National Institute for Health and Care Excellence

Final

Stroke rehabilitation in adults (update)

[E4] Evidence reviews for intensity of rehabilitation

NICE guideline NG236

Evidence reviews underpinning recommendations 1.2.15 to 1.2.22 and recommendations for research in the NICE guideline

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Final

These evidence reviews were developed by NICE

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Appendices

Appendix F – Qualitative themes and supporting quotes

Main findings	Statement of finding	Additional supporting quotes from studies
Key principles		
More therapy is better [stroke survivors, family members/carers, healthcare professionals]	There was a perception amongst stroke survivors and family members that the more therapy they received the better their recovery would be [6, 7, 17, 18, 31, 48, 68, 86, 90, 121, 131, 137]. This opinion was also held by some healthcare professionals, while others debated whether quality was more important[16, 18, 86, 116] Speech and Language therapy: Negative reports related to lack of, or limited, therapy; several participants would have liked a more intensive regime[87] [people with aphasia receiving peer befriending].	Bennett 2016[6]: The belief that more therapy meant better outcomes was expressed by many participants, who associated increased quantity with greater functional improvement, psychological benefits and earlier and greater independence [patients receiving circuit or 7 day therapy]. Bowen 2012[7]: Participants valued a high amount of contact, whether that be with the speech and language therapists or visitors [patients receiving communication therapy]. Clarke 2018[16]: “We’ve got to get out of this habit that just because a patient needs physiotherapy that the more they have, the better it is, that’s completely wrong thinking. (Physiotherapist, Unit 5)" [stroke survivors, carers and healthcare professionals]. Cobley 2013[17]: The intensity of rehabilitation provided, of up to four visits per day, seven days per week for a duration of six weeks was received very positively by virtually every respondent [patients and carers after early supported discharge]. Connell 2018[18]: Patients generally liked the high intensity and felt they accomplished something. The therapists were surprised how hard patients worked and tolerated intensive regime. The DOSE intervention fit better with some people's belief system than others due to conflict with quality of movement versus quantity of movement [healthcare professionals]. Galvin 2009[31]: Both groups agreed that people with stroke could benefit from more physiotherapy than they routinely receive, which according to the therapists

Main findings	Statement of finding	Additional supporting quotes from studies
		varied from 30 to 60 minutes a day five times per week [stroke rehabilitation Patients and therapists]. Janssen 2020[48]: Belief that extra exercise is beneficial. Limited concerns about it being too much/working too hard: actually positive about intensity/doing more [patients receiving high intensive training]. Last 2021[68]: The majority of participants who discussed quantity of therapy during rehabilitation felt they did/were not spending enough time actively participating in therapy activities. Participants perceived they were not getting enough therapy because of limited resources (previously mentioned) or they were not being offered enough opportunities for therapy [stroke survivors]. Morris 2007[86]: Finally, they believed more therapy was required, and lack of therapy was thought to be related to setbacks in the recovery process [stroke survivors, carers and staff]. Moss 2021[87]: Negative reports related to lack of, or limited, therapy; several participants would have liked a more intensive regime [people with aphasia having peer befriending]. Nguyen 2019[90]: All participants saw the room as an opportunity to exercises outside of their regular therapy sessions and a way to increase exposure to activities, complementing their therapy time [therapists delivering exergaming]. Taylor 2018[116]: Some patients were less concerned about the quantity of therapy offered to them than the quality of care and the nature of the therapy they received. Clinical leads felt that using session length as a measure of the quality of therapy was problematic; believing it was unachievable; and wanting to protect therapists from additional pressure [stroke survivors and clinical leads]. Van Kessel 2017[121]: The physiotherapists' positive attitude reflected their belief that 7-day services increased therapy time which contributed to improved function and some based this on positive feedback from patients [therapists].

Main findings	Statement of finding	Additional supporting quotes from studies
		Worrall 2011[131]: Most participants wanted speech therapy that met their needs at different stages of recovery, that was relevant to their life, that was more frequent, and that continued for longer. They wanted positive relationships and interactions with their speech therapists and other health service providers [stroke survivors]. Young 2013[137]: Participants valued a high amount of contact. More contact felt like more benefit in quite a straightforward equation for the majority of participants [stroke survivors and therapists].
Person centred care: Intensity tailored to the individual [stroke survivors, family members/carers, healthcare professionals]	The amount of rehabilitation provided should be tailored to the individual. While some people (stroke survivors and healthcare professionals) feel that more rehabilitation should be available, while others may not be able to achieve this level. [6, 7, 16, 18, 68, 80] Where people (stroke survivors) find it difficult to complete rehabilitation in time block, this could be delivered as more frequent shorter sessions.[6, 16, 19, 81] Person centred care was important. Care needed to be considered and tailored to the individuals needs. This view was shared by stroke survivors, carers and healthcare professionals alike. [51, 81, 86, 87, 107, 109, 123, 125, 137]. However, many carers that patients' care was often too standardised, focused only on physical care and not delivered in a way that met their individual needs. [86] Dependent on the situation there were varying levels of patient involvement in the decision-making process to delivery of physiotherapy[79, 107]. Most stroke survivors reported that they were actively involved in the decision-making on their	Bennett 2016[6]: More frequent sessions, rather than longer sessions were advocated by some, and other saw twice daily physio as a way of achieving more therapy time, and maintaining momentum [patients receiving circuit or 7 day therapy]. Bowen 2012[7]: People also discussed the importance of the quantity of contact being tempered with a sensitivity to meeting the particular needs that participants were experiencing at any given time [patients receiving communication therapy]. Clarke 2018 [16]: Therapists frequently provided shorter, less intensive treatments for fatiguing patients, reporting that ideally they would return to them later the same day to provide an appropriate overall therapy 'dose' [stroke survivors, carers and healthcare professionals]. Connell 2014 [19]: Therapists discussed different approaches to getting patients to complete the desired amount of practice, such as splitting GRASP up throughout the day and providing extra sessions with the rehabilitation assistant [healthcare professionals]. Kelly 2020[51]: They felt the timetabling was tailored to the needs of the individual and was important to maintain a focus on therapy time, providing intensity and repetition of practice with variety [chronic stroke survivors and healthcare providers].

Main findings	Statement of finding	Additional supporting quotes from studies
	goals and rehabilitation plan whilst others were happy to let the study physiotherapists decide on the rehabilitation plan[107]. Some physiotherapists believed that patients should have the choice to participate in therapy over the weekend or have time off with their families[121].	Last 2021[68]: Participants described instances where therapy was enhanced when activities were tailored to individual needs, preferences and goals. While some participants perceived therapy to be challenging, others criticized the simplicity of activities. If activities or exercises were perceived to be too easy, there was a risk of becoming bored and losing interest. Another participant made implications of pointlessness when describing therapy activities. Some participants noted that therapy was sufficiently challenging. In addition, therapy activities seemed to be most meaningful to participants when they were developed or refined to match the needs and goals of the individual. One participant talked about how they would collaborate with their therapists to think of new and unique activities for them and how this made therapy enjoyable and made them excited to participate [stroke survivors]. McGlinchey 2015[79]: Dependent on the situation there were varying levels of patient involvement in the decision-making process to delivery physiotherapy. This was often dependant on the patient's ability to interact with the physiotherapist. When patients were visibly tired, patients were often asked if they wanted to stop the session. In all interview's and observations, the patients request for preferred time of day was taken into consideration when therapy was delivered [neurophysiotherapists and patients on a stroke unit]. Merlo 2013[80]: Frequently, participants made comments regarding their perception of the intensity after initiation of the therapy and how their perception changed by the end. Harold commented, "At first, I thought the length was too long, 3 hours . . . but by the end, I thought it was fine." The majority of comments revolved around the therapy being difficult, yet doable. However, one participant did suggest the therapy time be reduced [stroke survivors on intensive task specific intervention]. Merriman 2020[81]: Stroke survivors recalled how their concentration would diminish and that fatigue would set in after 20 minutes and so believed they would be unable to engage in sessions longer than this. For others a 2 hour session one a week was considered feasible. some healthcare professionals added that more intense, short and frequent sessions should ideally take place based on the assumption that intensity and repetition in an acute setting can lead to better outcomes [stroke survivors].

Main findings	Statement of finding	Additional supporting quotes from studies
		Morris 2007 [86]: Patients and carers felt that broader human needs were not met and that care was overly narrow and focussed on physical care. Many participants commented on the lack of stimulation and its impact on moral [stroke survivors, carers and staff]. Morris 2007 [86]: The carer group believed that patients' care was often too standardized and not delivered in a way that met their individual needs [carers]. Moss 2021[87]: Personalized therapy and goal-setting were seen as motivating, as were positivity and encouragement [people with aphasia having peer befriending] Schnabel 2021[107]: Activities that were tailored to stroke survivors' needs and real-life activities that were meaningful to their daily lives, were perceived as being particularly valuable. Stroke survivors also appreciated that the activities were built on what was done the day before, challenging them a bit further. All stroke survivors and their carers felt that the intensity of the EVERLAP intervention was acceptable and well tolerated [stroke survivors and carers augmented arm training]. Schnabel 2021[107]: Most stroke survivors reported that they were actively involved in the decision-making on their goals and rehabilitation plan in relation to EVERLAP whilst others were happy to let the study physiotherapists decide on the rehabilitation plan [stroke survivors and carers augmented arm training]. Signal 2016[109]: None of the patients who were more severely affected by their stroke identified their disability as a limiting factor for engagement. patients with co-morbidities discussed how the intervention had to be modified to meet their needs [stroke survivors on high intensity group based exercise programme]. Van Kessel 2017[121]: One physiotherapist felt that their ability to implement 7-day therapy was limited by patient fatigue and the perception that patients may prefer spending time with families at weekends [therapist].

Main findings	Statement of finding	Additional supporting quotes from studies
		Vive 2020[123]: Stroke survivors noted that the intervention was more fitted and individualized, than the rehabilitative interventions at home [stroke survivors experience of experience of enriched rehabilitation]. Walker 2016[125]: Both participants indicated that meaningful occupations during therapy increased their motivation and adherence to the mCIMT protocol [stroke survivors]. Young 2013[137]: Participants discussed the importance of frequency of contact being tempered with sensitivity to meeting the particular needs which participants were experiencing at any given time. Part of this sensitivity was about flexibility and awareness of how easy it might be to feel overloaded which could undermine the benefits of a large amount of contact. Participants highly valued speech and language therapists or visitors who could make their interaction seem specifically relevant to the individual. The most effective examples of encounters were ones that felt tailored to who the participants were, not just what their clinical problem might be [stroke survivors].
Duration of therapy [stroke survivors, family members/carers, healthcare professionals]	A common theme among participants was that the therapy duration was too short. Participants frequently commented on how the therapy ended just as their body adjusted to the intensity [80, 113]. Most of the participants (rehabilitation professionals) believed that further rehabilitation for stroke patients was useful provided that the stroke patients are motivated to continue with the therapy. However, several were sceptical about the benefits of continued of rehabilitation for chronic stroke patients [81, 84, 107].	Merlo 2013[80]: A common theme among participants was that the therapy duration (10 days) was too short. Participants frequently commented on how the therapy ended just as their body adjusted to the intensity. The short duration also seemed to lead to personal frustration that something that was helping them was taken away [stroke survivors on intensive task specific intervention]. Merriman 2020[81]: Variation on the intervention duration ranged from a set period of 4 weeks to 10 weeks with some adding that a step down approach should be adopted when the intervention comes to an end [stroke survivors, carers, and healthcare professionals]. Mohd Nordin 2014[84]: Most of the participants believed that further rehabilitation for stroke patients was useful provided that the stroke patients are motivated to continue with the therapy. Nonetheless, a few participants from the rehabilitation professionals group were sceptical about the benefits of continued of rehabilitation for chronic stroke patients [stroke survivors, carers and health care professionals].

Main findings	Statement of finding	Additional supporting quotes from studies
		Schnabel 2021[107]: Several of the stroke survivors and their carers felt that six weeks of augmented arm rehabilitation was sufficient as they felt that the study physiotherapists had shown them most exercises and were not sure if a longer duration would have resulted in any further improvements. Some reported that six weeks was not long enough and suggested that rehabilitation programmes should be extended to 12 weeks [stroke survivors and carers augmented arm training]. Stark 2019 [113]: Patients, who, from their point of view, considered the therapy as not being successful, stated the following reasons: the four-week period was considered too short to make reasonable improvements and the stroke had occurred too long ago [stroke survivors on home CIMT].
Person factors		
<u>Medical status</u> [stroke survivors, family members/carers, healthcare professionals]	Stroke survivors perceived medical status or comorbidities may be a barrier to engaging in rehabilitation, [18, 22, 31, 81]. Therefore, interventions may need to be adjusted for people with co-morbidities [16, 109]. However, this led to dissatisfaction when patients perceptions of their capabilities and therapeutic needs differed from those of their healthcare providers [40]. Functional limitations of the clients that served as barriers included fatigue, communication limitations, physical limitations, cognitive limitations and level of independence. [90] [stroke therapists delivering exergaming].	Clarke 2018 [16]: Factors identified by therapists included clinical instability, post-stroke fatigue and concurrent medical illness. They discussed intervention safety with medical and nursing colleagues, completed individual assessments and adapted therapy accordingly [observations, stroke survivors, carers and healthcare professionals]. Connell 2018[18]: Recognition that this type of (intensive) intervention will not be suitable for all (especially elderly stroke survivors or those with co-morbidities) [healthcare professionals]. D'Souza 2021 [22]: Staff and patients perceived patients' medical status as a barrier to communication by limiting their ability to engage with their environment including independently seeking out activities and being able to use communal areas [stroke survivors and healthcare professionals]. Galvin 2009[31]: In contrast, physiotherapists reported that physical and cognitive impairments as well as medical complications impede recovery [stroke rehabilitation physiotherapists]. Hartford 2019[40]: Several survivors and caregivers expressed dissatisfaction most often when a preferred treatment or rehabilitation program was denied due to the stroke survivor's age or perceived lack of potential to improve. Descriptions provided by stroke survivors and caregivers indicated their perceptions of their

Main findings	Statement of finding	Additional supporting quotes from studies
		capabilities, therapeutic needs and expectations for the future often differed from those of their healthcare providers. A stroke survivor described being told that they had plateaued and that they must accept "this is as good as it gets" [stroke survivors and caregivers]. Merriman 2020[81]: Stroke survivors described how mood, functioning and fatigue levels differed on a daily basis and impacted on their ability to engage in rehabilitation [stroke survivors cognitive rehabilitation]. Nguyen 2019[90]: Functional limitations of the clients that served as barriers included fatigue, communication limitations, physical limitations, cognitive limitations and level of independence. [stroke therapists delivering exergaming] Signal 2016[109]: None of the patients who were more severely affected by their stroke identified their disability as a limiting factor for engagement. patients with co-morbidities discussed how the intervention had to be modified to meet their needs [stroke survivors on high intensity group based exercise programme].
<u>Fatigue</u> [stroke survivors, family members/carers, healthcare professionals]	Fatigue was often cited as a barrier for delivering more intense rehabilitation by both patients and health care professionals hence this was a factor that needed to be considered in the implementation of any rehabilitation programme [6, 16, 32, 68, 79, 80, 90, 107, 128]. One physiotherapist felt that their ability to implement 7-day therapy was limited by patient fatigue [121]. Some stroke survivors recalled how their concentration would diminish and that fatigue would set in after 20 minutes and so believed they would be unable to engage in sessions longer than this. [81] [stroke survivors].	Bennett 2016[6]: People with post-stroke fatigue may find it difficult to complete more intense rehabilitation [patients receiving circuit or 7 day therapy]. Clarke 2018[16]: Factors identified by therapists included clinical instability, post-stroke fatigue and concurrent medical illness. Experienced therapists reported these factors did not mean therapy would be withheld. Instead, they discussed intervention safety with medical and nursing colleagues, completed individual assessments and adapted therapy accordingly [stroke survivors, carers and healthcare professionals]. Galvin 2009[32]: One physiotherapist noted that fatigue was an issue for some of her patients in the acute setting and this this was a factor that needed to be considered in the rehabilitation programme [stroke rehabilitation physiotherapist]. Last 2021[68]: Participants described how being tired and having strength and energy 'taken away' from them made participating in activities a challenge. When questioned about what prevented her from being able to engage in therapy. In

Main findings	Statement of finding	Additional supporting quotes from studies
		addition, participants often appeared astonished by the impact post-stroke fatigue had on their physical capability [stroke survivor]. McGlinchey 2015[79]: When patients were visibly tired, patients were often asked if they wanted to stop the session [neurophysiotherapists on a stroke unit]. Merlo 2013[80]: Fatigue was the theme most discussed by participants. References related to fatigue included experiences such as the fatigue experienced during the therapy, as well as fatigue carried over to the home environment. A common perception was that some days of therapy were very difficult and others were not. Participants discussed going home and having to nap or rest on some days, and other days being able to go about their daily routine [stroke survivors on intensive task specific intervention]. Merriman 2020[81]: Some stroke survivors recalled how their concentration would diminish and that fatigue would set in after 20 minutes and so believed they would be unable to engage in sessions longer than this. For others a 2 hour session once a week was considered feasible. Mood, functioning and fatigue levels can differ on a daily basis and impact their ability to therapy engagement [stroke survivors, carers, and healthcare professionals]. Nguyen 2019[90]: Functional limitations of the clients that served as barriers included fatigue, communication limitations, physical limitations, cognitive limitations, and level of independence [therapists delivering exergaming]. Schnabel 2021[107]: It was often reported that tiredness, self-reported 'laziness', pain and other commitments imposed barriers to supported self management [stroke survivors and carers augmented arm training]. Van Kessel 2017[121]: A physiotherapist felt that their ability to implement 7-day therapy was limited by patient fatigue [healthcare professionals].

Main findings	Statement of finding	Additional supporting quotes from studies
		Withiel 2020[128]: A consistent barrier identified across groups was fatigue [stroke survivors on cognitive rehabilitation].
Physical factors [stroke survivors, healthcare professionals]	Previous activity levels: People who exercised more before their stroke may be more motivated to exercise after [48]. Similarly participants described their previous experience of exercises and the type they enjoyed doing related their enjoyment of the intervention[109]. Physical support: stroke survivors with a reduced capacity and who need lots of support may find it harder to engage with interventions[90, 113, 121].	Janssen 2020[48]: Exercise and lifestyle history (most people in this study had been involved in exercise or were active before their stroke). Most people active/open to exercise [patients receiving high intensive training]. Nguyen 2019[90]: Functional limitations of the clients that served as barriers included fatigue, communication limitations, physical limitations, cognitive limitations and level of independence [therapists delivering exergaming]. Stark 2019[113]: A reduced capacity and the feeling that managing everyday life was challenging enough after having suffered a stroke were perceived as additional reasons why homeCIMT was not always easily carried out in everyday life [stroke survivors on home constraint induced movement therapy]. Signal 2016[109]: Some participants described their previous experience of exercises and the type they enjoyed doing related their enjoyment of the intervention. [stroke survivors on high intensity group based exercise programme]. Van Kessel 2017[121]: Patients who needed lots of support and lacked agency were seen to create barriers to participation [physiotherapists delivering circuit classes].
Psychological factors [stroke survivors, family members/carers, healthcare professionals]	Sense of security: Response to a life changing event: People after a stroke described a new sense of vulnerability, loss of confidence and reduced independence, which lowered their mood. Resilience, determination and optimism were frequently reported to impact adjustment[87]. The consistency and regularly of sessions during a life changing event can be very useful[17]. Post-stroke denial can delay engagement with intense therapy[6].	Bennett 2016[6]: Post-stroke denial delayed initial engagement with therapy for one circuit participant: they believed they could have transcended this period of denial faster with individual (rather than group) therapy. Difficulty concentrating during physiotherapy sessions was experienced by some participants [patients receiving circuit or 7 day therapy]. Bennett 2016[6]: Many participants recounted feeling both challenged by their therapy and rewarded by the success of achieving milestones in mobility and independence [patients receiving circuit or 7 day therapy].

Main findings	Statement of finding	Additional supporting quotes from studies
	Concentration: Difficulty concentrating can interfere with participation in intense therapy[6, 81]. Mood and behaviour challenges: People with mood or behaviour challenges may have difficulties engaging with therapy[68, 81]. Personal achievement: People can feel motivated by achieving milestones in mobility and independence and seeing improvements in measures of achievement [6, 51, 92, 109]. The feeling to compete against previous achievement could be a contributory factor to adherence and acceptability of an intervention[114]. Sense of purpose: Training was described as providing a sense of purpose either to have an activity to fill time or too have a planned activity to get them out the house [48, 109, 128]. Setting and moving toward targets despite setbacks was key to adjustment and maintaining a positive outlook for some participants[68, 87].	Cobley 2013[17]: Participants talked about how the consistency and regularity of visits provided a sense of security during such a life-changing transitional period [patients and carers after ESD]. Janssen 2020[48]: Patients felt they were able to have structure in their day to fit in extra sessions [patients receiving high intensive training]. Kelly 2020[51]: The opportunity to successfully achieve their goals by practice and repetition of tasks with feedback also contributed to confidence building [chronic stroke survivors, care givers and healthcare providers]. Last 2021[68]: Participants frequently described how physical deficits post stroke created new challenged for them and how these deficits led to difficulties in daily activities and mobility. The process of adapting to these new challenges and living with a changed body appeared to trigger an emotional response. This emotional response appeared to impact desire to participate in rehabilitation for some individuals. Specifically, participants described their stroke as a life-changing event, often resulting in profound loss, leading to feelings of sadness, anger, frustration and depressive symptoms [stroke survivors]. Last 2021[68]: The importance of a person's attitude, such as "determination," and effort, were seen as an influential aspect of success in rehabilitation. Determination was contrasted by some participants who felt they were not making progress and made inferences of discouragement and lost hope [stroke survivors]. Merriman 2020[81]: Similar issues were reflected in healthcare professionals descriptions of the current challenges of delivering adequate rehabilitation in the face of limited staffing, limited competency or experience with cognitive problems and limited access to psychological services [healthcare professionals]. Moss 2021[87]: Setting and moving toward targets despite setbacks was key to adjustment and maintaining a positive outlook for some participants [people with aphasia having peer befriending].

Main findings	Statement of finding	Additional supporting quotes from studies
		Moss 2021[87]: Participants described a new sense of vulnerability, loss of confidence and reduced independence, which lowered their mood. Diminished confidence was sometimes associated with social withdrawal. Frustration or anxiety regarding recovery progress, and uncertainty over how much improvement they could expect, was a concern [people with aphasia having peer befriending]. Norris 2018[92]: Perceived changes came gradually and that sense of incremental build up and gradual challenge was identified as a key factor in the successful delivery of the training [stroke survivors]. Signal 2016[109]: The routine provided structure and purpose to some participants days which was valued [stroke survivors on high intensity group based exercise programme]. Signal 2016[109]: Positive outcomes in response to the intervention appeared to be a powerful modifier of participants perceptions of the intervention and their ability to continue to engage. The less relevant the individual perceived the intervention to their specific needs and desires the more challenging ongoing engagement was [stroke survivors receiving a high intensity group based exercise programme]. Sweeney 2020[114]: The feedback received through the use of timing specific tasks/activities to gauge potential improvement was identified as a motivating factor within the programme in both interviews. “they started timing them (activities) to show you the difference in time from when you start to when you finish…to see before and after was just amazing to be honest. It was like day and night” “It was just a confidence booster to see you were getting quicker” [stroke survivors on home based CIMT or RAT]. Withiel 2020[128]: Training was described as providing a sense of purpose either to have an activity to fill time or too have a planned activity to get them out the house [stroke survivors receiving cognitive rehabilitation].

Main findings	Statement of finding	Additional supporting quotes from studies
Motivation [stroke survivors]	Intensity as a source of motivation: Many participant's valued how the intensity of physical and mental effort forced them to focus and work hard and linked this to their success. Some identified a link between hard work and reward 'no pain no gain'[13, 80, 109]. Therapists were concerned that frustration from intense therapy may impact on adherence, while people with stroke did not highlight this as an issue[114]. Other sources of motivation: Participants referred to sources of motivation including self-motivation, motivation from family and therapists, motivation to return to 'normal', having an altruistic view towards research and other members of the group that encouraged and helped them sustain their engagement[51, 68, 107, 109, 113, 125, 131]. People [stroke survivors] may also be motivated by the use of novel techniques (such as robot assisted therapy)[114]. Motivation in the chronic phase: Two stroke survivors who have had severe stroke claimed that their motivation level declined as the stroke became chronic hence were not motivated to continue practicing the previously learnt exercises at home[84] [chronic rehab stroke survivors].	Chen 2020[13]: Overall, the external and internal motivation that drove patients to stay in the telerehabilitation program reduced their perceived effort for engaging in this rehabilitation program [stroke survivors engaging in telerehab]. Kelly 2020[51]: Stroke survivors discussed how motivation was drawn from a variety of sources. This included the enriched rehabilitation environment, variability of activities and incremental task progressed throughout the programme. Additionally, the focus on meaningful real-world tasks was considered important to improve intrinsic motivation. The collaborative team focus of the programme, provided opportunities for enhanced motivation and self-efficacy; driven by observation-in-action [chronic stroke survivors]. Last 2021[68]: Indirect peer interaction, or observing other patients, was also described as influential. It was not uncommon for participants to compare their abilities amongst each other. One admitted using the abilities of others to motivate themselves in therapy [stroke survivors]. Merlo 2013[80]: Despite the intensity and the associated fatigue of the therapy, participants frequently commented on their level of satisfaction and enjoyment of the therapeutic experience. Many participants commented on how this therapy has been different from what they have experienced in the past [patients' intensive rehab]. Mohd Nordin 2014[84]: Two participants who have had severe stroke claimed that their motivation level declined as the stroke became chronic hence were not motivated to continue practicing the previously learnt exercises at home [Chronic rehab stroke survivors]. Schnabel 2021[107]: Several stroke survivors reported that they were self-motivated to engage in exercises themselves. Most motivation was related to specific goals such as acquiring better dexterity [stroke survivors]. Signal 2016[109]: Many participant's valued how the intensity of physical and mental effort forced them to focus and work hard and linked this to their success. some identified a link between hard work and reward 'no pain no gain' and some

Main findings	Statement of finding	Additional supporting quotes from studies
		commented on the hard work becoming repetitive and requiring an attitude of 'slogging it out' [stroke survivors on high intensity group based exercise programme]. Stark 2019[113]: Stroke survivors experienced the therapists' motivation as particularly meaningful and felt motivated to stick to the therapy over the four-week course. However, there were also patients who said that more support from their therapists would have increased their motivation [stroke survivors on home CIMT]. Sweeney 2020[114]: Therapists were concerned that frustration from intense therapy may impact on adherence, while people with stroke did not highlight this as an issue [stroke survivors on home based CIMT or RAT]. Sweeney 2020[114]: The majority of participants [stroke survivors] reported high levels of motivation. With one participant acknowledging improved motivation through attending sessions. "I couldn't motivate myself the same (at home) as I could up here. half the participants indicated a novelty aspect to the treatment which may have led to increased enjoyment and consequently acceptability of RAT [stroke survivors on home based CIMT or RAT]. Walker 2016[125]: In relation to client motivation and adherence to protocol, it highlights the importance of meaningful and psychologically rewarding occupations. [stroke survivors]. Worrall 2011[131]: Most participants expressed their desire to be normal again and to escape their current situation and return home to the security of their old life. Their main priority was to be rid of the consequences of the stroke [stroke survivors].
<u>Social factors</u> [stroke survivors, family members/carers, healthcare professionals]	Observing and interacting with other stroke survivors: People can be provided hope and enhanced self-motivation through interacting with other stroke survivors and providing mutual support and encouragement[6, 22, 51, 68, 76, 81, 92, 109, 123, 128]. Stroke	Bennett 2016[6]: Camaraderie with other stroke survivors was reported by many participants, who valued the opportunity to talk and joke with others in similar circumstances [patients receiving circuit or 7 day therapy].

Main findings	Statement of finding	Additional supporting quotes from studies
	survivors were therefore largely supportive of being involved in group-based activities, due to the opportunity for social interaction, shared experiences and coping strategies[6, 81, 128] [stroke patients]. Relationship with healthcare professionals: Patients found the relationship with their therapist an important moderator for the success of the intervention[6, 7, 22, 48, 92, 109, 113, 137]. Faith: For a subset of participants, faith was highly important, helping them feel grateful, calm, and resilient[87].	Bowen 2012[7]: Participants drew attention to the importance of knowing that a friendly and supportive person was there for them, particularly when they were feeling 'low' [patients receiving communication therapy]. D'Souza 2021[22]: Staff described the importance of the use of communal areas given the large number of private rooms on the ward. Patients also described the need to be co-located to promote social interaction [stroke survivors and healthcare professionals]. D'Souza 2021[22]: Staff and patients talked about how individual characteristics of staff, including rapport building and being friendly, facilitated communication for patients with communication difficulties [healthcare professionals and stroke survivors on communication]. Janssen 2020[48]: Positive effect of therapists. More time with therapists (who were perceived to be their coach and motivator). Without exception, the participants developed a positive relationship with the therapist team [patients receiving high intensive training]. Kelly 2020[51]: Clinicians highlighted the support among the stroke survivors. Each group of stroke survivors became close-knit, encouraging and motivating each other during the programme, aiding the confidence building [healthcare providers]. Last 2021[68]: Peer interaction among patients was another prominent environmental factors identified by participants. Participants often reflected on their experiences in relation to other patients and described situations of making friends and planning social events, such as going for coffee together. Participants specifically described how these interactions contributed to their progress [stroke survivors]. Marklund 2010[76]: The strong group feeling gave the informants the strength to manage one more day [stroke survivors on CIMT].

Main findings	Statement of finding	Additional supporting quotes from studies
		Merriman 2020[81]: Stroke survivors were largely supportive of being involved in group-based activities, noting the social aspect of group work, including opportunities for social interaction and shared experiences and coping strategies [stroke survivors]. Norris 2018[92]: On the whole, the group nature of the intervention was seen as one of its most positive aspects and often discussed as integral to its perceived effectiveness. The concept of the teamwork and shared determination despite different abilities and histories within the groups was discussed by several participants. [stroke survivors]. Norris 2018[92]: Participants discussed how the personality of the trainer got them through the hardest parts of the course, encouraging and challenging them to take that additional step [stroke survivors]. Signal 2016[109]: The majority of participants referred to the groups positively describing a sense of belonging, camaraderie and caring. the group also provided a sense of competition. participants also valued the physiotherapists clinical expertise, the care and attention they provided and their ability to motivate and help the participants to maintain focus during the training and their belief in the participants to be successful [stroke survivors on high intensity group based exercise programme]. Stark 2019[113]: Stroke survivors experienced the therapists' motivation as particularly meaningful and felt motivated to stick to the therapy over the four-week course. However, there were also patients who said that more support from their therapists would have increased their motivation [stroke survivors on home CIMT]. Vive 2020[123]: Meeting with others in the same situation was perceived as both inspiring and comforting. The group setting was noted as an important factor in self-motivation and following the progress of others was both comforting and pleasing. The bonding between group members was evident [stroke survivors experience of experience of enriched rehabilitation].

Main findings	Statement of finding	Additional supporting quotes from studies
		Withiel 2020[128]: The most reported experience was the opportunity to talk with similar others and to share knowledge and experience. patients spoke about how seeing other allowed them to compare their journey and achievements so far and many felt lucky compared to others [stroke survivors on cognitive rehabilitation]. Young 2013[137]: Participants identified the positive effect on their mood of their speech and language therapy or visitor experiences as a key marker of effectiveness. This positive impact could occur either as a result of contact with someone who was friendly and supportive serving to lift them out of a low mood, or because such contact could distract them from the difficulties of living with the consequences of stroke [stroke survivors and therapists].
<u>Education</u> [stroke survivors, healthcare professionals]	Low awareness among patients and their families regarding optimum rehabilitation: The lack of awareness of the importance of optimum rehabilitation among patients and their families was seen to result in poor compliance to rehabilitation. This was attributed mainly to lack of patient education offered by highly occupied rehabilitation staff[84]. Moreover, a lack of information can lead to a sense of frustration, self-doubt, and a loss of confidence[81] [stroke survivors, cognitive rehabilitation]. Education to increase motivation: Participants noted the importance of knowing how and why the rehabilitation was done this way—elements they perceived as essential in motivating themselves to continue the high-intensity training[68, 123]. This view was shared by clinician who described Education as useful to overcome barriers to buy-in (to the rehabilitation programme)[51] [chronic stroke survivors, neurorehabilitation programme].	Demain 2013[25]: People after stroke and caregivers want information and will seek this from healthcare professionals or the internet. While they would prefer to seek this information from health professionals they trust, health professionals may be reluctant to provide this information in fear of providing false hope for technologies that have a poor evidence base and potential litigious consequences (both personally and for their organisation). If information is not provided by healthcare professionals then people may look for information in other sources and buy technologies to use without supervision [stroke patients and health care professionals on assistive technologies]. Demain 2013[25]: Participants in each group suggested they had not been given more information on technologies by therapists because: a) therapists were overworked, b) lacked knowledge and training about what was available, c) were reluctant to give information about devices that they could not provide within the state funded service [stroke patients on assistive technologies]. Kelly 2020[51]: Education was also described as useful to overcome barriers to buy-in [chronic stroke survivors, neurorehabilitation programme]. Kelly 2020[51]: A strategy described by many clinicians to support goal-achievement was education about functional task practice or activities rather than impairment-based goals [chronic stroke survivors and healthcare providers].

