was reported here as this is preferred by NICE.[24]
Overall applicability:(d) Partially applicable **Overall quality:**(e) Potentially serious limitations

Abbreviations: 95% CI= 95% confidence interval; BI= Barthel Index (scale 0-20, higher values are better); CUA= cost-utility analysis; EQ-5D-3L= EuroQol 3 dimensions 3 levels (scale: 0.0 [death] to 1.0 [full health], negative values mean worse than death); ICER= incremental cost-effectiveness ratio; mRS= modified Rankin scale (scale 0-6, lower values are better; NA= not applicable; NR= not reported; QALYs= quality-adjusted life years; RCT= randomised controlled trial.

a) Costs have been recalculated to reflect a UK NHS and PSS perspective to be consistent with NICE reference case; base-case analysis assessed home-based rehabilitation across 32 countries for a societal perspective that included productivity losses and informal care costs.

b) For studies where the time horizon is longer than the treatment duration, an assumption needs to be made about the continuation of the study effect. For example, does a difference in utility between groups during treatment continue beyond the end of treatment and if so for how long.

c) Results from UK-specific analysis presented here only: per patient results were calculated here using UK population of 79,122 eligible stroke patients reported in Appendix II of Candio 2022 supplementary material.[3]

d) Directly applicable / Partially applicable / Not applicable

e) Minor limitations / Potentially serious limitations / Very serious limitations

Appendix K – Health economic model

Health economic modelling was not prioritised for this question.

Appendix L – Excluded studies

Effectiveness studies

Table 43: Quantitative studies excluded from the clinical review

Study	Code [Reason]
Alim, M, Lindley, R, Felix, C et al. (2016) Family-led rehabilitation after stroke in India: the ATTEND trial, study protocol for a randomized controlled trial. Trials 17: 13	- Protocol only
Allen, Laura, John-Baptiste, Ava, Meyer, Matthew et al. (2019) Assessing the impact of a home-based stroke rehabilitation programme: A cost-effectiveness study. Disability and Rehabilitation: An International, Multidisciplinary Journal 41(17): 2060-2065	- Study does not contain an intervention relevant to this review protocol *Home rehabilitation - but not early supported discharge (after a mean of 62 days of hospital attendance)*
Burdea, Grigore C, Grampurohit, Namrata, Kim, Nam et al. (2020) Feasibility of integrative games and novel therapeutic game controller for telerehabilitation of individuals chronic post-stroke living in the community. Topics in stroke rehabilitation 27(5): 321-336	- Study does not contain an intervention relevant to this review protocol *Does not explicitly investigate early supported discharge (instead a technology that may be used to support early supported discharge)*
Butler, Andrew, Housley, Stephen, Wu, David et al. (2017) Effect of Home-Based Rehabilitation on Access to Cost Effective Therapy for Rural Veteran Stroke Survivors. Archives of Physical Medicine & Rehabilitation 98(10): e58-e59	- Conference abstract
Chang, Won Kee, Kim, Won-Seok, Sohn, Min Kyun et al. (2021) Korean Model for Post-acute Comprehensive rehabilitation (KOMPACT): The Study Protocol for a Pragmatic Multicenter Randomized Controlled Study on Early Supported Discharge. Frontiers in neurology 12: 710640	- Protocol only
Connor, E.O., Dolan, E., Horgan, F. et al. (2021) Experiences of early supported discharge services following a stroke: A qualitative evidence synthesis. European Geriatric Medicine 12(suppl1): 296	- Conference abstract
Deng, Aiwen; Yang, Sidong; Xiong, Ribo (2020) Effects of an integrated transitional care program for stroke survivors living in a rural	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
community: a randomized controlled trial. Clinical rehabilitation 34(4): 524-532	*Transitional care rather than early supported discharge - people are discharged around the same time*
Fisher, R.J., Cobley, C.S., Potgieter, I. et al. (2016) Is Stroke Early Supported Discharge still effective in practice? A prospective comparative study. Clinical rehabilitation 30(3): 268-276	- Data not reported in an extractable format or a format that can be analysed *Outcomes reported as median and interquartile range values*
Hofstad, H, Naess, H, Gjelsvik, B E B et al. (2017) Subjective health complaints predict functional outcome six months after stroke. Acta neurologica Scandinavica 135(2): 161-169	- Study design not relevant to this review protocol *Investigates predictors of functional outcome for people who have undergone early supported discharge - prognostic study that is not directly relevant to the protocol*
Jee, Sungju, Jeong, Minah, Paik, Nam-Jong et al. (2022) Early Supported Discharge and Transitional Care Management After Stroke: A Systematic Review and Meta-Analysis. Frontiers in neurology 13: 755316	- Systematic review used as source of primary studies *Systematic review that included people with a transient ischaemic attack and included transitional care management studies that were not necessarily early supported discharge studies. References checked.*
Kilbride, Cherry, Warland, Alyson, Stewart, Victoria et al. (2022) Rehabilitation using virtual gaming for Hospital and hOMe-Based training for the Upper limb post Stroke (RHOMBUS II): protocol of a feasibility randomised controlled trial. BMJ open 12(6): e058905	- Protocol only
Leach, Kathleen, Neale, Sharon, Steinfort, Sarah et al. (2020) Clinical outcomes for moderate and severe stroke survivors receiving early supported discharge: A quasi-experimental cohort study. The British Journal of Occupational Therapy 83(11): 680-689	- Study design not relevant to this review protocol *Non-randomised study when there is sufficient randomised evidence (identified in the Cochrane review)*
Liu, H., Mohammed, A., Felix, C. et al. (2017) Process evaluation of a randomised controlled trial of a post stroke family-led rehabilitation intervention in India. Journal of the Neurological Sciences 381(supplement1): 884	- Conference abstract
Liu, Hueiming, Lindley, Richard, Alim, Mohammed et al. (2019) Family-led rehabilitation in India (ATTEND)-Findings from the process evaluation of a randomized	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
controlled trial. International journal of stroke : official journal of the International Stroke Society 14(1): 53-60	*Study states that early supported discharge was not achieved and both groups were discharged at comparable times*
Mitchell, E., Ahern, E., Saha, S. et al. (2022) The Value of Nonpharmacological Interventions for People With an Acquired Brain Injury: A Systematic Review of Economic Evaluations. Value in Health	- Systematic review used as source of primary studies *Includes a variety of interventions including early supported discharge. References checked.*
Mulder, Marijn, Nikamp, Corien, Nijland, Rinske et al. (2022) Can telerehabilitation services combined with caregiver-mediated exercises improve early supported discharge services poststroke? A study protocol for a multicentre, observer-blinded, randomized controlled trial. BMC neurology 22(1): 29	- Protocol only
Neale, S; Shand, L; Wanasili, M (2018) Carer experience with Early Supported Discharge for stroke survivors in western Melbourne. International journal of stroke 13(1supplement1): 5	- Conference abstract
O Connor, Elaine, Dolan, Eamon, Horgan, Frances et al. (2020) A protocol for a qualitative synthesis exploring people with stroke, family members, caregivers and healthcare professionals experiences of early supported discharge (ESD) after stroke. HRB open research 3: 79	- Protocol only
Osborne, Candice L and Neville, Marsha (2019) Understanding the Experience of Early Supported Discharge from the Perspective of Patients with Stroke and Their Carers and Health Care Providers: A Qualitative Review. The Nursing clinics of North America 54(3): 367-384	- Systematic review used as source of primary studies
Rafsten, L. (2018) Gothenburg very early supported discharge: A block-randomized trial with superiority design of very early supported discharge for patients with stroke. European Stroke Journal 3(1supplement1): 9-10	- Conference abstract
Rodgers, H., Bhattarai, N., McMeekin, P. et al. (2019) Evaluation of an extended stroke rehabilitation service (extras): Cost-effectiveness results. European Stroke Journal 4(supplement1): 93	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Rodgers, H., Shaw, L., Bhattarai, N. et al. (2018) A trial to evaluate an extended rehabilitation service for stroke patients (EXTRAS): Main results. European Stroke Journal 3(1supplement1): 4	- Study does not contain an intervention relevant to this review protocol *Intervention after input from early supported discharge service*
Rodgers, H., Shaw, L., Bhattarai, N. et al. (2019) A trial to evaluate an extended rehabilitation service for stroke patients (extras): Main patient results. Age and Ageing 48(supplement1): i40	- Conference abstract
Rodgers, H, Shaw, L, Cant, R et al. (2015) Evaluating an extended rehabilitation service for stroke patients (EXTRAS): study protocol for a randomised controlled trial. Trials 16: 205	- Study does not contain an intervention relevant to this review protocol *Intervention after input from early supported discharge service*
Rodgers, Helen, Howel, Denise, Bhattarai, Nawaraj et al. (2019) Evaluation of an Extended Stroke Rehabilitation Service (EXTRAS): A Randomized Controlled Trial and Economic Analysis. Stroke 50(12): 3561-3568	- Study does not contain an intervention relevant to this review protocol *Intervention after input from early supported discharge service*
Shaw, L., Bhattarai, N., Francis, R. et al. (2019) Evaluation of an extended stroke rehabilitation service (EXTRAS) trial: Results from the carer study. International Journal of Stroke 14(4suppl): 11-12	- Study does not contain an intervention relevant to this review protocol *Intervention after input from early supported discharge service*
Shaw, Lisa, Bhattarai, Nawaraj, Cant, Robin et al. (2020) An extended stroke rehabilitation service for people who have had a stroke: the EXTRAS RCT. Health technology assessment (Winchester, England) 24(24): 1-202	- Study does not contain an intervention relevant to this review protocol *Intervention after input from early supported discharge service*
Visvanathan, Vicky (2019) Early supported discharge services for people with acute stroke: A Cochrane review summary. International Journal of Nursing Studies 94: 186-187	- Study design not relevant to this review protocol *Summary of the cochrane review only*
Weir, C.J., Assi, V., Na, L. et al. (2019) Unreported Summary Statistics in Trial Publications and Risk of Bias in Stroke Rehabilitation Systematic Reviews: An International Survey of Review Authors and Examination of Practical Solutions. Journal of Stroke Medicine 2(2): 136-142	- Study design not relevant to this review protocol *Systematic review to check on methods for estimating unreported summary statistics in the early supported discharge Cochrane review*

Study	Code [Reason]
White, Jocelyn, Nott, Melissa T, Barr, Chris et al. (2020) Stroke survivors' occupational performance and cognitive strategy use: A pilot exploration of strengths and difficulties using the Perceive Recall Plan Perform System of Task Analysis. The British Journal of Occupational Therapy 83(11): 701-709	- Study design not relevant to this review protocol *Investigating the use of a strategy to investigate changes in an early supported discharge service*
Williams, Susan, Morrissey, Ann-Marie, Steed, Fiona et al. (2022) Early supported discharge for older adults admitted to hospital with medical complaints: a systematic review and meta-analysis. BMC geriatrics 22(1): 302	- Population not relevant to this review protocol *Older adults, not just people who had a stroke*

Qualitative studies

Table 44: Qualitative studies excluded from this clinical review (as the aim is not relevant to this review), but included in review question 3.1 intensity of rehabilitation

Study	Code [Reason]
Bennett, L., Luker, J., English, C. et al. (2016) Stroke survivors' perspectives on two novel models of inpatient rehabilitation: seven-day a week individual therapy or five-day a week circuit class therapy. Disability & Rehabilitation 38(14): 1397-406	- Qualitative study (3.1 Intensity of rehabilitation)
Bowen, A., Hesketh, A., Patchick, E. et al. (2012) Clinical effectiveness, cost-effectiveness and service users' perceptions of early, well-resourced communication therapy following a stroke: a randomised controlled trial (the ACT NoW Study). Health Technology Assessment (Winchester, England) 16(26): 1-160	- Qualitative study (3.1 Intensity of rehabilitation)
Burke, J.; Palmer, R.; Harrison, M. (2021) What are the factors that may influence the implementation of self-managed computer therapy for people with long term aphasia following stroke? A qualitative study of speech and language therapists' experiences in the Big CACTUS trial. Disability & Rehabilitation: 1-13	- Qualitative study (3.1 Intensity of rehabilitation)
Celinder, D. and Peoples, H. (2012) Stroke patients' experiences with Wii Sports during	- Qualitative study (3.1 Intensity of rehabilitation)