Main findings	Statement of finding	Additional supporting quotes from studies
	Information on technologies: People after stroke and caregivers want information and will seek this from healthcare professionals or the internet. While they would prefer to seek this information from health professionals they trust, health professionals may be reluctant to provide this information in fear of providing false hope for technologies that have a poor evidence base and potential litigious consequences (both personally and for their organisation). If information is not provided by healthcare professionals then people may look for information in other sources and buy technologies to use without supervision[25].	Last 2021[68]: Participants reported they found information shared by their therapists to be infrequent and sometimes unclear. They expressed confusion about what they were being asked to do, why they were being asked to do certain things, and how it would impact their progress. Participants expressed how they wanted the therapists to educate them on the underlying therapeutic value of activities. Another participant described they appreciated how their therapist explained the purpose of the exercises they were performing in relation to performing daily activities, such as putting away groceries [stroke survivors]. Merriman 2020[81]: Stroke survivors noted that lack of information and poor communication had contributed to their sense of frustration, self-doubt, and loss of confidence [stroke survivors, cognitive rehabilitation]. Mohd Nordin 2014[84]: A lack of education and awareness among patients and their families regarding the importance of optimum rehabilitation was seen to result in poor compliance to rehabilitation [health care professionals]. Vive 2020[123]: Participants noted the importance of knowing how and why the rehabilitation was done this way—elements they perceived as essential in motivating themselves to continue the high-intensity training [stroke survivors experience of experience of enriched rehabilitation].
People requiring specific consideration		
People with communication difficulties [stroke survivors, healthcare professionals]	People with communication difficulties may require additional opportunities for improving communication outside of formal rehabilitation sessions. However, while in hospital, the nature of interactions are driven towards patient's care, restricting opportunities for communication beyond this context [22]. Resources to aid communication with people with aphasia may not be used (including volunteer services to promote communication opportunities)[22]. Some staff perceived communication as a task separate from the responsibility of their role, therefore limiting communication opportunities. They may also	No additional quotes

Main findings	Statement of finding	Additional supporting quotes from studies
	have a lack of skills in communicating to people with communication difficulties leading to avoidance of or unsuccessful interactions[22].	
People with cognitive difficulties [stroke survivors, family members/carers, healthcare professionals]	People may have 'hidden needs' that need additional consideration[86]. The individual's cognitive impairment level may determine the utility of group activities[81]. People may experience daily changes in mood, functioning and fatigue that can impact their ability to engage in rehabilitation[81]. Physiotherapists also reported that cognitive impairment could impede recovery because of limited carryover by the patient[32]. When to deliver more intense rehabilitation may vary. A commonly articulated view was that the further the person is into recovery the more likely they will be able to engage in activities for longer and more intense periods of time[81].	Galvin 2009[32]: Physiotherapists also reported that cognitive impairment could impede recovery because of limited carryover by the patient [stroke rehabilitation physiotherapists]. Merriman 2020[81]: The individual's cognitive impairment level may determine the utility of group activities [healthcare professionals]. Merriman 2020[81]: People may experience daily changes in mood, functioning and fatigue that can impact their ability to engage in rehabilitation[stroke survivors, carers and healthcare professionals]. Merriman 2020[81]: A commonly articulated view was that the further the person is into recovery the more likely they will be able to engage in activities for longer and more intense periods of time[stroke survivors, carers and healthcare professionals]. Morris 2007[86]: Better consideration of patients' individual needs, especially 'hidden' needs such as cognitive disabilities (was required) [stroke survivors, carers and staff].
Carer/family member factors		
<u>Support of family and friends</u> [stroke survivors, healthcare professionals]	Motivation and support of the family was mentioned as a contributory factor for success of the intervention by both the stroke survivors and therapists[13, 19, 22, 32, 48, 68, 87, 107, 109, 113, 123, 132] [stroke rehab physiotherapists]. However, wanting to spend time with families at the weekend rather than in therapy was identified as a potential barrier to 7-day therapy by some physiotherapists [121][Physiotherapists delivering circuit classes].	Chen 2020[13]: Besides caregivers, social influence mainly came from family members. Even though the system was used by a single user and not in a social model, they reflected being able to receive attention from their friends and family motivated them to continue engaging in their therapy using this system [stroke survivors engaging in telerehab]. Connell 2014[19]: All therapists reported that family played an important role in GRASP. The readiness and willingness of family members, as determined by the therapists, would influence the extent to which they would be involved [healthcare professionals on stroke rehabilitation].

Main findings	Statement of finding	Additional supporting quotes from studies
		D'Souza 2021[22]: Staff identified visitors as a facilitator to communication interaction for patients outside of therapy times during their inpatient admission [healthcare professionals]. Galvin 2009[32]: Therapists and people with stroke reported that families are eager and motivated to participate in the physiotherapy and that their involvement can be advantageous both physically and emotionally. Motivation of the family was mentioned as a contributory factor for success [stroke rehabilitation physiotherapists and stroke survivors]. Janssen 2020[48]: Family and friends generally supportive (both practical and emotional) during rehabilitation. Other family members needed to come around to the idea of intense therapy [patients receiving high intensive training]. Last 2021[68]: Family and friends were also described as an important aspect of the social environment. Their role as facilitators for participation in rehabilitation was noted through the encouragement and emotional support they provided as well as their involvement in the patients' rehabilitation processes and their overall presence. One participant described how support from family allowed him to participate in the inpatient rehabilitation program [stroke survivors]. Moss 2021[87]: Participants were overwhelmingly positive about the central role of family in their recovery after stroke. Family members also provided practical support [people with aphasia receiving peer befriending]. Stark 2019[113]: Both patients and non-professional coaches described practicing together during home CIMT as a positive experience in the sense of spending more time with each other [stroke survivors on home CIMT]. Signal 2016[109]: Motivation from other sources included family having an altruistic view towards research and other members of the group [stroke survivors on high intensity group based exercise programme].

Main findings	Statement of finding	Additional supporting quotes from studies
		Schnabel 2021[107]: Several stroke survivors reported that they had a carer who was involved in their rehabilitation. The majority of those included said that their carers acted as a reminder and sometimes a controller for doing supported self-management. These findings show that the engagement and commitment of a support network is vital in the recovery after stroke [stroke survivors]. Van Kessel 2017[121]: One physiotherapist felt that their ability to implement 7-day therapy was limited by patient fatigue and the physiotherapists perception that patients may prefer spending time with families at weekends [healthcare professionals]. Vive 2020[123]: Another external (successful) factor identified by the respondents was the support from family and relatives. Many participants were accompanied by relatives, whose attendance was described as significant [stroke survivors experience of experience of enriched rehabilitation]. Wray 2020[132]: Therapists highlighted the important role family members could play in supporting self-management. Although benefits of involving family members were recognised, barriers to involving family members were also reported. Practical barriers identified included whether or not the family member was available to be involved in the therapy session. Some suggested that some family members may have certain expectations about the role of the therapist that influences their level of involvement. Family members' expectations about their involvement were also reported to be related to 'readiness' to accept the potentially longer-term implications of living with aphasia [healthcare professionals].
Continuity of care [stroke survivors, family members/carers, healthcare professionals]	A potential approach to increase the continuity of rehabilitation, was to involve the family members and carers in conducting basic therapy at home. However, the majority of participants (rehabilitation therapists and stroke survivors) felt that the family of stroke patients had not given adequate support throughout the rehabilitation process, especially in the later stage of stroke recovery. [81, 84, 107].	Merriman 2020[81]: In addition to trained staff, involvement of carers in a cognitive rehabilitation programme was considered important by all interviewees. Involving carers was also described as being important for passing on information and skills so that carers can support stroke survivors between rehabilitation sessions to work on their goals [stroke survivors, carers and healthcare professionals on cognitive rehabilitation]. Mohd Nordin 2014[84]: A potential approach to increase the continuity of rehabilitation, was to involve the family members in conducting basic therapy at

Main findings	Statement of finding	Additional supporting quotes from studies
		home. Although family-assisted therapy was seen as one possible approach to continuity of rehabilitation, the commitment of family members was questionable. The majority of participants felt that the family of stroke patients had not given adequate support throughout the rehabilitation process, especially in the later stage of stroke recovery [rehabilitation professionals and stroke survivors on long term rehabilitation]. Schnabel 2021[107]: Several stroke survivors reported that they had a carer who was involved in their rehabilitation. The majority of those included said that their carers acted as a reminder and sometimes a controller for doing supported self-management. These findings show that the engagement and commitment of a support network is vital in the recovery after stroke [stroke survivors and carers on augmented arm training].
Healthcare professional factors		
Beliefs about intensity of rehabilitation [stroke survivors, family members/carers, healthcare professionals]	Conflict between quality and quantity of rehabilitation: Therapists may not engage in more time intensive rehabilitation as they believe that more quality movement for less time is as effective[18]. Patients were less concerned about the quantity of therapy offered to them than the quality of care and the nature of the therapy they received[116]. Knowledge of the evidence for increased frequency and intensity of therapy: Therapists may not be aware of the evidence for increased frequency and intensity of therapy and need to balance these findings with the needs of the person[16, 19] The influence of experience: The physiotherapists beliefs were linked strongly to their experiences, including university training, professional development, observation of colleges, previous	Clarke 2018[16]: All therapists referred to clinical reasoning as the basis for decision-making regarding therapy frequency and intensity. this followed patient assessment involving direct observation, information from colleagues regarding patient engagement, and from patients and their families about pre-stroke functioning. few were aware of the evidence underpinning the recommendations, or discussed how this informed clinical decision-making and therapy provision [stroke survivors, carers and healthcare professionals]. Connell 2014[19]: Practical experience of using the intervention tended to outweigh publications. Some mention of importance of having underpinning research. Therapists' beliefs about the quality of exercises that patients would be able to complete outside of therapy time influenced the way in which GRASP was used in practice (e.g. completing GRASP exercises during therapy time) [healthcare professionals]. Hartford 2019[40]: A stroke survivor suggested that healthcare providers, such as physiotherapists, had limited their physical recovery as they tended to rely on test results and theoretical expected progression to determine therapy. This information was prioritized over their perception of their capabilities and expectations [stroke survivor].

Main findings	Statement of finding	Additional supporting quotes from studies
	work experience, current work experience and direct experience with research. physiotherapists advocated that stroke rehabilitation models should support physiotherapists to modify and adapt approaches to the goals of the individual patients and respond to the diversity of patient needs[40, 121]. Most had a positive attitude about 7-day rehabilitation based on the effects on their patients. only one therapist had a negative attitude based on their personal experience that the quality of therapy over a weekend may not consistently match weekday services[121].	Taylor 2018[116]: Patients were less concerned about the quantity of therapy offered to them than the quality of care and the nature of the therapy they received [stroke survivors]. Van Kessel 2017[121]: The physiotherapists beliefs were linked strongly to their experiences, including university training, professional development, observation of colleges, previous work experience, current work experience and direct experience with research. Models should support physiotherapists to modify and adapt approaches to the goals of the individual patients and respond to the diversity of patient needs [healthcare professionals]. Van Kessel 2017[121]: Most had a positive attitude about 7-day rehabilitation based on the effects on their patients. only one therapist had a negative attitude based on their personal experience that the quality of therapy over a weekend may not consistently match weekday services [Physiotherapists delivering circuit classes].
Communication [stroke survivors]	People after stroke benefited from encouragement, motivation and honesty. They wanted therapists to discourage overoptimistic expectations[31, 87, 92, 109] [stroke survivors]. Participants identified five helpful characteristics for positive interactions during contact: the ability to put someone at ease; the ability to make an individual feel important; the visitor/speech and language therapist displaying a positive mood themselves; being empathic; being a good communicator[7, 137].	Bowen 2012[7]: The professional identity or role of the individual speech and language therapist or visitor was of far less importance than their personal qualities. Participants identified five helpful characteristics for positive interactions during contact: the ability to put someone at ease; the ability to make an individual feel important; the visitor/speech and language therapist displaying a positive mood themselves; being empathic; being a good communicator [stroke survivors]. Galvin 2009[31]: People with stroke also identified encouragement and honest as two important characteristics in a physiotherapist involved in the rehabilitation of a person with stroke. Although physiotherapists need to encourage patients to participate in physiotherapy, they also need to be pragmatic and discourage overoptimistic expectations that may develop through the process [stroke survivors]. Moss 2021[87]: Rapport was an important factor in how participants experienced therapy and its providers. Personalized therapy and goal-setting were seen as motivating, as were positivity and encouragement [people with aphasia having peer befriending].

Main findings	Statement of finding	Additional supporting quotes from studies
		Norris 2018[92]: Participants discussed how the personality of the trainer got them through the hardest parts of the course, encouraging and challenging them to take that additional step [stroke survivors]. Signal 2016[109]: Participants also valued the physiotherapists clinical expertise, the care and attention they provided and their ability to motivate and help the participants to maintain focus during the training and their belief in the participants to be successful [stroke survivors on high intensity group based exercise programme]. Young 2013[137]: Participants identified five helpful characteristics for positive interactions during contact: • the ability to put someone at ease; • the ability to make an individual feel important; • the visitor/speech and language therapist displaying a positive mood themselves; • being empathic; • being a good communicator [stroke survivors].
Feedback [stroke survivors, healthcare professionals]	Stroke survivors may benefit from receiving feedback during therapy sessions (whether from a therapist or another source, though therapist input was seen to hold validity due to professional status)[6, 7, 9, 13, 25, 48, 68, 76, 92, 114, 137] [stroke survivors and therapists]	Bennett 2016[6]: Feedback from staff during therapy sessions was highly valued. One circuit participant believed the amount of feedback received from staff during physiotherapy sessions was comparatively less in a group format, than in one-to-one sessions [patients receiving circuit or 7 day therapy]. Bowen 2012[7]: Participants described how therapists might deliberately point out their areas of weakness or skills they needed to develop in a targeted way [patients receiving communication therapy]. Burke 2021[9]: Participants valued the software's capacity to provide feedback on success directly to the person with aphasia [speech and language therapists]. Chen 2020[13]: People rated highly their experience using the videoconference, which provided a channel for therapists to observe, correct and provide feedback and encouragement. During the session, the therapist would go over many games and exercises with the patients and watch participant movements, and they could verbally correct exercise performance, make adjustments and answer questions [stroke survivors engaging in telerehab].

Main findings	Statement of finding	Additional supporting quotes from studies
		Demain 2013[25]: Assistive technology needed to be simple to apply, easy to use, motivating and to provide feedback on performance. All participants recognised the motivational aspect of assistive technologies [stroke patients and health care professionals on assistive technologies]. Janssen 2020[48]: Feedback devices seen as helpful to monitor outcome but problematic when unreliable [patients receiving high intensive training]. Last 2021[68]: Participants also valued feedback and validation from the therapists, which helped them to improve performance and gauge progress. One participant expressed one of the best parts of his therapy was the validation he received from his therapists. Conversely, participants described feeling discouraged when therapists told them they would likely be unable to progress to the extent they hoped [stroke survivors]. Marklund 2010[76]: They made demands, spurred on, gave positive feedback, encouraged and confirmed; and this made the informants feel that their work was strenuous [stroke survivors on CIMT]. Norris 2018[92]: Participants discussed how the personality of the trainer got them through the hardest parts of the course, encouraging and challenging them to take that additional step [stroke survivors]. Sweeney 2020[114]: The feedback received through the use of timing specific tasks/activities to gauge potential improvement was identified as a motivating factor within the programme in both interviews. “they started timing them (activities) to show you the difference in time from when you start to when you finish…to see before and after was just amazing to be honest. It was like day and night” “It was just a confidence booster to see you were getting quicker” [stroke survivors on home based CIMT or RAT]. Young 2013[137]: Those with therapy experience described how the therapist might deliberately point out their areas of weakness or skills they needed to develop/re-learn in a targeted way [stroke survivors].

Main findings	Statement of finding	Additional supporting quotes from studies
Confidence [stroke survivors, healthcare professionals]	Therapists require signs (objective and subjective) from the patient that the therapy is tolerable, and that research supports the intensive approach to feel confident delivering the therapy[18]. Similarly, the stroke survivors had to trust the competence of the rehabilitation staff to feel confident undertaking the intensive training[51, 123].	Connell 2018[18]: Therapists gained confidence to "push people harder" due to; the graded exercise test making them confident patients had the "all clear", seeing patients able to work harder, using heart rate monitors and step counters as objective measures [healthcare professionals]. Kelly 2020[51]: The stroke survivors stressed the importance of the skillset and expertise of the clinicians on the programme, as well as the collaborative relationships between clinician-patient and physiotherapist-occupational therapist [chronic stroke survivors]. Vive 2020[123]: To undertake the intense training, patients had to trust the competence of the rehabilitation staff [stroke survivors experience of experience of enriched rehabilitation].
Safety [healthcare professionals]	Therapists needed to balance the intensity against the safety of the intervention for the patient[121]. Safety was often cited as a barrier for prescribing unsupervised exercises[19].	Connell 2014[19]: Barriers to prescribing exercises to be completed outside of therapy time included therapists' beliefs about patients' ability to correctly complete exercises, patient safety awareness, cognitive impairment and lack of family support for self-directed exercise. As a result exercises were most often completed with the supervision of a rehabilitation assistant [healthcare professionals on stroke rehabilitation]. Van Kessel 2017[121]: Therapists also felt that their ability to implement circuit class therapy was limited by the need to keep therapy safe and it was more difficult when dealing with patients with diverse needs [healthcare professionals].
Prioritisation [stroke survivors, healthcare professionals]	Prioritisation was used to plan physiotherapy. Patients perceived to be higher priorities were more likely to be seen regularly and for a length of time and time of day relating to achieving their goals[79]. High priority patients included; newly admitted patients, patients demonstrating potential to rehabilitate, patients who are complaint and motivated, patients who missed out on therapy the previous day, patients at risk of deteriorating, patients requiring imminent discharge[79]. [neurophysiotherapists and patients on a stroke unit]	McGlinchey 2015[79]: Higher priority patients were often seen at a time of day that would enable maximal active participation during sessions. Patients perceived to be of a lower priority, were more likely to be seen less frequently and possibly for a shorter length of time, particularly if there were higher priority patients perceived to need more input.

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Consistency in care [family members/carers]	Carers expressed that their loved ones care could be improved if they were consistently seen by the same healthcare professional who was familiar with the stroke survivor and their condition[81]	Merriman 2020[81]: Common across all interviewee groups was the need for regularity and consistency, which SS06 described as providing “an anchor”.
Intervention factors		
Methods of achieving more intense rehabilitation		
Individual therapy	[18, 19, 68]	Not applicable
Group-based therapy	[6, 16, 68, 92, 109, 121, 123]	Not applicable
‘Homework’/self management interventions	[7, 9, 107, 113]	Demain 2013[25]: Healthcare professionals recognised the potential for assistive technologies to provide intensive therapy and a means of self-management. All patient participants were keen to self-manage. They were all actively engaged in looking for solutions to promote arm recovery and were prepared to spend time and, if necessary, money on potential solutions. The opportunity for self-management was influenced by a) device design, b) access to information and access to devices [stroke patients and health care professionals on assistive technologies]. Schnabel 2021[107]: The majority liked the opportunity to engage in supported self-management [stroke survivors and carers augmented arm training]. Schnabel 2021[107]: It was often reported that tiredness, self-reported ‘laziness’, pain and other commitments such as engaging with visitor’s or home helper’s imposed barriers to supported self management [stroke survivors and carers augmented arm training]. Stark 2019[113]: For employed patients as well as non-professional coaches regardless of employment status, the lack of time was considered a stress factor. An employed patient reported that he experienced performing homeCIMT in the evening after a full working day as demanding and his muscles of the affected arm did not feel as strong as in the morning, which made the exercises more difficult for him [stroke survivors and coaches on home based CIMT].
Telerehabilitation, assistive technology	[9, 12-14, 25, 114, 128]	Gustavsson 2020[37]: Some of the professionals used computer software for home training for the patients. They described this as increasing independence, as well

Main findings	Statement of finding	Additional supporting quotes from studies
and computer-based tools		as intensity level and motivation in the rehabilitation process [healthcare professionals views on ICT to support rehabilitation].
7-day working	[121]	Not applicable
Longer term rehabilitation	[84]	
Intervention themes		
Increased opportunities for social stimulation [stroke survivors, family members/carers, healthcare professionals]	Hospital based/Group based therapies: Stroke survivors were largely supportive of being involved in group-based activities, noting the social aspect of group work, including opportunities for social interaction and shared experiences and coping strategies[6, 68, 81, 92]. However, carers expressed some reservation about group activities citing issues such as noise and lacking confidence to speak out[81]. However, this was also a problem noted from hospital based therapy regardless[68]. Computer based therapies: The video-conferencing allowed them to talk to their therapist and therefore feel more connected[13].	Bennett 2016[6]: Camaraderie with other stroke survivors was reported by many participants, who valued the opportunity to talk and joke with others in similar circumstances [stroke patients receiving circuit or 7 day therapy]. Chen 2020[13]: They considered talking to the therapist as a way to socially connect with others However, the video-conferencing allowed them to talk to their therapist and therefore feel more connected. Most patients established a personal connection with the therapist through use of the telerehabilitation system [stroke survivors engaging in telerehab]. Merriman 2020[81]: Group based activities were described as being particularly used for education, general cognitive stimulation and social interaction. Carers expressed some reservation about group activities citing issues such as noise and lacking confidence to speak out [stroke survivors, carers, and healthcare professionals]. Norris 2018[92]: The group nature of the intervention was seen as one of its most positive aspects and often discussed as integral to its perceived effectiveness. The concept of the teamwork and shared determination despite different abilities and histories within the groups was discussed by several participants [stroke survivors]. Last 2021[68]: Noise and disruptions in the hospital environment were identified as particular concerns by both patients and their family members [stroke survivors].
Variety in activities and choice	Computer based therapies: Stroke survivors felt that computer based and 'high-tech' assisted therapies were more enjoyable, challenging and fun than traditional	Bennett 2016[6]: Most participants from both formats were content with the variety of exercises in their programme. Some participants valued the variety that accompanied staff rotations. This was especially evident in examples provided by

Main findings	Statement of finding	Additional supporting quotes from studies
[stroke survivors, healthcare professionals]	therapy exercises. This included assistive technology[25], using a Nintendo Wii device[12], computerised cognitive therapy[128] and robot assistive devices[14]. This view was shared by health care professionals and led to an increase in referrals to exergaming rehabilitation[90]. On the contrary some stroke survivors felt the games were tedious if they were too repetitive or weren't taxing enough [114]. Through choosing and playing a variety of games, people perceived the exercises to be more engaging compared with conventional repetitive rehabilitative exercises[13, 128]. Group based therapies: Most participants from both formats (individual and group based) were content with the variety of exercises in their programme. Some participants valued the variety that accompanied staff rotations and enjoyed a change in routine and challenges with weekend staff[6].	participants receiving seven-day therapy, who enjoyed a change in routine and challenges with weekend staff [patients receiving circuit or 7 day therapy]. Celinder 2012[12]: Participants found the Wii intervention added variety by 1) breaking up the day, 2) adding a new topic of conversation and 3) engaging in meaningful occupations [stroke patients using wii]. Chen 2020[13]: Through choosing and playing a variety of games, people perceived the exercises to be more engaging compared with conventional repetitive rehabilitative exercises [stroke survivors telerehabilitation] Cherry 2017[14]: People felt using the devices reduced these mental issues because they found the device fun and challenging, and using it decreased boredom and gave them something to look forward to [stroke patients using robot assisted devices]. Demain 2013[25]: The fact that they were 'hi-tech' and designed specifically for rehabilitation made them more credible and enjoyable than traditional therapy exercises, which were often deemed to be boring and difficult to notice improvement. [stroke patients and health care professionals on assistive technologies] Nguyen 2019[90]: Half the participants reports that the variety of activities positively influenced their referral decision. For instances games were function, provided bilateral tasks and worked on versatile goals. Conversely some felt the games failed to challenge clients cognitive, social and problem-solving skills [therapists delivering exergaming]. Sweeney 2020[114]: People may be motivated by the use of novel techniques (such as robot assisted therapy and virtual reality therapy) [stroke survivors on home based CIMT or RAT].

Main findings	Statement of finding	Additional supporting quotes from studies
		Sweeney 2020[114]: "There was some of the games, you could say were a bit tedious. That was maybe because they didn't tax you enough" [stroke survivors on home based CIMT or RAT]. Withiel 2020[128]: Other individuals reported the games were repetitive or frustrating. Memory skills group participants reported only positive experiences mainly related to the variety of content [stroke survivors on cognitive rehabilitation].
Level of person centred care [stroke survivors, family members/carers, healthcare professionals]	Group based therapies The capacity to juggle group needs alongside individual problems and attention was noted by several participants[81, 92]. Others found that group based therapies met their needs[109] [stroke survivors]. Limitations and lack of choice within therapy sessions were reported by some participants and in some instances individual needs were not optimally met[6]. Computer based therapies Some of the professionals used computer software for home training for the patients. They described this as increasing independence, as well as intensity level and motivation in the rehabilitation process. Being able to share the progress of the rehabilitation and communicate from a distance were considered to generate a sense of closeness and be motivating for both patients and professionals[37].	Bennett 2016[6]: Limitations and lack of choice within therapy sessions were reported by some participants and in some instances individual needs were not optimally met. Some circuit participants reported that the opportunity for longer individual overground walking with the support of a staff member was limited in a group format, as staff availability was restricted by the number and needs of others in the group [patients receiving circuit or 7 day therapy]. Gustavsson 2020[37]: Being able to share the progress of the rehabilitation and communicate from a distance were considered to generate a sense of closeness and be motivating for both patients and professionals [healthcare professionals views on ICT to support rehabilitation]. Merriman 2020[81]: Interviewees suggested that individual cognitive impairment levels determine the utility of group activities, suggesting that group activities would only be useful where people have good awareness if their deficits, have sufficient ability to maintain attention and concentration and where major mood or behaviour issues are not present [stroke survivors, carers, and healthcare professionals]. Norris 2018[92]: The capacity to juggle group needs alongside individual problems and attention was noted by several participants [stroke survivors]. Signal 2016[109]: All participants described how well the intervention's met their needs and goals [stroke survivors on high intensity group based exercise programme].

Main findings	Statement of finding	Additional supporting quotes from studies
Provision of feedback [stroke survivors, healthcare professionals]	Computer based therapies: Computer based and VR therapies can provide immediate feedback which participants felt added excitement and motivation to beat their previous scores[9, 12, 128]. People [stroke survivors] rated highly their experience using the videoconference, which provided a channel for therapists to observe, correct and provide feedback and encouragement[13]. Group based rehabilitation: Participants discussed how the personality of the trainer got them through the hardest parts of the course, encouraging and challenging them to take that additional step[92]. Home-based: Feedback was seen as useful when receiving therapy at home[114].	Burke 2021[9]: Participants valued the software's capacity to provide feedback on success directly to the person with aphasia [speech and language therapists]. Celinder 2012[12]: Patients felt the Wii added excitement and provided motivation for rehabilitation to beat their own scores [stroke patients using the Nintendo Wii device]. Chen 2020[13]: People rated highly their experience using the videoconference, which provided a channel for therapists to observe, correct and provide feedback and encouragement [stroke survivors engaging in telerehabilitation]. Norris 2018[92]: Participants discussed how the personality of the trainer got them through the hardest parts of the course, encouraging and challenging them to take that additional step [stroke survivors]. Norris 2018[92]: Participants discussed how the personality of the trainer got them through the hardest parts of the course, encouraging and challenging them to take that additional step [stroke survivors]. Sweeney 2020[114]: The feedback received through the use of timing specific tasks/activities to gauge potential improvement was identified as a motivating factor within the programme in both interviews. "they started timing them (activities) to show you the difference in time from when you start to when you finish…to see before and after was just amazing to be honest. It was like day and night" "It was just a confidence booster to see you were getting quicker" [stroke survivors constraint induced movement therapy home based]. Withiel 2020[128]: Most participants described how (cognitive) computer training provided them with a goal and noted how the positive automated feedback motivated them. Yet negative automated feedback was a source of frustration (ie receiving a lower score than previously) [stroke survivors on cognitive rehabilitation].
Travel time	Home-based:	Cherry 2017[14]: The ability to use the device in the home was also very important because of the multiple barriers that participants faced due to their often remote

Main findings	Statement of finding	Additional supporting quotes from studies
[stroke survivors, family members/carers, healthcare professionals]	Stroke survivors spoke positively about their experience of having someone visit them in their home[81]. The participants expressed the convenience of using the devices in their homes rather than traveling to therapy (counteracting the difficulties of getting to therapy appointments)[14]. Non-home based: There was consensus that the rehabilitation should be delivered at a location that was accessible and within the local community. Suggestions included local community centres, hospitals and outpatient clinics[81]. Computer based therapies Barriers included transportation and financial difficulties for out patients needing to commute to the hospital[90] [therapists delivering exergaming]. The professionals discussed the possibilities of using ICT to enhance communication and follow up the progress of rehabilitation from a distance, for example, through videoconferencing. These solutions could save time and money through less travel, both for professionals and for patients[25, 37].	locations. The participants expressed the convenience of using the devices in their homes rather than traveling to therapy (counteracting the difficulties of getting to therapy appointments) [stroke patients using robot assisted devices]. Demain 2013[25]: Healthcare professionals recognised the potential for assistive technologies to provide intensive therapy and a means of self-management [healthcare professionals]. Gustavsson 2020[37]: The professionals discussed the possibilities of using ICT to enhance communication and follow up the progress of rehabilitation from a distance, for example, through videoconferencing. These solutions could save time and money through less travel, both for professionals and for patients [healthcare professionals views on ICT to support rehabilitation]. Merriman 2020[81]: Suggestions included local community centres, hospitals and outpatient clinics [stroke survivors, carers, and healthcare professionals]. Nguyen 2019[90]: Barriers included transportation and financial difficulties for out patients needing to commute to the hospital [therapists delivering exergaming]. Signal 2016[109]: Factors which facilitated engagement included the provision of transportation, the location of the venues, accessibility of parking, availability of amenities such as a cafe, and administrative and family support [stroke survivors on high intensity group based exercise programme].
Need for technical support and training [stroke survivors, healthcare professionals]	The need for technical support and training along with difficulties in the setting up of equipment were identified as barriers for the implementation of computer based and assistive technologies by HCPs[9, 13, 14, 90] Using computers requires technical skills and technical support, availability of devices that can	Burke 2021[9]: Acknowledge and accept that familiarisation with new software take time; training of whole speech and language therapist team, get support from IT department; explore funding and loaning models that work for the local context; iterative process of checking patient capability to use software, followed by use of a few exercises to check patient engaged before investing time in full personalisation and tailoring; Consider software and hardware requirements of individual patients [speech and language therapists]

Main findings	Statement of finding	Additional supporting quotes from studies
	use any relevant software and acquisition and funding of software. This can be facilitated through tailoring the approach to the individual, training, developing a shared understanding with IT departments, exploring funding and loaning models that work for the local context (including charity funding) [9, 25, 37]	Burke 2021[9]: 83% of the participants reported issues with the software/games, indicating this was at times a source of frustration. "There was some of the games, you could say were a bit tedious. That was maybe because they didn't tax you enough". Half of participants identified they had experienced difficulties getting to grips with setting-up and delivering the computer therapy [speech and language therapists]. Chen 2020[13]: Several participants reported minor technical issues at the beginning of the study but appreciated that they were able to receive support in time [stroke survivors engaging in telerehabilitation]. Cherry 2017[14]: Although participants reported some technical difficulties, everyone reported that the devices were "easy to use" even though many had limited previous knowledge of and experience with computers or gaming devices [stroke patients using robot assisted devices]. Demain 2013[25]: Concerns were expressed about devices which needed complex adjustment between patients (robots and dynamic splints), and were complex to programme (electrical stimulation, robots) [stroke patients and health care professionals on assistive technologies]. Demain 2013[25]: Patient and family caregivers worried about the quality of the information available from these sources and the relevance of the information to their own situation. They would have liked to be able to seek advice from a therapist they knew and trusted [stroke patients on assistive technologies]. Gustavsson 2020[37]: The professionals stated that there was a need for them to assess the patients' ability and need to use ICT in their everyday lives, including rehabilitation after stroke, and then offer support [healthcare professionals views on ICT to support rehabilitation]. Nguyen 2019[90]: Clinicians reported that insufficient training and lack of hands on practice with the VR systems was a barrier to referrals [therapists delivering exergaming].

Main findings	Statement of finding	Additional supporting quotes from studies
Physical environment [stroke survivors, healthcare professionals]	The accessibility of the room to patients along with the low amount of resources required to operate the room was deemed to be a facilitator. Some barriers were identified such as the needs for more varied exergames systems, additional rooms and space[90] [therapists delivering exergaming]. Concerns were expressed about devices which needed complex adjustment between patients (robots and dynamic splints), which might be difficult to move to the patient (robots), which were complex to programme (electrical stimulation, robots), which were time consuming to clean (most products) and difficult to store (robots in particular)[14, 25].	Cherry 2017[14]: One of the complaints was the size and weight of the device, and the difficulty moving them around the home as a result [stroke patients using robot assisted devices].
Goal setting [stroke survivors, family members/carers, healthcare professionals]	Setting personalised and functional goals assisted with engagement in rehabilitation programmes[51, 68, 87]. Goals were identified by the participants, as part of the motivation process to give them strength for the intensive training[76] [patients receiving constraint induced movement therapy].	Kelly 2020[51]: Stroke survivors identified that the programme gave them the opportunity to set personalised goals collaboratively with an occupational therapist and physiotherapist, which impacted on their relationships with clinicians and engagement in the programme. A strategy described by many clinicians to support goal-achievement was education about functional task practice or activities rather than impairment-based goals [chronic stroke survivors, care givers and healthcare providers]. Last 2021[68]: Participants described instances where therapy was enhanced when activities were tailored to individual needs, preferences and goals. While some participants perceived therapy to be challenging, others criticized the simplicity of activities. If activities or exercises were perceived to be too easy, there was a risk of becoming bored and losing interest. Another participant made implications of pointlessness when describing therapy activities. Some participants noted that therapy was sufficiently challenging. In addition, therapy activities seemed to be most meaningful to participants when they were developed or refined to match the needs and goals of the individual [stroke survivors].

Main findings	Statement of finding	Additional supporting quotes from studies
		Marklund 2010[76]: During the preparations, goal and goal images were identified by the participants, as part of the motivation process to give them strength for the intensive training [patients receiving constraint induced movement therapy]. Moss 2021[87]: Participants described setting short-term tasks immediately post-onset, such as completing a word puzzle, and more long-term incentives to recovery, such as pre-booking a theatre ticket. Some said their confidence in achieving goals had increased rather than diminished [people with aphasia having peer befriending].
Use of expensive/additional equipment [stroke survivors, family members/carers, healthcare professionals]	Using computers requires technical skills and technical support, availability of devices that can use any relevant software and acquisition and funding of software. This can be facilitated through training, developing a shared understanding with IT departments, exploring funding and loaning models that work for the local context (including charity funding)[9, 25, 37]. A lack of funding for specialist equipment was often cited as a barrier for intensive rehabilitation[9, 25]. The cost of software licenses, assistive technologies and the need for a graded exercise test, and ideally equipment (heart rate monitors, step counters, treadmills, harnesses) make the intensive intervention more difficult to implement[18].	Burke 2021[9]: The cost of software licenses would require funding by the NHS and may provide challenge [SALT treating aphasia]. Connell 2018[18]: The need for a graded exercise test, and ideally equipment (heart rate monitors, step counters, treadmills, harnesses) make the intervention more difficult to implement [healthcare professionals on stroke rehabilitation]. Demain 2013[25]: A recurrent theme was the lack of funding for upper limb assistive technologies. People with stroke and their family caregivers focussed more on lack of funding rather than lack of evidence as the reason why assistive technologies were not available [patients/carers/health care professionals discussing assistive technology]. Gustavsson 2020[37]: A prerequisite (for telerehabilitation) was that patients were able to download applications and software on their own devices. Moreover, they had to be able to pay for this themselves [healthcare professionals views on ICT to support rehabilitation].
Meaningful activities [stroke survivors, family members/carers, healthcare professionals]	Tasks which were deemed to be meaningful or related to patients' personal goals led to increased motivation and adherence to the rehabilitation programme[68, 81, 107, 109, 125, 131].	Last 2021[68]: Another participant made implications of pointlessness when describing therapy activities. Some participants noted that therapy was sufficiently challenging. In addition, therapy activities seemed to be most meaningful to participants when they were developed or refined to match the needs and goals of the individual. One participant talked about how they would collaborate with their therapists to think of new and unique activities for them and how this made therapy enjoyable and made them excited to participate. Personalised

Main findings	Statement of finding	Additional supporting quotes from studies
		rehabilitation through meaningful activity is illustrated by one participant who had a goal of kayaking-was a valued pre-stroke activity and their therapists incorporated it into therapy. People also shared examples of aspects or events that were individually meaningful to them and revealed the impact they had on the patient experience. Some participants described situations specific to the program, such as how family could join in on classes or how being able togo home on weekends added a sense of normalcy to the experience. Another participant expressed how meaningful it was that their pet could visit them on hospital grounds [stroke survivors]. Merriman 2020[81]: Health care professionals recognised that while it was important to include evidence based exercises, this had to be balance with the interests of the patients and these should be tailored to their individual abilities and goals [healthcare professionals]. Signal 2016 [109]: The less relevant the individual perceived the intervention to their specific needs and desires the more challenging ongoing engagement was [stroke survivors on high intensity group based exercise programme]. Schnabel 2021[107]: Activities that were tailored to stroke survivors' needs and real-life activities that were meaningful to their daily lives, were perceived as being particularly valuable [stroke survivors and carers augmented arm training]. Walker 2016[125]: Both participants indicated that meaningful occupations during therapy increased their motivation and adherence to the mCIMT protocol [stroke survivors]. Worrall 2011[131]: They spoke about the need for communication rehabilitation to be connected to real life. Participants often mentioned specific words or names they wanted to say in real life [stroke survivors].
Environmental factors		
Hospital care	Hospital environments do not encourage socialisation (with background noise and environmental distractions in large rooms) which	

Main findings	Statement of finding	Additional supporting quotes from studies
[stroke survivors, healthcare professionals]	can make it hard for people with communication difficulties to communicate[22]. Shared rooms can give more opportunities for socialisation (including communal areas for people in private rooms) – this is particularly important for people with communication difficulties[22].	
Home [stroke survivors, family members/carers, healthcare professionals]	Rehabilitation in the home environment was seen to be more cost-effective and less demanding. Furthermore, the home environment was perceived to be more focused toward rehabilitation outcomes and stroke survivors spoke positively about their experience of having someone visit them in their home[17, 81]. However the lack of supervision during a home based programme was highlighted as a barrier to engagement by one stroke survivor completing CIMT[125]. Conversely limited space at home made it difficult for people to participate in exercises[13, 25].	Cobley 2013[17]: Commonly, the home environment was described as a more private and individualised arena for rehabilitation. Rehabilitation in the home environment was seen to be more cost-effective and less demanding. Furthermore, the home environment was perceived to be more focused toward rehabilitation outcomes [patients and carers after ESD]. Chen 2020[13]: Some had limited space in their homes. Therefore, despite all the benefits of the telerehabilitation systems, they found it inconvenient at times [stroke survivors engaging in telerehabilitation]. Demain 2013[25]: Concerns were expressed about devices which needed complex adjustment between patients (robots and dynamic splints), which might be difficult to move to the patient (robots), which were complex to programme (electrical stimulation, robots), which were time consuming to clean (most products) and difficult to store (robots in particular) [stroke patients and health care professionals on assistive technologies]. Merriman 2020[81]: Health care professionals commonly stressed the importance of off site services provided in the home setting as being necessary - this was particularly stressed by OTs. stroke survivors spoke positively about their experience of having someone visit them in their home [healthcare professionals]. Walker 2016[125]: With therapist support, she was significantly more engaged and able to persevere in using the affected hand. In contrast, during the home-based programme, she reported reverting to using both hands [stroke survivors].

Main findings	Statement of finding	Additional supporting quotes from studies
Enriched/adapted environment [stroke survivors]	Training in a specially adapted or well-resourced environment was felt to be stimulating and facilitated the success of the intervention[51, 76, 123].	Kelly 2020[51]: Stroke survivors perceived that small group sizes and a well-resourced environment was beneficial in supporting clinicians and important in programme success [chronic stroke survivors]. Marklund 2010[76]: That the training was conducted in an adapted environment, even though in cramped premises, was felt to be stimulating [stroke survivors on constraint induced movement therapy]. Vive 2020[123]: Training in an enriched environment that was different from where they received regular care at home was a positive experience [stroke survivors experience of experience of enriched rehabilitation].
Accessible therapy [stroke survivors, family members/carers, healthcare professionals]	In person: People agreed that rehabilitation should be delivered at a location that is accessible and within the local community. Suggestions included local community centres, hospitals and outpatient clinics[51, 81, 84, 109] Remotely: Technology that allows therapy to be delivered remotely can improve geographic accessibility and reduce effort to the stroke survivor and any caregivers[13, 25, 37], but can provide additional barriers dependent on the persons ability to use computers[9, 37, 81].The convenience in location and time led to have higher doses of therapy compared to that achieved when having to travel to a therapist at a scheduled time[13].	Burke 2021[9]: Beliefs were highly influenced by the individuals computer literacy and their beliefs regarding how the person with aphasia's degree of familiarity with computers impacts upon their ability to engage with self-managed computerised therapy. Despite the usefulness of training, approximately half of participants identified they had experienced difficulties getting to grips with setting-up and delivering the computer therapy [speech and language therapists]. Chen 2020[13]: The convenience in location and time led to have higher doses of therapy compared to that achieved when having to travel to a therapist at a scheduled time [stroke survivors engaging in telerehab]. Demain 2013[25]: People with stroke and their families suggested that they could be taught how to apply and use assistive technologies whilst in hospital, be provided with an assistive technology to take home and then use this to deliver intense, repetitive therapy both before and after their home therapy commenced. [stroke patients and families on assistive technologies] Gustavsson 2020[37]: The professionals discussed the possibilities of using ICT to enhance communication and follow up the progress of rehabilitation from a distance, for example, through videoconferencing. These solutions could save time and money through less travel, both for professionals and for patients. On the other hand, they expressed difficulties such as a lack of accessible and understandable information, or a lack of ICT [healthcare professionals views on ICT to support rehabilitation].

Main findings	Statement of finding	Additional supporting quotes from studies
		Kelly 2020[51]: Stroke survivors reported the positive impact of extension of rehabilitation opportunities into the community when linked to their goals, for example, access to pushbikes, local gyms and swimming pools [chronic stroke survivors]. Mohd Nordin 2014[84]: Living far away from hospital has caused patients with low socioeconomic status to not be able to pay for public transport to attend rehabilitation for an extended period of time [health care professionals treating chronic stroke survivors]. Merriman 2020[81]: People agreed that rehabilitation should be delivered at a location that is accessible and within the local community. Suggestions included local community centres, hospitals and outpatient clinics [stroke survivors, carers, and healthcare professionals] Signal 2016[109]: Factors which facilitated engagement included the provision of transportation, the location of the venues, accessibility of parking, availability of amenities such as a cafe, and administrative and family support [stroke survivors on high intensity group based exercise programme].
Supervision [stroke survivors, healthcare professionals]	Lack of supervision was cited as barrier to intensive training for both stroke survivors[76, 107] and healthcare professionals[6, 90]. More specifically the barriers to prescribing exercises to be completed outside of therapy time included therapists' beliefs about patients' ability to correctly complete exercises, patient safety awareness, cognitive impairment and lack of family support for self-directed exercise. As a result exercises were most often completed with the supervision of a rehabilitation assistant[19, 92]. Remote communication via telerehabilitation led to an increase in adherence as participants felt	Bennett 2016[6]: Some participants would have appreciated more supervision than they received. The need for closer supervision was particularly evident when using equipment like the treadmill [patients receiving circuit or 7 day therapy]. Chen 2020[13]: Externally, communicating with therapists three times a week held patients accountable for conducting the exercises. During study participation, they knew that a therapist would connect and talk with them, and so they felt more obliged to complete their assignments, including in comparison to working with the system by themselves [stroke survivors engaging in telerehabilitation]. Connell 2014[19]: Barriers to prescribing exercises to be completed outside of therapy time included therapists' beliefs about patients' ability to correctly complete exercises, patient safety awareness, cognitive impairment and lack of family support for self-directed exercise. As a result exercises were most often

Main findings	Statement of finding	Additional supporting quotes from studies
	more obliged to complete their assignments in comparison to working by themselves[13].	completed with the supervision of a rehabilitation assistant [healthcare professionals on stroke rehabilitation]. Marklund 2010[76]: The informants felt that they could not manage to train intensively themselves: recurrent periods of lower-limb constraint induced movement therapy were needed [stroke survivors on constraint induced movement therapy]. Nguyen 2019[90]: Most clinicians found the lack of staff and supervision in the room to be a barrier to referral [therapists delivering exergaming]. Norris 2018[92]: The loss of the classes themselves and specifically access to the trainer were a concern, which could potentially impact on the actualisation of that continued commitment [stroke survivors]. Schnabel 2021[107]: Participants reported that it was easier for them to engage in the exercises when the study physiotherapist was present but that they did not do so when they were on their own at home [stroke survivors augmented arm training]. Walker 2016[125]: With therapist support, she was significantly more engaged and able to persevere in using the affected hand. In contrast, during the home-based programme, she reported reverting to using both hands [stroke survivors].
Service factors		
Time spent in information exchange [stroke survivors, family members/carers, healthcare professionals]	Therapist time spent in information exchange activities (for example: daily handovers or board rounds) limits the time they have to deliver more intense therapy. These may include repetition of information that is not relevant to therapists and therapist attendance could be minimised to increase availability for therapy [16]. Staff meetings, in-service training and ward handovers also reduced the amount of time available for treatment sessions[79]. Some view these activities as useful or essential if all of the multidisciplinary	Clarke 2018[16]: The most significant factor was the time therapists routinely spent in information exchange activities. These included daily handovers or board rounds where typically, one nurse delivered information to individual therapists or groups of therapists on a unit. Each handover tended to report on all patients and lasted between 15 and 60 minutes. Some therapists reported handovers were valuable provided that the process was based on exchange of information and not simply receipt [stroke survivors, carers and healthcare professionals].

Main findings	Statement of finding	Additional supporting quotes from studies
	team was involved and if the process is based on exchange of information and not simply receipt[16, 86].	McGlinchey 2015[79]: Staff meetings, in-service training and ward handovers also reduced the amount of time available for treatment sessions [neurophysiotherapy on a stroke unit]. Morris 2007[86]: A daily multi-professional ward round to improve communication, more mixing of staff between units, improved consistency of care [stroke survivors, carers and staff].
Time spent in other non-patient contact activities [stroke survivors, family members/carers, healthcare professionals]	Other administrative tasks may reduce time therapists have to deliver more intense therapy.[9, 16, 79] This included planning therapy, documenting therapy provided; discharge planning, ordering equipment and transport; developing patient and family/carer training and information packages; supervising and training staff[16]. Therapists would justify the recording of administration as therapy time based on the argument that facilitating the patient's discharge was their therapy priority and should therefore be seen as valuable use of their therapists' time[116].	Burke 2021[9]: Other administrative tasks may reduce time therapists have to deliver more intense therapy [speech and language therapists]. Clarke 2018[16]: This included planning therapy, documenting therapy provided; discharge planning, ordering equipment and transport; developing patient and family/carer training and information packages; supervising and training staff [stroke survivors, carers and healthcare professionals]. Clarke 2018[16]: Duplication of documentation can play a role in this. [stroke survivors, carers and healthcare professionals] Taylor 2018[116]: Therapists would justify the recording of administration as therapy time based on the argument that facilitating the patient's discharge was their therapy priority and should therefore be seen as valuable use of their therapists' time.
Staffing levels and deployment [stroke survivors, family members/carers, healthcare professionals]	Lack of staff availability may make it difficult to deliver more intense therapy[9, 16, 18, 22, 40, 41, 68, 79, 86, 121, 132]. Participants viewed limited resources in the current healthcare system as a major barrier [68, 84, 86, 87]. A stroke survivor and spouse both reported that scheduled therapy sessions were often cancelled due to unavailability of rehabilitation staff. Another spouse suggested that essential intensive therapy was minimal and not prioritized by the healthcare system[40]. This view was shared by healthcare professionals who highlighted that not having sufficient resources to do lots of one to one	Burke 2021[9]: Participants highlighted not having sufficient resources to do lots of one to one therapy sessions anymore, or only having short windows of therapy time with patients after their stroke and so giving less therapy than they would like [speech and language therapists]. Clarke 2018[16]: Maintaining or increasing staffing levels and providing therapy consistent with guideline recommendations was challenging [stroke survivors, carers and healthcare professionals]. Connell 2018[18]: The frequency and duration of sessions was considered difficult to implement outside of the study (in terms of staffing) [healthcare professionals on stroke rehabilitation].

Main findings	Statement of finding	Additional supporting quotes from studies
	therapy sessions, or only having short windows of therapy time with patients after their stroke led to them giving less therapy than they would like. [9]	D'Souza 2021[22]: Both patients and staff perceived staff time pressures as a barrier negatively affecting communication on the wards. This may be the reflection of actual time pressures, or staff perceptions of their available time [stroke survivors and healthcare professionals]. Hartford 2019[40]: A stroke survivor and spouse both reported that scheduled therapy sessions were often cancelled due to unavailability of rehabilitation staff. Hitch 2020[41]: Perceptions of the duration and scope of ESD also became more positive, with duration influenced at times by staff attempting to meet their commitment to client centred practice [staff perceptions of early supported discharge]. Last 2021[68]: Availability of resources was discussed in most participant interviews, with the majority of participants referring to ratio of patients to staff/therapist and having to wait for therapy. Many participants noted the low patient-to-therapist ratio as a concern and emphasized how this impacted their efforts to participate in rehabilitation [stroke survivors]. McGlinchey 2015[79]: Available staffing was a major influence and resulted in patients being seen less frequently and for a shorter time. This can be a barrier to delivering person centred care. Deciding the frequency of sessions was the only element of physiotherapy delivery where physiotherapists did not involve the patient. this was determined by available time and perceived need [neurophysiotherapists on a stroke unit]. Mohd Nordin 2014[84]: Participants viewed limited resources in the current healthcare system as a major barrier. Staff shortages requiring workers to care for too many patients at once had affected the staffs' amount of contact time with their patients. They claimed that caring for stroke patients for an extended period for long term rehabilitation would only make this situation worse [stroke survivors, carers and health care professionals].

Main findings	Statement of finding	Additional supporting quotes from studies
		Morris 2007[86]: 'Better nursing staff ratios' (were required) [stroke survivors, carers and staff]. Moss 2021[87]: The availability of staff to provide care and treatment was discussed at length by both groups, particularly the availability of nursing/care staff. [patients and carers views, people with aphasia having peer befriending]. Van Kessel 2017[121]: Constraints to leaders management decisions were more likely to be in the form of issues with resources [physiotherapists delivering circuit classes]. Wray 2020[132]: In the community setting, therapists identified constraints on the number of sessions they were able to offer as a barrier to supporting people to manage in the longer-term. Therapists described how limited time impacted delivery of therapy which was perceived to be important in relation to self-management. Building confidence in communication was perceived to be an important role in relation to self-management [healthcare professionals].
Seven day working [stroke survivors, family members/carers, healthcare professionals]	The majority of stroke survivors and healthcare professionals had a positive view on 7-day services, and believed that it increased therapy time[68, 121]. Managers perceived the benefits to be in preventing patient deterioration over the weekend, rather than improving function. Conversely the physiotherapists felt that it led to improved function and based this on positive feedback from patients[121]. Keeping busy was important to some stroke survivors and seven-day therapy provided an antidote to boredom on weekends[6]. An alternative view was that seven-day services may not increase therapy frequency and intensity if existing staff take weekdays off in lieu, depleting their numbers[16].	Bennett 2016[6]: Keeping busy was important to some participants and seven-day therapy provided an antidote to boredom on weekends. Conversely, having a break to rest and recover on weekends was valued in both groups [patients receiving circuit or 7 day therapy]. Clarke 2018[16]: Seven-day services may not increase therapy frequency and intensity if existing staff take weekdays off in lieu, depleting their numbers. Providing seven-day services did not appear to increase therapy frequency and intensity in any unit [stroke survivors, carers and healthcare professionals]. Last 2021[68]: Other participants further highlighted a lack of therapy and therapy staff on weekends and holidays. Participants expressed frustration because of the impact of this scheduling issue on their progress [stroke survivors]. Van Kessel 2017[121]: Participants had positive attitude to 7-day services but the managers were influenced by others, such as senior staff and researches, while the junior therapists were influenced by observations on the effects on patients.

Main findings	Statement of finding	Additional supporting quotes from studies
		Managers favourable evaluation was ascribed to a conviction about the importance of implementing research evidence into practice. Most physiotherapists had a positive attitude about 7-day rehabilitation based on the effects on their patients. only one therapist had a negative attitude based on their personal experience that the quality of therapy over a weekend may not consistently match weekday services [Physiotherapists delivering circuit classes]. Van Kessel 2017[121]: Managers believed that a 7-day therapy service increased the amount of therapy time. However, they perceived the benefits to be in preventing patient deterioration over the weekend, or reducing the effects of deconditioning during hospital stays, rather than improving function. the physiotherapists positive attitude reflected their belief that 7-day services increased therapy time which contributed to improved function and some based this on positive feedback from patients.
Influence of external audit [stroke survivors, family members/carers, healthcare professionals]	Auditing can make it more likely for targets to be met [20]. The SSNAP audit helps to improve stroke services, providing evidence to support additional staffing requirements. However, this can shape therapists' behaviour; making their focus on increasing recording therapy minutes rather than providing more patients with more therapy more frequently[16]. For therapists in all stroke units, there was ambiguity about what counted as auditable therapy. Therapists questioned the quality of the national audit data for therapy, and they used language such as 'bending the rules', 'playing the numbers game' or 'lying' when discussing the practices of other teams[116].	Connell 2016[20]: Participants confirmed that the audit tool in weekly meetings acted as a reminder to keep up with the PRACTISE activities. At the development site, upper limb therapy input was used for the team's internal annual audit, which acted as a driving force to sustain implementation even after the research team's involvement had come to an end [healthcare professionals]. Clarke 2018 [16]: The SSNAP shaped many therapists' behaviour; their focus was on increasing recorded therapy minutes to improve performance ratings, rather than on providing more patients with more therapy more frequently [stroke survivors, carers and healthcare professionals]. Taylor 2018[116]: Some clinical leads believed that using session length as a measure of the quality of therapy was problematic; believing it was unachievable; and wanting to protect therapists from additional pressure [clinical leads].
Use of therapy timetabling [stroke survivors, family members/carers, healthcare professionals]	Daily or weekly timetabling of therapist activity may help nurses to prioritise their workload (by ensuring patients were out of bed and ready for therapy) and for staff not involved in timetabling to use the schedules to work around planned therapy[16, 18, 79, 86]. The net effect of shared timetables was that patients were available for	Clarke 2018[16]: Ensuring patients were ready for therapy was largely viewed as a nursing role. Numerous factors impacted on the process of ensuring patients were out of bed, had received meals and medication and were appropriately dressed for scheduled therapy [healthcare professionals]. Clarke 2018[16]: The net effect of shared timetables was that patients were available for therapy, therapists did not compete for the same time-slot, few

Main findings	Statement of finding	Additional supporting quotes from studies
	therapy, therapists did not compete for the same time slot, few sessions were missed and more minutes could be provided[16].	sessions were missed and more minutes could be provided [healthcare professionals]. Connell 2018[18]: Communication important to ensure treatment schedules work to allow for longer sessions [healthcare professionals on stroke rehabilitation]. McGlinchey 2015[79]: Delays in multi-disciplinary involvement also impacted upon the provision of physiotherapy. For example patients not being washed and dressed at the time of their scheduled therapy therefore they would try and see another patient in the vacant slot [neurophysiotherapists on a stroke unit]. Morris 2007[86]: Improved consistency of care is perceived as a benefit to delivering interventions [stroke survivors, carers and staff].
Dedicated stroke care, staff training and expertise [stroke survivors, family members/carers, healthcare professionals]	All three staff groups described ways in which the dedicated stroke service and care pathway were key strengths. Staff develop expertise in stroke care, which benefits patients and carers through the provision of tailored input[86]. Conversely where there were physical or professional separations in the service, problems occurred[86] [stroke survivors, carers and staff].	
An emphasis on discharge planning versus treatment [stroke survivors, healthcare professionals]	A shift of emphasis from treatment to discharge planning was acknowledged by clinical leaders[116]. Discharge planning for patients (particularly those with complex needs) increased administration, which therapists often prioritised over face-to-face therapy[16].	Clarke 2018[16]: Discharge planning for patients with complex needs increased administration, which therapists prioritised over face-to-face therapy [healthcare professionals]. Taylor 2018[116]: A shift of emphasis from treatment to discharge planning was acknowledged by clinical leaders [stroke survivors and healthcare professionals]. Taylor 2018[116]: Therapists would justify the recording of administration as therapy time based on the argument that facilitating the patient's discharge was their therapy priority and should therefore be seen as valuable use of their therapists' time [stroke survivors and healthcare professionals].
Transitioning from hospital care to	Stroke survivors, carers and healthcare professionals all felt that transitions between	Cobley 2013[17]: People were referred onto appropriate community services for on-going support and rehabilitation. However, some felt that the six-week cut off was

Main findings	Statement of finding	Additional supporting quotes from studies
community-based stroke rehabilitation [stroke survivors, family members/carers, healthcare professionals]	services were a source of challenge and could lead to a lack of support[17, 48, 81]. Assistive technologies were seen as a possible way of bridging this gap[25]. Healthcare professionals and stroke survivors agreed that community-based rehabilitation centres are greatly needed to manage long term stroke patients[84]. One stroke survivor indicated that stroke recovery groups substituted for the lack of rehabilitation discharge follow-up by providing an environment where stroke survivors could obtain therapy services, as well as emotional support[40].	'abrupt' and not 'continuous enough'. Furthermore, some transferred to further services did not feel that this transition was always well managed [patients and carers after early supported discharge]. Demain 2013[25]: They reported a discontinuity between therapy in hospital and at home, with long waits before home-based therapy commenced and a reduction in intensity when it did. People with stroke and their families suggested that they could be taught how to apply and use assistive technologies whilst in hospital, be provided with an assistive technology to take home and then use this to deliver intense, repetitive therapy both before and after their home therapy commenced [stroke patients and health care professionals on assistive technologies]. Hartford 2019[40]: A stroke survivor indicated stroke recovery groups substituted for the lack of rehabilitation discharge follow-up by providing an environment where stroke survivors could obtain therapy services, as well as emotional support [stroke survivor]. Hartford 2019[40]: A stroke survivor indicated stroke recovery groups substituted for the lack of rehabilitation discharge follow-up by providing an environment where stroke survivors could obtain therapy services, as well as emotional support [stroke survivor]. Janssen 2020[48]: Healthcare professionals mentioned that a good support network was needed once you were discharged from the rehabilitation hospital) [patients receiving high intensive training]. Merriman 2020[81]: People felt that transitions between services were a source of challenge and could lead to a lack of support [stroke survivors, carers, and healthcare professionals]. Mohd Nordin 2014[84]: Participants agreed that community-based rehabilitation centres are greatly needed to manage long term stroke patients [stroke survivors, carers and health care professionals].

Appendix G – Forest plots (effectiveness evidence)

G.1 Physiotherapy

G.1.1 Physiotherapy (no communication difficulties) - ≤45 minutes, <5 days a week compared to usual care for people after a first or recurrent stroke

Figure 1: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months

	≤45 min <5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Yoo 2010	31.5	17.82	28	26.87	15.74	31	4.63 [-3.99, 13.25]

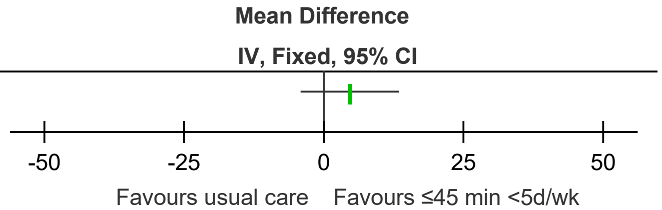


Figure 2: Discontinuation from study at <6 months

	≤45 min <5 d/wk		Usual care			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Gjellesvik 2020	3	36	3	34	68.0%	-0.00 [-0.14, 0.13]
Verheyden 2009	0	17	0	16	32.0%	0.00 [-0.11, 0.11]
Total (95% CI)		**53**		**50**	**100.0%**	**-0.00 [-0.10, 0.09]**
Total events	3		3			

Heterogeneity: Chi² = 0.00, df = 1 (P = 0.95); I² = 0%

Test for overall effect: Z = 0.07 (P = 0.95)

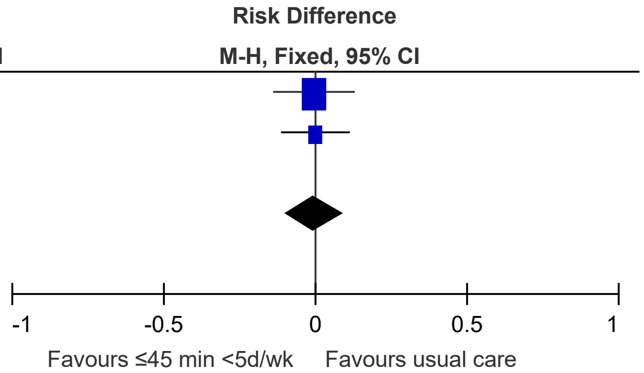
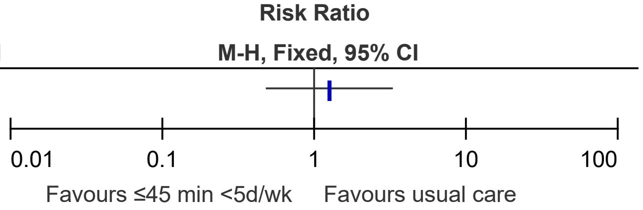


Figure 3: Discontinuation from study at ≥6 months

	≤45 min <5 d/wk		Usual care		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Gjellesvik 2020	8	36	6	34	1.26 [0.49, 3.25]



G.1.2 Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Figure 4: Person/participant health-related quality of life (Stroke Impact Scale mobility subscale, 0-100, higher values are better, final value) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Vloothuis 2019	77.95	21.44	31	69.35	20.81	28	8.60 [-2.19, 19.39]

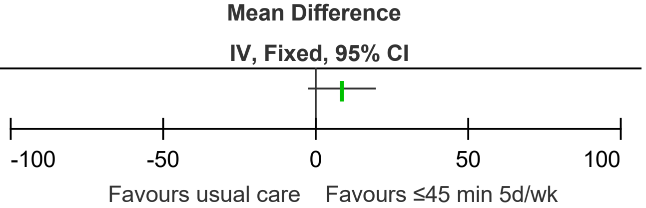


Figure 5: Person/participant health-related quality of life (SF-36 physical component, 0-100, higher values are better, final value) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Zengin-Metli 2018	34.57	10.07	20	34.56	10.38	15	0.01 [-6.85, 6.87]	

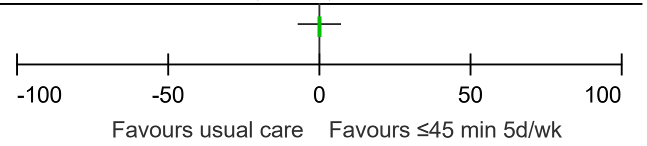


Figure 6: Person/participant health-related quality of life (SF-36 mental component, 0-100, higher values are better, final value) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Zengin-Metli 2018	52.55	9.4	20	38.95	15.2	15	13.60 [4.87, 22.33]	

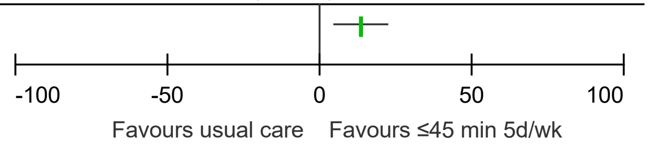


Figure 7: Carer health-related quality of life (Carer Quality of Life, 0-14, lower values are better, final value) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Vloothuis 2019	10.52	2.03	31	10.96	2.16	28	-0.44 [-1.51, 0.63]	

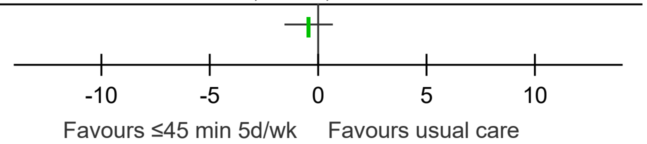


Figure 8: Stroke outcome - modified Rankin Scale (modified Rankin Scale, 0-5, lower values are better, final value) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Vloothuis 2019	2.23	1.02	31	2.44	1.28	28	-0.21 [-0.80, 0.38]

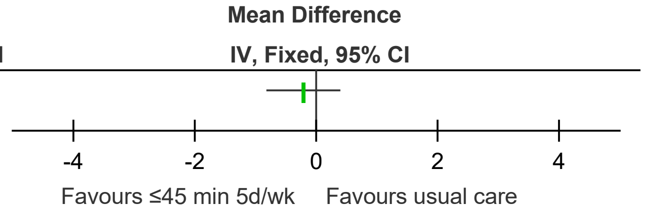


Figure 9: Activities of daily living (Barthel index, 0-100, higher values are better, change score) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Cui 2022	43.75	14.25	16	20.25	12.22	16	23.50 [14.30, 32.70]

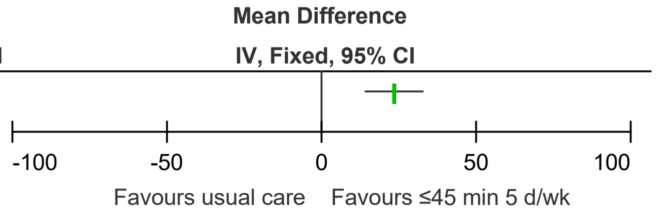


Figure 10: Activities of daily living (Barthel Index, [different scale ranges], higher values are better, final values) at <6 months

Study or Subgroup	≤45 min 5 d/wk Mean	SD	Total	Usual care Mean	SD	Total	Weight	Std. Mean Difference IV, Fixed, 95% CI
Galvin 2011	32.3	24	20	16.3	14.2	20	38.7%	0.80 [0.15, 1.44]
Vloothuis 2019	17.86	3.3	31	16.89	3.47	28	61.3%	0.28 [-0.23, 0.80]
Total (95% CI)			**51**			**48**	**100.0%**	**0.48 [0.08, 0.88]**

Heterogeneity: Chi² = 1.48, df = 1 (P = 0.22); I² = 32%

Test for overall effect: Z = 2.35 (P = 0.02)

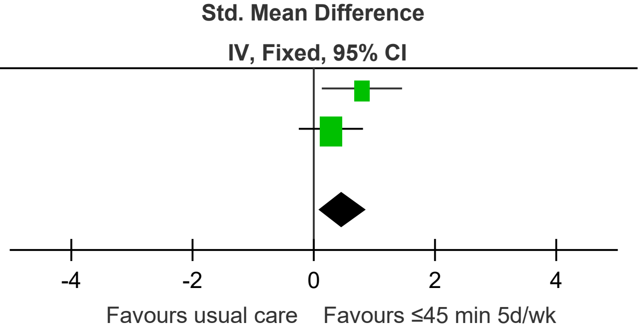


Figure 11: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at <6 months

Study or Subgroup	≤45 min 5 d/wk Mean	SD	Total	Usual care Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Zengin-Metli 2018	24.65	4.56	20	24.65	4.56	15	0.00 [-3.05, 3.05]

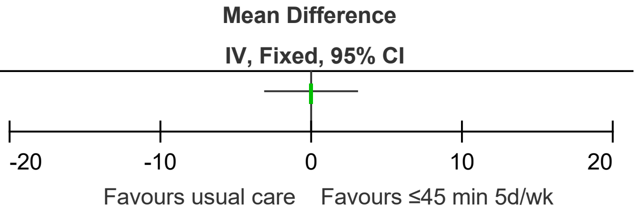


Figure 12: Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, 0-34, higher values are better, change score) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**IV, Fixed, 95% CI**
Galvin 2011	9.5	9.9	20	1.75	6.3	20	7.75 [2.61, 12.89]

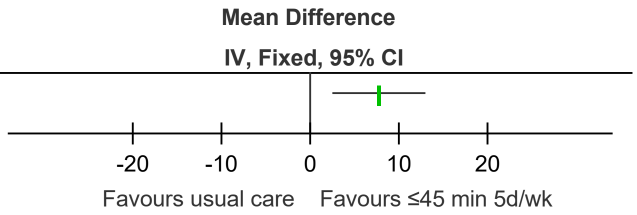


Figure 13: Physical function - lower limb (Fugl Meyer lower extremity, Berg Balance Scale, Rivermead Mobility Index [different scale ranges], higher values are better, final values) at <6 months

	≤45 min 5 d/wk			Usual care				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Random, 95% CI**
Cui 2022	22.44	6.51	16	17.94	5.74	16	27.6%	0.71 [-0.00, 1.43]
Ko 2015	49.8	8.7	26	37	14.8	26	34.2%	1.04 [0.46, 1.62]
Vloothuis 2019	11.66	3.26	31	10.83	3.61	28	38.2%	0.24 [-0.27, 0.75]
Total (95% CI)			**73**			**70**	**100.0%**	**0.64 [0.14, 1.14]**

Heterogeneity: $Tau^2 = 0.10$; $Chi^2 = 4.18$, df = 2 (P = 0.12); $I^2 = 52\%$

Test for overall effect: Z = 2.53 (P = 0.01)