Study	Code [Reason]
inpatient rehabilitation. Scandinavian journal of occupational therapy 19(5): 457-463	
Chen, Y., Chen, Y., Zheng, K. et al. (2020) A qualitative study on user acceptance of a home-based stroke telerehabilitation system. Topics in Stroke Rehabilitation 27(2): 81-92	- Qualitative study (3.1 Intensity of rehabilitation)
Cherry, C. O., Chumbler, N. R., Richards, K. et al. (2017) Expanding stroke telerehabilitation services to rural veterans: a qualitative study on patient experiences using the robotic stroke therapy delivery and monitoring system program. Disability & Rehabilitation Assistive Technology 12(1): 21-27	- Qualitative study (3.1 Intensity of rehabilitation)
Clarke, D. J., Burton, L. J., Tyson, S. F. et al. (2018) Why do stroke survivors not receive recommended amounts of active therapy? Findings from the ReAcT study, a mixed-methods case-study evaluation in eight stroke units. Clinical Rehabilitation 32(8): 1119-1132	- Qualitative study (3.1 Intensity of rehabilitation)
Clarke, D. J., Tyson, S., Rodgers, H. et al. (2015) Why do patients with stroke not receive the recommended amount of active therapy (ReAcT)? Study protocol for a multisite case study investigation. BMJ Open 5(8): e008443	- Qualitative study (3.1 Intensity of rehabilitation)
Connell, Louise A., Klassen, Tara K., Janssen, Jessie et al. (2018) Delivering Intensive Rehabilitation in Stroke: Factors Influencing Implementation. Physical Therapy 98(4): 243-250	- Qualitative study (3.1 Intensity of rehabilitation)
Connell, Louise A., McMahon, Naoimh E., Harris, Jocelyn E. et al. (2014) A formative evaluation of the implementation of an upper limb stroke rehabilitation intervention in clinical practice: a qualitative interview study. Implementation Science 9(1): 90-90	- Qualitative study (3.1 Intensity of rehabilitation)
Connell, Louise A., McMahon, Naoimh E., Tyson, Sarah F. et al. (2016) Mechanisms of action of an implementation intervention in stroke rehabilitation: a qualitative interview study. BMC Health Services Research 16: 534-534	- Qualitative study (3.1 Intensity of rehabilitation)
D'Souza, S., Godecke, E., Ciccone, N. et al. (2021) Hospital staff, volunteers' and patients'	- Qualitative study (3.1 Intensity of rehabilitation)

Study	Code [Reason]
perceptions of barriers and facilitators to communication following stroke in an acute and a rehabilitation private hospital ward: a qualitative description study. BMJ Open 11(5): e043897	
Demain, S., Burridge, J., Ellis-Hill, C. et al. (2013) Assistive technologies after stroke: self-management or fending for yourself? A focus group study. BMC Health Services Research 13: 334	- Qualitative study (3.1 Intensity of rehabilitation)
Galvin, R.; Cusack, T.; Stokes, E. (2009) To what extent are family members and friends involved in physiotherapy and the delivery of exercises to people with stroke?. Disability & Rehabilitation 31(11): 898-905	- Qualitative study (3.1 Intensity of rehabilitation)
Galvin, R.; Cusack, T.; Stokes, E. (2009) Physiotherapy after stroke in Ireland: a qualitative insight into the patients' and physiotherapists' experience. International Journal of Rehabilitation Research 32(3): 238-44	- Qualitative study (3.1 Intensity of rehabilitation)
Gustavsson, Martha; Ytterberg, Charlotte; Guidetti, Susanne (2020) Exploring future possibilities of using information and communication technology in multidisciplinary rehabilitation after stroke – a grounded theory study. Scandinavian Journal of Occupational Therapy 27(3): 223-230	- Qualitative study (3.1 Intensity of rehabilitation)
Hartford, W.; Lear, S.; Nimmon, L. (2019) Stroke survivors' experiences of team support along their recovery continuum. BMC Health Services Research 19(1): 723	- Qualitative study (3.1 Intensity of rehabilitation)
Janssen, J., Klassen, T. D., Connell, L. A. et al. (2020) Factors Influencing the Delivery of Intensive Rehabilitation in Stroke: Patient Perceptions Versus Rehabilitation Therapist Perceptions. Physical Therapy 100(2): 307-316	- Qualitative study (3.1 Intensity of rehabilitation)
Kelly, K., Brander, F., Strawson, A. et al. (2020) Pushing the limits of recovery in chronic stroke survivors: a descriptive qualitative study of users perceptions of the Queen Square Upper Limb Neurorehabilitation Programme. BMJ Open 10(10): e036481	- Qualitative study (3.1 Intensity of rehabilitation)

Study	Code [Reason]
Last, N., Packham, T. L., Gewurtz, R. E. et al. (2021) Exploring patient perspectives of barriers and facilitators to participating in hospital-based stroke rehabilitation. Disability & Rehabilitation: 1-10	- Qualitative study (3.1 Intensity of rehabilitation)
Marklund, I.; Klassbo, M.; Hedelin, B. (2010) "I got knowledge of myself and my prospects for leading an easier life": Stroke patients' experience of training with lower-limb CIMT. Advances in Physiotherapy 12(3): 134-141	- Qualitative study (3.1 Intensity of rehabilitation)
McGlinchey, M. P. and Davenport, S. (2015) Exploring the decision-making process in the delivery of physiotherapy in a stroke unit. Disability & Rehabilitation 37(14): 1277-84	- Qualitative study (3.1 Intensity of rehabilitation)
Merlo, A. R., Goodman, A., McClenaghan, B. A. et al. (2013) Participants' perspectives on the feasibility of a novel, intensive, task-specific intervention for individuals with chronic stroke: a qualitative analysis. Physical Therapy 93(2): 147-57	- Qualitative study (3.1 Intensity of rehabilitation)
Merriman, N. A., Bruen, C., Gorman, A. et al. (2020) "I'm just not a Sudoku person": analysis of stroke survivor, carer, and healthcare professional perspectives for the design of a cognitive rehabilitation intervention. Disability & Rehabilitation 42(23): 3359-3369	- Qualitative study (3.1 Intensity of rehabilitation)
Mohd Nordin, Nor Azlin, Aziz, Noor Azah Abd, Abdul Aziz, Aznida Firzah et al. (2014) Exploring views on long term rehabilitation for people with stroke in a developing country: findings from focus group discussions. BMC Health Services Research 14(1): 118-118	- Qualitative study (3.1 Intensity of rehabilitation)
Morris, R.; Payne, O.; Lambert, A. (2007) Patient, carer and staff experience of a hospital-based stroke service. International Journal for Quality in Health Care 19(2): 105-12	- Qualitative study (3.1 Intensity of rehabilitation)
Moss, B., Northcott, S., Behn, N. et al. (2021) 'Emotion is of the essence. ... Number one priority': A nested qualitative study exploring psychosocial adjustment to stroke and aphasia. International Journal of Language & Communication Disorders 56(3): 594-608	- Qualitative study (3.1 Intensity of rehabilitation)

Study	Code [Reason]
Nguyen, Ai-Vi, Ong, Yau-Lok Austin, Luo, Cindy Xin et al. (2019) Virtual reality exergaming as adjunctive therapy in a sub-acute stroke rehabilitation setting: facilitators and barriers. Disability & Rehabilitation: Assistive Technology 14(4): 317-324	- Qualitative study (3.1 Intensity of rehabilitation)
Norris, M., Poltawski, L., Calitri, R. et al. (2018) Acceptability and experience of a functional training programme (ReTrain) in community-dwelling stroke survivors in South West England: a qualitative study. BMJ Open 8(7): e022175	- Qualitative study (3.1 Intensity of rehabilitation)
Schnabel, Stefanie, van Wijck, Frederike, Bain, Brenda et al. (2021) Experiences of augmented arm rehabilitation including supported self-management after stroke: a qualitative investigation. Clinical Rehabilitation 35(2): 288-301	- Qualitative study (3.1 Intensity of rehabilitation)
Signal, N., McPherson, K., Lewis, G. et al. (2016) What influences acceptability and engagement with a high intensity exercise programme for people with stroke? A qualitative descriptive study. Neurorehabilitation 39(4): 507-517	- Qualitative study (3.1 Intensity of rehabilitation)
Stark, A., Farber, C., Tetzlaff, B. et al. (2019) Stroke patients' and non-professional coaches' experiences with home-based constraint-induced movement therapy: a qualitative study. Clinical Rehabilitation 33(9): 1527-1539	- Qualitative study (3.1 Intensity of rehabilitation)
Sweeney, Gillian; Barber, Mark; Kerr, Andrew (2020) Exploration of barriers and enablers for evidence-based interventions for upper limb rehabilitation following a stroke: Use of Constraint Induced Movement Therapy and Robot Assisted Therapy in NHS Scotland. British Journal of Occupational Therapy 83(11): 690-700	- Qualitative study (3.1 Intensity of rehabilitation)
Taylor, E.; Jones, F.; McKevitt, C. (2018) How is the audit of therapy intensity influencing rehabilitation in inpatient stroke units in the UK? An ethnographic study. BMJ Open 8(12): e023676	- Qualitative study (3.1 Intensity of rehabilitation)
Van Kessel, G.; Hillier, S.; English, C. (2017) Physiotherapists' attitudes toward circuit class	- Qualitative study (3.1 Intensity of rehabilitation)

Study	Code [Reason]
therapy and 7 day per week therapy is influenced by normative beliefs, past experience, and perceived control: A qualitative study. Physiotherapy Theory & Practice 33(11): 850-858	
Vive, S.; Bunketorp-Kall, L.; Carlsson, G. (2020) Experience of enriched rehabilitation in the chronic phase of stroke. Disability & Rehabilitation: 1-8	- Qualitative study (3.1 Intensity of rehabilitation)
Walker, Johanne and Moore, Melanie (2016) Adherence to modified constraint-induced movement therapy: the case for meaningful occupation. Journal of Primary Health Care 8(3): 263-266	- Qualitative study (3.1 Intensity of rehabilitation)
Withiel, T. D., Sharp, V. L., Wong, D. et al. (2020) Understanding the experience of compensatory and restorative memory rehabilitation: A qualitative study of stroke survivors. Neuropsychological Rehabilitation 30(3): 503-522	- Qualitative study (3.1 Intensity of rehabilitation)
Worrall, Linda, Sherratt, Sue, Rogers, Penny et al. (2011) What people with aphasia want: Their goals according to the ICF. Aphasiology 25(3): 309-322	- Qualitative study (3.1 Intensity of rehabilitation)
Wray, F.; Clarke, D.; Forster, A. (2020) "Guiding them to take responsibility": exploring UK speech and language therapists' views of supporting self-management of aphasia. Aphasiology 34(4): 411-430	- Qualitative study (3.1 Intensity of rehabilitation)
Young, A., Gomersall, T., Bowen, A. et al. (2013) Trial participants' experiences of early enhanced speech and language therapy after stroke compared with employed visitor support: a qualitative study nested within a randomized controlled trial. Clinical Rehabilitation 27(2): 174-82	- Qualitative study (3.1 Intensity of rehabilitation)

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Table 45: Qualitative studies excluded from the clinical review for other reasons

Study	Code [Reason]
Abrahamson, V. and Wilson, P. M. (2019) How unmet are unmet needs post-stroke? A policy analysis of the six-month review. BMC Health Services Research 19(1): 480	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Ahmad Ainuddin, H., Romli, M. H., Hamid, T. A. et al. (2021) An Exploratory Qualitative Study With Older Malaysian Stroke Survivors, Caregivers, and Healthcare Practitioners About Falls and Rehabilitation for Falls After Stroke. Frontiers in Public Health 9: 611814	- No relevant themes to answer the review question
Alanko, Tuulikki, Karhula, Maarit, Kröger, Teppo et al. (2019) Rehabilitees perspective on goal setting in rehabilitation – a phenomenological approach. Disability & Rehabilitation 41(19): 2280-2288	- Population not relevant to this review protocol
Alguren, B.; Lundgren-Nilsson, A.; Sunnerhagen, K. S. (2009) Facilitators and barriers of stroke survivors in the early post-stroke phase. Disability & Rehabilitation 31(19): 1584-91	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Asplund, K., Jonsson, F., Eriksson, M. et al. (2009) Patient dissatisfaction with acute stroke care. Stroke 40(12): 3851-6	- Survey data that only reported descriptive quantitative data
Atteih, S., Mellon, L., Hall, P. et al. (2015) Implications of stroke for caregiver outcomes: findings from the ASPIRE-S study. International Journal of Stroke 10(6): 918-23	- Survey data that only reported descriptive quantitative data
Aziz, N. A., Pindus, D. M., Mullis, R. et al. (2016) Understanding stroke survivors' and informal carers' experiences of and need for primary care and community health services--a systematic review of the qualitative literature: protocol. BMJ Open 6(1): e009244	- Protocol only
Baatiema, Leonard, Otim, Michael E., Mnatzaganian, George et al. (2017) Health professionals' views on the barriers and enablers to evidence-based practice for acute stroke care: a systematic review. Implementation Science 12: 1-15	- Aims of the study are not relevant to the review question
Bailey, Ryan R. and Stevenson, Jennifer L. (2021) How Adults With Stroke Conceptualize	- No relevant themes to answer the review question