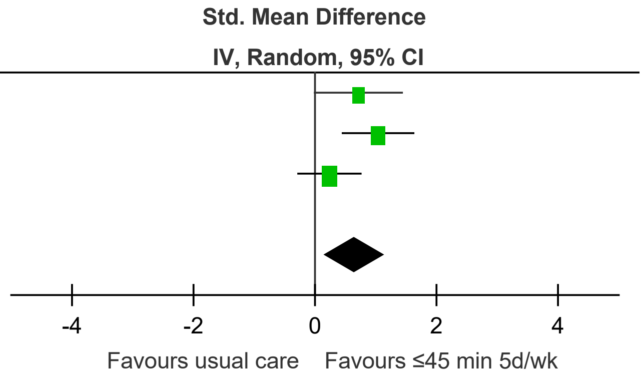
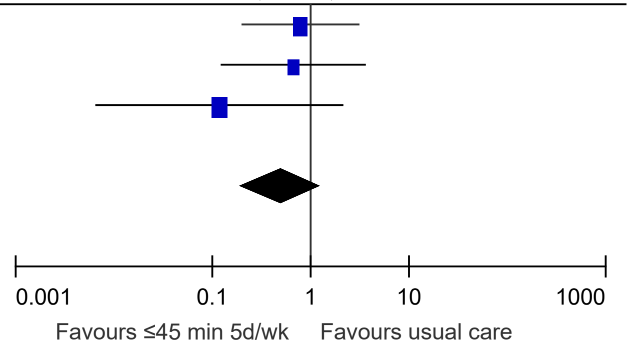


Figure 14: Discontinuation from study at <6 months

Study or Subgroup	≤45 min 5 d/wk Events	≤45 min 5 d/wk Total	Usual care Events	Usual care Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Cui 2022	3	19	4	20	34.6%	0.79 [0.20, 3.07]
Galvin 2011	2	20	3	20	26.6%	0.67 [0.12, 3.57]
Vloothuis 2019	0	32	4	34	38.8%	0.12 [0.01, 2.11]
Total (95% CI)		**71**		**74**	**100.0%**	**0.50 [0.19, 1.29]**
Total events	5		11			

Heterogeneity: Chi² = 1.52, df = 2 (P = 0.47); I² = 0%

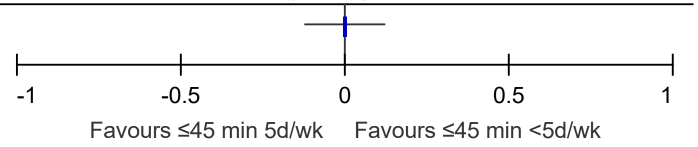
Test for overall effect: Z = 1.43 (P = 0.15)



G.1.3 Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 15: Discontinuation from study at <6 months

Study or Subgroup	≤45 min 5 d/wk Events	≤45 min 5 d/wk Total	≤45 min <5 d/wk Events	≤45 min <5 d/wk Total	Risk Difference M-H, Fixed, 95% CI
Mustafaoglu 2018	0	15	0	15	0.00 [-0.12, 0.12]

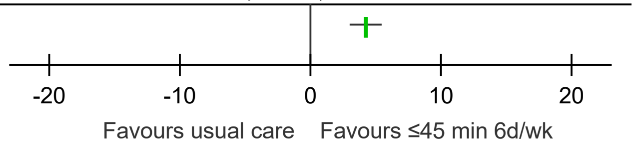


G.1.4 Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week compared to usual care for people after a first or recurrent stroke

Figure 16: Physical function - lower limb (Trunk Impairment Scale, 0-23, higher values are better, final value) at <6 months

	≤45 min 6 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kumar 2011	18.43	1.1	10	14.2	1.5	10	4.23 [3.08, 5.38]

Mean Difference
IV, Fixed, 95% CI



G.1.5 Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Figure 17: Person/participant health-related quality of life (SF-36 physical function subscale, 0-100, higher values are better, final value) at <6 months

	≤45 min 6 d/wk			>45 min-1 hour <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Malagoni 2016	67	15	6	47	17	6	20.00 [1.86, 38.14]

Mean Difference
IV, Fixed, 95% CI

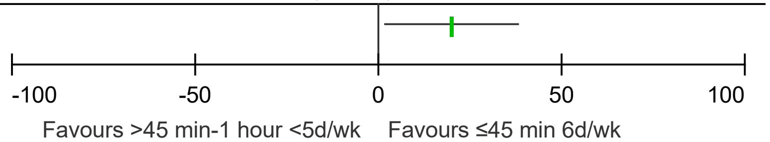


Figure 18: Physical function - lower limb (6-minute walk test, meters, higher values are better, final value) at <6 months

	≤45 min 6 d/wk			>45 min-1 hour <5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Malagoni 2016	308	104.3	6	251.2	127.4	6	56.80 [-74.94, 188.54]	

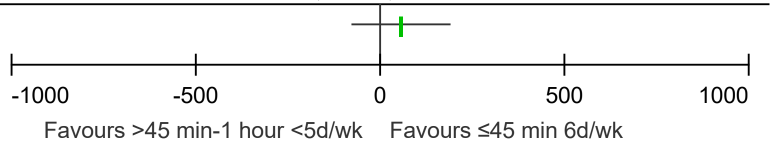
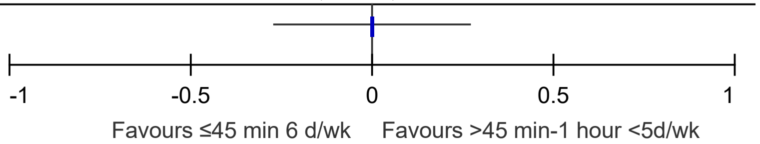


Figure 19: Discontinuation from study at <6 months

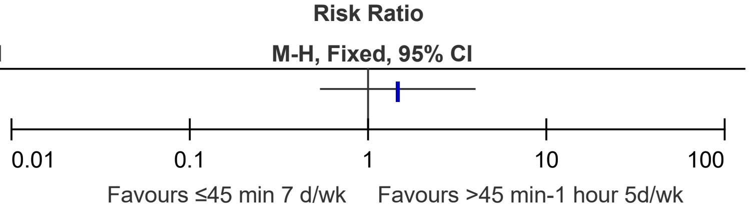
	≤45 min 6 d/wk		>45 min-1 hour <5d/wk		Risk Difference	Risk Difference
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI	M-H, Fixed, 95% CI
Malagoni 2016	0	6	0	6	0.00 [-0.27, 0.27]	



G.1.6 Physiotherapy (no communication difficulties) - ≤45 minutes, 7 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Figure 20: Discontinuation from study at ≥6 months

	≤45 min 7 d/wk		>45 min-1 hour 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
English 2015	9	96	6	94	1.47 [0.54, 3.96]



G.1.7 Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 21: Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at <6 months

	>45 min-1 hour <5d/wk			≤45 min <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Donaldson 2009	42.7	18.39	20	45	13.93	8	-2.30 [-14.88, 10.28]

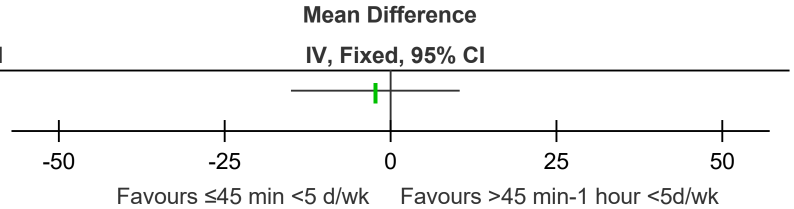
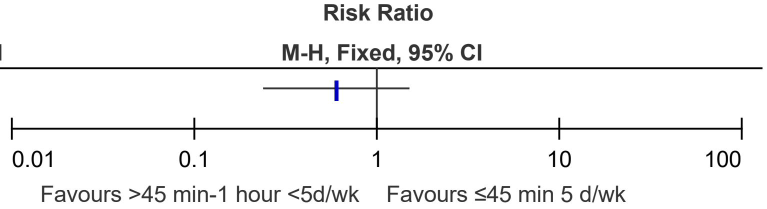


Figure 22: Discontinuation from study at <6 months

	>45 min-1 hour <5d/wk		≤45 min <5 d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Donaldson 2009	6	20	5	10	0.60 [0.24, 1.49]



G.1.8 Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 23: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months

	>45 min-1 hour 5d/wk			≤45 min <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Mustafaoglu 2018	47.7	7.2	15	42.9	2.6	15	4.80 [0.93, 8.67]

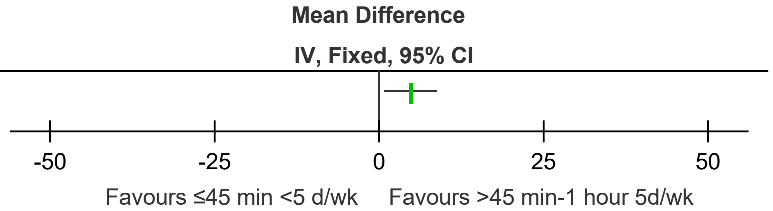
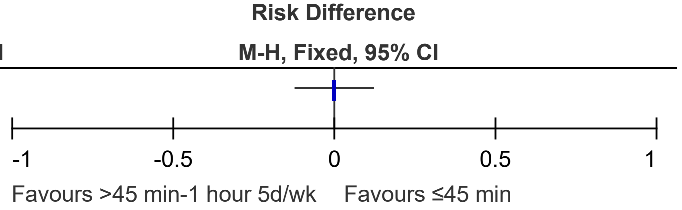


Figure 24: Discontinuation from study at <6 months

Study or Subgroup	>45 min-1 hour 5d/wk Events	>45 min-1 hour 5d/wk Total	≤45 min <5 d/wk Events	≤45 min <5 d/wk Total	Risk Difference M-H, Fixed, 95% CI
Mustafaoglu 2018	0	15	0	15	0.00 [-0.12, 0.12]



G.1.9 Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Figure 25: Person/participant generic health-related quality of life (Stroke Impact Scale - hand, 5-25, higher values are better, final value) at <6 months

Study or Subgroup	>45 min-1 hour 5d/wk Mean	>45 min-1 hour 5d/wk SD	>45 min-1 hour 5d/wk Total	≤45 min 5d/wk Mean	≤45 min 5d/wk SD	≤45 min 5d/wk Total	Mean Difference IV, Fixed, 95% CI
Kwakkel 2016	21.65	2.98	29	18.71	6.97	29	2.94 [0.18, 5.70]

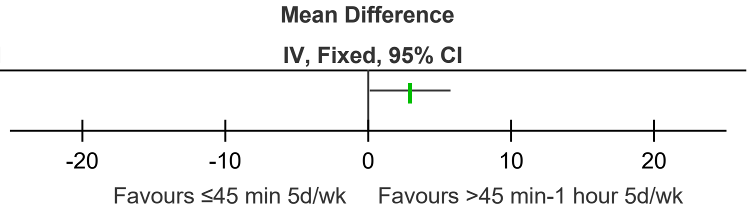


Figure 26: Person/participant generic health-related quality of life (Stroke Impact Scale - hand, 5-25, higher values are better, final value) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kwakkel 2016	22.45	3.02	29	20.04	6.38	29	2.41 [-0.16, 4.98]

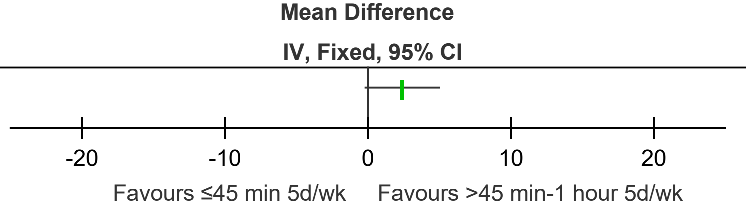


Figure 27: Activities of daily living (Modified Barthel Index, 0-100, higher values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Min 2020	67.94	16.61	19	59.63	18.96	19	49.2%	8.31 [-3.02, 19.64]
Park 2021	77.68	19.79	22	71.18	17.94	22	50.8%	6.50 [-4.66, 17.66]
Total (95% CI)			**41**			**41**	**100.0%**	**7.39 [-0.56, 15.34]**

Heterogeneity: Chi² = 0.05, df = 1 (P = 0.82); I² = 0%

Test for overall effect: Z = 1.82 (P = 0.07)

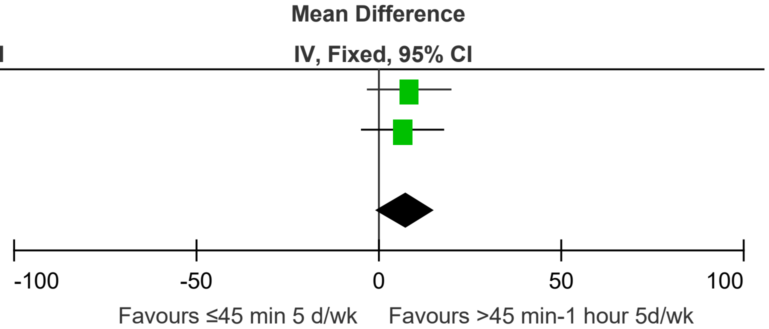


Figure 28: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk				Std. Mean Difference	Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Hunter 2011	6.8	8.9528	18	6.5	11.4952	19	30.6%	0.03 [-0.62, 0.67]	
Park 2021	87.95	14.16	22	86	15.97	22	36.3%	0.13 [-0.46, 0.72]	
Platz 2005	32.7	16.3	20	31.6	15.7	20	33.1%	0.07 [-0.55, 0.69]	
Total (95% CI)			**60**			**61**	**100.0%**	**0.08 [-0.28, 0.43]**	

Heterogeneity: Chi² = 0.05, df = 2 (P = 0.98); I² = 0%

Test for overall effect: Z = 0.42 (P = 0.67)

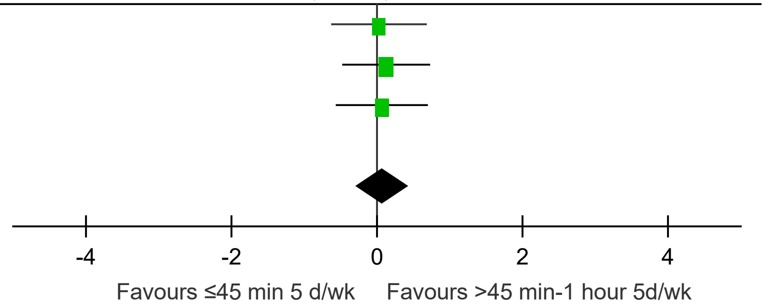


Figure 29: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Kwakkel 2016	60.69	5.36	29	57.48	12.78	29	3.21 [-1.83, 8.25]	

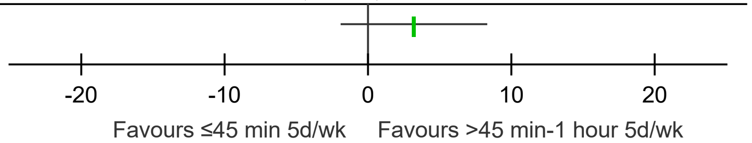


Figure 30: Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, Berg Balance Scale [different scale ranges], higher values are better, change scores) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Kim 2015B	1.75	1.52	16	0.4	0.88	16	59.7%	1.06 [0.31, 1.81]
Park 2017	9.8	4.85	10	6.2	5.22	10	40.3%	0.68 [-0.22, 1.59]
Total (95% CI)			**26**			**26**	**100.0%**	**0.91 [0.33, 1.48]**

Heterogeneity: Chi² = 0.39, df = 1 (P = 0.53); I² = 0%

Test for overall effect: Z = 3.09 (P = 0.002)

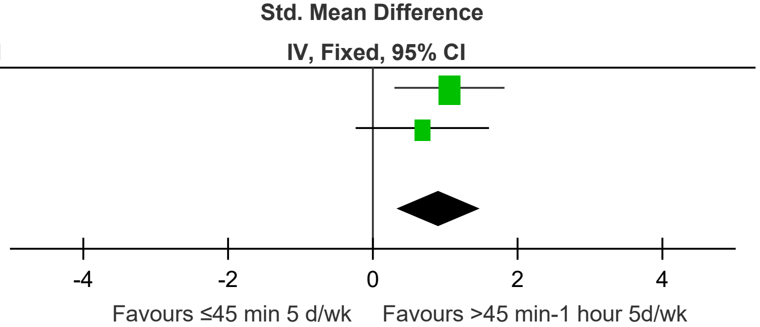


Figure 31: Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, Berg Balance Scale [different scale ranges], higher values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Lee 2014	49.9	6	10	42.4	6.3	11	23.2%	1.17 [0.23, 2.11]
Min 2020	25.73	4.36	19	19.42	5.5	19	41.8%	1.24 [0.54, 1.95]
Mustafaoglu 2018	47.7	7.2	15	41.8	3.7	15	35.0%	1.00 [0.24, 1.77]
Total (95% CI)			**44**			**45**	**100.0%**	**1.14 [0.69, 1.60]**

Heterogeneity: Chi² = 0.21, df = 2 (P = 0.90); I² = 0%

Test for overall effect: Z = 4.94 (P < 0.00001)

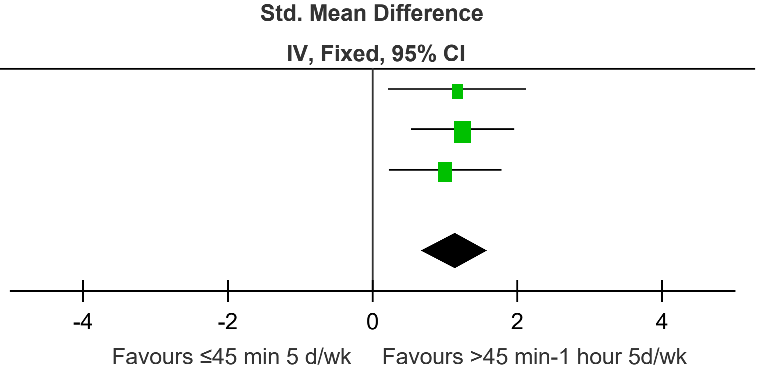


Figure 32: Physical function - lower limb (Timed walk, units unclear, lower values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Partridge 2000	49.2	32	33	39.9	29.9	22	9.30 [-7.29, 25.89]

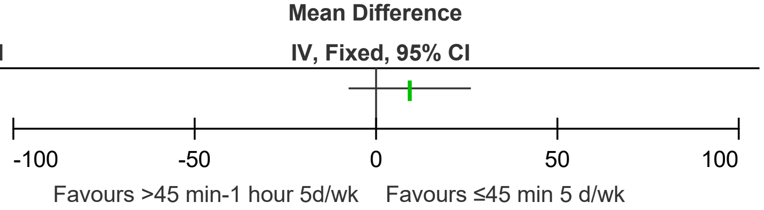


Figure 33: Physical function - lower limb (Timed walk, units unclear, lower values are better, final values) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Partridge 2000	35.8	16.5	27	49.4	32.1	33	-13.60 [-26.20, -1.00]

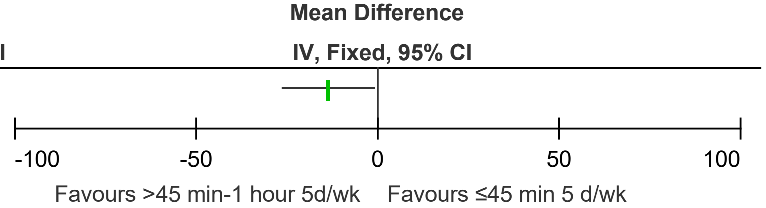


Figure 34: Psychological distress - depression (HADS depression, 0-42, lower values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Partridge 2000	12.6	7.6	46	12.9	7.1	46	-0.30 [-3.31, 2.71]

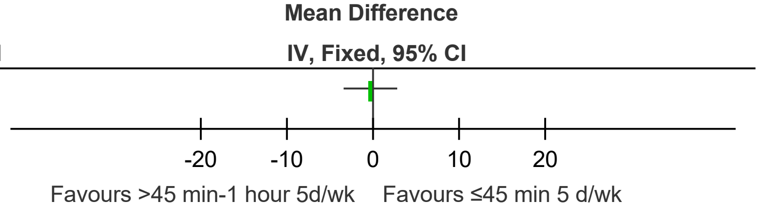


Figure 35: Psychological distress - depression (HADS depression, 0-42, lower values are better, final values) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Partridge 2000	12.9	7.9	43	12.9	7	43	0.00 [-3.15, 3.15]

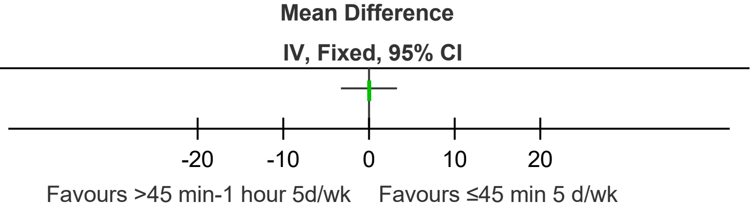


Figure 36: Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Hunter 2011	0	18	0	19	8.8%	0.00 [-0.10, 0.10]
Kwakkel 2016	2	29	0	29	13.8%	0.07 [-0.04, 0.18]
Lee 2014	2	10	1	11	5.0%	0.11 [-0.19, 0.41]
Min 2020	0	19	0	19	9.0%	0.00 [-0.10, 0.10]
Mirela Cristina 2015	0	7	0	8	3.6%	0.00 [-0.22, 0.22]
Mustafaoglu 2018	0	15	0	15	7.1%	0.00 [-0.12, 0.12]
Park 2017	2	12	2	12	5.7%	0.00 [-0.30, 0.30]
Park 2021	0	22	0	22	10.5%	0.00 [-0.08, 0.08]
Partridge 2000	4	60	2	54	27.0%	0.03 [-0.05, 0.11]
Platz 2005	1	20	1	20	9.5%	0.00 [-0.14, 0.14]
Total (95% CI)		**212**		**209**	**100.0%**	**0.02 [-0.02, 0.07]**
Total events	11		6			

Heterogeneity: Chi² = 2.05, df = 9 (P = 0.99); I² = 0%

Test for overall effect: Z = 1.06 (P = 0.29)

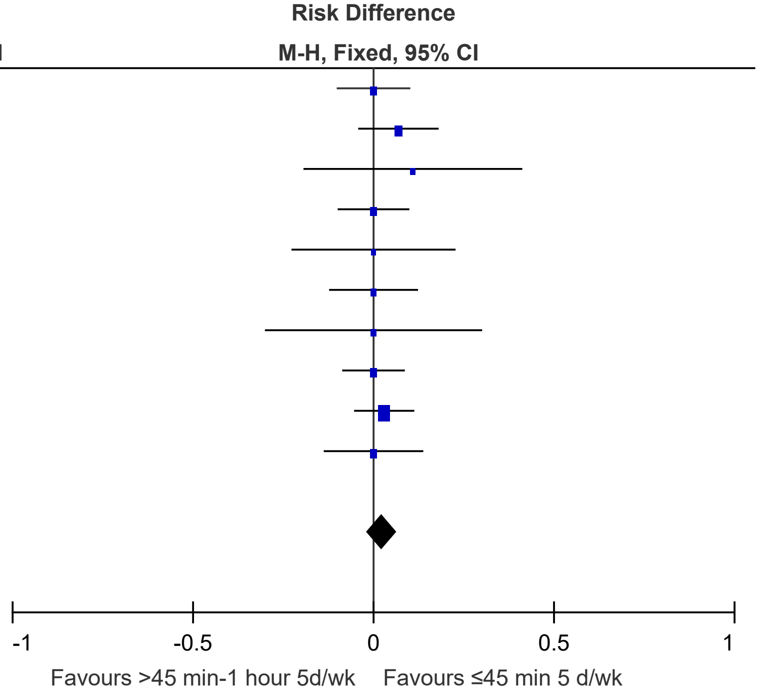
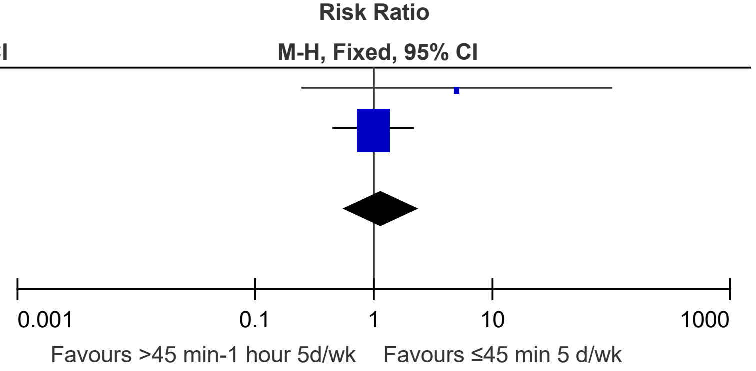


Figure 37: Discontinuation from study at ≥6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk			Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Kwakkel 2016	2	29	0	29	4.5%	5.00 [0.25, 99.82]
Partridge 2000	11	60	10	54	95.5%	0.99 [0.46, 2.15]
Total (95% CI)		**89**		**83**	**100.0%**	**1.17 [0.56, 2.44]**
Total events	13		10			
Heterogeneity: Chi² = 1.08, df = 1 (P = 0.30); I² = 8%						
Test for overall effect: Z = 0.42 (P = 0.67)						



G.1.10 Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Figure 38: Activities of daily living (Functional Independence Measure - Upper and Lower Limbs, 0-77, higher values are better, final value) at <6 months

	>45 min-1 hour 5d/wk			>45 min-1 hour <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Fasoli 2004	54.5	9.859	30	44.6	13.2575	26	9.90 [3.70, 16.10]

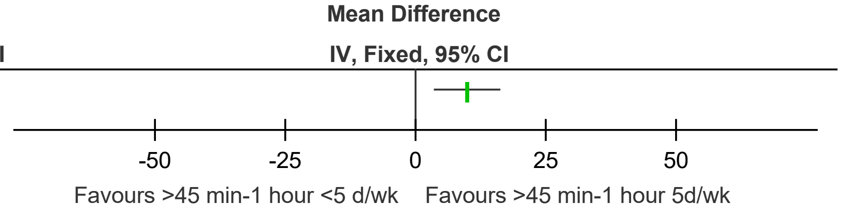


Figure 39: Activities of daily living (Functional Independence Measure - Upper limb Self-Care, 0-42, higher values are better, final value) at <6 months

	>45 min-1 hour 5d/wk			>45 min-1 hour <5 d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Fasoli 2004	29.9	6.5727	30	25	7.6485	26	4.90 [1.14, 8.66]	

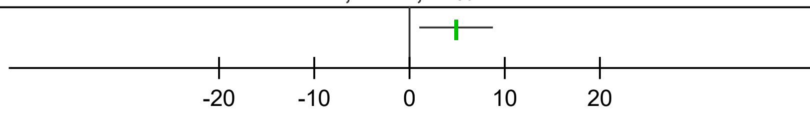


Figure 40: Activities of daily living (Functional Independence Measure - cognitive, 0-35, higher values are better, final value) at <6 months

	>45 min-1 hour 5d/wk			>45 min-1 hour <5 d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Fasoli 2004	30.4	4.3818	30	23.2	6.1188	26	7.20 [4.37, 10.03]	

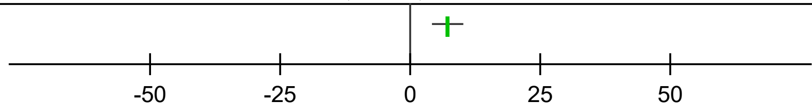
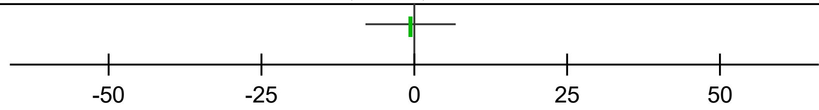


Figure 41: Physical function - upper limb (Fugl-Meyer Assessment, 0-66, higher values are better, final value) at <6 months

	>45 min-1 hour 5d/wk			>45 min-1 hour <5 d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Fasoli 2004	15.7	10.9545	30	16.3	15.807	26	-0.60 [-7.83, 6.63]	



G.1.11 Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 7 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 42: Person/participant health-related quality of life (Stroke Impact Scale, 0-100, higher values are better, final value) at ≥6 months

	>45 min-1 hour 7d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Askim 2018	72.8	36.4139	186	73.5	35.9352	194	-0.70 [-7.98, 6.58]

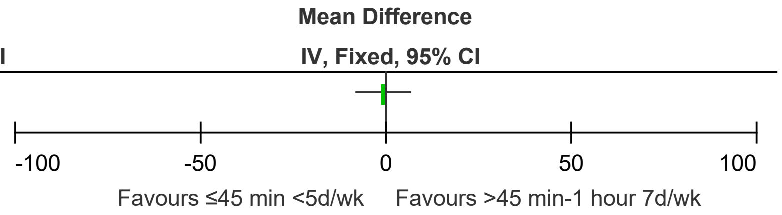


Figure 43: Stroke outcome - modified Rankin scale (modified Rankin scale, 0-6, lower values are better, final value) at ≥6 months

	>45 min-1 hour 7d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Askim 2018	1.28	1.6366	186	1.33	1.5321	194	-0.05 [-0.37, 0.27]

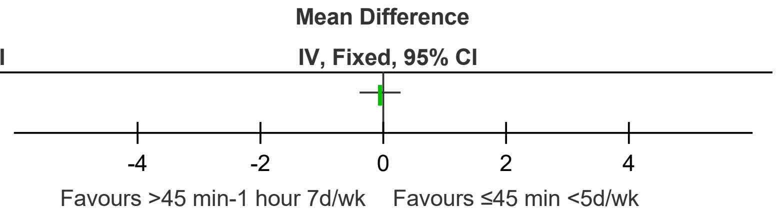


Figure 44: Activities of daily living (Barthel Index, 0-100, higher values are better, final value) at ≥6 months

	>45 min-1 hour 7d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Askim 2018	90.2	2.4549	186	90.2	2.2285	194	0.00 [-0.47, 0.47]

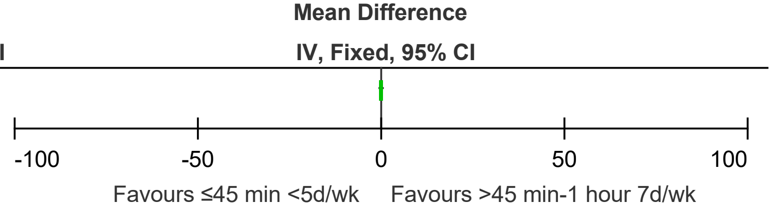


Figure 45: Physical function - lower limb (Berg Balance Scale item 14, 0-4, higher values are better, final value) at ≥6 months

	>45 min-1 hour 7d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Askim 2018	2.63	1.6366	186	2.71	1.3928	194	-0.08 [-0.39, 0.23]

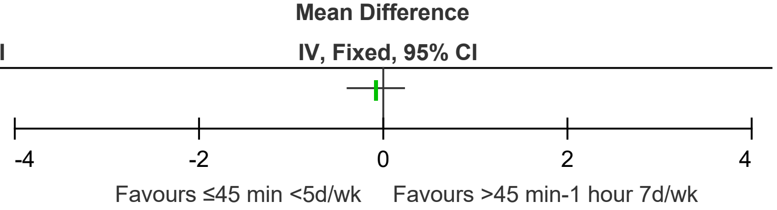
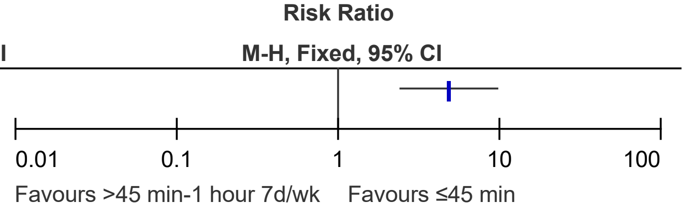


Figure 46: Discontinuation from study at ≥6 months

	>45 min-1 hour 7d/wk		≤45 min <5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Askim 2018	42	186	9	194	4.87 [2.44, 9.72]



G.1.12 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 47: Physical function - upper limb (grip strength, kg, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Takatori 2012	27.2	9.3	22	19.9	7.2	22	7.30 [2.39, 12.21]

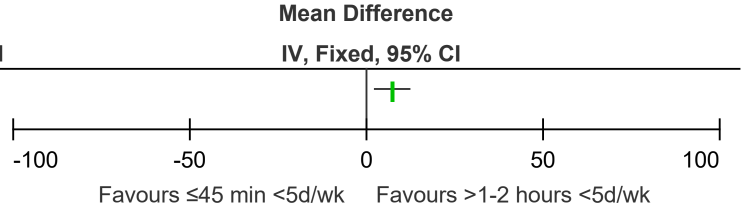


Figure 48: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kim 2009	51.17	4.02	12	48.25	4.22	12	2.92 [-0.38, 6.22]

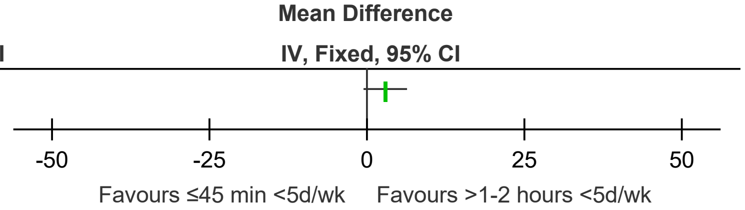


Figure 49: Physical function - lower limb (timed up and go, seconds, lower values are better, final value) at <6 months

	>1-2 hours <5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Takatori 2012	15.4	11.1	22	21.2	14.4	22	-5.80 [-13.40, 1.80]

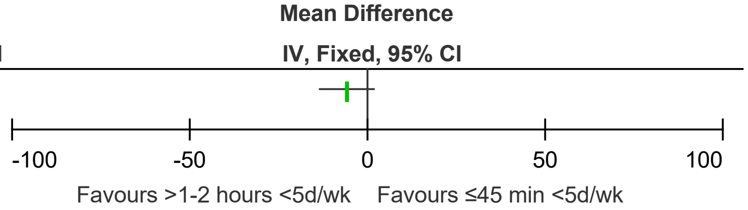


Figure 50: Physical function - lower limb (sit-to-stand test, seconds, lower values are better, final value) at <6 months

Study or Subgroup	>1-2 hours <5d/wk Mean	SD	Total	≤45 min <5d/wk Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Howe 2005	3.1	3.1	14	2.5	1.3	12	0.60 [-1.18, 2.38]

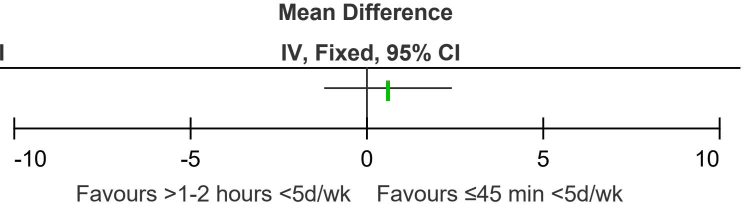
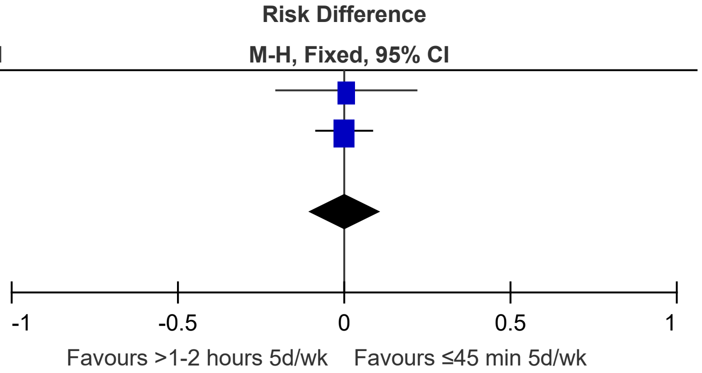


Figure 51: Discontinuation from study at <6 months

Study or Subgroup	>1-2 hours <5d/wk Events	Total	≤45 min <5d/wk Events	Total	Weight	Risk Difference M-H, Fixed, 95% CI
Howe 2005	2	17	2	18	44.3%	0.01 [-0.20, 0.22]
Takatori 2012	0	22	0	22	55.7%	0.00 [-0.08, 0.08]
Total (95% CI)		**39**		**40**	**100.0%**	**0.00 [-0.10, 0.11]**
Total events	2		2			

Heterogeneity: Chi² = 0.01, df = 1 (P = 0.94); I² = 0%
Test for overall effect: Z = 0.05 (P = 0.96)



G.1.13 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Figure 52: Patient/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			>45 min-1 hour <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Cooke 2010	0.6	0.28	71	0.6	0.29	38	0.00 [-0.11, 0.11]

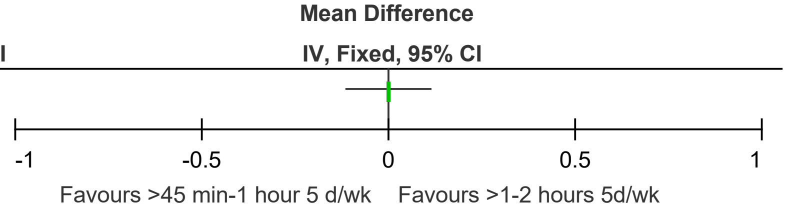


Figure 53: Physical function - lower limb (Modified Rivermead mobility index, 0-40, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			>45 min-1 hour <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Cooke 2010	38.3	8.7	71	39.7	5.7	38	-1.40 [-4.12, 1.32]

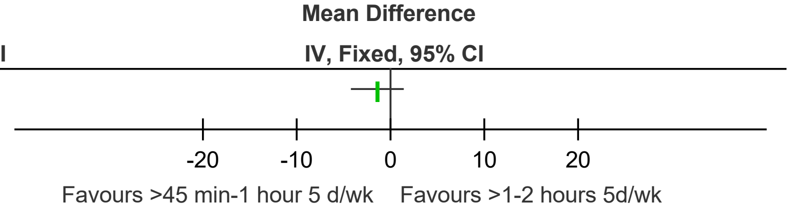


Figure 54: Physical function - lower limb (6-minute walk test, meters, higher values are better, change score) at <6 months

	Favours >45 min-1 hour 5 d/wk			>45 min-1 hour <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kim 2014A	55	56.38	10	8.7	9.84	10	46.30 [10.83, 81.77]

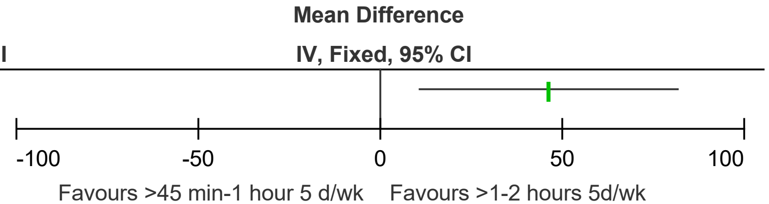


Figure 55: Physical function - lower limb (Timed up and go, 0-3, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			>45 min-1 hour <5 d/wk			Mean Difference	Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**IV, Fixed, 95% CI**	**IV, Fixed, 95% CI**
Unal 2020	2.33	0.61	15	1.93	0.88	15	0.40 [-0.14, 0.94]	

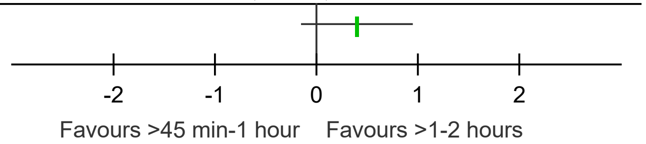
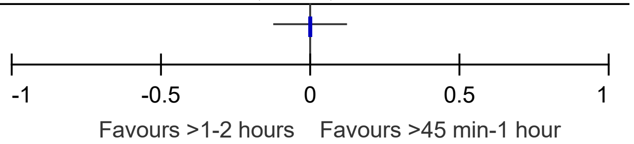


Figure 56: Discontinuation from study at <6 months

	>1-2 hours <5d/wk		>45 min-1 hour <5 d/wk		Risk Difference	Risk Difference
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Unal 2020	0	15	0	15	0.00 [-0.12, 0.12]	



G.1.14 Physiotherapy (communication difficulties) - >1 hour to 2 hours, <5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Figure 57: Activities of daily living (Functional Independence Measure, 1-7, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			>45 min-1 hour <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Barcala 2013	6.12	0.68	10	5.72	0.67	10	0.40 [-0.19, 0.99]

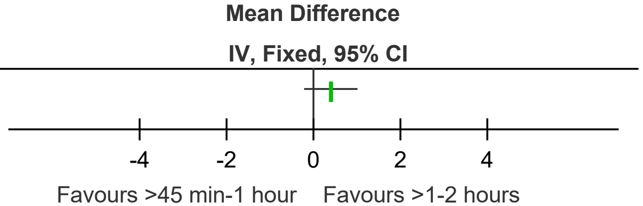


Figure 58: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			>45 min-1 hour <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Barcala 2013	41.9	6.91	10	42.2	4.8	10	-0.30 [-5.51, 4.91]

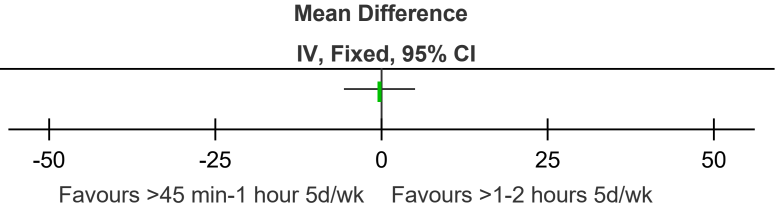
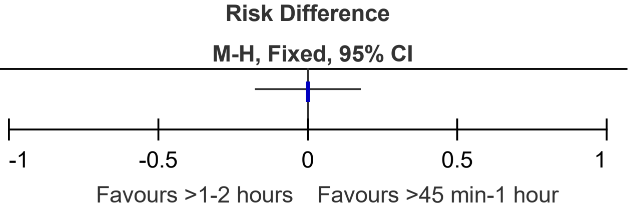


Figure 59: Discontinuation from study at <6 months

	>1-2 hours <5d/wk		>45 min-1 hour <5d/wk		Risk Difference
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Barcala 2013	0	10	0	10	0.00 [-0.17, 0.17]



G.1.15 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to usual care for people after a first or recurrent stroke

Figure 60: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, motor function, 0-66, higher values are better, change score) at <6 months

	>1-2 hours 5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Winstein 2004	17.35	13.49	40	9.05	7.6	20	8.30 [2.95, 13.65]

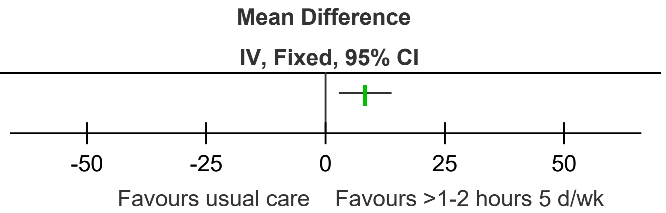


Figure 61: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, motor function, 0-66, higher values are better, change score) at ≥6 months

	>1-2 hours 5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Winstein 2004	5.5	7.29	29	8.33	11.26	15	-2.83 [-9.12, 3.46]

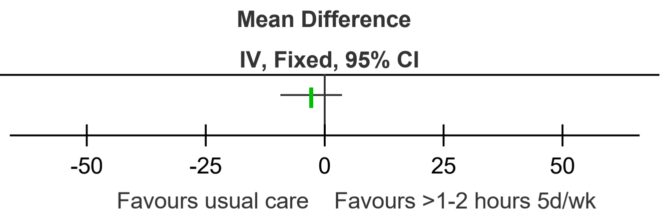


Figure 62: Discontinuation from study at <6 months

	>1-2 hours 5 d/wk		Usual care		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Winstein 2004	1	40	3	20	0.17 [0.02, 1.50]

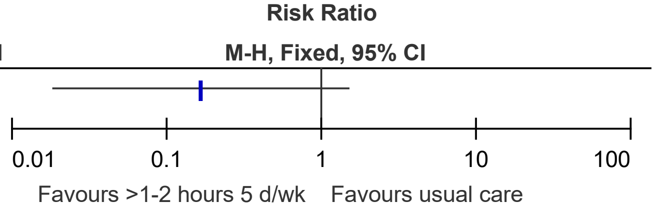
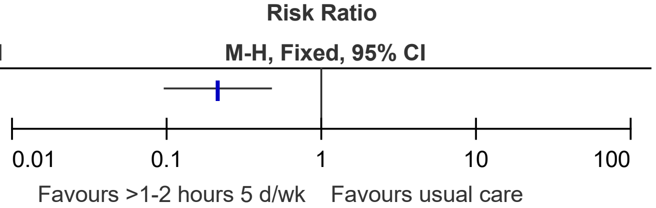


Figure 63: Discontinuation from study at ≥6 months

	>1-2 hours 5 d/wk		Usual care		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Winstein 2004	6	40	14	20	0.21 [0.10, 0.47]



G.1.16 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 64: Physical function - upper limb (Wolf Motor Function Test Performance Time, 0-120 seconds, lower values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Jo 2012	36.4	21.1	15	42.8	13.1	14	-6.40 [-19.09, 6.29]

Mean Difference
IV, Fixed, 95% CI

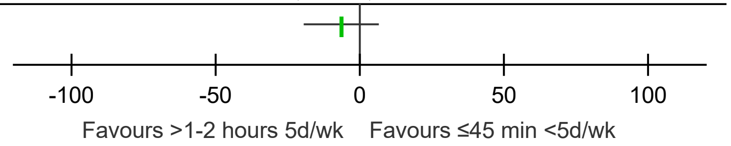


Figure 65: Stroke-related scale of cognition - spatial attention (Motor-free visual perception test, 0-46, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Jo 2012	26.8	3.6	15	23.9	4.2	14	2.90 [0.04, 5.76]

Mean Difference
IV, Fixed, 95% CI

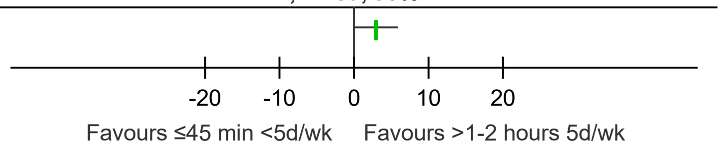
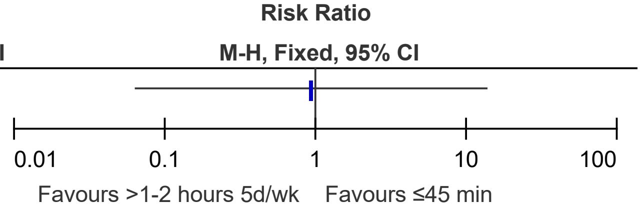


Figure 66: Discontinuation from study at <6 months

Study or Subgroup	>1-2 hours 5d/wk Events	>1-2 hours 5d/wk Total	≤45 min <5d/wk Events	≤45 min <5d/wk Total	Risk Ratio M-H, Fixed, 95% CI
Jo 2012	1	16	1	15	0.94 [0.06, 13.68]



G.1.17 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Figure 67: Person/participant health-related quality of life (EuroQol, 0-100, higher values are better, change score) at ≥6 months

Study or Subgroup	>1-2 hours 5d/wk Mean	>1-2 hours 5d/wk SD	>1-2 hours 5d/wk Total	≤45 min 5d/wk Mean	≤45 min 5d/wk SD	≤45 min 5d/wk Total	Mean Difference IV, Fixed, 95% CI
Glasgow Augmented Physiotherapy Study 2004	9.78	30.8	30	-2	20.8	34	11.78 [-1.27, 24.83]

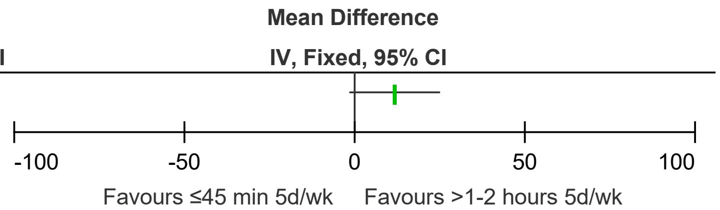


Figure 68: Activities of daily living (Barthel Index, 0-100, higher values are better, change score and final value) at <6 months

Study or Subgroup	>1-2 hours 5d/wk Mean	SD	Total	≤45 min 5d/wk Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
Di Lauro 2003	3.2	2	26	3.2	2.6	24	55.2%	0.00 [-1.29, 1.29]
Glasgow Augmented Physiotherapy Study 2004	16.6	2.8	32	16.1	3.3	34	42.6%	0.50 [-0.97, 1.97]
Yoo 2013	77.9	9.7	11	75.4	5.1	11	2.2%	2.50 [-3.98, 8.98]
Total (95% CI)			**69**			**69**	**100.0%**	**0.27 [-0.69, 1.23]**

Heterogeneity: Chi² = 0.72, df = 2 (P = 0.70); I² = 0%
Test for overall effect: Z = 0.55 (P = 0.58)

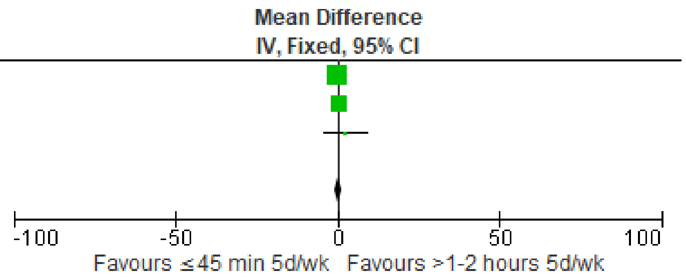


Figure 69: Activities of daily living (Barthel Index, 0-100, higher values are better, change score) at ≥6 months

Study or Subgroup	>1-2 hours 5d/wk Mean	SD	Total	≤45 min 5d/wk Mean	SD	Total	Weight	Mean Difference IV, Fixed, 95% CI
Glasgow Augmented Physiotherapy Study 2004	5.1	3.7	30	5.9	4.1	34	43.5%	-0.80 [-2.71, 1.11]
Di Lauro 2003	8	2.8	22	7.7	3	24	56.5%	0.30 [-1.38, 1.98]
Total (95% CI)			**52**			**58**	**100.0%**	**-0.18 [-1.44, 1.08]**

Heterogeneity: Chi² = 0.72, df = 1 (P = 0.40); I² = 0%
Test for overall effect: Z = 0.28 (P = 0.78)

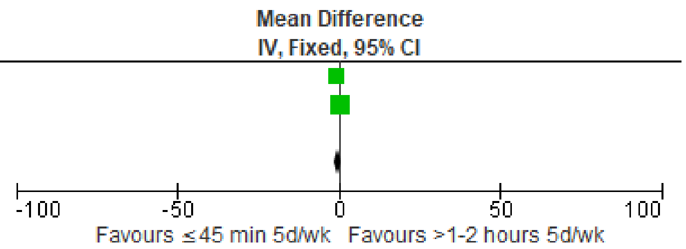


Figure 70: Physical function - upper limb (Action Research Arm Test, Wolf Motor Function [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			≤45 min 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Hunter 2011	6.6	11.4818	18	6.5	11.4952	19	46.9%	0.01 [-0.64, 0.65]
Shaukat 2022	39.01	6.54	11	37.93	5.61	11	27.8%	0.17 [-0.67, 1.01]
Yoo 2013	43.4	15.9	11	33.3	6.3	11	25.4%	0.80 [-0.07, 1.68]
Total (95% CI)			**40**			**41**	**100.0%**	**0.26 [-0.19, 0.70]**

Heterogeneity: Chi² = 2.11, df = 2 (P = 0.35); I² = 5%
Test for overall effect: Z = 1.13 (P = 0.26)

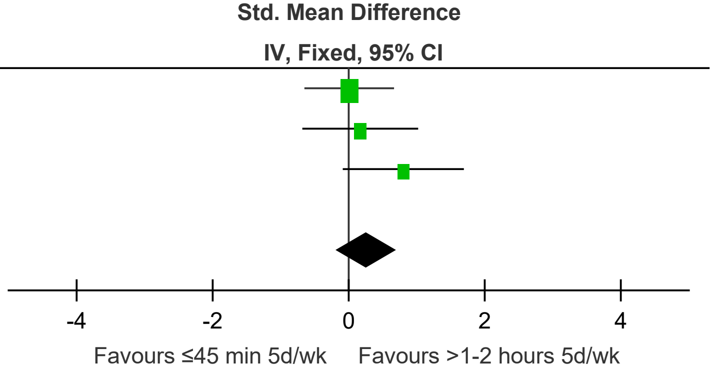


Figure 71: Physical function - upper limb (functional reach test, cm, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 min 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Seo 2012	15.34	4.63	6	10.44	6.77	6	4.90 [-1.66, 11.46]

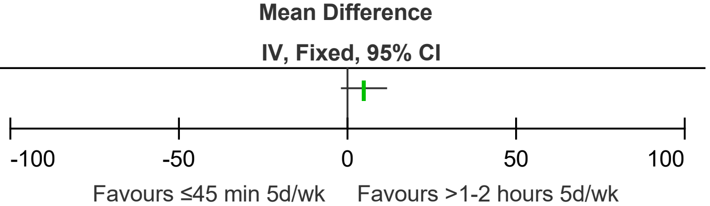


Figure 72: Physical function - lower limb (Rivermead Mobility Index, 0-15, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			≤45 min 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Glasgow Augmented Physiotherapy Study 2004	4.7	2.8	32	3.5	2.8	34	1.20 [-0.15, 2.55]

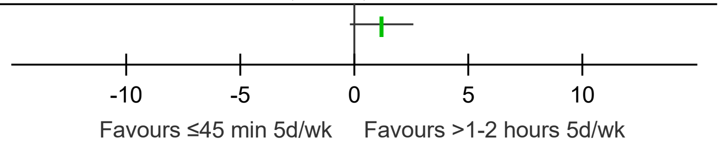


Figure 73: Physical function - lower limb (Postural Assessment Scale for Stroke patients, 0-36, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 min 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Seo 2012	32.67	2.8	6	32.5	1.87	6	0.17 [-2.52, 2.86]

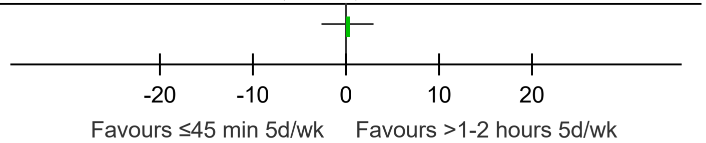


Figure 74: Physical function - lower limb (Rivermead Mobility Index, 0-15, higher values are better, change score) at ≥6 months

	>1-2 hours 5d/wk			≤45 min 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Glasgow Augmented Physiotherapy Study 2004	5.1	2.7	30	4.4	3.2	34	0.70 [-0.75, 2.15]

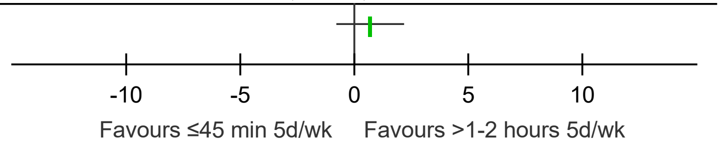


Figure 75: Discontinuation from study at <6 months

	>1-2 hours 5d/wk		≤45 min 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Allison 2007	3	17	0	10	7.3%	0.18 [-0.04, 0.40]
Di Lauro 2003	3	29	2	29	16.7%	0.03 [-0.11, 0.18]
English 2015	9	93	6	94	53.9%	0.03 [-0.04, 0.11]
Hunter 2011	1	19	0	19	10.9%	0.05 [-0.08, 0.19]
Seo 2012	3	9	2	8	4.9%	0.08 [-0.35, 0.51]
Shaukat 2022	0	11	0	11	6.3%	0.00 [-0.16, 0.16]
Total (95% CI)		**178**		**171**	**100.0%**	**0.05 [-0.01, 0.10]**
Total events	19		10			

Heterogeneity: Chi² = 1.84, df = 5 (P = 0.87); I² = 0%

Test for overall effect: Z = 1.54 (P = 0.12)

Risk Difference
M-H, Fixed, 95% CI

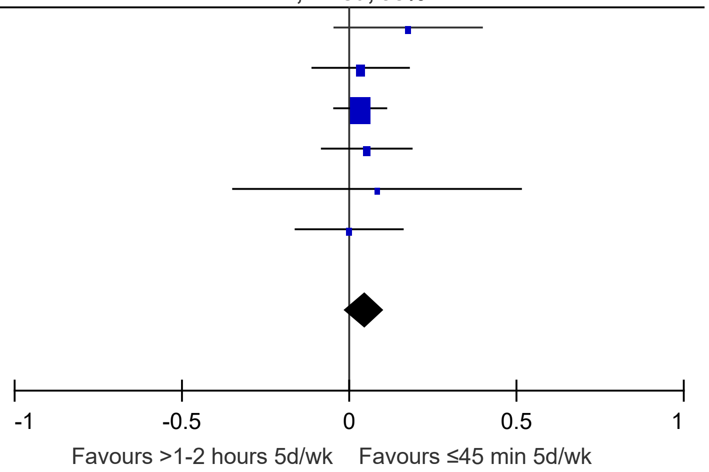
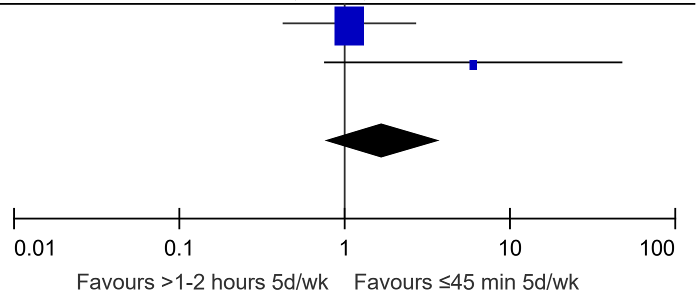


Figure 76: Discontinuation from study at ≥6 months

	>1-2 hours 5d/wk		≤45 min 5d/wk			Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Di Lauro 2003	7	29	7	31	87.1%	1.07 [0.43, 2.67]
Glasgow Augmented Physiotherapy Study 2004	6	35	1	35	12.9%	6.00 [0.76, 47.29]
Total (95% CI)		**64**		**66**	**100.0%**	**1.70 [0.76, 3.81]**
Total events	13		8			
Heterogeneity: Chi² = 2.42, df = 1 (P = 0.12); I² = 59%						
Test for overall effect: Z = 1.30 (P = 0.19)						

Risk Ratio
M-H, Fixed, 95% CI

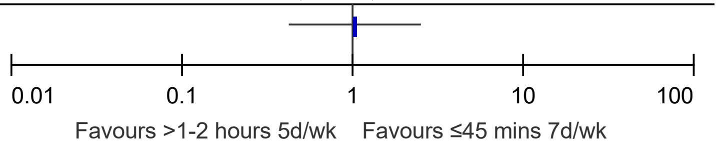


G.1.18 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, 7 days a week for people after a first or recurrent stroke

Figure 77: Discontinuation from study at <6 months

	>1-2 hours 5d/wk		≤45 mins 7d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
English 2015	9	93	9	96	1.03 [0.43, 2.49]

Risk Ratio
M-H, Fixed, 95% CI



G.1.19 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Figure 78: Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Klassen 2020	0.82	0.09	24	0.75	0.13	49	44.7%	0.07 [0.02, 0.12]
Rodgers 2019	0.47	0.26	468	0.42	0.29	207	55.3%	0.05 [0.00, 0.10]
Total (95% CI)			**492**			**256**	**100.0%**	**0.06 [0.02, 0.09]**

Heterogeneity: Chi² = 0.32, df = 1 (P = 0.57); I² = 0%
Test for overall effect: Z = 3.38 (P = 0.0007)

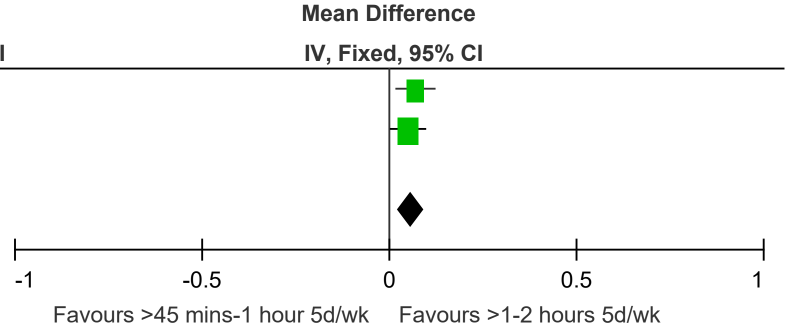


Figure 79: Person/participant health-related quality of life (EQ-VAS, 0-100, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Tollar 2021	9.5	8.74	286	4.85	8.25	355	4.65 [3.32, 5.98]

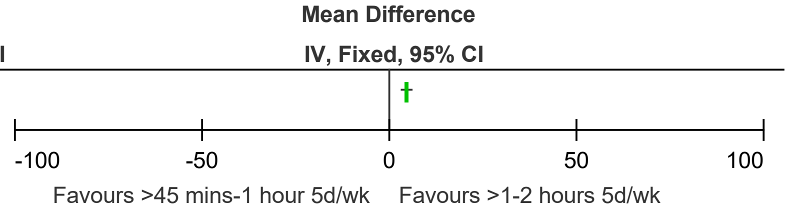


Figure 80: Person/participant health-related quality of life (Stroke Impact Scale Social Participation, 0-100, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kim 2014B	12.49	10.17	11	4.25	3.77	11	8.24 [1.83, 14.65]

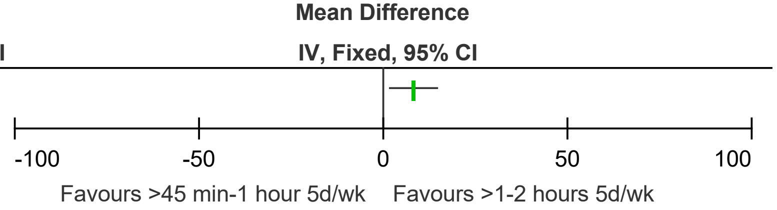


Figure 81: Person/participant health-related quality of life (stroke specific quality of life, 49-245, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Taravati 2021	138.59	34.3	17	140.8	30.72	20	-2.21 [-23.36, 18.94]

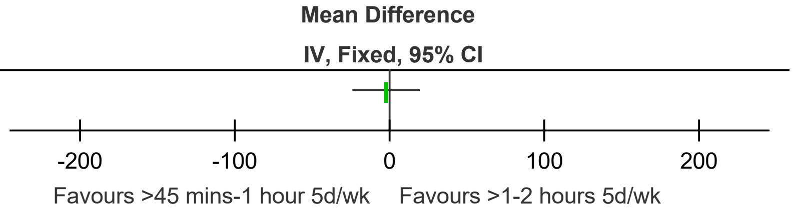


Figure 82: Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final values) at ≥6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Klassen 2020	0.83	0.08	21	0.79	0.15	37	38.0%	0.04 [-0.02, 0.10]	
Rodgers 2019	0.48	0.28	445	0.46	0.27	190	62.0%	0.02 [-0.03, 0.07]	
Total (95% CI)			**466**			**227**	**100.0%**	**0.03 [-0.01, 0.06]**	

Heterogeneity: Chi² = 0.27, df = 1 (P = 0.60); I² = 0%

Test for overall effect: Z = 1.48 (P = 0.14)

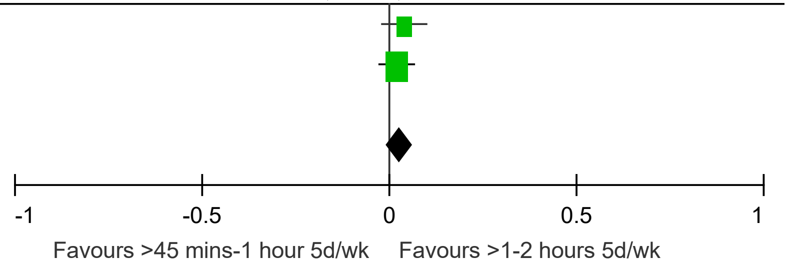


Figure 83: Stroke outcome - modified Rankin scale (modified Rankin Scale, 0-6, lower values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Tollar 2021	-1.8	0.81	286	-1.24	0.95	355	-0.56 [-0.70, -0.42]	

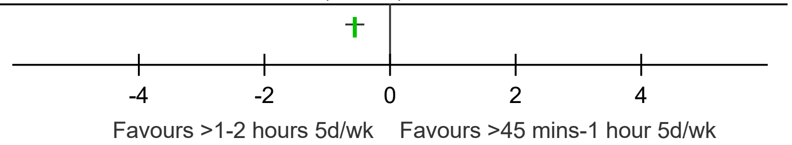


Figure 84: Activities of daily living (Barthel Index, Functional Independence Measure - self-care score [different scale ranges], higher values are better, change scores) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Cabanas-Valdes 2016	36.5	18.81	40	23.33	16.87	40	27.5%	0.73 [0.28, 1.18]
Ikbali Afsar 2018	11	3.16	19	10.33	3.79	16	21.6%	0.19 [-0.48, 0.86]
Kim 2016	21.3	15.13	10	27.9	14.93	10	16.5%	-0.42 [-1.31, 0.47]
Tollar 2021	27.2	8.92	286	17.1	12.1	355	34.4%	0.93 [0.77, 1.10]
Total (95% CI)			**355**			**421**	**100.0%**	**0.49 [0.00, 0.99]**

Heterogeneity: Tau² = 0.18; Chi² = 12.89, df = 3 (P = 0.005); I² = 77%
Test for overall effect: Z = 1.96 (P = 0.05)

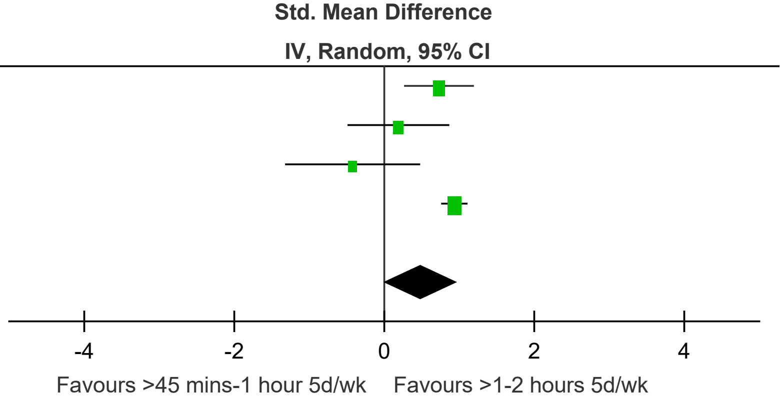


Figure 85: Activities of daily living (Barthel Index, Functional Independence Measure, Canadian Occupational Performance Measure [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
, 2020	72.17	13.47	23	62.5	12.13	22	5.6%	0.74 [0.13, 1.35]
Han 2013	88	10.33	10	85	11.79	10	2.7%	0.26 [-0.62, 1.14]
Lee 2012	70.4	18	20	68.1	12.6	20	5.3%	0.15 [-0.48, 0.77]
Rodgers 2019	15.7	3.4	468	15.3	3.8	207	76.8%	0.11 [-0.05, 0.28]
Ross 2009	-5.4	1.9	18	-5.4	2.9	17	4.7%	0.00 [-0.66, 0.66]
Taravati 2021	96.47	23.55	17	93.15	21.99	20	4.9%	0.14 [-0.50, 0.79]
Total (95% CI)			**556**			**296**	**100.0%**	**0.15 [0.01, 0.29]**

Heterogeneity: Chi² = 4.09, df = 5 (P = 0.54); I² = 0%

Test for overall effect: Z = 2.05 (P = 0.04)

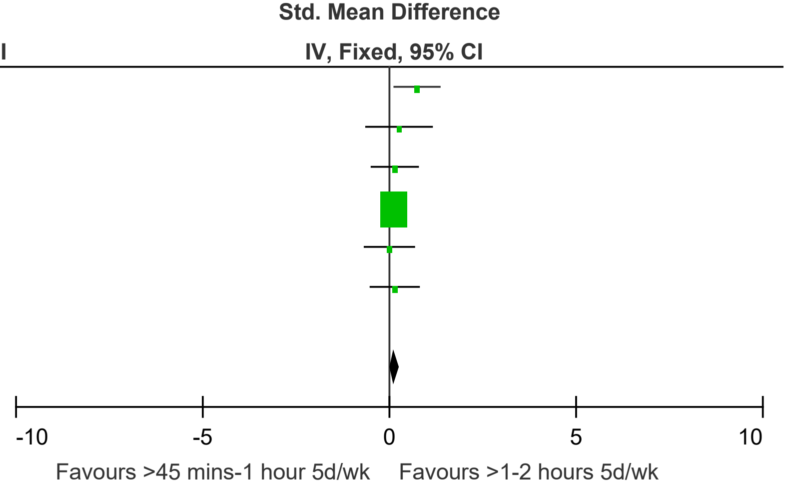


Figure 86: Activities of daily living (Barthel Index, 0-100, higher values are better, final value) at ≥6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Rodgers 2019	15.8	4.5	445	15.3	3.7	190	0.50 [-0.17, 1.17]