Study	Code [Reason]
Physical Activity: An Exploratory Qualitative Study. American Journal of Occupational Therapy 75(2): 1-6	
Bakas, T., Austin, J. K., Okonkwo, K. F. et al. (2002) Needs, concerns, strategies, and advice of stroke caregivers the first 6 months after discharge. Journal of Neuroscience Nursing 34(5): 242-51	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Barker, R. and Brauer, S. (2005) Upper limb recovery after stroke: the stroke survivors' perspective. Disability & Rehabilitation 27(20): 1213-1223	- No relevant themes to answer the review question
Barreca, Susan and Wilkins, Seanne (2008) Experiences of nurses working in a stroke rehabilitation unit. Journal of Advanced Nursing (Wiley-Blackwell) 63(1): 36-44	- Aims of the study are not relevant to the review question
Bayley, M. T., Hurdowar, A., Teasell, R. et al. (2007) Priorities for stroke rehabilitation and research: results of a 2003 Canadian Stroke Network Consensus Conference. Archives of Physical Medicine & Rehabilitation 88(4): 526-528	- Aims of the study are not relevant to the review question
Bayley, Mark T., Hurdowar, Amanda, Richards, Carol L. et al. (2012) Barriers to implementation of stroke rehabilitation evidence: findings from a multi-site pilot project. Disability & Rehabilitation 34(19): 1633-1638	- Aims of the study are not relevant to the review question
Beaudry, L.; Rochette, A.; Fortin, S. (2022) Use of Adapted Dance to Intensify Subacute Rehabilitation Post-Stroke: A Qualitative Study on the Participation Experience and Active Participation Time. Alternative therapies in health and medicine 28(7): 40-51	- Study does not contain an intervention relevant to this review protocol *Identified during the rerun searches, does not investigate a more intense intervention relevant to the review (intervention offered for less than 5 days a week) and offers no additional information relevant to the themes identified in the review*
Beckett, J.; Barley, J.; Ellis, C. (2015) Patient perspectives of barriers and facilitators of treatment-seeking behaviors for stroke care. Journal of Neuroscience Nursing 47(3): 154-9	- Aims of the study are not relevant to the review question
Bendz, M. (2003) The first year of rehabilitation after a stroke - from two perspectives.	- No relevant themes to answer the review question

Study	Code [Reason]
Scandinavian Journal of Caring Sciences 17(3): 215-22	
Berg, Karianne, Askim, Torunn, Balandin, Susan et al. (2017) Experiences of participation in goal setting for people with stroke-induced aphasia in Norway. A qualitative study. Disability & Rehabilitation 39(11): 1122-1130	- Aims of the study are not relevant to the review question
Blonski, Diane C., Covert, Megan, Gauthier, Roxanne et al. (2014) Barriers to and Facilitators of Access and Participation in Community-Based Exercise Programmes from the Perspective of Adults with Post-stroke Aphasia. Physiotherapy Canada 66(4): 367-375	- Aims of the study are not relevant to the review question
Booth, J. and Hewison, A. (2002) Role overlap between occupational therapy and physiotherapy during in-patient stroke rehabilitation: an exploratory study. Journal of Interprofessional Care 16(1): 31-40	- No relevant themes to answer the review question
Brady, M. C., Clark, A. M., Dickson, S. et al. (2011) Dysarthria following stroke: the patient's perspective on management and rehabilitation. Clinical Rehabilitation 25(10): 935-52	- Aims of the study are not relevant to the review question
Bright, Felicity A. S., Kayes, Nicola M., McPherson, Kathryn M. et al. (2018) Engaging people experiencing communication disability in stroke rehabilitation: a qualitative study. International Journal of Language & Communication Disorders 53(5): 981-994	- Aims of the study are not relevant to the review question
Brouns, B., Meesters, J. J. L., Wentink, M. M. et al. (2018) Why the uptake of eRehabilitation programs in stroke care is so difficult-a focus group study in the Netherlands. Implementation Science 13(1): 133	- No relevant themes to answer the review question
Busetto, L., Stang, C., Hoffmann, J. et al. (2020) Patient-centredness in acute stroke care - a qualitative study from the perspectives of patients, relatives and staff. European Journal of Neurology 27(8): 1638-1646	- No relevant themes to answer the review question
Butler, Jenny and Smith, Teresa (2002) Community Care and Rehabilitation after Stroke in Japan. British Journal of Occupational Therapy 65(8): 363-370	- Aims of the study are not relevant to the review question

Study	Code [Reason]
Cahill, L. S., Carey, L. M., Mak-Yuen, Y. et al. (2021) Factors influencing allied health professionals' implementation of upper limb sensory rehabilitation for stroke survivors: a qualitative study to inform knowledge translation. BMJ Open 11(2): e042879	- Aims of the study are not relevant to the review question
Cameron, J. I., Naglie, G., Silver, F. L. et al. (2013) Stroke family caregivers' support needs change across the care continuum: a qualitative study using the timing it right framework. Disability & Rehabilitation 35(4): 315-24	- Aims of the study are not relevant to the review question
Cammarata, Michael, Mueller, Alexandra S., Harris, Jocelyn et al. (2017) The Role of the Occupational Therapist in Driver Rehabilitation After Stroke. Physical & Occupational Therapy in Geriatrics 35(1): 20-33	- Aims of the study are not relevant to the review question
Carragher, M., Steel, G., O'Halloran, R. et al. (2020) Aphasia disrupts usual care: the stroke team's perceptions of delivering healthcare to patients with aphasia. Disability & Rehabilitation: 1-12	- Aims of the study are not relevant to the review question
Chang, L. H. and Hasselkus, B. R. (1998) Occupational therapists' expectations in rehabilitation following stroke: sources of satisfaction and dissatisfaction. American Journal of Occupational Therapy 52(8): 629-37	- No relevant themes to answer the review question
Chang, L. H. and Wang, J. (2013) Institutional contexts contribute to the low priority given to developing self-care independence in a rehabilitation ward: a qualitative study. Clinical Rehabilitation 27(6): 538-45	- Population not relevant to this review protocol
Chang, W. H., Shin, Y. I., Lee, S. G. et al. (2015) Characteristics of inpatient care and rehabilitation for acute first-ever stroke patients. Yonsei Medical Journal 56(1): 262-70	- Survey data that only reported descriptive quantitative data
Chen, L.; Xiao, L. D.; De Bellis, A. (2016) First-time stroke survivors and caregivers' perceptions of being engaged in rehabilitation. Journal of Advanced Nursing 72(1): 73-84	- Aims of the study are not relevant to the review question
Chesson, R.; Massie, S.; Reid, A. (1999) Carers' perceptions of rehabilitation in a stroke unit.	- No relevant themes to answer the review question

Study	Code [Reason]
British Journal of Therapy & Rehabilitation 6(1): 32-37	
Chiu, L., Tang, K. Y., Shyu, W. C. et al. (1999) The willingness of families caring for victims of stroke to pay for in-home respite care--results of a pilot study in Taiwan. Health Policy 46(3): 239-54	- Survey data that only reported descriptive quantitative data
Christiansen, B. and Feiring, M. (2017) Challenges in the nurse's role in rehabilitation contexts. Journal of Clinical Nursing 26(1920): 3239-3247	- No relevant themes to answer the review question
Christie, D. and Lawrence, L. (1978) Patients and hospitals: a study of the attitudes of stroke patients. Social Science and Medicine 12(1a): 49-51	- Survey data that only reported descriptive quantitative data
Clark, M. S. (2000) Patient and spouse perceptions of stroke and its rehabilitation. International Journal of Rehabilitation Research 23(1): 19-29	- Survey data that only reported descriptive quantitative data
Clarke, D., Gombert-Waldron, K., Honey, S. et al. (2021) Co-designing organisational improvements and interventions to increase inpatient activity in four stroke units in England: a mixed-methods process evaluation using normalisation process theory. BMJ Open 11(1): e042723	- No relevant themes to answer the review question
Connor, E.O., Dolan, E., Horgan, F. et al. (2021) Experiences of early supported discharge services following a stroke: A qualitative evidence synthesis. European Geriatric Medicine 12(suppl1): 296	- Conference abstract
Cowdell, F. and Garrett, D. (2003) Recreation in stroke rehabilitation part two: exploring patients' views...including commentary by Lo J and Eng J. International Journal of Therapy & Rehabilitation 10(10): 456-462	- No relevant themes to answer the review question
Cox, E. O., Dooley, A., Liston, M. et al. (1998) Coping with stroke: Perceptions of elderly who have experienced stroke and rehabilitation interventions. Topics in Stroke Rehabilitation 4(4): 76-88	- Aims of the study are not relevant to the review question

Study	Code [Reason]
Dalvandi, A., Ekman, S. L., Khankeh, H. R. et al. (2012) Rehabilitation experts' experience of community rehabilitation services for stroke survivors in Iran. Topics in Stroke Rehabilitation 19(5): 395-404	- Aims of the study are not relevant to the review question
Daniëls, R.; Winding, K.; Borell, L. (2002) Experiences of occupational therapists in stroke rehabilitation: dilemmas of some occupational therapists in inpatient stroke rehabilitation. Scandinavian Journal of Occupational Therapy 9(4): 167-175	- No relevant themes to answer the review question
Davoody, N., Koch, S., Krakau, I. et al. (2016) Post-discharge stroke patients' information needs as input to proposing patient-centred eHealth services. BMC Medical Informatics & Decision Making 16: 66	- Aims of the study are not relevant to the review question
Demain, S., Wiles, R., Roberts, L. et al. (2006) Recovery plateau following stroke: fact or fiction?. Disability & Rehabilitation 28(1314): 815-21	- Systematic review used as source of primary studies
Demers, M. and McKinley, P. (2015) Feasibility of delivering a dance intervention for subacute stroke in a rehabilitation hospital setting. International Journal of Environmental Research & Public Health [Electronic Resource] 12(3): 3120-32	- No relevant themes to answer the review question
Demir, Y. P., Balci, N. C., Unluer, N. O. et al. (2015) Three different points of view in stroke rehabilitation: patient, caregiver, and physiotherapist. Topics in Stroke Rehabilitation 22(5): 377-85	- Survey data that only reported descriptive quantitative data
Denham, A. M. J., Wynne, O., Baker, A. L. et al. (2020) The long-term unmet needs of informal carers of stroke survivors at home: a systematic review of qualitative and quantitative studies. Disability & Rehabilitation: 1-12	- No relevant themes to answer the review question
Denham, A. M. J., Wynne, O., Baker, A. L. et al. (2019) "This is our life now. Our new normal": A qualitative study of the unmet needs of carers of stroke survivors. PLoS ONE [Electronic Resource] 14(5): e0216682	- No relevant themes to answer the review question

Study	Code [Reason]
DiGregorio, Tony and Matthew, Janine (2020) Interviewing stroke survivors about experiences of their stroke journey. British Journal of Neuroscience Nursing 16(sup2): S16-S17	- No relevant themes to answer the review question
Donnellan, Claire; Sweetman, S.; Shelley, E. (2013) Implementing clinical guidelines in stroke: A qualitative study of perceived facilitators and barriers. Health Policy 111(3): 234-244	- Aims of the study are not relevant to the review question
Dowswell, G., Dowswell, T., Lawler, J. et al. (2002) Patients' and caregivers' expectations and experiences of a physiotherapy intervention 1 year following stroke: A qualitative study. Journal of Evaluation in Clinical Practice 8(3): 361-365	- No relevant themes to answer the review question
Dowswell, G., Lawler, J., Young, J. et al. (1997) A qualitative study of specialist nurse support for stroke patients and care-givers at home. Clinical Rehabilitation 11(4): 293-301	- Aims of the study are not relevant to the review question
Doyle, Susan D.; Bennett, Sally; Dudgeon, Brian (2014) Upper limb post-stroke sensory impairments: the survivor's experience. Disability & Rehabilitation 36(12): 993-1000	- No relevant themes to answer the review question
Eilertsen, G.; Kirkevold, M.; Bjork, I. T. (2010) Recovering from a stroke: a longitudinal, qualitative study of older Norwegian women. Journal of Clinical Nursing 19(1314): 2004-13	- No relevant themes to answer the review question
Eilertsen, Grethe; Ormstad, Heidi; Kirkevold, Marit (2013) Experiences of poststroke fatigue: qualitative meta-synthesis. Journal of Advanced Nursing (John Wiley & Sons, Inc.) 69(3): 514-525	- Systematic review used as source of primary studies
Ekstam, L., Johansson, U., Guidetti, S. et al. (2015) The combined perceptions of people with stroke and their carers regarding rehabilitation needs 1 year after stroke: a mixed methods study. BMJ Open 5(2): e006784	- No relevant themes to answer the review question
Elizabeth Tremayne, Julie; Freeman, Jennifer; Coppola, Ali (2021) Stroke survivors' experiences and perceptions of post-stroke fatigue education in the subacute phase of	- Aims of the study are not relevant to the review question

Study	Code [Reason]
stroke. The FASE qualitative study. British Journal of Occupational Therapy 84(2): 111-121	
Ellis, C., Egede, L. E., Ellis, Charles et al. (2009) Racial/ethnic differences in poststroke rehabilitation utilization in the USA. Expert Review of Cardiovascular Therapy 7(4): 405-410	- Study design not relevant to this review protocol
Eng, Janice J., Bird, Marie-Louise, Godecke, Erin et al. (2019) Moving Stroke Rehabilitation Research Evidence into Clinical Practice: Consensus-Based Core Recommendations From the Stroke Recovery and Rehabilitation Roundtable. Neurorehabilitation & Neural Repair 33(11): 935-942	- Survey data that only reported descriptive quantitative data
Ewijk, Lizet, Bootsma, Tjitske M. C., Rijssen, Maren et al. (2021) Speech language therapists' experiences with subjective well-being in people with aphasia. International Journal of Language & Communication Disorders 56(3): 473-484	- No relevant themes to answer the review question
Fisher, R., Chouliara, N., Byrne, A. et al. (2019) What is the impact of large-scale implementation of stroke Early Supported Discharge? A mixed methods realist evaluation study protocol. Implementation Science 14(1): 61	- Protocol only
Flinn, N. A. and Stube, J. E. (2010) Post-stroke fatigue: qualitative study of three focus groups. Occupational Therapy International 17(2): 81-91	- Aims of the study are not relevant to the review question
Foley, N., McClure, J. A., Meyer, M. et al. (2012) Inpatient rehabilitation following stroke: amount of therapy received and associations with functional recovery. Disability & Rehabilitation 34(25): 2132-8	- Survey data that only reported descriptive quantitative data
Forster, A., Young, J., Nixon, J. et al. (2015) Protocol of a cluster randomized trial evaluation of a patient and carer-centered system of longer-term stroke care (LoTS care). International Journal of Stroke 10(2): 259-63	- Protocol only
Foster, Abby, Worrall, Linda, Rose, Miranda et al. (2015) 'That doesn't translate': the role of evidence-based practice in disempowering speech pathologists in acute aphasia	- Aims of the study are not relevant to the review question

Study	Code [Reason]
management. International Journal of Language & Communication Disorders 50(4): 547-563	
Gallacher, K., Morrison, D., Jani, B. et al. (2013) Uncovering treatment burden as a key concept for stroke care: a systematic review of qualitative research. PLoS Medicine / Public Library of Science 10(6): e1001473	- Systematic review used as source of primary studies
Geerars, M.; Wondergem, R.; Pisters, M. F. (2021) Decision-Making on Referral to Primary Care Physiotherapy After Inpatient Stroke Rehabilitation. Journal of Stroke & Cerebrovascular Diseases 30(5): 105667	- No relevant themes to answer the review question
Geidl, W., Knocke, K., Schupp, W. et al. (2018) Measuring stroke patients' exercise preferences using a discrete choice experiment. Neurology International 10(1): 6993	- Aims of the study are not relevant to the review question
Gibbon, B. (2003) The contribution of the nurse to stroke units in the United Kingdom. Journal of the Australasian Rehabilitation Nurses' Association (JARNA) 6(2): 8-13	- Aims of the study are not relevant to the review question
Gibbon, B. (2004) Service user involvement: the impact of stroke and the meaning of rehabilitation. Journal of the Australasian Rehabilitation Nurses' Association (JARNA) 7(2): 8-12	- No relevant themes to answer the review question
Gibbon, B. (1994) Stroke nursing care and management in the community: a survey of district nurses' perceived contribution in one health district in England. Journal of Advanced Nursing 20(3): 469-76	- Aims of the study are not relevant to the review question
Graven, C., Sansonetti, D., Moloczij, N. et al. (2013) Stroke survivor and carer perspectives of the concept of recovery: a qualitative study. Disability & Rehabilitation 35(7): 578-85	- Aims of the study are not relevant to the review question
Greene, Jennifaye V. (2014) Exploring the role of culture and race in stroke rehabilitation disparities. Dissertation Abstracts International: Section B: The Sciences and Engineering 74(10be): nopaginationspecified-	- Dissertation only
Greenwood, N., Holley, J., Ellmers, T. et al. (2016) Qualitative focus group study	- Aims of the study are not relevant to the review question

Study	Code [Reason]
investigating experiences of accessing and engaging with social care services: perspectives of carers from diverse ethnic groups caring for stroke survivors. BMJ Open 6(1): e009498	*Does not discuss early supported discharge*
Gregory, P., Edwards, L., Faurot, K. et al. (2010) Patient preferences for stroke rehabilitation. Topics in Stroke Rehabilitation 17(5): 394-400	- Survey data that only reported descriptive quantitative data
Greveson, G. and James, O. (1991) Improving long-term outcome after stroke--the views of patients and carers. Health Trends 23(4): 161-2	- No relevant themes to answer the review question
Gustafsson, L. and Bootle, K. (2013) Client and carer experience of transition home from inpatient stroke rehabilitation. Disability & Rehabilitation 35(16): 1380-6	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Haese, J. B.; Trotter, A. B.; Flynn, R. T. (1970) Attitudes of stroke patients toward rehabilitation and recovery. American Journal of Occupational Therapy 24(4): 285-9	- Survey data that only reported descriptive quantitative data
Hakkennes, Sharon, Hill, Keith D., Brock, Kim et al. (2013) SELECTION FOR INPATIENT REHABILITATION AFTER SEVERE STROKE: WHAT FACTORS INFLUENCE REHABILITATION ASSESSOR DECISION MAKING?. Journal of Rehabilitation Medicine (Stiftelsen Rehabiliteringsinformation) 45(1): 24-31	- Survey data that only reported descriptive quantitative data
Hale, L. A. and Piggot, J. (2005) Exploring the content of physiotherapeutic home-based stroke rehabilitation in New Zealand. Archives of Physical Medicine & Rehabilitation 86(10): 1933-1940	- Study does not contain an intervention relevant to this review protocol *Not specifically about early supported discharge*
Hale, L., Bennett, D., Bentley, M. et al. (2003) Stroke rehabilitation -- comparing hospital and home-based physiotherapy: the patient's perception. New Zealand Journal of Physiotherapy 31(2): 84-92	- Aims of the study are not relevant to the review question
Halle, M. C. and Le Dorze, G. (2014) Understanding significant others' experience of aphasia and rehabilitation following stroke. Disability & Rehabilitation 36(21): 1774-82	- Aims of the study are not relevant to the review question

Study	Code [Reason]
Hansen, G. M.; Brunner, I.; Pallesen, H. (2021) Patients' and Health Professionals' Experiences of Group Training to Increase Intensity of Training after Acquired Brain Injury: A Focus Group Study. Rehabilitation Research and Practice 2021 (no pagination)	- Population not relevant to this review protocol *Acquired brain injury in general, not specifically stroke*
Hardicre, N. K., Crocker, T. F., Wright, A. et al. (2018) An intervention to support stroke survivors and their carers in the longer term (LoTS2Care): study protocol for the process evaluation of a cluster randomised controlled feasibility trial. Trials [Electronic Resource] 19(1): 368	- Protocol only
Harris Walker, G., Oyesanya, T. O., Hurley, A. et al. (2021) Recovery experiences of younger stroke survivors who are parents: A qualitative content analysis. Journal of Clinical Nursing 30(12): 126-135	- Population not relevant to this review protocol
Harrison, M., Ryan, T., Gardiner, C. et al. (2017) Psychological and emotional needs, assessment, and support post-stroke: a multi-perspective qualitative study. Topics in Stroke Rehabilitation 24(2): 119-125	- No relevant themes to answer the review question
Henderson, A.; Milburn, D.; Everingham, K. (1998) Where to from here: patients of a day hospital rehabilitation programme perceived needs following stroke. Contemporary Nurse 7(4): 211-6	- No relevant themes to answer the review question
Hersh, Deborah, Sherratt, Sue, Howe, Tami et al. (2012) An analysis of the “goal” in aphasia rehabilitation. Aphasiology 26(8): 971-984	- No relevant themes to answer the review question
Higgins, M.; McKevitt, C.; Wolfe, C. D. (2005) Reading to stroke unit patients: perceived impact and potential of an innovative arts based therapy. Disability & Rehabilitation 27(22): 1391-8	- No relevant themes to answer the review question
Hillsdon, K. M.; Kersten, P.; Kirk, H. J. (2013) A qualitative study exploring patients' experiences of standard care or cardiac rehabilitation post minor stroke and transient ischaemic attack. Clinical Rehabilitation 27(9): 845-53	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Hjelmblink, F.; Holmström, I.; Sanner, M. (2009) The meaning of rehabilitation for older people who have survived stroke. Journal of Nursing & Healthcare of Chronic Illnesses 1(2): 186-195	- No relevant themes to answer the review question
Hodson, Tenelle; Aplin, Tammy; Gustafsson, Louise (2016) Understanding the dimensions of home for people returning home post stroke rehabilitation. British Journal of Occupational Therapy 79(7): 427-433	- No relevant themes to answer the review question
Hole, E., Stubbs, B., Roskell, C. et al. (2014) The patient's experience of the psychosocial process that influences identity following stroke rehabilitation: a metaethnography. Thescientificworldjournal 2014: 349151	- No relevant themes to answer the review question
Holmqvist, L. W.; von Koch, L.; de Pedro-Cuesta, J. (2000) Use of healthcare, impact on family caregivers and patient satisfaction of rehabilitation at home after stroke in southwest Stockholm. Scandinavian Journal of Rehabilitation Medicine 32(4): 173-9	- Survey data that only reported descriptive quantitative data
Horne, M., Thomas, N., Vail, A. et al. (2015) Staff's views on delivering patient-led therapy during inpatient stroke rehabilitation: a focus group study with lessons for trial fidelity. Trials [Electronic Resource] 16: 137	- Aims of the study are not relevant to the review question
Howe, T., Davidson, B., Worrall, L. et al. (2012) 'You needed to rehab ... families as well': family members' own goals for aphasia rehabilitation. International Journal of Language & Communication Disorders 47(5): 511-21	- No relevant themes to answer the review question
Hunt, D. and Smith, J. A. (2004) The personal experience of carers of stroke survivors: an interpretative phenomenological analysis. Disability & Rehabilitation 26(16): 1000-11	- No relevant themes to answer the review question
Jellema, S., Bakker, K., Nijhuis-van der Sanden, M. W. G. et al. (2021) The role of the social network during inpatient rehabilitation: A qualitative study exploring the views of older stroke survivors and their informal caregivers. Topics in Stroke Rehabilitation: 1-10	- No relevant themes to answer the review question
Jones, M., O'Neill, P., Waterman, H. et al. (1997) Building a relationship: communications	- No relevant themes to answer the review question