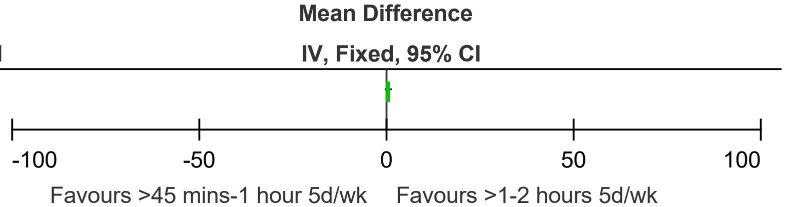


Figure 87: Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, change scores) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Coskunsu 2022	15.73	14.409	11	20	11.608	9	45.5%	-0.31 [-1.20, 0.58]
Ikbali Afsar 2018	18.74	7.67	19	13.94	6.58	16	54.5%	0.65 [-0.03, 1.34]
Total (95% CI)			**30**			**25**	**100.0%**	**0.21 [-0.72, 1.15]**

Heterogeneity: Tau² = 0.30; Chi² = 2.82, df = 1 (P = 0.09); I² = 65%

Test for overall effect: Z = 0.45 (P = 0.65)

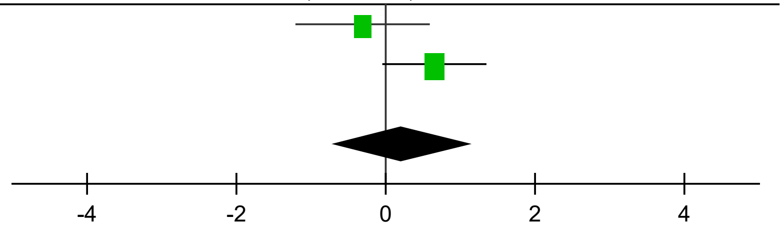


Figure 88: Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
, 2020	48.87	8.63	23	41.91	7.71	22	5.6%	0.83 [0.22, 1.45]
Han 2013	19.7	7.09	10	13	6.38	10	2.4%	0.95 [0.02, 1.89]
Hunter 2011	6.6	11.4818	18	6.8	8.9528	18	4.9%	-0.02 [-0.67, 0.63]
Rodgers 2019	77.2	22.5	468	74.2	23.6	207	77.5%	0.13 [-0.03, 0.29]
Ross 2009	21	23	18	24	26	17	4.7%	-0.12 [-0.78, 0.54]
Taravati 2021	24.24	10.02	17	23.35	10.01	20	5.0%	0.09 [-0.56, 0.73]
Total (95% CI)			**554**			**294**	**100.0%**	**0.17 [0.02, 0.31]**

Heterogeneity: Chi² = 8.54, df = 5 (P = 0.13); I² = 41%

Test for overall effect: Z = 2.29 (P = 0.02)

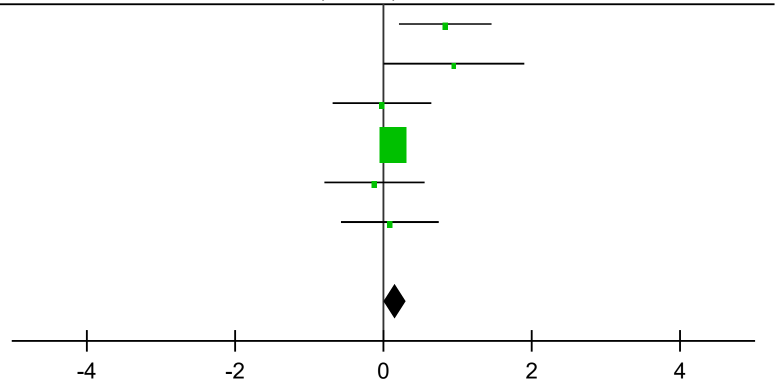


Figure 89: Physical function - upper limb (Fugl Meyer Upper Extremity - shoulder, elbow and forearm, 0-36, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Kim 2022	31.29	3.51	24	29.42	4.87	12	1.87 [-1.22, 4.96]	

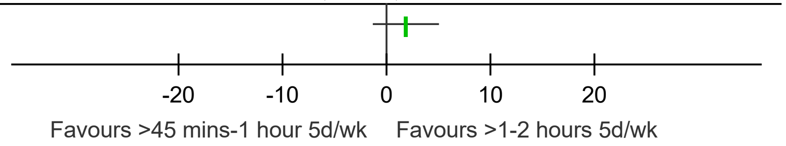


Figure 90: Physical function - upper limb (Fugl Meyer Upper Extremity - wrist, 0-10, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Kim 2022	7.29	2.07	24	6	1.28	12	1.29 [0.19, 2.39]	

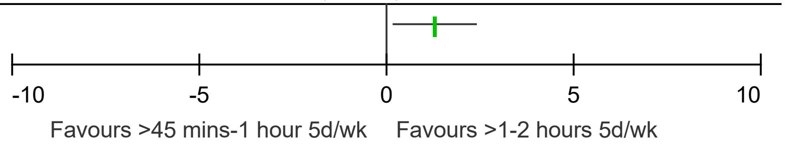


Figure 91: Physical function - upper limb (Fugl Meyer Upper Extremity - hand, 0-14, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Kim 2022	9.25	2.28	24	8	1.04	12	1.25 [0.16, 2.34]	

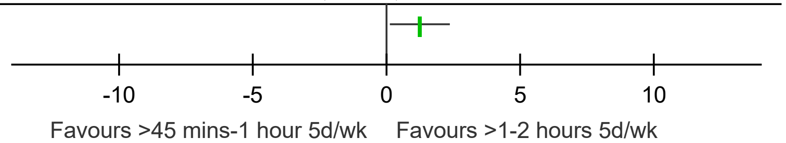


Figure 92: Physical function - upper limb (Fugl Meyer Upper Extremity - coordination, 0-6, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kim 2022	3.79	1.04	24	3.67	0.89	12	0.12 [-0.53, 0.77]

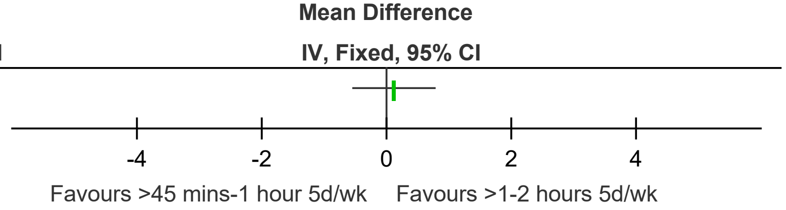


Figure 93: Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-120, higher values are better, final value) at ≥6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Rodgers 2019	78.8	23.5	445	77.9	23.2	190	0.90 [-3.06, 4.86]

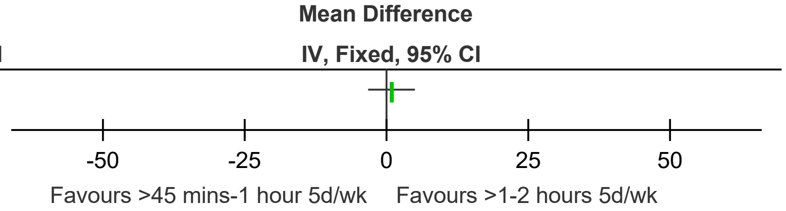


Figure 94: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, change score and final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Klassen 2020	48.6	8.7	24	47.1	8.6	49	4.7%	1.50 [-2.73, 5.73]
Lee 2012	45.7	7.8	20	41.7	6.9	20	4.0%	4.00 [-0.56, 8.56]
Tollar 2021	6.8	6.28	286	4.2	6	355	91.3%	2.60 [1.64, 3.56]
Total (95% CI)			**330**			**424**	**100.0%**	**2.60 [1.69, 3.52]**

Heterogeneity: Chi² = 0.62, df = 2 (P = 0.73); I² = 0%
Test for overall effect: Z = 5.57 (P < 0.00001)

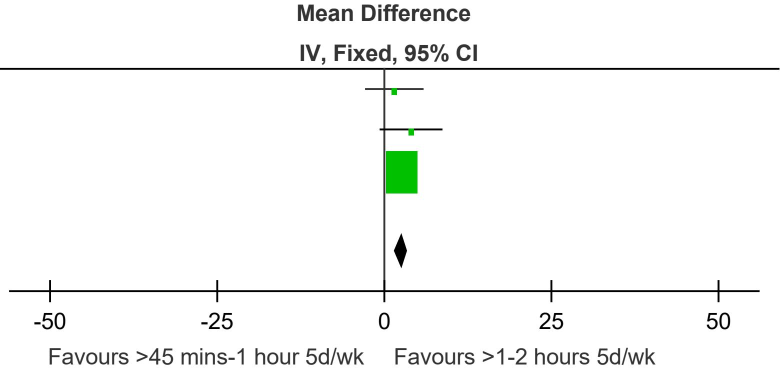


Figure 95: Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, 0-36, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kim 2016	2	2.79	10	3	4.6	10	-1.00 [-4.33, 2.33]

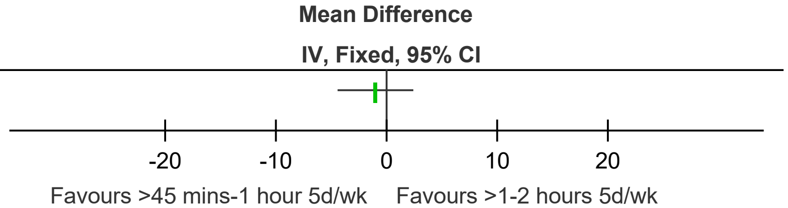


Figure 96: Physical function - lower limb (6-minute walk test, meters, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Park 2011	67	48.78	13	23.75	61.45	12	43.25 [-0.48, 86.98]

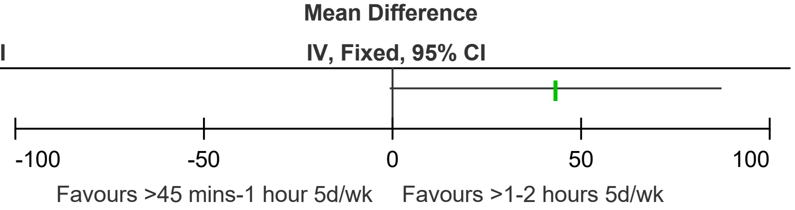


Figure 97: Physical function - lower limb (10 meter walk test, m/s, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kim 2014B	0.19	0.17	11	0.07	0.07	11	0.12 [0.01, 0.23]

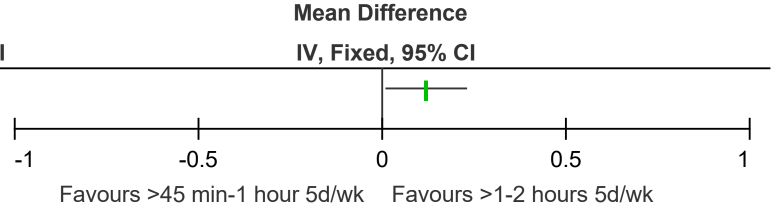


Figure 98: Physical function - lower limb (fast walking speed, m/s, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kuys 2011	0.36	0.26	12	0.12	0.13	12	0.24 [0.08, 0.40]

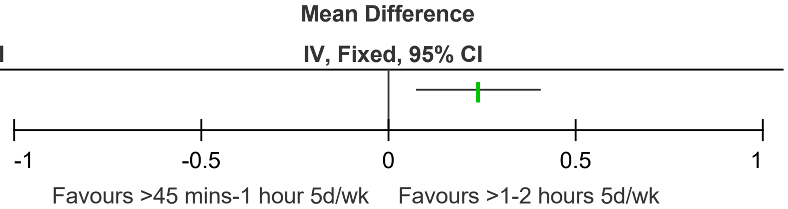


Figure 99: Physical function - lower limb (Dynamic Balance Ability, scale range unclear, higher values are better, change score) at <6 months

Study or Subgroup	>1-2 hours 5d/wk Mean	SD	Total	>45 min-1 hour 5d/wk Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Park 2014	1.1	1.2	10	0.9	1.2	10	0.20 [-0.85, 1.25]

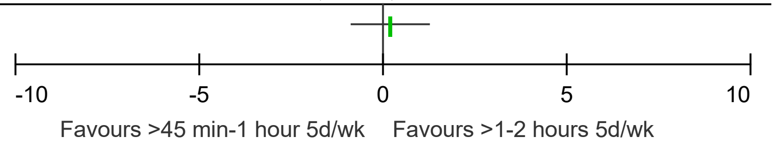


Figure 100: Physical function - lower limb (Rivermead Motor Assessment Gross motor function subscale, 0-13, higher values are better, final value) at <6 months

Study or Subgroup	>1-2 hours 5d/wk Mean	SD	Total	>45 mins-1 hour 5d/wk Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Peurala 2009	8.4	3.4	37	6.3	3.2	10	2.10 [-0.17, 4.37]

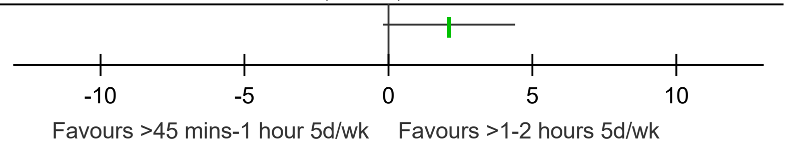


Figure 101: Physical function - lower limb (Rivermead Motor Assessment leg and trunk subscale, 0-13, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Peurala 2009	6.9	2.8	37	4.5	2.7	10	2.40 [0.50, 4.30]

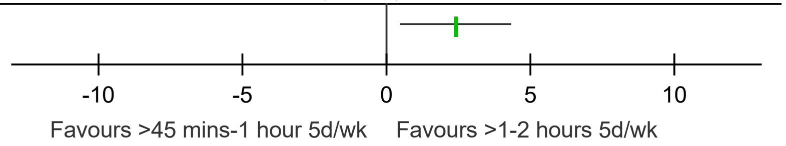


Figure 102: Physical function - lower limb (Rivermead Motor Assessment Gross motor function subscale, 0-13, higher values are better, final value) at ≥6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Peurala 2009	10.8	2.7	35	8.8	2.5	10	2.00 [0.21, 3.79]

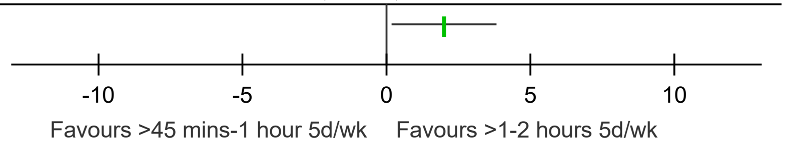


Figure 103: Physical function - lower limb (Rivermead Motor Assessment leg and trunk subscale, 0-13, higher values are better, final value) at ≥6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Peurala 2009	7.8	2.6	35	5.8	2.4	10	2.00 [0.28, 3.72]

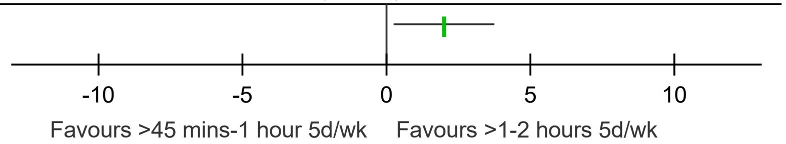


Figure 104: Physical function - lower limb (6-minute walk test, meters, higher values are better, final value) at ≥6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Klassen 2020	375	147	21	376	165.8	36	-1.00 [-83.98, 81.98]

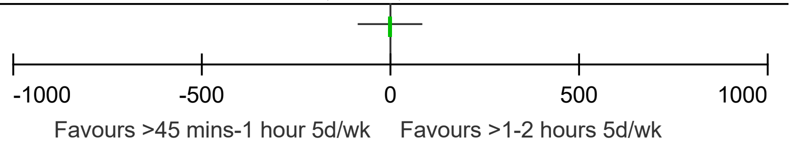


Figure 105: Psychological distress - depression (PHQ-9, Center for Epidemiological Studies - Depression [different scale ranges], lower values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Klassen 2020	3.8	3.7	24	4.3	5.5	48	55.8%	-0.10 [-0.59, 0.39]
Taravati 2021	19.41	8.32	17	26.1	8.18	20	44.2%	-0.79 [-1.47, -0.12]
Total (95% CI)			**41**			**68**	**100.0%**	**-0.41 [-1.08, 0.27]**

Heterogeneity: Tau² = 0.15; Chi² = 2.67, df = 1 (P = 0.10); I² = 63%

Test for overall effect: Z = 1.18 (P = 0.24)

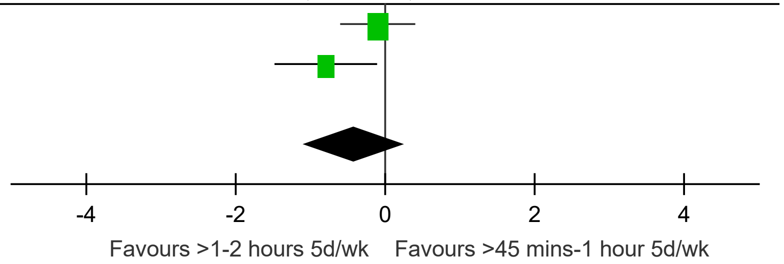


Figure 106: Discontinuation from study at <6 months

Study or Subgroup	>1-2 hours 5d/wk Events	>1-2 hours 5d/wk Total	>45 mins-1 hour 5d/wk Events	>45 mins-1 hour 5d/wk Total	Weight	Risk Difference M-H, Random, 95% CI
Cabanas-Valdes 2016	0	40	1	40	18.8%	-0.03 [-0.09, 0.04]
Coskunsu 2022	1	12	3	12	1.0%	-0.17 [-0.46, 0.12]
Han 2013	0	10	1	11	1.7%	-0.09 [-0.31, 0.13]
Hunter 2011	1	19	0	18	4.5%	0.05 [-0.08, 0.19]
Ikbali Afsar 2018	2	21	5	21	1.7%	-0.14 [-0.36, 0.08]
Kim 2022	4	28	2	14	1.7%	0.00 [-0.22, 0.22]
Klassen 2020	1	25	1	50	11.2%	0.02 [-0.07, 0.11]
Kuys 2011	4	15	3	15	0.9%	0.07 [-0.24, 0.37]
Lee 2012	0	20	0	20	9.8%	0.00 [-0.09, 0.09]
Park 2011	1	14	1	13	2.1%	-0.01 [-0.20, 0.19]
Park 2014	1	11	1	11	1.4%	0.00 [-0.24, 0.24]
Peurala 2009	6	43	3	13	1.3%	-0.09 [-0.34, 0.16]
Rodgers 2019	31	516	31	244	38.4%	-0.07 [-0.11, -0.02]
Ross 2009	0	18	2	17	2.7%	-0.12 [-0.29, 0.06]
Taravati 2021	5	22	3	23	1.7%	0.10 [-0.13, 0.32]
Total (95% CI)		**827**		**535**	**100.0%**	**-0.03 [-0.06, -0.00]**
Total events	59		59			

Heterogeneity: Tau² = 0.00; Chi² = 11.38, df = 15 (P = 0.73); I² = 0%

Test for overall effect: Z = 2.29 (P = 0.02)

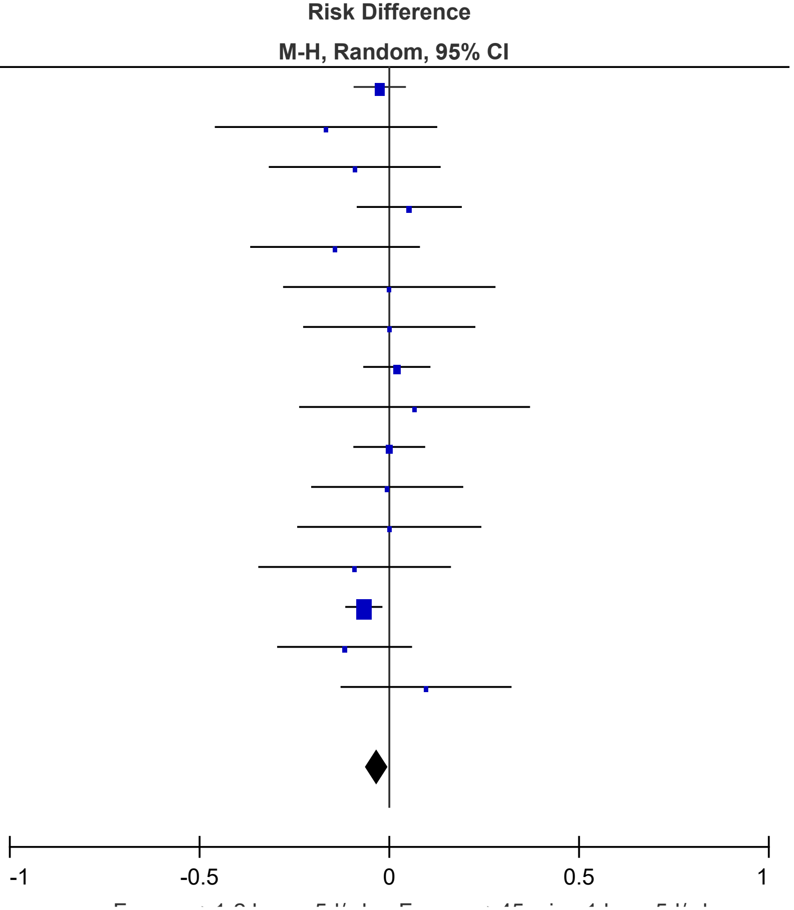
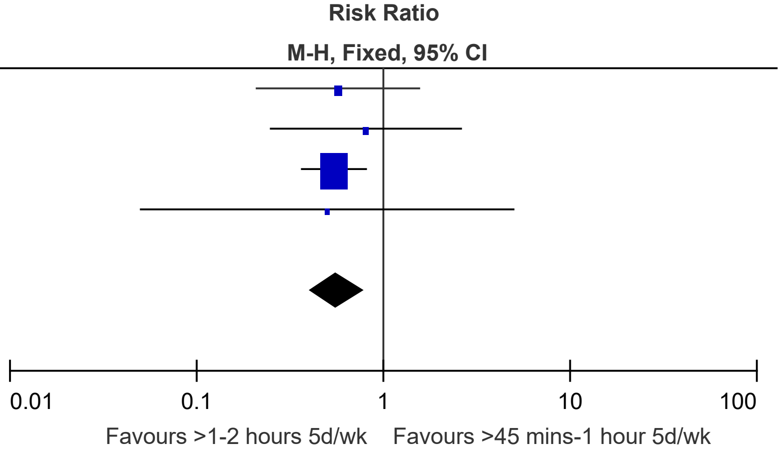


Figure 107: Discontinuation from study at ≥6 months

Study or Subgroup	>1-2 hours 5d/wk Events	>1-2 hours 5d/wk Total	>45 mins-1 hour 5d/wk Events	>45 mins-1 hour 5d/wk Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Klassen 2020	4	25	14	50	13.3%	0.57 [0.21, 1.56]
Peurala 2009	8	43	3	13	6.6%	0.81 [0.25, 2.61]
Rodgers 2019	46	516	40	244	77.3%	0.54 [0.37, 0.81]
Wall 2020	1	16	2	16	2.8%	0.50 [0.05, 4.98]
Total (95% CI)		**600**		**323**	**100.0%**	**0.56 [0.40, 0.80]**
Total events	59		59			

Heterogeneity: Chi² = 0.40, df = 3 (P = 0.94); I² = 0%

Test for overall effect: Z = 3.24 (P = 0.001)



G.1.20 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Figure 108: Person/participant health-related quality of life (Stroke Impact Scale - Mobility subscale, 0-100, higher values are better, final value) at ≥6 months

Study or Subgroup	>1-2 hours 6d/wk Mean	>1-2 hours 6d/wk SD	>1-2 hours 6d/wk Total	>45 mins-1 hour 5d/wk Mean	>45 mins-1 hour 5d/wk SD	>45 mins-1 hour 5d/wk Total	Mean Difference IV, Fixed, 95% CI
Askim 2010	81	18.1	30	79.5	21.1	32	1.50 [-8.27, 11.27]

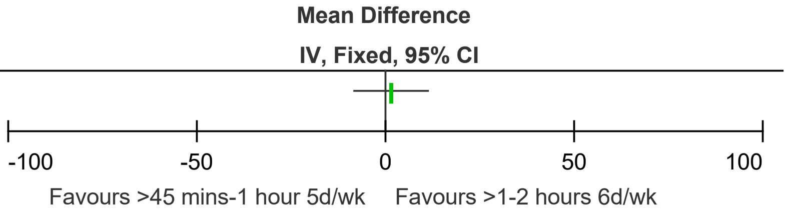


Figure 109: Person/participant health-related quality of life (Stroke Impact Scale - Recovery subscale, 0-100, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Askim 2010	66	17.1	30	63.1	21.1	32	2.90 [-6.63, 12.43]	

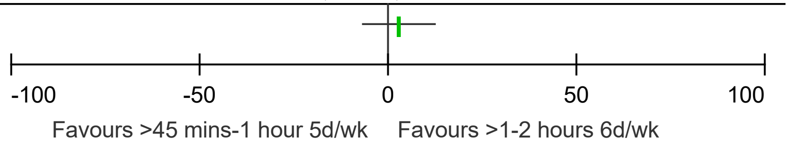


Figure 110: Activities of daily living (Barthel index, 0-100, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Askim 2010	92.5	9.7	30	91.4	16.9	32	1.10 [-5.71, 7.91]	

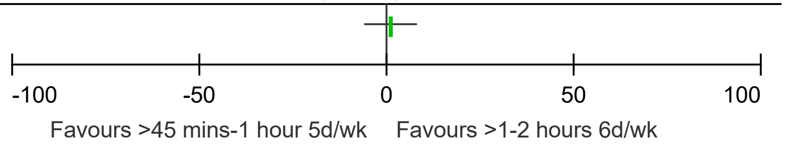


Figure 111: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Askim 2010	46.9	10.6	30	45.1	11.6	32	1.80 [-3.73, 7.33]	

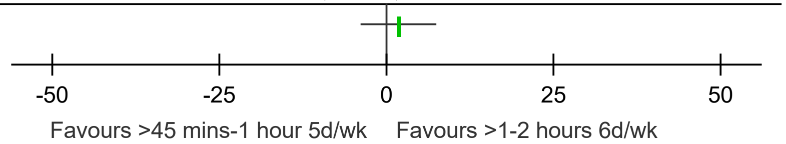
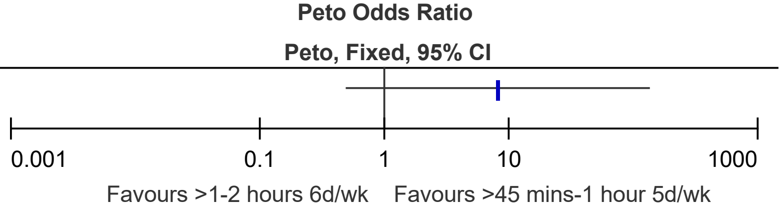


Figure 112: Discontinuation from study at ≥6 months

	>1-2 hours 6d/wk		>45 mins-1 hour 5d/wk		Peto Odds Ratio
Study or Subgroup	Events	Total	Events	Total	Peto, Fixed, 95% CI
Askim 2010	2	30	0	32	8.18 [0.50, 133.94]



G.1.21 Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week compared to >45 minutes to 1 hour, 6 days a week for people after a first or recurrent stroke

Figure 113: Person/participant health-related quality of life (Stroke Impact Scale - Strength subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Valkenborghs 2019	32.8	10.9	9	45	20.5	9	-12.20 [-27.37, 2.97]

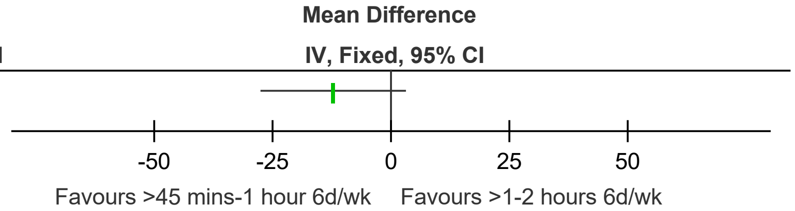


Figure 114: Person/participant health-related quality of life (Stroke Impact Scale - Memory subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Valkenborghs 2019	65.7	12.7	9	61.8	15.6	9	3.90 [-9.24, 17.04]

Mean Difference
IV, Fixed, 95% CI

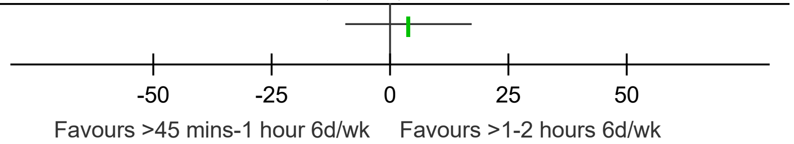


Figure 115: Person/participant health-related quality of life (Stroke Impact Scale - Mood subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Valkenborghs 2019	53.6	18.2	9	58.4	11.9	9	-4.80 [-19.01, 9.41]

Mean Difference
IV, Fixed, 95% CI

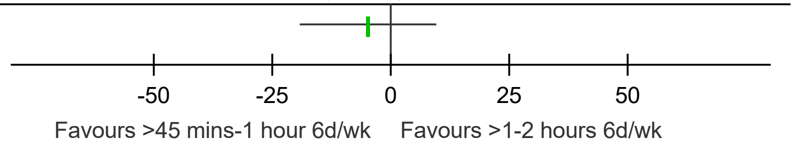


Figure 116: Person/participant health-related quality of life (Stroke Impact Scale - Communication subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Valkenborghs 2019	59.4	21.2	9	58.7	18.7	9	0.70 [-17.77, 19.17]

Mean Difference
IV, Fixed, 95% CI

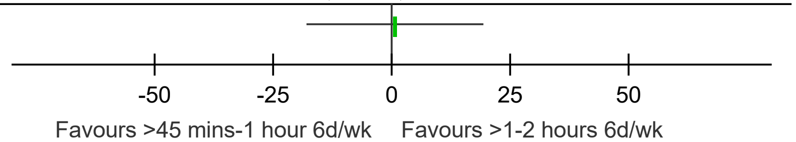


Figure 117: Person/participant health-related quality of life (Stroke Impact Scale - Activities of daily living subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Valkenborghs 2019	49.6	12	9	58.6	17.3	9	-9.00 [-22.76, 4.76]

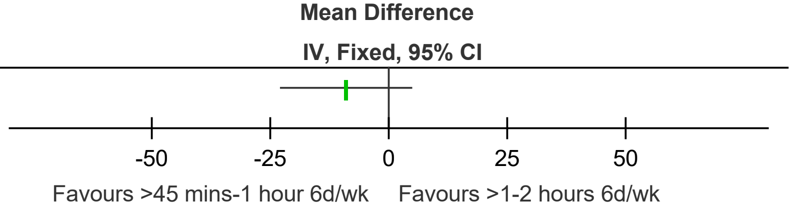


Figure 118: Person/participant health-related quality of life (Stroke Impact Scale - Mobility subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Valkenborghs 2019	59	15.1	9	63.8	11.9	9	-4.80 [-17.36, 7.76]

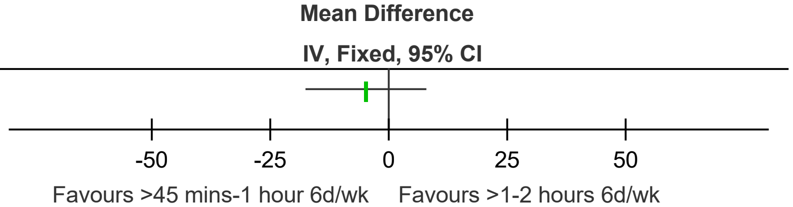


Figure 119: Person/participant health-related quality of life (Stroke Impact Scale - Hand use subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Valkenborghs 2019	18.7	26.6	9	24	23.6	9	-5.30 [-28.53, 17.93]	

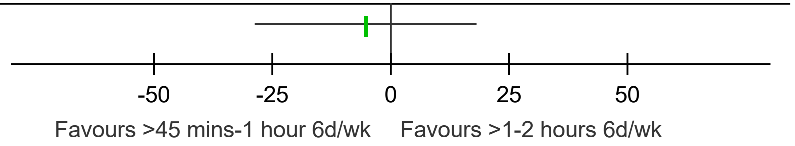


Figure 120: Person/participant health-related quality of life (Stroke Impact Scale - Activities subscale, 0-80, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Valkenborghs 2019	37.5	16.4	9	55	17.7	9	-17.50 [-33.26, -1.74]	

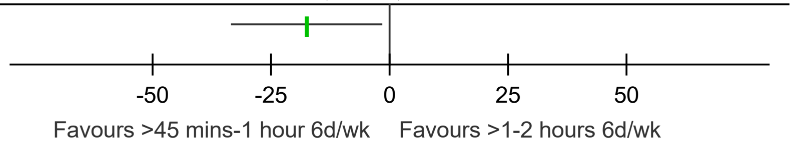


Figure 121: Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at ≥6 months

	>1-2 hours 6d/wk			>45 mins-1 hour 6d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Valkenborghs 2019	11.8	14.3	9	14.8	19.7	9	-3.00 [-18.90, 12.90]	

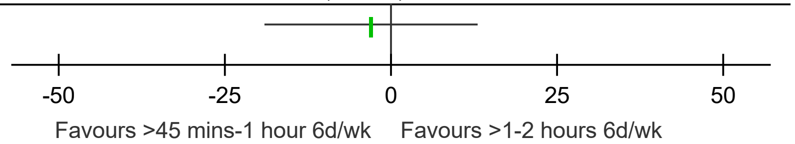
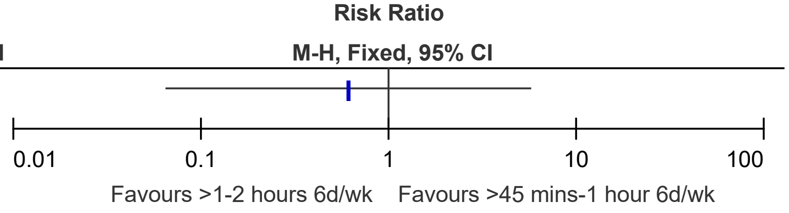


Figure 122: Discontinuation from study at ≥6 months

	>1-2 hours 6d/wk		>45 mins-1 hour 6d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Valkenborghs 2019	1	9	2	11	0.61 [0.07, 5.70]



G.1.22 Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Figure 123: Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at <6 months

	Favours ≤45 mins 5d/wk			≤45 mins 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Hunter 2011	9.8	12.8878	20	6.5	11.4952	19	3.30 [-4.36, 10.96]