Study	Code [Reason]
and relationships between staff and stroke patients on a rehabilitation ward. Journal of Advanced Nursing 26(1): 101-10	
Jones, S. P., Auton, M. F., Burton, C. R. et al. (2008) Engaging service users in the development of stroke services: an action research study. Journal of Clinical Nursing 17(10): 1270-9	- No relevant themes to answer the review question
Kalavina, R., Chisati, E., Mlenzana, N. et al. (2019) The challenges and experiences of stroke patients and their spouses in Blantyre, Malawi. Malawi Medical Journal 31(2): 112-117	- No relevant themes to answer the review question
Kamalakannan, S., Gudlavalleti Venkata, M., Prost, A. et al. (2016) Rehabilitation Needs of Stroke Survivors After Discharge From Hospital in India. Archives of Physical Medicine & Rehabilitation 97(9): 1526-1532.e9	- No relevant themes to answer the review question
Kennedy, G. M., Brock, K. A., Lunt, A. W. et al. (2012) Factors influencing selection for rehabilitation after stroke: a questionnaire using case scenarios to investigate physician perspectives and level of agreement. Archives of Physical Medicine & Rehabilitation 93(8): 1457-9	- Survey data that only reported descriptive quantitative data
Khondowe, O.; Rhoda, A.; Mpofu, R. (2007) Perceived needs of caregivers of stroke patients' receiving out-patient physiotherapy treatment in Lusaka, Zambia. South African Journal of Physiotherapy 63(1): 14-17	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Khoshbakht Pishkhani, M., Dalvandi, A., Ebadi, A. et al. (2019) Factors affecting adherence to rehabilitation in Iranian stroke patients: A qualitative study. Journal of Vascular Nursing 37(4): 264-271	- Aims of the study are not relevant to the review question
Kitko, L. and Hupcey, J. E. (2008) Factors that influence health-seeking behaviors of patients experiencing acute stroke. Journal of Neuroscience Nursing 40(6): 333-40	- No relevant themes to answer the review question
Kitson, A. L., Dow, C., Calabrese, J. D. et al. (2013) Stroke survivors' experiences of the fundamentals of care: a qualitative analysis. International Journal of Nursing Studies 50(3): 392-403	- No relevant themes to answer the review question

Study	Code [Reason]
Kraut, J. C.; Singer, B. J.; Singer, K. P. (2014) Referrer and service provider beliefs and attitudes towards rehabilitation in the home; factors related to utilisation of Early Supported Discharge. Disability & Rehabilitation 36(25): 2178-86	- Survey data that only reported descriptive quantitative data
Krieger, T.; Feron, F.; Dorant, E. (2017) Developing a complex intervention programme for informal caregivers of stroke survivors: The Caregivers' Guide. Scandinavian Journal of Caring Sciences 31(1): 146-156	- No relevant themes to answer the review question
Krishnan, S., Hay, C. C., Pappadis, M. R. et al. (2019) Stroke Survivors' Perspectives on Post-Acute Rehabilitation Options, Goals, Satisfaction, and Transition to Home. Journal of Neurologic Physical Therapy 43(3): 160-167	- No relevant themes to answer the review question
Kulnik, Stefan Tino, Mohapatra, Sushmita, Gawned, Sara et al. (2020) Managing the severely impaired arm after stroke: a mixed-methods study with qualitative emphasis. Disability & Rehabilitation 42(13): 1826-1834	- Aims of the study are not relevant to the review question
Kvigne, K.; Kirkevold, M.; Gjengedal, E. (2005) The nature of nursing care and rehabilitation of female stroke survivors: the perspective of hospital nurses. Journal of Clinical Nursing 14(7): 897-905	- No relevant themes to answer the review question
Kylen, Maya, Ytterberg, Charlotte, von Koch, Lena et al. (2022) How is the environment integrated into post-stroke rehabilitation? A qualitative study among community-dwelling persons with stroke who receive home rehabilitation in Sweden. Health & social care in the community 30(5): 1933-1943	- Study does not contain an intervention relevant to this review protocol *Home-based rehabilitation but not early supported discharge*
Lamontagne, M. E., Richards, C., Azzaria, L. et al. (2019) Perspective of patients and caregivers about stroke rehabilitation: the Quebec experience. Topics in Stroke Rehabilitation 26(1): 39-48	- No relevant themes to answer the review question
Lang, C. E., MacDonald, J. R., Reisman, D. S. et al. (2009) Observation of amounts of movement practice provided during stroke rehabilitation. Archives of Physical Medicine & Rehabilitation 90(10): 1692-1698	- Survey data that only reported descriptive quantitative data

Study	Code [Reason]
Large, R.; Samuel, V.; Morris, R. (2020) A changed reality: Experience of an acceptance and commitment therapy (ACT) group after stroke. Neuropsychological Rehabilitation 30(8): 1477-1496	- Aims of the study are not relevant to the review question
Laver, K., Ratcliffe, J., George, S. et al. (2013) Preferences for rehabilitation service delivery: a comparison of the views of patients, occupational therapists and other rehabilitation clinicians using a discrete choice experiment. Australian Occupational Therapy Journal 60(2): 93-100	- Survey data that only reported descriptive quantitative data
Laver, K., Ratcliffe, J., George, S. et al. (2011) Early rehabilitation management after stroke: what do stroke patients prefer?. Journal of Rehabilitation Medicine 43(4): 354-8	- Survey data that only reported descriptive quantitative data
Lawrence, M. and Kinn, S. (2013) Needs, priorities, and desired rehabilitation outcomes of family members of young adults who have had a stroke: findings from a phenomenological study. Disability & Rehabilitation 35(7): 586-95	- Full text paper not available
Lawrence, Maggie and Kinn, Sue (2012) Determining the needs, priorities, and desired rehabilitation outcomes of young adults who have had a stroke. Rehabilitation Research & Practice: 1-9	- No relevant themes to answer the review question
Lawton, Michelle, Haddock, Gillian, Conroy, Paul et al. (2018) People with aphasia's perception of the therapeutic alliance in aphasia rehabilitation post stroke: a thematic analysis. Aphasiology 32(12): 1397-1417	- Aims of the study are not relevant to the review question
Lawton, Michelle, Sage, Karen, Haddock, Gillian et al. (2018) Speech and language therapists' perspectives of therapeutic alliance construction and maintenance in aphasia rehabilitation post-stroke. International Journal of Language & Communication Disorders 53(3): 550-563	- Aims of the study are not relevant to the review question
Le Dorze, G. and Signori, F. H. (2010) Needs, barriers and facilitators experienced by spouses of people with aphasia. Disability & Rehabilitation 32(13): 1073-87	- No relevant themes to answer the review question

Study	Code [Reason]
Lemke, M., Rodriguez Ramirez, E., Robinson, B. et al. (2020) Motivators and barriers to using information and communication technology in everyday life following stroke: a qualitative and video observation study. Disability & Rehabilitation 42(14): 1954-1962	- Aims of the study are not relevant to the review question
Levack, W. M., Dean, S. G., Siegert, R. J. et al. (2011) Navigating patient-centered goal setting in inpatient stroke rehabilitation: how clinicians control the process to meet perceived professional responsibilities. Patient Education & Counseling 85(2): 206-13	- No relevant themes to answer the review question
Lewinter, M. and Mikkelsen, S. (1995) Therapists and the rehabilitation process after stroke. Disability & Rehabilitation 17(5): 211-216	- No relevant themes to answer the review question
Lindblom, Sebastian (2021) Understanding the links: The exploration of care transitions between hospital and continued rehabilitation in the home after stroke. Dissertation Abstracts International: Section B: The Sciences and Engineering 82(8b): nopaginationspecified-	- Thesis only
Linton, K. F., Ing, M. M., Vento, M. A. et al. (2015) From discharge planner to "concierge": recommendations for hospital social work by clients with intracerebral hemorrhage. Social Work in Public Health 30(6): 486-95	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Lloyd, A., Bannigan, K., Sugavanam, T. et al. (2018) Experiences of stroke survivors, their families and unpaid carers in goal setting within stroke rehabilitation: a systematic review of qualitative evidence. JBI Database Of Systematic Reviews And Implementation Reports 16(6): 1418-1453	- Aims of the study are not relevant to the review question
Lloyd, A.; Roberts, A. R.; Freeman, J. A. (2014) 'Finding a balance' in involving patients in goal setting early after stroke: a physiotherapy perspective. Physiotherapy research international : the journal for researchers and clinicians in physical therapy 19(3): 147-157	- No relevant themes to answer the review question
Loft, M. I., Martinsen, B., Esbensen, B. A. et al. (2019) Call for human contact and support: an interview study exploring patients' experiences with inpatient stroke rehabilitation and their perception of nurses' and nurse assistants' roles	- Aims of the study are not relevant to the review question

Study	Code [Reason]
and functions. Disability & Rehabilitation 41(4): 396-404	
Loft, Mia I., Poulsen, Ingrid, Esbensen, Bente A. et al. (2017) Nurses' and nurse assistants' beliefs, attitudes and actions related to role and function in an inpatient stroke rehabilitation unit-A qualitative study. Journal of Clinical Nursing (John Wiley & Sons, Inc.) 26(2324): 4905-4914	- No relevant themes to answer the review question
Lou, S., Carstensen, K., Jorgensen, C. R. et al. (2017) Stroke patients' and informal carers' experiences with life after stroke: an overview of qualitative systematic reviews. Disability & Rehabilitation 39(3): 301-313	- No relevant themes to answer the review question
Low, J. T.; Roderick, P.; Payne, S. (2004) An exploration looking at the impact of domiciliary and day hospital delivery of stroke rehabilitation on informal carers. Clinical Rehabilitation 18(7): 776-84	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Lui, M. H. and MacKenzie, A. E. (1999) Chinese elderly patients' perceptions of their rehabilitation needs following a stroke. Journal of Advanced Nursing 30(2): 391-400	- No relevant themes to answer the review question
Luker, J. A., Bernhardt, J., Grimmer, K. A. et al. (2014) A qualitative exploration of discharge destination as an outcome or a driver of acute stroke care. BMC Health Services Research 14: 193	- Aims of the study are not relevant to the review question
Luker, J. A., Craig, L. E., Bennett, L. et al. (2016) Implementing a complex rehabilitation intervention in a stroke trial: a qualitative process evaluation of AVERT. BMC Medical Research Methodology 16: 52	- Discusses very early mobilisation
Luker, J., Lynch, E., Bernhardsson, S. et al. (2015) Stroke Survivors' Experiences of Physical Rehabilitation: A Systematic Review of Qualitative Studies. Archives of Physical Medicine & Rehabilitation 96(9): 1698-708.e10	- Systematic review used as source of primary studies
Luker, J., Murray, C., Lynch, E. et al. (2017) Carers' Experiences, Needs, and Preferences During Inpatient Stroke Rehabilitation: A Systematic Review of Qualitative Studies. Archives of Physical Medicine & Rehabilitation 98(9): 1852-1862.e13	- Systematic review used as source of primary studies

Study	Code [Reason]
Lutz, B. J., Young, M. E., Cox, K. J. et al. (2011) The crisis of stroke: experiences of patients and their family caregivers. Topics in Stroke Rehabilitation 18(6): 786-97	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Lynch, E. A., Luker, J. A., Cadilhac, D. A. et al. (2016) Inequities in access to rehabilitation: exploring how acute stroke unit clinicians decide who to refer to rehabilitation. Disability & Rehabilitation 38(14): 1415-24	- Aims of the study are not relevant to the review question
MacDonald, Grace A.; Kayes, Nicola M.; Bright, Felicity (2013) Barriers and facilitators to engagement in rehabilitation for people with stroke: a review of the literature. New Zealand Journal of Physiotherapy 41(3): 112-121	- No relevant themes to answer the review question
Maclean, N., Pound, P., Wolfe, C. et al. (2000) Qualitative analysis of stroke patients' motivation for rehabilitation. BMJ 321(7268): 1051-4	- No relevant themes to answer the review question
Maclean, N., Pound, P., Wolfe, C. et al. (2002) The concept of patient motivation: A qualitative of stroke professionals' attitudes. Stroke 33(2): 444-448	- Aims of the study are not relevant to the review question
Magwood, G. S., Ellis, C., Nichols, M. et al. (2019) Barriers and Facilitators of Stroke Recovery: Perspectives From African Americans With Stroke, Caregivers and Healthcare Professionals. Journal of Stroke & Cerebrovascular Diseases 28(9): 2506-2516	- No relevant themes to answer the review question
Mangset, M., Tor Erling, Dahl, Forde, R. et al. (2008) 'We're just sick people, nothing else': ... factors contributing to elderly stroke patients' satisfaction with rehabilitation. Clinical Rehabilitation 22(9): 825-35	- Aims of the study are not relevant to the review question
Manning, M., MacFarlane, A., Hickey, A. et al. (2020) The relevance of stroke care for living well with post-stroke aphasia: a qualitative interview study with working-aged adults. Disability & Rehabilitation: 1-13	- No relevant themes to answer the review question
Marwaa, M. N., Kristensen, H. K., Guidetti, S. et al. (2020) Physiotherapists' and occupational therapists' perspectives on information and communication technology in stroke	- Aims of the study are not relevant to the review question

Study	Code [Reason]
rehabilitation. PLoS ONE [Electronic Resource] 15(8): e0236831	
McCurley, J. L., Funes, C. J., Zale, E. L. et al. (2019) Preventing Chronic Emotional Distress in Stroke Survivors and Their Informal Caregivers. Neurocritical Care 30(3): 581-589	- Aims of the study are not relevant to the review question
McGinnes, A., Easton, S., Williams, J. et al. (2010) The role of the community stroke rehabilitation nurse. British Journal of Nursing 19(16): 1033-1038	- Study design not relevant to this review protocol
Meadmore, Katie L., Hallewell, Emma, Freeman, Chris et al. (2019) Factors affecting rehabilitation and use of upper limb after stroke: views from healthcare professionals and stroke survivors. Topics in Stroke Rehabilitation 26(2): 94-100	- Aims of the study are not relevant to the review question
Meads, Hayley, Hunt, Jamie, Page, Alister et al. (2020) Stroke survivors' experiences of upper limb recovery: a systematic review of qualitative studies. Physical Therapy Reviews 25(56): 316-330	- Systematic review used as source of primary studies
Merlo, Angela (2011) Participants' perspectives on the feasibility and benefits of an intensive, task-specific intervention for individuals with chronic stroke: A qualitative analysis. Dissertation Abstracts International: Section B: The Sciences and Engineering 72(2b): 840	- Full text paper not available
Meyer, M. J., Teasell, R., Kelloway, L. et al. (2018) Timely access to inpatient rehabilitation after stroke: a qualitative study of perceived barriers and potential solutions in Ontario, Canada. Disability & Rehabilitation 40(26): 3120-3126	- Population not relevant to this review protocol
Miao, Melissa; Power, Emma; O'Halloran, Robyn (2015) Factors affecting speech pathologists' implementation of stroke management guidelines: a thematic analysis. Disability & Rehabilitation 37(8): 674-685	- No relevant themes to answer the review question
Michael, K. (2002) Fatigue and stroke. Rehabilitation Nursing Journal 27(3): 89-94, 103	- Review article but not a systematic review

Study	Code [Reason]
Miller, N. and Bloch, S. (2017) A survey of speech-language therapy provision for people with post-stroke dysarthria in the UK. International Journal of Language & Communication Disorders 52(6): 800-815	- Survey data that only reported descriptive quantitative data
Mold, F.; McKevitt, C.; Wolfe, C. (2003) A review and commentary of the social factors which influence stroke care: issues of inequality in qualitative literature. Health & Social Care in the Community 11(5): 405-414	- No relevant themes to answer the review question
Mold, F.; Wolfe, C.; McKevitt, C. (2006) Falling through the net of stroke care. Health & Social Care in the Community 14(4): 349-56	- No relevant themes to answer the review question
Moncion, Kevin, Biasin, Louis, Jagroop, David et al. (2020) Barriers and Facilitators to Aerobic Exercise Implementation in Stroke Rehabilitation: A Scoping Review. Journal of Neurologic Physical Therapy 44(3): 179-187	- No relevant themes to answer the review question
Morris, J. H., Oliver, T., Kroll, T. et al. (2015) From physical and functional to continuity with pre-stroke self and participation in valued activities: a qualitative exploration of stroke survivors', carers' and physiotherapists' perceptions of physical activity after stroke. Disability & Rehabilitation 37(1): 64-77	- Aims of the study are not relevant to the review question
Murdolo, Y., Brown, T., Fielding, L. et al. (2017) Stroke survivors' experiences of using the Graded Repetitive Arm Supplementary Program (GRASP) in an Australian acute hospital setting: A mixed-methods pilot study. Australian Occupational Therapy Journal 64(4): 305-313	- Discusses very early mobilisation
Nemeth, L. S., Jenkins, C., Jauch, E. C. et al. (2016) A Community-Engaged Assessment of Barriers and Facilitators to Rapid Stroke Treatment. Research in Nursing & Health 39(6): 438-448	- Aims of the study are not relevant to the review question
O'Connell, B., Hanna, B., Penney, W. et al. (2001) Recovery after stroke: a qualitative perspective. Journal of Quality in Clinical Practice 21(4): 120-5	- Aims of the study are not relevant to the review question
Olivier, C. L.; Phillips, J.; Roy, D. E. (2018) To be or not to be? A caregiver's question: the lived	- No relevant themes to answer the review question

Study	Code [Reason]
experience of a stroke family during the first 18 months poststroke. Scandinavian Journal of Caring Sciences 32(1): 270-279	
op Reimer, W. J., Scholte de Haan, R. J., Rijnders, P. T. et al. (1999) Unmet care demands as perceived by stroke patients: deficits in health care?. Quality in Health Care 8(1): 30-5	- Survey data that only reported descriptive quantitative data
Osborne, C. L. and Neville, M. (2019) Understanding the Experience of Early Supported Discharge from the Perspective of Patients with Stroke and Their Carers and Health Care Providers: A Qualitative Review. Nursing Clinics of North America 54(3): 367-384	- Systematic review used as source of primary studies
Otterman, N. M., van der Wees, P. J., Bernhardt, J. et al. (2012) Physical therapists' guideline adherence on early mobilization and intensity of practice at dutch acute stroke units: a country-wide survey. Stroke 43(9): 2395-401	- Survey data that only reported descriptive quantitative data
Oyake, K., Suzuki, M., Otaka, Y. et al. (2020) Motivational Strategies for Stroke Rehabilitation: A Delphi Study. Archives of Physical Medicine & Rehabilitation 101(11): 1929-1936	- Survey data that only reported descriptive quantitative data
Parsons, J. G. M., Plant, S. E., Slark, J. et al. (2018) How active are patients in setting goals during rehabilitation after stroke? A qualitative study of clinician perceptions. Disability & Rehabilitation 40(3): 309-316	- No relevant themes to answer the review question
Peiris, C. L.; Taylor, N. F.; Shields, N. (2012) Patients value patient-therapist interactions more than the amount or content of therapy during inpatient rehabilitation: a qualitative study. Journal of Physiotherapy 58(4): 261-8	- Population not relevant to this review protocol
Peoples, H.; Satink, T.; Steultjens, E. (2011) Stroke survivors' experiences of rehabilitation: a systematic review of qualitative studies. Scandinavian Journal of Occupational Therapy 18(3): 163-71	- No relevant themes to answer the review question
Pessah-Rasmussen, H. and Wendel, K. (2009) Early supported discharge after stroke and continued rehabilitation at home coordinated and delivered by a stroke unit in an urban area. Journal of Rehabilitation Medicine 41(6): 482-8	- Survey data that only reported descriptive quantitative data

Study	Code [Reason]
Pindus, D. M., Mullis, R., Lim, L. et al. (2018) Stroke survivors' and informal caregivers' experiences of primary care and community healthcare services - A systematic review and meta-ethnography. PLoS ONE [Electronic Resource] 13(2): e0192533	- No relevant themes to answer the review question
Plant, S. E., Tyson, S. F., Kirk, S. et al. (2016) What are the barriers and facilitators to goal-setting during rehabilitation for stroke and other acquired brain injuries? A systematic review and meta-synthesis. Clinical Rehabilitation 30(9): 921-30	- Aims of the study are not relevant to the review question
Plant, S., Tyson, S., Parson, J. et al. (2017) What are the barriers and facilitators to goal-setting during stroke rehabilitation? A systematic review and meta-synthesis. Clinical Rehabilitation 31(3): 426-426	- Duplicate reference
Poltawski, Leon, Boddy, Kate, Forster, Anne et al. (2015) Motivators for uptake and maintenance of exercise: perceptions of long-term stroke survivors and implications for design of exercise programmes. Disability & Rehabilitation 37(9): 795-801	- Aims of the study are not relevant to the review question
Poslawsky, I. E., Schuurmans, M. J., Lindeman, E. et al. (2010) A systematic review of nursing rehabilitation of stroke patients with aphasia. Journal of Clinical Nursing 19(12): 17-32	- Study design not relevant to this review protocol
Pound, P., Bury, M., Gompertz, P. et al. (1994) Views of survivors of stroke on benefits of physiotherapy. Quality in Health Care 3(2): 69-74	- No relevant themes to answer the review question
Pound, P., Bury, M., Gompertz, P. et al. (1995) Stroke patients' views on their admission to hospital. BMJ 311(6996): 18-22	- No relevant themes to answer the review question
Pound, P. and Ebrahim, S. (1997) Redefining 'doing something': health professionals' views on their role in the care of stroke patients. Physiotherapy Research International 2(2): 12-28	- No relevant themes to answer the review question
Proot, I. M., Abu-Saad, H. H., de Esch-Janssen, W. P. et al. (2000) Patient autonomy during rehabilitation: the experiences of stroke patients	- No relevant themes to answer the review question

Study	Code [Reason]
in nursing homes. International Journal of Nursing Studies 37(3): 267-76	
Proot, I. M., ter Meulen, R. H. J., Abu-Saad, H. H. et al. (2007) Supporting stroke patients' autonomy during rehabilitation. Nursing Ethics 14(2): 229-241	- No relevant themes to answer the review question
Purvis, Tara, Moss, Karen, Francis, Linda et al. (2017) Benefits of clinical facilitators on improving stroke care in acute hospitals: a new programme for Australia. Internal Medicine Journal 47(7): 775-784	- Aims of the study are not relevant to the review question
Putman, K., De Wit, L., Schupp, W. et al. (2009) Variations in follow-up services after inpatient stroke rehabilitation: a multicentre study. Journal of Rehabilitation Medicine 41(8): 646-53	- Survey data that only reported descriptive quantitative data
Quinn, K.; Murray, C.; Malone, C. (2014) Spousal experiences of coping with and adapting to caregiving for a partner who has a stroke: a meta-synthesis of qualitative research. Disability & Rehabilitation 36(3): 185-98	- No relevant themes to answer the review question
Reed, M. C., Wood, V., Harrington, R. et al. (2012) Developing stroke rehabilitation and community services: a meta-synthesis of qualitative literature. Disability & Rehabilitation 34(7): 553-63	- Aims of the study are not relevant to the review question
Reed, M., Harrington, R., Duggan, A. et al. (2010) Meeting stroke survivors' perceived needs: a qualitative study of a community-based exercise and education scheme. Clinical Rehabilitation 24(1): 16-25	- No relevant themes to answer the review question
Reunanen, M. A., Jarvikoski, A., Talvitie, U. et al. (2016) Individualised home-based rehabilitation after stroke in eastern Finland--the client's perspective. Health & Social Care in the Community 24(1): 77-85	- Study does not contain an intervention relevant to this review protocol *Does not relate to early supported discharge*
Rhoda, A., Cunningham, N., Azaria, S. et al. (2015) Provision of inpatient rehabilitation and challenges experienced with participation post discharge: quantitative and qualitative inquiry of African stroke patients. BMC Health Services Research 15: 423	- No relevant themes to answer the review question

Study	Code [Reason]
Rittman, M., Boylstein, C., Hinojosa, R. et al. (2007) Transition experiences of stroke survivors following discharge home. Topics in Stroke Rehabilitation 14(2): 21-31	- Study does not contain an intervention relevant to this review protocol *Discusses people after discharge home but does not appear to report people's experiences after early supported discharge*
Rochette, A., Racine, E., Lefebvre, H. et al. (2014) Ethical issues relating to the inclusion of relatives as clients in the post-stroke rehabilitation process as perceived by patients, relatives and health professionals. Patient Education & Counseling 94(3): 384-9	- No relevant themes to answer the review question
Rodgers, H., Shaw, L., Cant, R. et al. (2015) Evaluating an extended rehabilitation service for stroke patients (EXTRAS): study protocol for a randomised controlled trial. Trials [Electronic Resource] 16: 205	- Protocol only
Rosewilliam, S.; Roskell, C. A.; Pandyan, A. D. (2011) A systematic review and synthesis of the quantitative and qualitative evidence behind patient-centred goal setting in stroke rehabilitation. Clinical Rehabilitation 25(6): 501-14	- Aims of the study are not relevant to the review question
Rosewilliam, S., Sintler, C., Pandyan, A. D. et al. (2016) Is the practice of goal-setting for patients in acute stroke care patient-centred and what factors influence this? A qualitative study. Clinical Rehabilitation 30(5): 508-19	- Aims of the study are not relevant to the review question
Ryan, T., Harrison, M., Gardiner, C. et al. (2017) Challenges in building interpersonal care in organized hospital stroke units: The perspectives of stroke survivors, family caregivers and the multidisciplinary team. Journal of Advanced Nursing 73(10): 2351-2360	- No relevant themes to answer the review question
Sabini, Rosanna C.; Dijkers, Marcel P. J. M.; Raghavan, Preeti (2013) Stroke survivors talk while doing: Development of a therapeutic framework for continued rehabilitation of hand function post stroke. Journal of Hand Therapy 26(2): 124-131	- No relevant themes to answer the review question
Sadler, E., Porat, T., Marshall, I. et al. (2017) Shaping innovations in long-term care for stroke survivors with multimorbidity through	- Aims of the study are not relevant to the review question