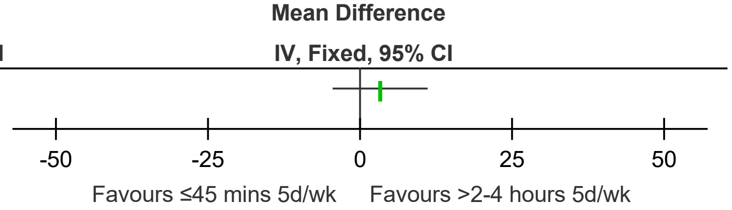
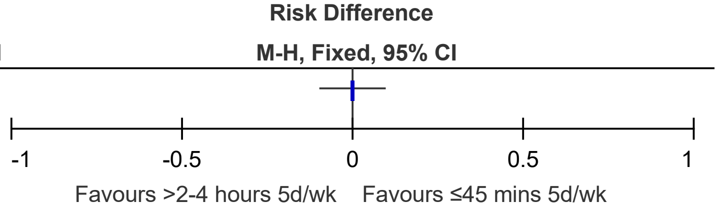


Figure 124: Discontinuation from study at <6 months

	>2-4 hours 5d/wk		≤45 mins 5d/wk		Risk Difference
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Hunter 2011	0	20	0	19	0.00 [-0.09, 0.09]



G.1.23 Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Figure 125: Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at <6 months

	>2-4 hours 5d/wk			>45 min-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Han 2013	89.5	6.85	10	85	11.79	10	46.9%	0.45 [-0.44, 1.34]
Huseyinsinoglu 2012	116.3	11.1	11	115.7	10.9	11	53.1%	0.05 [-0.78, 0.89]
Total (95% CI)			**21**			**21**	**100.0%**	**0.24 [-0.37, 0.85]**

Heterogeneity: Chi² = 0.40, df = 1 (P = 0.53); I² = 0%

Test for overall effect: Z = 0.76 (P = 0.45)

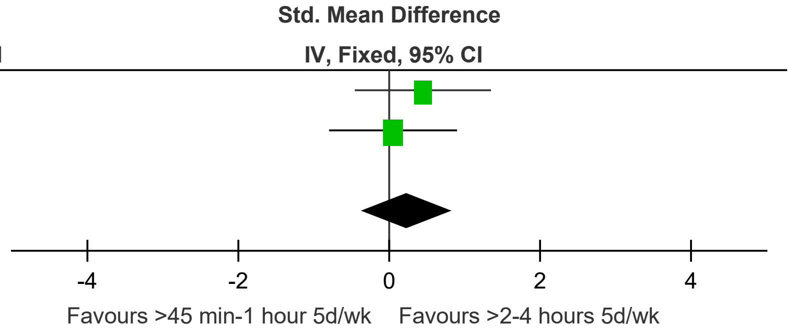


Figure 126: Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months

	>2-4 hours 5d/wk			>45 min-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**Weight**	**IV, Random, 95% CI**
Han 2013	24.5	7.96	10	13	6.38	10	44.8%	1.53 [0.50, 2.55]
Hunter 2011	9.8	12.8878	20	6.8	8.9528	18	55.2%	0.26 [-0.38, 0.90]
Total (95% CI)			**30**			**28**	**100.0%**	**0.83 [-0.40, 2.06]**

Heterogeneity: Tau² = 0.61; Chi² = 4.22, df = 1 (P = 0.04); I² = 76%

Test for overall effect: Z = 1.32 (P = 0.19)

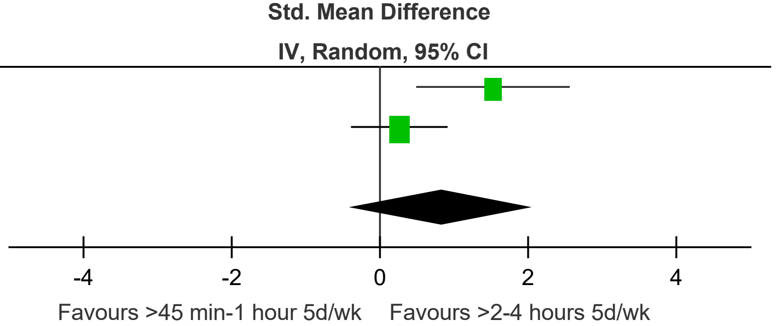


Figure 127: Physical function - lower limb (Wolf Motor Function Test Performance Time, 0-120 seconds, lower values are better, final values) at <6 months

	>2-4 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**IV, Fixed, 95% CI**
Huseyinsinoglu 2012	15.2	13.7	11	20.5	18	11	-5.30 [-18.67, 8.07]

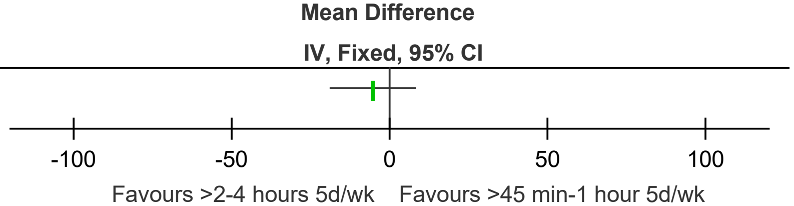
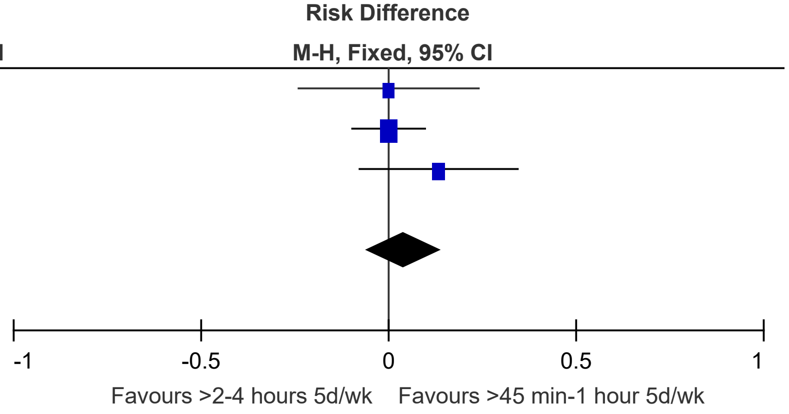


Figure 128: Discontinuation from study at <6 months

	>2-4 hours 5d/wk		>45 min-1 hour 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Han 2013	1	11	1	11	25.8%	0.00 [-0.24, 0.24]
Hunter 2011	0	20	0	18	44.4%	0.00 [-0.10, 0.10]
Huseyinsinoglu 2012	2	15	0	11	29.8%	0.13 [-0.08, 0.34]
Total (95% CI)		**46**		**40**	**100.0%**	**0.04 [-0.06, 0.14]**
Total events	3		1			

Heterogeneity: Chi² = 1.50, df = 2 (P = 0.47); I^2 = 0%

Test for overall effect: Z = 0.76 (P = 0.45)



G.1.24 Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Figure 129: Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Han 2013	89.5	6.85	10	88	10.33	10	32.1%	0.16 [-0.71, 1.04]
Ikizler May 2020	107.4	13.3	21	74.3	22.5	21	34.6%	1.76 [1.03, 2.48]
Yoon 2014	62.94	14.21	17	57.44	26.35	9	33.2%	0.28 [-0.53, 1.09]
Total (95% CI)			**48**			**40**	**100.0%**	**0.75 [-0.30, 1.81]**

Heterogeneity: Tau² = 0.70; Chi² = 10.31, df = 2 (P = 0.006); I² = 81%

Test for overall effect: Z = 1.41 (P = 0.16)

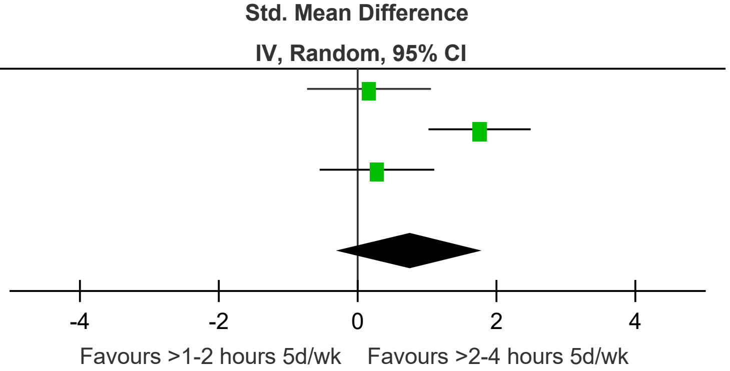


Figure 130: Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Han 2013	24.5	7.96	10	19.7	7.09	10	24.0%	0.61 [-0.29, 1.51]
Hunter 2011	9.8	12.8878	20	6.6	11.4818	18	47.7%	0.26 [-0.38, 0.90]
Yoon 2014	50.35	19.99	17	37	21.06	9	28.3%	0.64 [-0.19, 1.46]
Total (95% CI)			**47**			**37**	**100.0%**	**0.45 [0.01, 0.89]**

Heterogeneity: Chi² = 0.67, df = 2 (P = 0.72); I² = 0%

Test for overall effect: Z = 1.99 (P = 0.05)

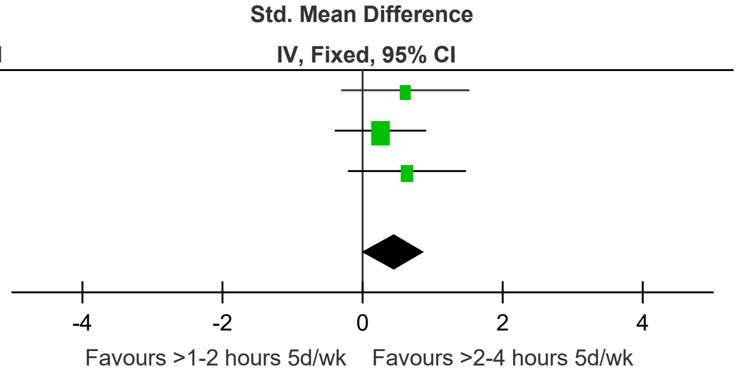


Figure 131: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final values) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Ikizler May 2020	39.5	11.2	21	15.9	14.3	21	23.60 [15.83, 31.37]

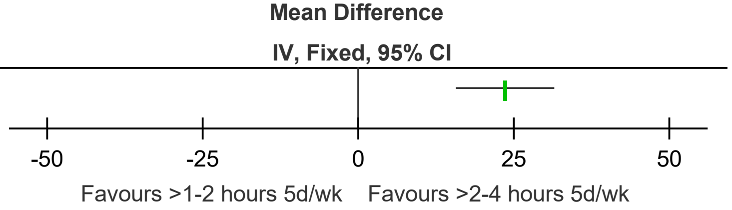
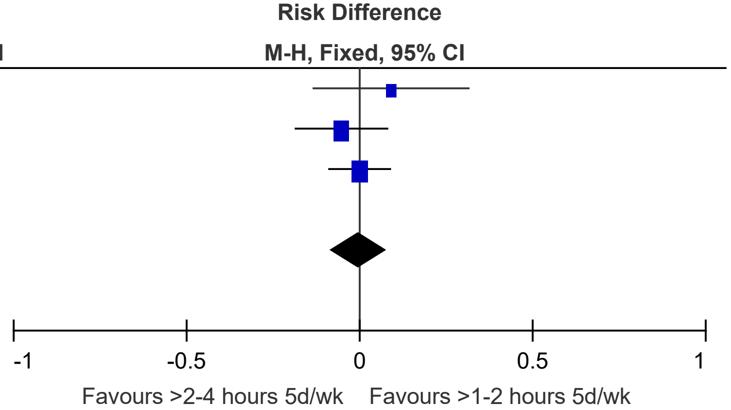


Figure 132: Discontinuation from study at <6 months

	>2-4 hours 5d/wk		>1-2 hours 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Han 2013	1	11	0	10	20.6%	0.09 [-0.13, 0.31]
Hunter 2011	0	20	1	19	38.2%	-0.05 [-0.19, 0.08]
Ikizler May 2020	0	21	0	21	41.2%	0.00 [-0.09, 0.09]
Total (95% CI)		**52**		**50**	**100.0%**	**-0.00 [-0.08, 0.08]**
Total events	1		1			

Heterogeneity: Chi² = 1.23, df = 2 (P = 0.54); I² = 0%

Test for overall effect: Z = 0.03 (P = 0.97)



G.1.25 Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 6 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Figure 133: Physical Function - upper limb (Action Research Arm Test, 0-57, higher values are better, change score) at <6 months

	>2-4 hours 6d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Harris 2009	11.7	10.5212	53	7	10.5561	50	4.70 [0.63, 8.77]

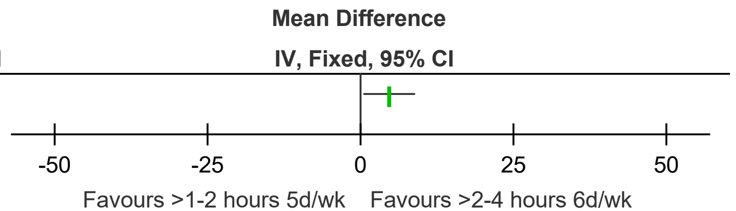
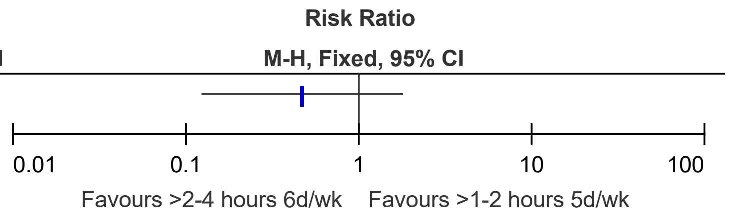


Figure 134: Discontinuation of study at <6 months

	>2-4 hours 6d/wk		>1-2 hours 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Harris 2009	3	53	6	50	0.47 [0.12, 1.79]



G.1.26 Physiotherapy (no communication difficulties) - >4 hours, 5 days a week compared to usual care for people after a first or recurrent stroke

Figure 135: Person/participant health-related quality of life (Stroke impact scale hand function, scale range unclear, higher values are better, change score) at ≥6 months

Study or Subgroup	Mean Difference	SE	>4 hours 5d/wk Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
Wolf 2006	0.3	0.1327	106	116	0.30 [0.04, 0.56]

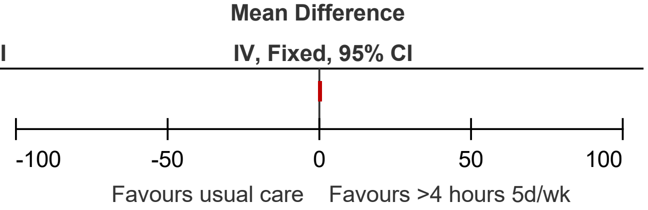


Figure 136: Person/participant health-related quality of life (Stroke impact scale physical function, scale range unclear, higher values are better, change score) at ≥6 months

Study or Subgroup	Mean Difference	SE	>4 hours 5d/wk Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
Wolf 2006	7.04	3.898	106	116	7.04 [-0.60, 14.68]

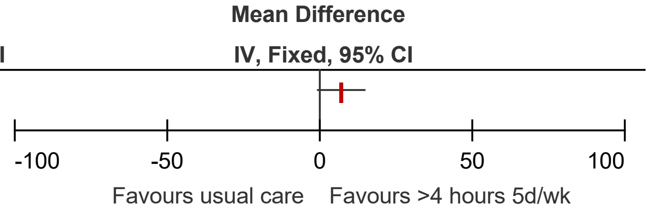


Figure 137: Physical function - lower limb (Wolf Motor Function Test Log Performance Time, higher values are better, change score) at ≥6 months

Study or Subgroup	Mean Difference	SE	>4 hours 5d/wk Total	Usual care Total	Mean Difference IV, Fixed, 95% CI
Wolf 2006	1.14	3.0613	106	116	1.14 [-4.86, 7.14]

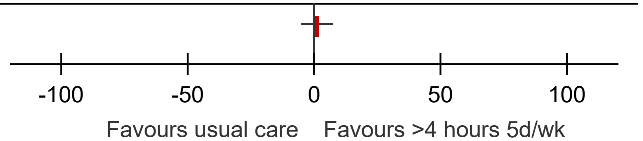


Figure 138: Discontinuation from study at <6 months

Study or Subgroup	>4 hours 5d/wk Events	>4 hours 5d/wk Total	Usual care Events	Usual care Total	Risk Ratio M-H, Fixed, 95% CI
Wolf 2006	8	106	11	116	0.80 [0.33, 1.90]

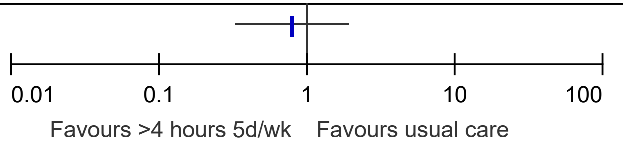
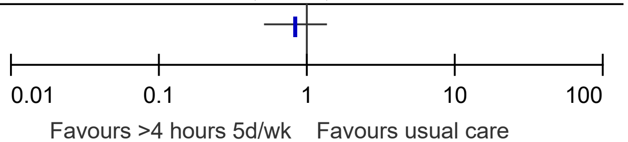


Figure 139: Discontinuation from study at ≥6 months

Study or Subgroup	>4 hours 5d/wk Events	>4 hours 5d/wk Total	Usual care Events	Usual care Total	Risk Ratio M-H, Fixed, 95% CI
Wolf 2006	23	106	30	116	0.84 [0.52, 1.35]



G.1.27 Physiotherapy (no communication difficulties) - >4 hours, 5 days a week compared to >2 hours to 4 hours, 5 days a week for people after a first or recurrent stroke

Figure 140: Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-66, higher values are better, final value) at <6 months

	>4 hours 5d/wk			>2-4 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Yadav 2016	50.57	4.97	30	46.93	3.41	30	3.64 [1.48, 5.80]

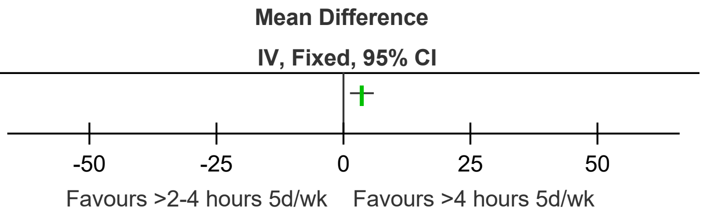
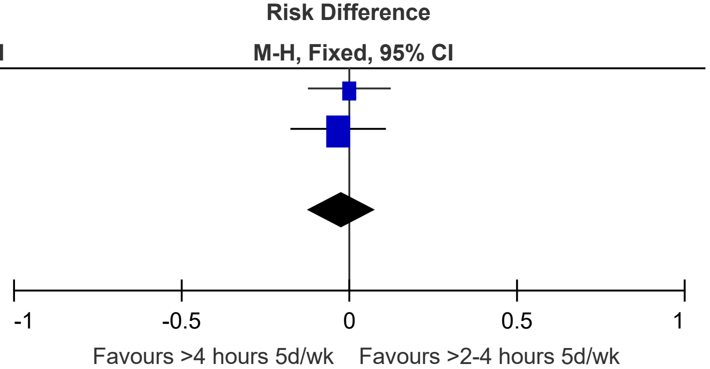


Figure 141: Discontinuation from study at <6 months

	>4 hours 5d/wk		>2-4 hours 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Pervane Vural 2016	0	15	0	15	33.3%	0.00 [-0.12, 0.12]
Yadav 2016	2	30	3	30	66.7%	-0.03 [-0.17, 0.11]
Total (95% CI)		**45**		**45**	**100.0%**	**-0.02 [-0.12, 0.08]**
Total events	2		3			

Heterogeneity: Chi² = 0.15, df = 1 (P = 0.69); I² = 0%

Test for overall effect: Z = 0.43 (P = 0.67)



G.2 Occupational Therapy

G.2.1 Occupational therapy (no communication difficulties) - ≤45 minutes, <5 days a week compared to usual care for people after a first or recurrent stroke

Figure 142: Person/participant health-related quality of life (Stroke Impact Scale total, 0-100, higher values are better, final value) at <6 months

	≤45 min <5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Norouzi-Gheidari 2019	75.8	14	9	73.5	14.7	9	2.30 [-10.96, 15.56]

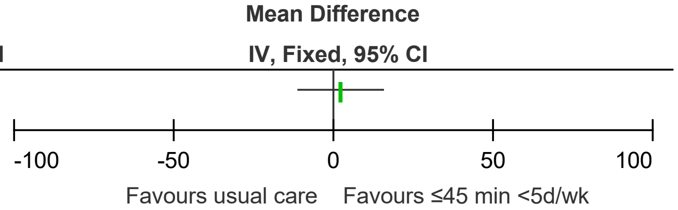


Figure 143: Physical function - upper limb (Fugl Meyer Assessment - Upper Extremity, 0-66, higher values are better, final value) at <6 months

	≤45 min <5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Norouzi-Gheidari 2019	47.2	14.7	9	47.6	13.3	9	-0.40 [-13.35, 12.55]

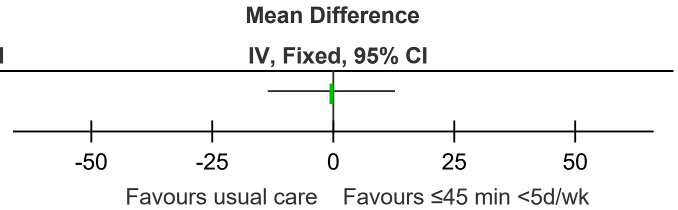


Figure 144: Discontinuation from study at <6 months

	≤45 min <5 d/wk		Usual care		Risk Ratio	Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Gilbertson 2000	3	67	2	71	1.59 [0.27, 9.22]	

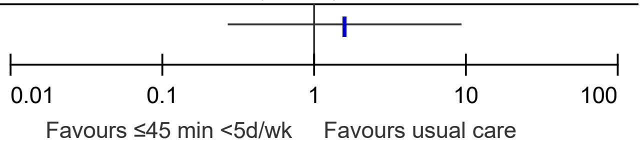
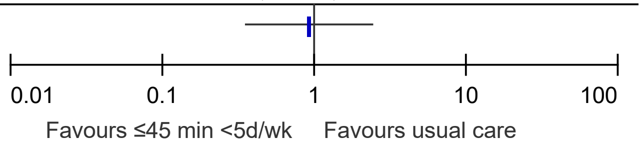


Figure 145: Discontinuation from study at ≥6 months

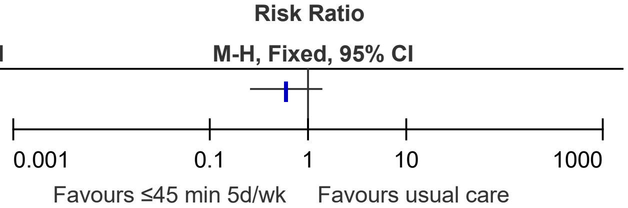
	≤45 min <5 d/wk		Usual care		Risk Ratio	Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Gilbertson 2000	7	67	8	71	0.93 [0.36, 2.42]	



G.2.2 Occupational therapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Figure 146: Discontinuation from study at <6 months

	≤45 min 5 d/wk		Usual care		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Mudie 2002	9	30	5	10	0.60 [0.26, 1.37]



G.2.3 Occupational therapy (communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Figure 147: Activities of daily living (Korean Shoulder Disability Questionnaire, 0-100, lower values are better, final values) at <6 months

	≤45 min 5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kim 2019	65	6	18	82	10	18	-17.00 [-22.39, -11.61]

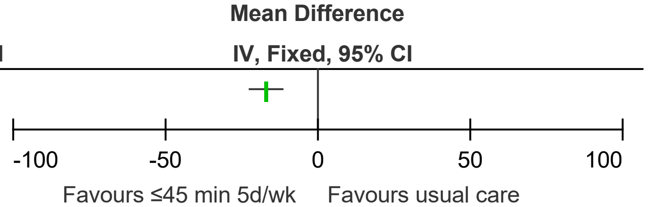
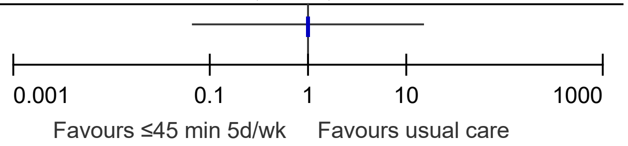


Figure 148: Discontinuation from study at <6 months

Study or Subgroup	≤45 min 5 d/wk Events	≤45 min 5 d/wk Total	Usual care Events	Usual care Total	Risk Ratio M-H, Fixed, 95% CI
Kim 2019	1	19	1	19	1.00 [0.07, 14.85]



G.2.4 Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 149: Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months

Study or Subgroup	>45 min-1 hour <5d/wk Mean	>45 min-1 hour <5d/wk SD	>45 min-1 hour <5d/wk Total	≤45 min <5 d/wk Mean	≤45 min <5 d/wk SD	≤45 min <5 d/wk Total	Mean Difference IV, Fixed, 95% CI
Lee 2013	71.42	15	7	61.24	11.93	7	10.18 [-4.02, 24.38]

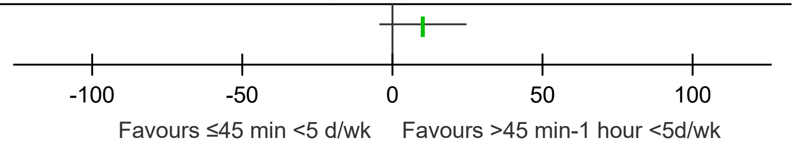


Figure 150: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months

	>45 min-1 hour <5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Sin 2013	10.89	6.31	18	6.53	2.6	17	4.36 [1.19, 7.53]

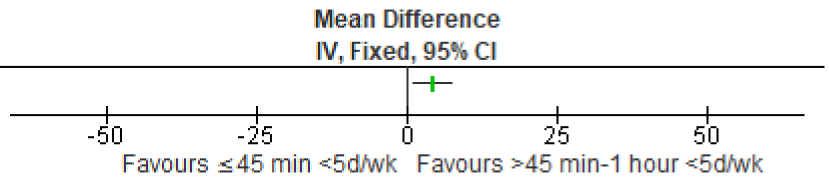
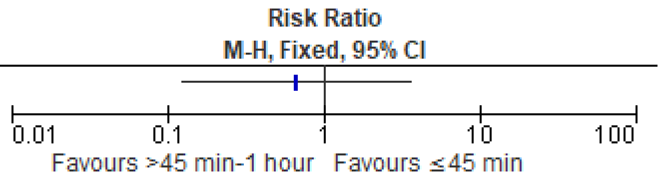


Figure 151: Discontinuation from study at <6 months

	>45 min-1 hour <5d/wk		≤45 min <5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Sin 2013	2	20	3	20	0.67 [0.12, 3.57]



G.2.5 Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 152: Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months

	>45 min-1 hour 5d/wk			≤45 min <5 d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Masiero 2007	44.2	12.1	17	29.7	14.5	18	14.50 [5.67, 23.33]	

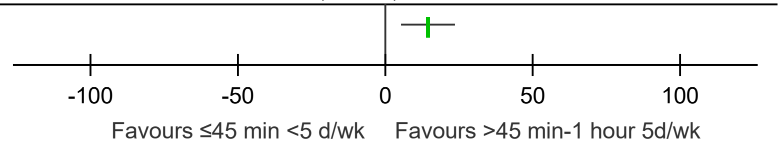


Figure 153: Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min <5 d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Masiero 2007	46.2	10.4	17	31.8	14.6	18	14.40 [6.04, 22.76]	

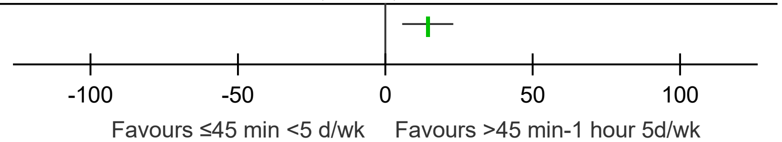


Figure 154: Physical function - upper limb (Fugl Meyer Assessment - Shoulder/elbow and coordination subsections, 0-42, higher values are better, final value) at <6 months

	>45 min-1 hour 5d/wk			≤45 min <5 d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Masiero 2007	18.8	6.4	17	8.9	8.3	18	9.90 [5.01, 14.79]	

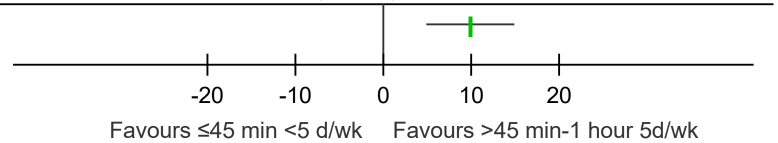


Figure 155: Physical function - upper limb (Fugl Meyer Assessment - Shoulder/elbow and coordination subsections, 0-42, higher values are better, final value) at ≥6 months

Study or Subgroup	>45 min-1 hour 5d/wk Mean	SD	Total	≤45 min <5 d/wk Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Masiero 2007	20	7.8	17	10.5	13.1	18	9.50 [2.40, 16.60]

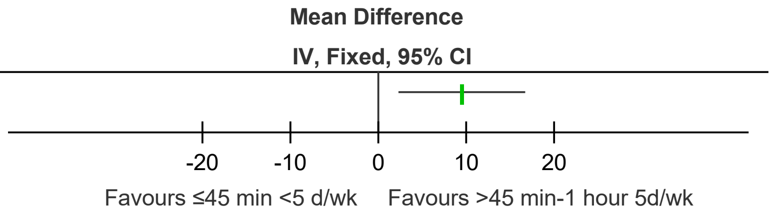


Figure 156: Physical function - upper limb (Fugl Meyer Assessment - Wrist/hand subsections, 0-24, higher values are better, final value) at <6 months

Study or Subgroup	>45 min-1 hour 5d/wk Mean	SD	Total	≤45 min <5 d/wk Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Masiero 2007	5.8	3.1	17	6.1	3.1	18	-0.30 [-2.35, 1.75]

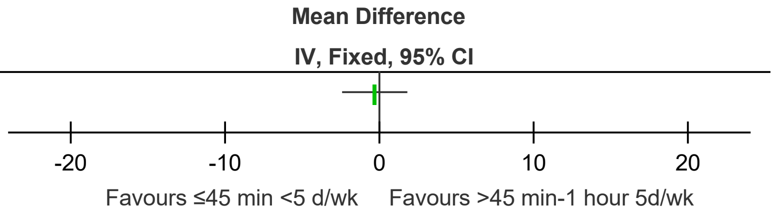
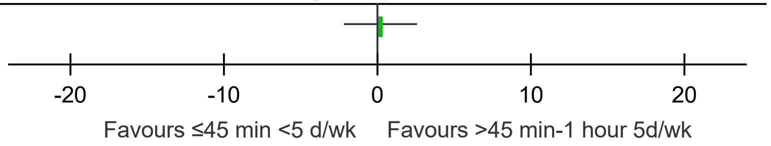


Figure 157: Physical function - upper limb (Fugl Meyer Assessment - Wrist/hand subsections, 0-24, higher values are better, final value) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Masiero 2007	6	3.2	17	5.8	3.8	18	0.20 [-2.12, 2.52]



G.2.6 Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Figure 158: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Guo 2019	20.38	3.5	60	17.23	3.91	30	50.9%	3.15 [1.49, 4.81]
Page 2012	1.3	2.2	8	1.6	2.3	16	49.1%	-0.30 [-2.20, 1.60]
Total (95% CI)			**68**			**46**	**100.0%**	**1.46 [-1.92, 4.84]**

Heterogeneity: Tau² = 5.13; Chi² = 7.22, df = 1 (P = 0.007); I² = 86%

Test for overall effect: Z = 0.84 (P = 0.40)

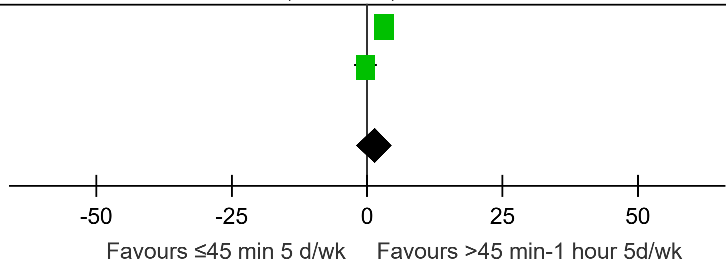


Figure 159: Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Guo 2019	25.98	4.37	60	19.46	2.87	30	6.52 [5.01, 8.03]

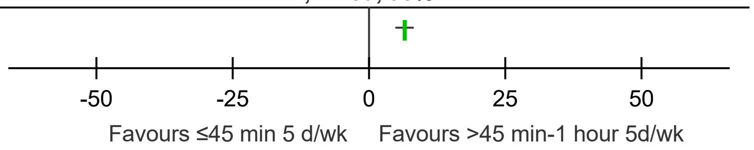


Figure 160: Swallow function and ability (Penetration Aspiration Scale, 1-8, lower values are better, change score) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Moon 2017	-2.67	0.87	9	-1.11	1.05	9	-1.56 [-2.45, -0.67]

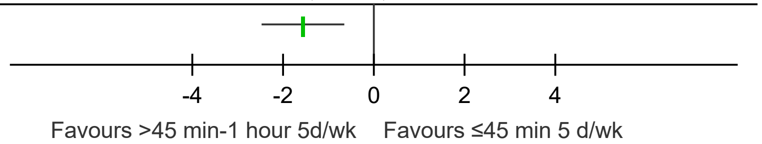


Figure 161: Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk			Risk Difference
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**
Guo 2019	0	60	0	30	81.6%	0.00 [-0.05, 0.05]
Moon 2017	0	9	0	9	18.4%	0.00 [-0.19, 0.19]
Total (95% CI)		**69**		**39**	**100.0%**	**0.00 [-0.06, 0.06]**
Total events	0		0			

Heterogeneity: Chi² = 0.00, df = 1 (P = 1.00); I² = 0%

Test for overall effect: Z = 0.00 (P = 1.00)

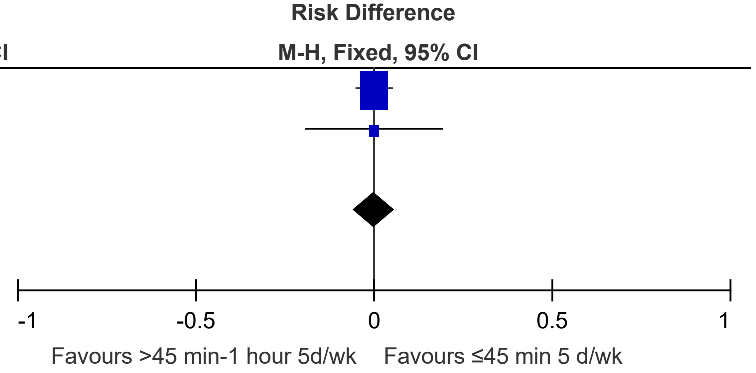
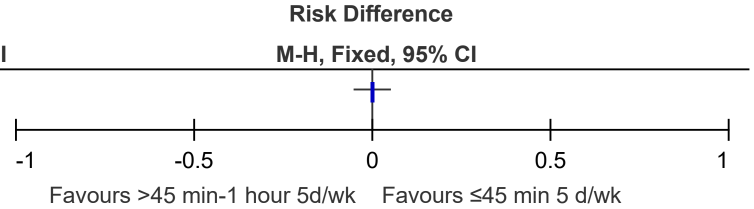