Study	Code [Reason]
stakeholder engagement. PLoS ONE [Electronic Resource] 12(5): e0177102	
Salbach, N. M., Veinot, P., Rappolt, S. et al. (2009) Physical therapists' experiences updating the clinical management of walking rehabilitation after stroke: a qualitative study. Physical Therapy 89(6): 556-68	- Aims of the study are not relevant to the review question
Salisbury, L., Wilkie, K., Bulley, C. et al. (2010) 'After the stroke': patients' and carers' experiences of healthcare after stroke in Scotland. Health & Social Care in the Community 18(4): 424-32	- Aims of the study are not relevant to the review question
Scheffler, E. and Mash, R. (2020) Figuring it out by yourself: Perceptions of home-based care of stroke survivors, family caregivers and community health workers in a low-resourced setting, South Africa. African Journal of Primary Health Care & Family Medicine 12(1): e1-e12	- Aims of the study are not relevant to the review question
Schouten, Linda, Murray, Carolyn, Boshoff, Kobie et al. (2011) Overcoming the long-term effects of stroke: qualitative perceptions of involvement in a group rehabilitation programme. International Journal of Therapy & Rehabilitation 18(4): 198-208	- No relevant themes to answer the review question
Schwarz, B.; Claros-Salinas, D.; Streibelt, M. (2018) Meta-Synthesis of Qualitative Research on Facilitators and Barriers of Return to Work After Stroke. Journal of Occupational Rehabilitation 28(1): 28-44	- Aims of the study are not relevant to the review question
Scorrano, Maryke; Ntsiea, Veronica; Maleka, Douglas (2018) Enablers and barriers of adherence to home exercise programmes after stroke: caregiver perceptions. International Journal of Therapy & Rehabilitation 25(7): 353-364	- No relevant themes to answer the review question
Secrest, J. S. (2002) How stroke survivors and primary support persons experience nurses in rehabilitation. Rehabilitation Nursing Journal 27(5): 176-81	- No relevant themes to answer the review question
Shafer, J. S.; Shafer, P. R.; Haley, K. L. (2019) Caregivers navigating rehabilitative care for people with aphasia after stroke: a multi-lens	- No relevant themes to answer the review question

Study	Code [Reason]
perspective. International Journal of Language & Communication Disorders 54(4): 634-644	
Shannon, R. L.; Forster, A.; Hawkins, R. J. (2016) A qualitative exploration of self-reported unmet need one year after stroke. Disability & Rehabilitation 38(20): 2000-7	- No relevant themes to answer the review question
Siemonsma, Petra, Döpp, Carola, Alpay, Laurence et al. (2014) Determinants influencing the implementation of home-based stroke rehabilitation: a systematic review. Disability & Rehabilitation 36(24): 2019-2030	- Systematic review used as source of primary studies
Sit, J. W. H., Wong, T. K. S., Clinton, M. et al. (2004) Stroke care in the home: the impact of social support on the general health of family caregivers. Journal of Clinical Nursing (Wiley-Blackwell) 13(7): 816-824	- Survey data that only reported descriptive quantitative data
Skubik-Peplaski, Camille, Howell, Dana M., Hunter, Elizabeth G. et al. (2015) Occupational therapists' perceptions of environmental influences on practice at an inpatient stroke rehabilitation program: A pilot study. Physical & Occupational Therapy in Geriatrics 33(3): 250-262	- Aims of the study are not relevant to the review question
Smith, R.; Burgess, C.; Sorinola, I. (2018) The effect of a dysfunctional upper limb on community-dwelling stroke survivors and their carers: An interpretative phenomenological analysis. Physiotherapy Research International 23(4): e1726	- Aims of the study are not relevant to the review question
Stephenson, S. and Wiles, R. (2000) Advantages and disadvantages of the home setting for therapy: Views of patients and therapists. British Journal of Occupational Therapy 63(2): 59-64	- No relevant themes to answer the review question
Stewart, C., Power, E., McCluskey, A. et al. (2020) Development of a participatory, tailored behaviour change intervention to increase active practice during inpatient stroke rehabilitation. Disability & Rehabilitation 42(24): 3516-3524	- Aims of the study are not relevant to the review question
Sunnerhagen, Katharina S., Danielsson, Anna, Rafsten, Lena et al. (2013) Gothenburg very early supported discharge study (GOTVED) NCT01622205: A block randomized trial with	- Protocol only

Study	Code [Reason]
superiority design of very early supported discharge for patients with stroke. BMC Neurology Vol 13 2013, ArtID 66 13	
Sutter-Leve, R., Passint, E., Ness, D. et al. (2021) The Caregiver Experience After Stroke in a COVID-19 Environment: A Qualitative Study in Inpatient Rehabilitation. Journal of Neurologic Physical Therapy 45(1): 14-20	- Aims of the study are not relevant to the review question
Taylor, E. and Jones, F. (2014) Lost in translation: exploring therapists' experiences of providing stroke rehabilitation across a language barrier. Disability & Rehabilitation 36(25): 2127-35	- Aims of the study are not relevant to the review question
Taylor, E.; McKevitt, C.; Jones, F. (2015) Factors shaping the delivery of acute inpatient stroke therapy: a narrative synthesis. Journal of Rehabilitation Medicine 47(2): 107-19	- Systematic review used as source of primary studies
Teel, C. S.; Duncan, P.; Lai, S. M. (2001) Caregiving experiences after stroke. Nursing Research 50(1): 53-60	- Survey data that only reported descriptive quantitative data
Theofanidis, Dimitrios (2015) A qualitative study on discrimination and ethical implications in stroke care in contemporary Greece. Journal of Vascular Nursing 33(4): 138-142	- Aims of the study are not relevant to the review question
Theofanidis, Dimitrios and Gibbon, Bernard (2016) Exploring the experiences of nurses and doctors involved in stroke care: a qualitative study. Journal of Clinical Nursing (John Wiley & Sons, Inc.) 25(1314): 1999-2007	- Aims of the study are not relevant to the review question
Thompson, Stephanie, Ranta, Annemarei, Porter, Karen et al. (2019) How much rehabilitation are our patients with stroke receiving?. New Zealand Medical Journal 132(1499): 49-55	- Survey data that only reported descriptive quantitative data
Tistad, M., von Koch, L., Sjostrand, C. et al. (2013) What aspects of rehabilitation provision contribute to self-reported met needs for rehabilitation one year after stroke--amount, place, operator or timing?. Health Expectations 16(3): e24-35	- Survey data that only reported descriptive quantitative data

Study	Code [Reason]
Tole, G., Raymond, M. J., Williams, G. et al. (2020) Strength training to improve walking after stroke: how physiotherapist, patient and workplace factors influence exercise prescription. Physiotherapy Theory & Practice: 1-9	- No relevant themes to answer the review question
Tutton, E., Seers, K., Langstaff, D. et al. (2012) Staff and patient views of the concept of hope on a stroke unit: a qualitative study. Journal of Advanced Nursing 68(9): 2061-9	- Aims of the study are not relevant to the review question
Tyson, S. F. and Turner, G. (1999) The process of stroke rehabilitation: what happens and why. Clinical Rehabilitation 13(4): 322-32	- Survey data that only reported descriptive quantitative data
van der Gaag, A., Smith, L., Davis, S. et al. (2005) Therapy and support services for people with long-term stroke and aphasia and their relatives: a six-month follow-up study. Clinical Rehabilitation 19(4): 372-80	- Study design not relevant to this review protocol
van Vliet, P. M.; Lincoln, N. B.; Robinson, E. (2001) Comparison of the content of two physiotherapy approaches for stroke. Clinical Rehabilitation 15(4): 398-414	- Study design not relevant to this review protocol
Vincent, C., Deaudelin, I., Robichaud, L. et al. (2007) Rehabilitation needs for older adults with stroke living at home: perceptions of four populations. BMC Geriatrics 7: 20	- No relevant themes to answer the review question
Vincent-Onabajo, G. and Mohammed, Z. (2018) Preferred rehabilitation setting among stroke survivors in Nigeria and associated personal factors. African Journal of Disability 7: 352	- Study design not relevant to this review protocol
Vingerhoets, Catherine; Hay-Smith, Jean; Graham, Fiona (2020) Intersection of the Elements of Evidence-Based Practice in Interdisciplinary Stroke Rehabilitation: A Qualitative Study. New Zealand Journal of Physiotherapy 48(3): 148-154	- Aims of the study are not relevant to the review question
Visser-Meily, J. M.; van den Bos, G. A.; Kappelle, L. J. (2009) Better acute treatment induces more investments in chronic care for stroke patients. International Journal of Stroke 4(5): 352-3	- Study design not relevant to this review protocol

Study	Code [Reason]
von Koch, L. and Holmqvist, L. W. (2001) Early supported discharge and continued rehabilitation at home after stroke. Physical Therapy Reviews 6(2): 119-140	- Study design not relevant to this review protocol
Wallengren, C.; Friberg, F.; Segesten, K. (2008) Like a shadow--on becoming a stroke victim's relative. Scandinavian Journal of Caring Sciences 22(1): 48-55	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
Walsh, Mary E., Galvin, Rose, Loughnane, Cliona et al. (2015) Factors associated with community reintegration in the first year after stroke: a qualitative meta-synthesis. Disability & Rehabilitation 37(18): 1599-1608	- Aims of the study are not relevant to the review question
Wei, Koh; Barr, Christopher; George, Stacey (2014) Factors influencing post-stroke rehabilitation participation after discharge from hospital. International Journal of Therapy & Rehabilitation 21(6): 260-267	- Aims of the study are not relevant to the review question
Weiss, Z., Snir, D., Zohar, R. et al. (2004) Allocation and preference of patients for domiciliary or institutional rehabilitation after a stroke. International Journal of Rehabilitation Research 27(2): 155-158	- Survey data that only reported descriptive quantitative data
Wenzel, Robin A., Zgoda, Emily A., Clair, Mia C. St et al. (2021) A Qualitative Study Investigating Stroke Survivors' Perceptions of their Psychosocial Needs Being Met During Rehabilitation. Open Journal of Occupational Therapy (OJOT) 9(2): 1-17	- Aims of the study are not relevant to the review question
White, C. L., Korner-Bitensky, N., Rodrigue, N. et al. (2007) Barriers and facilitators to caring for individuals with stroke in the community: the family's experience. Canadian Journal of Neuroscience Nursing 29(2): 5-12	- Study does not contain an intervention relevant to this review protocol *Does not discuss early supported discharge*
White, J. H., Bartley, E., Janssen, H. et al. (2015) Exploring stroke survivor experience of participation in an enriched environment: a qualitative study. Disability & Rehabilitation 37(7): 593-600	- Aims of the study are not relevant to the review question
White, Jennifer Helen, Gray, Kimberley R., Magin, Parker et al. (2012) Exploring the experience of post-stroke fatigue in community	- No relevant themes to answer the review question

Study	Code [Reason]
dwelling stroke survivors: a prospective qualitative study. Disability & Rehabilitation 34(16): 1376-1384	
Wiles, R., Pain, H., Buckland, S. et al. (1998) Providing appropriate information to patients and carers following a stroke. Journal of Advanced Nursing 28(4): 794-801	- No relevant themes to answer the review question
Wohlin Wottrich, A., Stenstrom, C. H., Engardt, M. et al. (2004) Characteristics of physiotherapy sessions from the patient's and therapist's perspective. Disability & Rehabilitation 26(20): 1198-205	- Aims of the study are not relevant to the review question
Woodford, J., Farrand, P., Watkins, E. R. et al. (2018) "I Don't Believe in Leading a Life of My Own, I Lead His Life": A Qualitative Investigation of Difficulties Experienced by Informal Caregivers of Stroke Survivors Experiencing Depressive and Anxious Symptoms. Clinical Gerontologist 41(4): 293-307	- Aims of the study are not relevant to the review question
Wray, F.; Clarke, D.; Forster, A. (2019) How do stroke survivors with communication difficulties manage life after stroke in the first year? A qualitative study. International Journal of Language & Communication Disorders 54(5): 814-827	- Aims of the study are not relevant to the review question
Wressle, E.; Oberg, B.; Henriksson, C. (1999) The rehabilitation process for the geriatric stroke patient--an exploratory study of goal setting and interventions. Disability & Rehabilitation 21(2): 80-7	- No relevant themes to answer the review question
Young, C. A., Mills, R. J., Gibbons, C. et al. (2013) Poststroke fatigue: the patient perspective. Topics in Stroke Rehabilitation 20(6): 478-84	- No relevant themes to answer the review question
Young, Laura, Shrubsole, Kirstine, Worrall, Linda et al. (2018) Factors that influence Australian speech-language pathologists' self-reported uptake of aphasia rehabilitation recommendations from clinical practice guidelines. Aphasiology 32(6): 646-665	- Survey data that only reported descriptive quantitative data
Zawawi, N. S. M., Aziz, N. A., Fisher, R. et al. (2020) The Unmet Needs of Stroke Survivors and Stroke Caregivers: A Systematic Narrative	- No relevant themes to answer the review question

Study	Code [Reason]
Review. Journal of Stroke and Cerebrovascular Diseases 29 (8)	
Zhang, L., Sui, M., Yan, T. et al. (2017) A study in persons later after stroke of the relationships between social participation, environmental factors and depression. Clinical Rehabilitation 31(3): 394-402	- Survey data that only reported descriptive quantitative data

Health Economic studies

Published health economic studies that met the inclusion criteria (relevant population, comparators, economic study design, published 2006 or later and not from non-OECD country or USA) but that were excluded following appraisal of applicability and methodological quality are listed below. Also listed are papers that were included in the previous version of this guideline but are now excluded for any reason. See the health economic protocol for more details.

Table 46: Studies excluded from the health economic review

Reference	Reason for exclusion
Anderson 2000[1]	These studies were included as part of the economic evidence for the previous guideline but are now excluded as they were published before 2006.
Beech 1999[2]	
Donnelly 2004[7]	
Fjaertoft 2005[10]	
McNamee 1998[20]	
National Audit Office 2010[22]	This study was included as part of the economic evidence for the previous guideline but is now excluded as the resource use data was predominantly from before 2006.
Von Koch 2001[41]	These studies were included as part of the economic evidence for the previous guideline but are now excluded as they were published before 2006.
Teng 2003[37]	

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References

1. Anderson C, Rubenach S, Mhurchu CN, Clark M, Spencer C, Winsor A. Home or hospital for stroke rehabilitation? results of a randomized controlled trial : I: health outcomes at 6 months. Stroke. 2000; 31(5):1024-1031

2. Beech R, Rudd AG, Tilling K, Wolfe CDA. Economic consequences of early inpatient discharge to community-based rehabilitation for stroke in an inner-London teaching hospital. Stroke. 1999; 30(4):729-735

3. Candio P, Violato M, Luengo-Fernandez R, Leal J. Cost-effectiveness of home-based stroke rehabilitation across Europe: A modelling study. Health Policy. 2022; 126(3):183-189

4. Chouliara N, Fisher RJ, Kerr M, Walker MF. Implementing evidence-based stroke Early Supported Discharge services: a qualitative study of challenges, facilitators and impact. Clinical Rehabilitation. 2014; 28(4):370-377

5. Cobley CS, Fisher RJ, Chouliara N, Kerr M, Walker MF. A qualitative study exploring patients' and carers' experiences of Early Supported Discharge services after stroke. Clinical Rehabilitation. 2013; 27(8):750-757

6. Collins G, Breen C, Walsh T, McGrath M. An exploration of the experience of early supported discharge from the perspective of stroke survivors. International journal of therapy & rehabilitation. 2016; 23(5):207-214

7. Donnelly M, Power M, Russell M, Fullerton K. Randomized controlled trial of an early discharge rehabilitation service: the Belfast community stroke trial. Stroke. 2004; 35(1):127-133

8. Ellis-Hill C, Robison J, Wiles R, McPherson K, Hyndman D, Ashburn A. Going home to get on with life: patients and carers experiences of being discharged from hospital following a stroke. Disability and Rehabilitation. 2009; 31(2):61-72

9. Fisher RJ, Walker MF, Golton I, Jenkinson D. The implementation of evidence-based rehabilitation services for stroke survivors living in the community: the results of a Delphi consensus process. Clinical Rehabilitation. 2013; 27(8):741-749

10. Fjaertoft H, Indredavik B, Magnussen J, Johnsen R. Early supported discharge for stroke patients improves clinical outcome. Does it also reduce use of health services and costs? One-year follow-up of a randomized controlled trial. Cerebrovascular diseases (basel, switzerland). 2005; 19(6):376-383

11. Ganesh A, Luengo-Fernandez R, Rothwell PM. Late functional improvement and 5-year poststroke outcomes: A population-based cohort study. Journal of Neurology, Neurosurgery and Psychiatry. 2020; 91(8):831-839

12. Hillier S, Inglis-Jassiem G. Rehabilitation for community-dwelling people with stroke: home or centre based? A systematic review. International Journal of Stroke. 2010; 5(3):178-186

13. Hitch D, Leech K, Neale S, Malcolm A. Evaluating the implementation of an early supported discharge (ESD) program for stroke survivors: A mixed methods longitudinal case study. PLoS ONE [Electronic Resource]. 2020; 15(6):e0235055

14. Institute of Health Metrics. Global Burden of Disease 2017. 2017. Available from: https://www.healthdata.org/search?search_terms=global+burden+of+disease Last accessed: 21/12/2022.

15. Kj?rhauge Christiansen L, Rasmussen AM, Mouritzen HS, stervig Buus AA, Gr?nkj?r M. Quickly home again: patients' experiences of early discharge after minor stroke. Scandinavian Journal of Caring Sciences. 2021; 35(4):1187-1195

16. Kjork EK, Gunnel C, Lundgren-Nilsson A, Sunnerhagen KS. Experiences, needs, and preferences for follow-up after stroke perceived by people with stroke and healthcare professionals: A focus group study. PLoS ONE [Electronic Resource]. 2019; 14(10):e0223338

17. Kraut J, Singer B, Singer K. Clinician and client views of utilising early supported discharge services. International journal of therapy & rehabilitation. 2016; 23(10):464-471

18. Lou S, Carstensen K, Moldrup M, Shahla S, Zakharia E, Nielsen CP. Early supported discharge following mild stroke: a qualitative study of patients' and their partners' experiences of rehabilitation at home. Scandinavian Journal of Caring Sciences. 2017; 31(2):302-311

19. Luengo-Fernandez R, Gray AM, Bull L, Welch S, Cuthbertson F, Rothwell PM et al. Quality of life after TIA and stroke: ten-year results of the Oxford Vascular Study. Neurology. 2013; 81(18):1588-1595

20. McNamee P, Christensen J, Soutter J, Rodgers H, Craig N, Pearson P et al. Cost analysis of early supported hospital discharge for stroke. Age and Ageing. 1998; 27(3):345-351

21. Moule P, Young P, Glogowska M, Weare J, Fisher R, Pessah-Rasmussen Hln. Early Stroke Discharge Team: a participatory evaluation. International journal of therapy & rehabilitation. 2011; 18(6):319-328

22. National Audit O. Progress in Improving Stroke Care: report by the Comptroller and Auditor General. 2010.

23. National Guideline Centre & SSNAP. Sentinel Stroke National Audit Programme: Cost and cost effeciveness analysis. London. 2016. Available from: https://www.strokeaudit.org/SupportFiles/Documents/Health-Economics/Health-economic-report-March-2017-FINAL-DRAFT-(1).aspx

24. National Institute for Health and Care Excellence. Developing NICE guidelines: the manual [updated January 2022]. London. National Institute for Health and Care Excellence, 2014. Available from: https://www.nice.org.uk/process/pmg20

25. Neale S, Leach K, Steinfort S, Hitch D. Costs and length of stay associated with early supported discharge for moderate and severe stroke survivors: Costs & LOS for ESD. Journal of Stroke and Cerebrovascular Diseases. 2020; 29(8)

26. Nordin A, Sunnerhagen KS, Axelsson AB. Patients' expectations of coming home with Very Early Supported Discharge and home rehabilitation after stroke - an interview study. BMC Neurology. 2015; 15:235

27. Organisation for Economic Co-operation and Development (OECD). Purchasing power parities (PPP). 2012. Available from: http://www.oecd.org/std/ppp Last accessed: 01/02/2023.

28. Rasmussen RS, Ostergaard A, Kjaer P, Skerris A, Skou C, Christoffersen J et al. Stroke rehabilitation at home before and after discharge reduced disability and improved quality of life: a randomised controlled trial. Clinical Rehabilitation. 2016; 30(3):225-236

29. Ringsberg KC, Holmgren B. Home rehabilitation of stroke patients from the perspective of the patients and their relatives. Nordisk Fysioterapi. 2003; 7(3):21-31

30. Rivero-Arias O, Ouellet M, Gray A, Wolstenholme J, Rothwell PM, Luengo-Fernandez R. Mapping the modified Rankin scale (mRS) measurement into the generic EuroQol (EQ-5D) health outcome. Medical Decision Making. 2010; 30(3):341-354

31. Rochette A, Dugas A, Morissette-Gravel AS. Inclusion of relatives in stroke rehabilitation: Perception of quality of services they received in the context of early supported discharged (ESD), in- and out-patient services. Topics in Stroke Rehabilitation. 2021; 28(2):142-152

32. SSNAP - Sentinel Stroke National Audit Programme. National Results. 2022. Available from: https://www.strokeaudit.org/results/Clinical-audit/National-Results.aspx Last accessed: 25/08/2022.

33. Statistics Sweden. Available from: www.scb.se

34. Swedish Association of Local Authorities and Regions. Statistics on health care services and regional development 2012. 2013. Available from: http://webbutik.skl.se/sv/artiklar/ekonomi/statistik-om-halso-ochsjukvard-samt-regional-utveckling-2012.html

35. Taule T, Raheim M. Life changed existentially: a qualitative study of experiences at 6-8 months after mild stroke. Disability and Rehabilitation. 2014; 36(25):2107-2119

36. Taule T, Strand LI, Skouen JS, R?heim MI. Striving for a life worth living: stroke survivors' experiences of home rehabilitation. Scandinavian Journal of Caring Sciences. 2015; 29(4):651-661

37. Teng J, Mayo NE, Latimer E, Hanley J, Wood-Dauphinee S, C?t R et al. Costs and caregiver consequences of early supported discharge for stroke patients. Stroke. 2003; 34(2):528-536

38. Tham K, Von Koch L. The rehabilitation process after stroke - patients and relatives needs. 2012. Available from: https://ki.se/en/nvs/the-rehabilitation-process-after-stroke-patients-and-relatives-needs

39. Tistad M, von Koch L. Usual Clinical Practice for Early Supported Discharge after Stroke with Continued Rehabilitation at Home: An Observational Comparative Study. PLoS ONE [Electronic Resource]. 2015; 10(7):e0133536

40. van der Veen DJ, Dopp CME, Siemonsma PC, Nijhuis-van der Sanden MWG, de Swart BJM, Steultjens EM. Factors influencing the implementation of Home-Based Stroke Rehabilitation: Professionals' perspective. PLoS ONE [Electronic Resource]. 2019; 14(7):e0220226

41. von Koch L, de Pedro-Cuesta J, Kostulas V, Almaz?n J, Wid?n Holmqvist L. Randomized controlled trial of rehabilitation at home after stroke: one-year follow-up of patient outcome, resource use and cost. Cerebrovascular diseases (basel, switzerland). 2001; 12(2):131-138

42. von Koch L, Holmqvist LW, Wottrich AW, Tham K, de Pedro-Cuesta J. Rehabilitation at home after stroke: a descriptive study of an individualized intervention. Clinical Rehabilitation. 2000; 14(6):574-583

43. Whynes DK, Sprigg N, Selby J, Berge E, Bath PM. Testing for differential item functioning within the EQ-5D. Medical Decision Making. 2013; 33(2):252-260

44. Wilkinson G, Benfield JK, Everton LF, Bath PM. Swallowing therapy for dysphagia in acute and subacute stroke. 2022, Issue [unpublished]. Art. No.: CD000323. DOI: 10.1002/14651858.CD000323.pub4.

45. Wolfe CD, Crichton SL, Heuschmann PU, McKevitt CJ, Toschke AM, Grieve AP et al. Estimates of outcomes up to ten years after stroke: analysis from the prospective South London Stroke Register. PLoS Medicine. 2011; 8(5):e1001033

46. Wottrich AW, von Koch L, Tham K. The meaning of rehabilitation in the home environment after acute stroke from the perspective of a multiprofessional team...including commentary by Jensen GM. Physical Therapy. 2007; 87(6):778-788

47. Xu XM, Vestesson E, Paley L, Desikan A, Wonderling D, Hoffman A et al. The economic burden of stroke care in England, Wales and Northern Ireland: Using a national stroke register to estimate and report patient-level health economic outcomes in stroke. European Stroke Journal. 2018; 3(1):82-91