Figure 162: Discontinuation from study at ≥6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk		Risk Difference
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**M-H, Fixed, 95% CI**
Guo 2019	0	60	0	30	0.00 [-0.05, 0.05]



G.2.7 Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 163: Person/participant health-related quality of life (Stroke Impact Scale-16, 0-100, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
de Diego 2013	9.83	1.91	12	0.25	3.12	9	9.58 [7.27, 11.89]

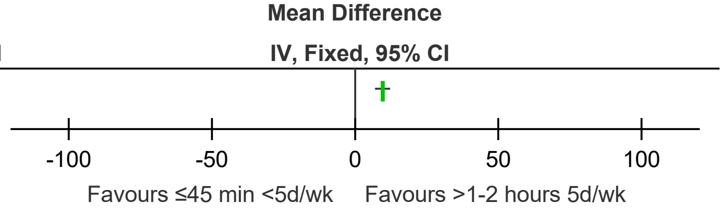
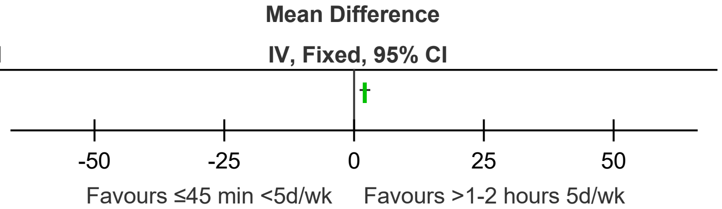


Figure 164: Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-66, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
de Diego 2013	5.1	1.1	12	3	0.85	9	2.10 [1.27, 2.93]



G.2.8 Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Figure 165: Person/participant health-related quality of life (stroke-specific quality of life, 49-245, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 mins 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kang 2012	147.7	22.9	25	144.5	24.7	25	3.20 [-10.00, 16.40]

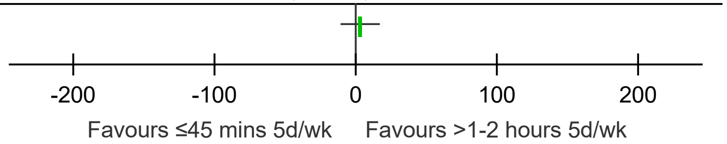


Figure 166: Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 mins 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kang 2012	74.2	7.5	25	72.9	9.9	25	1.30 [-3.57, 6.17]

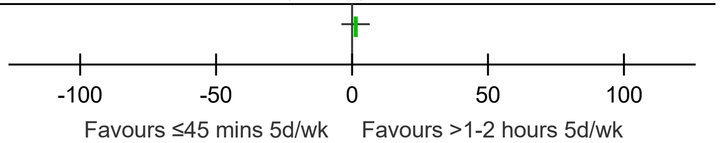


Figure 167: Physical function - upper limb (Fugl-Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			≤45 mins 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Page 2012	4.1	2.9	8	1.6	2.3	16	2.50 [0.20, 4.80]

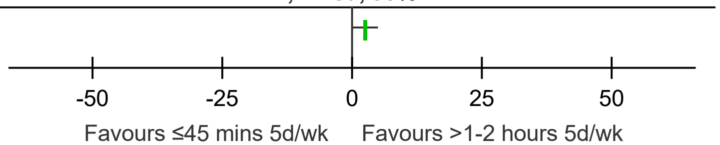


Figure 168: Psychological distress - depression (Beck Depression Inventory, 0-63, lower values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 mins 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kang 2012	26.8	6	25	29.2	4.2	25	-2.40 [-5.27, 0.47]

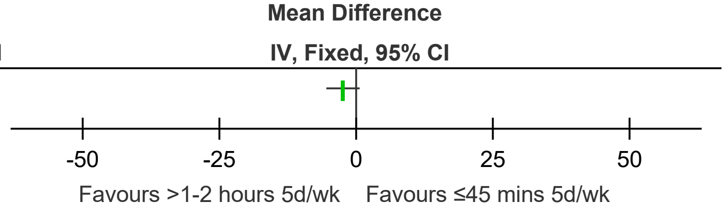


Figure 169: Swallow function and ability (Functional Oral Intake Scale, 1-7, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			≤45 mins 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kang 2012	4.6	1	25	3.6	1.2	25	1.00 [0.39, 1.61]

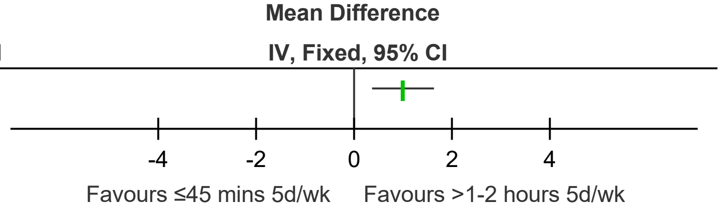
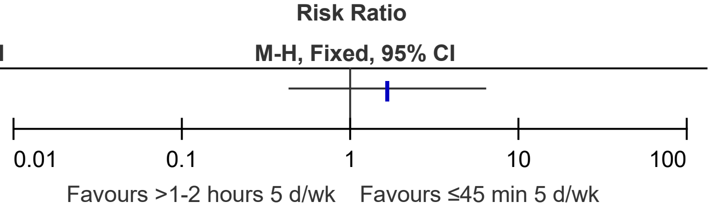


Figure 170: Discontinuation from study at <6 months

	>1-2 hours 5 d/wk		≤45 min 5 d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Long 2020	5	30	3	30	1.67 [0.44, 6.36]



G.2.9 Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Figure 171: Person/participant health-related quality of life (Stroke Impact Scale - Upper Limb Items, 5-25, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kong 2016	12.3	8.2	70	13.5	6.9	35	-1.20 [-4.19, 1.79]

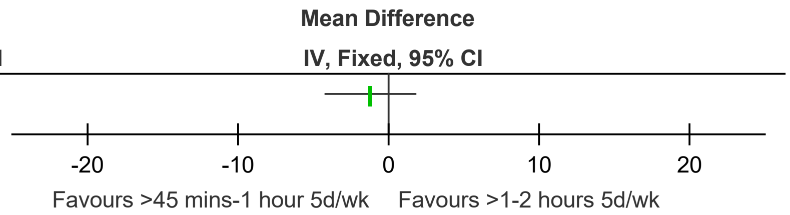


Figure 172: Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kong 2016	106.1	22	70	113.4	16.6	35	-7.30 [-14.84, 0.24]

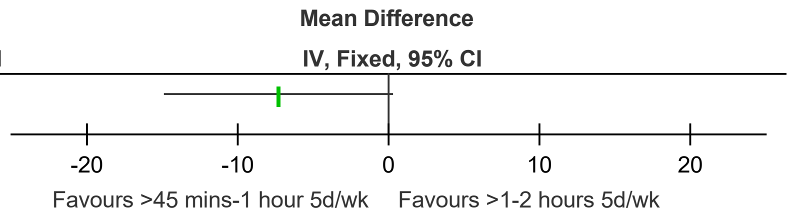


Figure 173: Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, change score and final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Kong 2016	38.7	20.2	70	41.6	18.1	35	29.2%	-2.90 [-10.54, 4.74]
Page 2012	4.1	2.9	8	1.3	2.2	8	70.8%	2.80 [0.28, 5.32]
Total (95% CI)			**78**			**43**	**100.0%**	**1.14 [-3.94, 6.22]**

Heterogeneity: Tau² = 7.82; Chi² = 1.93, df = 1 (P = 0.16); I² = 48%
Test for overall effect: Z = 0.44 (P = 0.66)

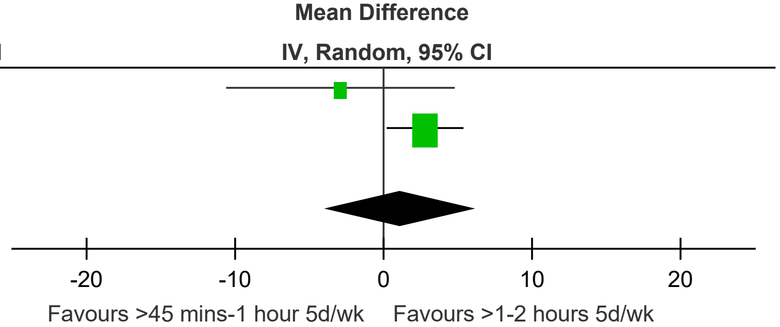


Figure 174: Physical function - upper limb (Motor Assessment Scale, 0-18, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Horsley 2019	4.4	5.4	23	3.1	4.9	22	1.30 [-1.71, 4.31]

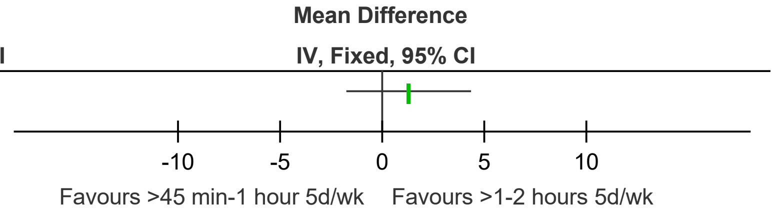


Figure 175: Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, change score and final value) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Cho 2012	4	1.18	11	2.81	0.4	11	98.9%	1.19 [0.45, 1.93]
Kim 2012	50.1	5.05	10	44.6	10.17	10	1.1%	5.50 [-1.54, 12.54]
Total (95% CI)			**21**			**21**	**100.0%**	**1.24 [0.50, 1.97]**

Heterogeneity: Chi² = 1.43, df = 1 (P = 0.23); I² = 30%
Test for overall effect: Z = 3.31 (P = 0.0009)

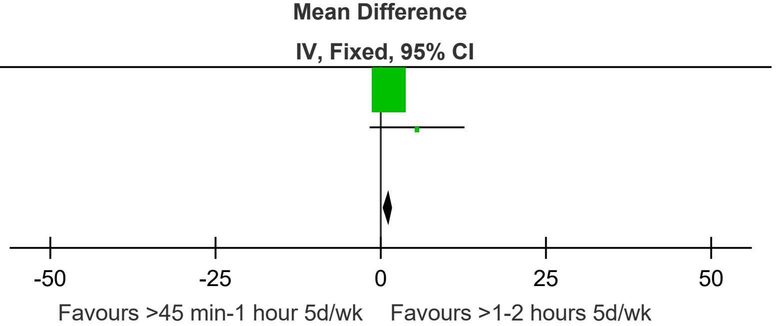
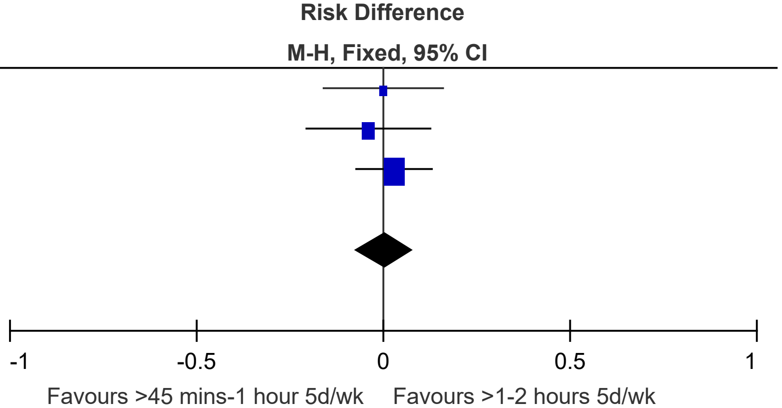


Figure 176: Discontinuation from study at <6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Cho 2012	0	11	0	11	13.3%	0.00 [-0.16, 0.16]
Horsley 2019	2	25	3	25	30.2%	-0.04 [-0.21, 0.13]
Kong 2016	6	70	2	35	56.5%	0.03 [-0.07, 0.13]
Total (95% CI)		**106**		**71**	**100.0%**	**0.00 [-0.08, 0.08]**
Total events	8		5			

Heterogeneity: Chi² = 0.50, df = 2 (P = 0.78); I² = 0%
Test for overall effect: Z = 0.10 (P = 0.92)



G.2.10 Occupational therapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Figure 177: Activities of daily living (Functional Independence Measure, 13-91, higher values are better, final value) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Dai 2013	76.21	23.08	24	65.17	21.55	24	0.49 [-0.09, 1.06]

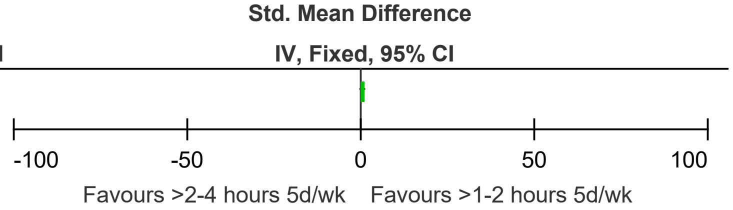


Figure 178: Physical function - lower limb (Postural outcome assessment scale, 0-36, higher values are better, final value) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Dai 2013	21.54	7.16	24	18.04	7.04	24	3.50 [-0.52, 7.52]

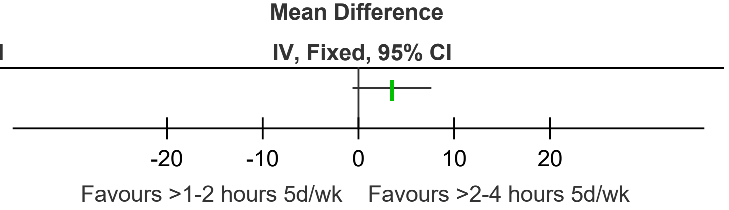


Figure 179: Stroke-related scale of cognition - spatial attention (Behavioural inattention test conventional, 0-146, higher values are better, final value) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Dai 2013	88.71	44.56	24	68.83	44.72	24	19.88 [-5.38, 45.14]

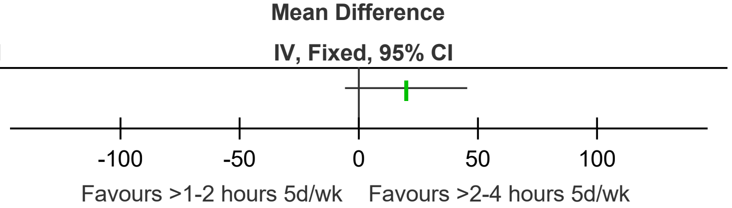
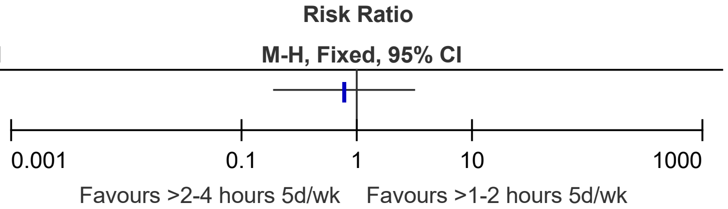


Figure 180: Discontinuation of study at <6 months

	>2-4 hours 5d/wk		>1-2 hours 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Dai 2013	3	27	4	28	0.78 [0.19, 3.16]



G.3 Speech and Language Therapy (individual patient data network meta-analysis results)

G.3.1 Speech and Language Therapy (communication difficulties) – 9+ hours per week compared to 4-9 hours per week for people after a first or recurrent stroke

Figure 181: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

Study or Subgroup	9+ hours per week Mean	SD	Total	4-9 hours per week Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Brady 2021	15.64	32.0799	96	12.22	27.0587	50	3.42 [-6.45, 13.29]

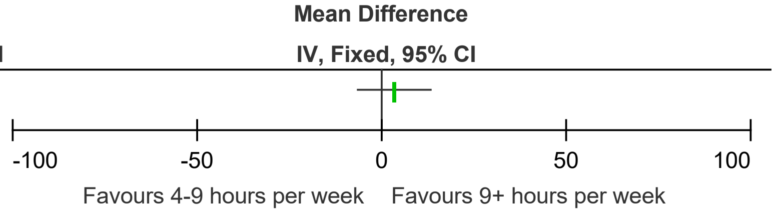


Figure 182: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

Study or Subgroup	9+ hours per week Mean	SD	Total	4-9 hours per week Mean	SD	Total	Mean Difference IV, Fixed, 95% CI
Brady 2021	2.87	20.5749	46	5.71	24.6801	41	-2.84 [-12.45, 6.77]

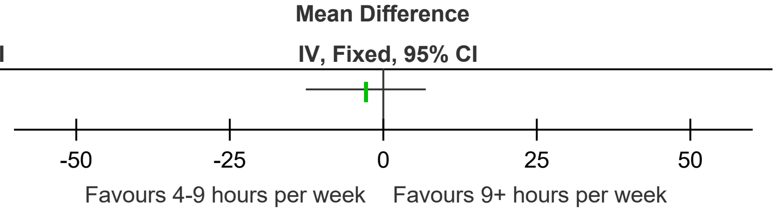


Figure 183: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			4-9 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	7.3	19.2795	141	2.47	17.6013	103	4.83 [0.17, 9.49]	

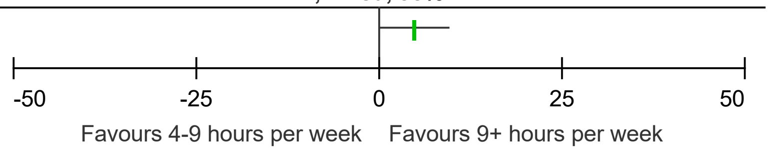
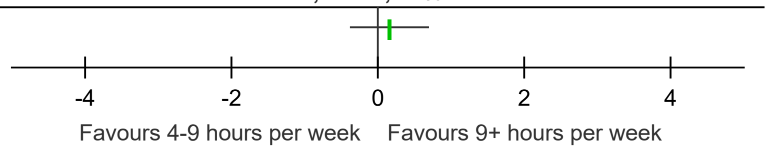


Figure 184: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			4-9 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	0.69	1.3936	60	0.53	1.5349	59	0.16 [-0.37, 0.69]	



G.3.2 Speech and Language Therapy (communication difficulties) – 9+ hours per week compared to 3-4 hours per week for people after a first or recurrent stroke

Figure 185: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			3-4 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	15.64	32.0799	96	15.8	35.7372	104	-0.16 [-9.56, 9.24]	

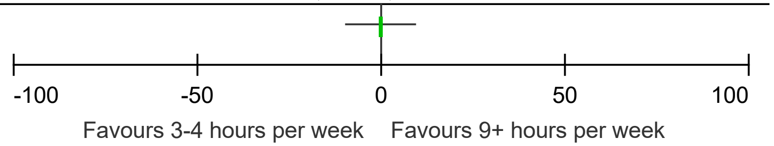


Figure 186: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			3-4 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	2.87	20.5749	46	9.7	39.8621	127	-6.83 [-15.96, 2.30]	

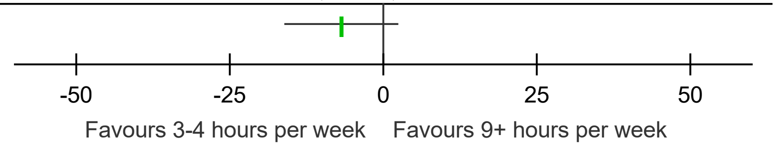


Figure 187: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			3-4 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	7.3	19.2795	141	6.01	26.5434	112	1.29 [-4.57, 7.15]

Mean Difference
IV, Fixed, 95% CI

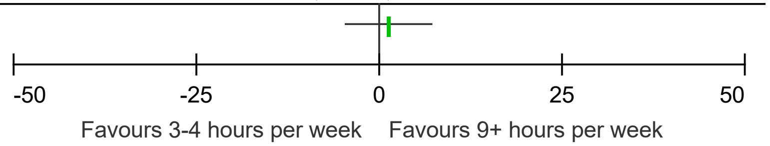
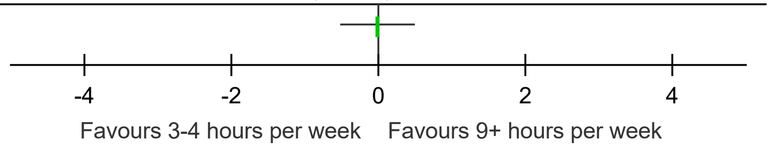


Figure 188: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			3-4 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.69	1.3936	60	0.7	2.3662	178	-0.01 [-0.51, 0.49]

Mean Difference
IV, Fixed, 95% CI



G.3.3 Speech and Language Therapy (communication difficulties) – 9+ hours per week compared to 2-3 hours per week for people after a first or recurrent stroke

Figure 189: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	15.64	32.0799	96	10.18	29.862	93	5.46 [-3.37, 14.29]

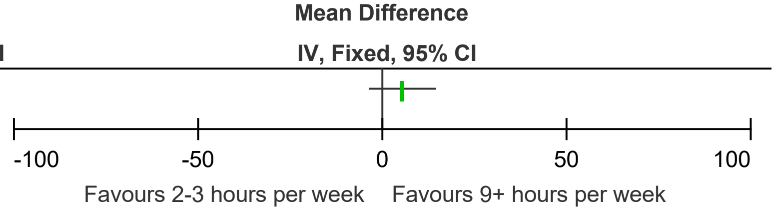


Figure 190: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	2.87	20.5749	46	6.05	30.9504	101	-3.18 [-11.65, 5.29]

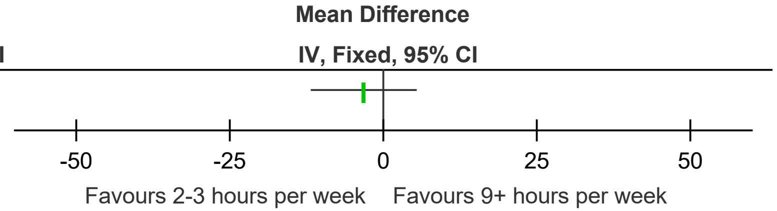


Figure 191: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			2-3 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	7.3	19.2795	141	0.32	18.9757	120	6.98 [2.33, 11.63]	

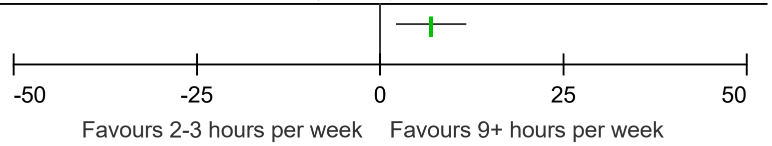
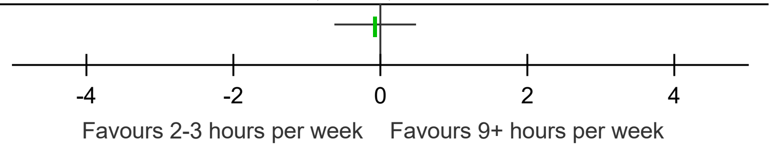


Figure 192: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			2-3 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	0.69	1.3936	60	0.76	1.8001	73	-0.07 [-0.61, 0.47]	



G.3.4 Speech and Language Therapy (communication difficulties) – 9+ hours per week compared to up to 2 hours per week for people after a first or recurrent stroke

Figure 193: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			Up to 2 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	15.64	32.0799	96	15.85	33.1506	72	-0.21 [-10.20, 9.78]	

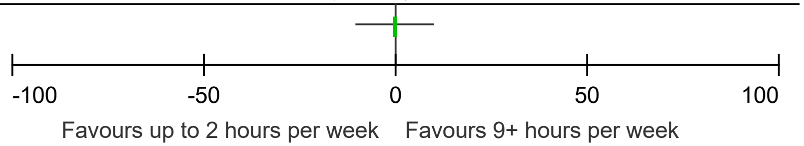


Figure 194: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			Up to 2 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	2.87	20.5749	46	13.83	16.0872	18	-10.96 [-20.48, -1.44]	

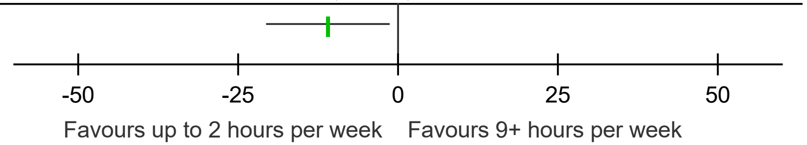


Figure 195: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	7.3	19.2795	141	6.5	9.9173	19	0.80 [-4.68, 6.28]

Mean Difference
IV, Fixed, 95% CI

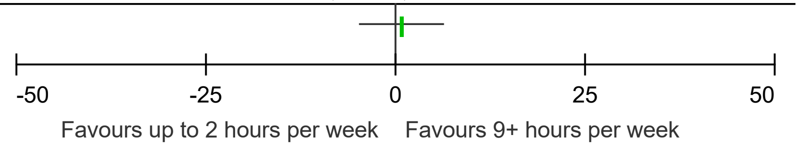
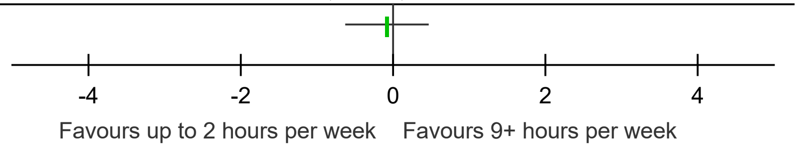


Figure 196: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	9+ hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.69	1.3936	60	0.77	1.8777	83	-0.08 [-0.62, 0.46]

Mean Difference
IV, Fixed, 95% CI



G.3.5 Speech and Language Therapy (communication difficulties) – 4-9 hours per week compared to 3-4 hours per week for people after a first or recurrent stroke

Figure 197: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			3-4 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	12.22	27.0587	50	15.8	35.7372	104	-3.58 [-13.75, 6.59]	

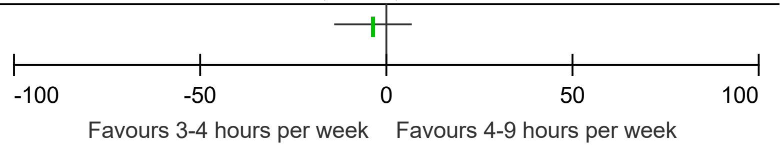


Figure 198: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			3-4 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	5.71	24.6801	41	9.7	39.8621	127	-3.99 [-14.24, 6.26]	

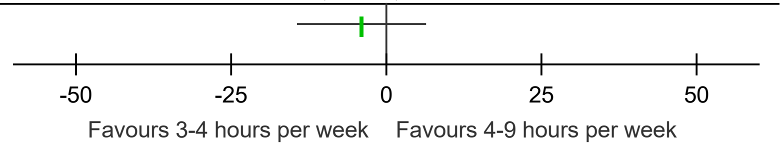


Figure 199: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			3-4 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	2.47	17.6013	103	6.01	26.5434	112	-3.54 [-9.52, 2.44]

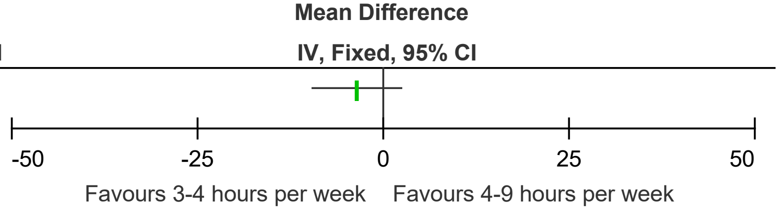
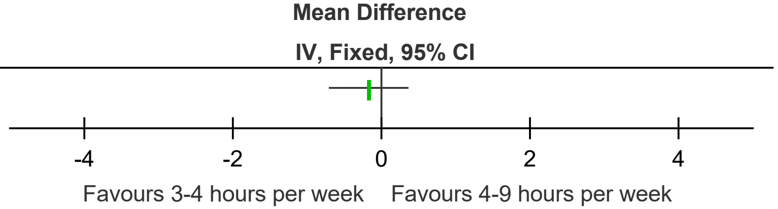


Figure 200: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			3-4 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.53	1.5349	59	0.7	2.3662	178	-0.17 [-0.69, 0.35]



G.3.6 Speech and Language Therapy (communication difficulties) – 4-9 hours per week compared to 2-3 hours per week for people after a first or recurrent stroke

Figure 201: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	12.22	27.0587	50	10.18	29.862	93	2.04 [-7.61, 11.69]

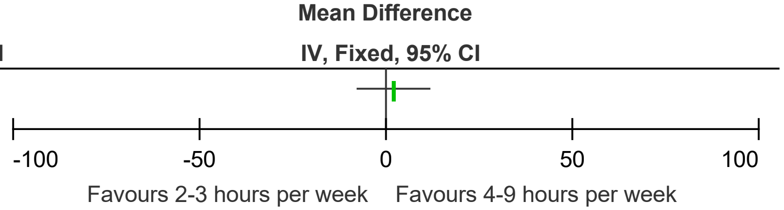


Figure 202: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	5.71	24.6801	41	6.05	30.9504	101	-0.34 [-10.01, 9.33]

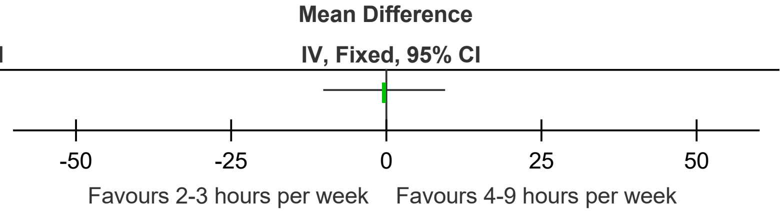


Figure 203: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	2.47	17.6013	103	0.32	18.9757	120	2.15 [-2.65, 6.95]

Mean Difference
IV, Fixed, 95% CI

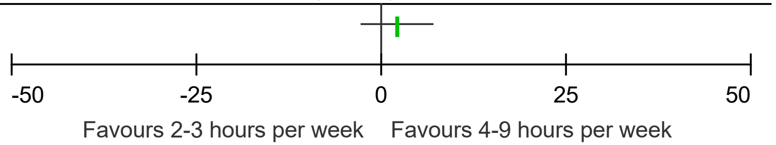
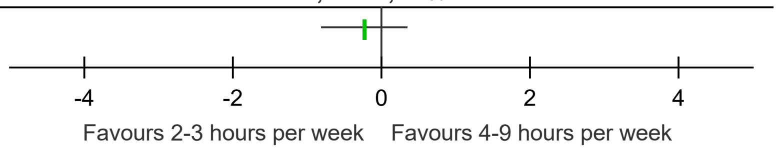


Figure 204: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.53	1.5349	59	0.76	1.8001	73	-0.23 [-0.80, 0.34]

Mean Difference
IV, Fixed, 95% CI



G.3.7 Speech and Language Therapy (communication difficulties) – 4-9 hours per week compared to up to 2 hours per week for people after a first or recurrent stroke

Figure 205: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	12.22	27.0587	50	15.85	33.1506	72	-3.63 [-14.35, 7.09]

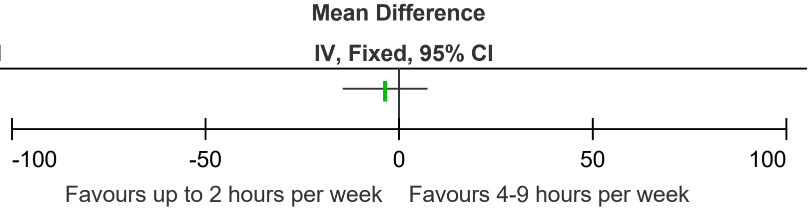


Figure 206: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	5.71	24.6801	41	13.83	16.0872	18	-8.12 [-18.72, 2.48]

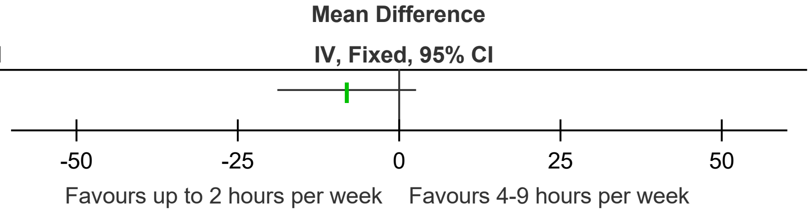


Figure 207: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			Up to 2 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	2.47	17.6013	103	6.5	9.9173	19	-4.03 [-9.64, 1.58]	

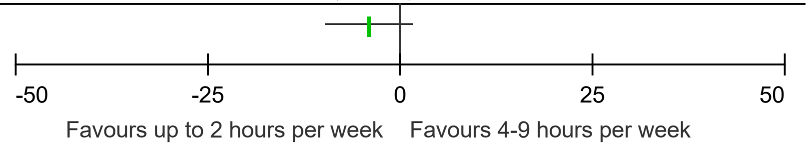
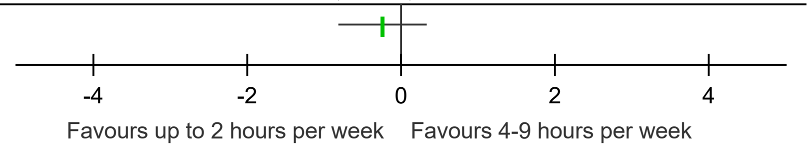


Figure 208: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	4-9 hours per week			Up to 2 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	0.53	1.5349	59	0.77	1.8777	83	-0.24 [-0.80, 0.32]	



G.3.8 Speech and Language Therapy (communication difficulties) – 3-4 hours per week compared to 2-3 hours per week for people after a first or recurrent stroke

Figure 209: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	15.8	35.7372	104	10.18	29.862	93	5.62 [-3.55, 14.79]

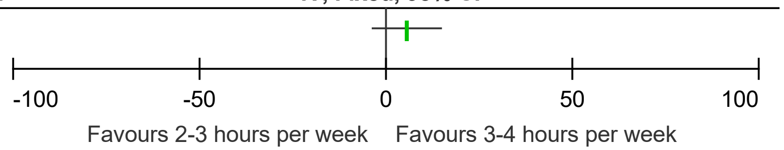


Figure 210: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			2-3 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	9.7	39.8621	127	6.05	30.9504	101	3.65 [-5.54, 12.84]

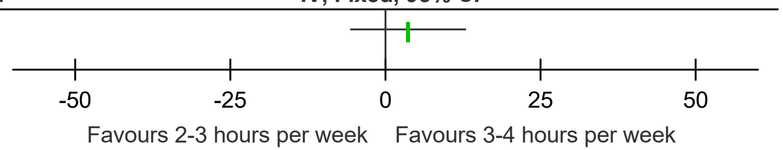


Figure 211: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			2-3 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	6.01	26.5434	112	0.32	18.9757	120	5.69 [-0.28, 11.66]	

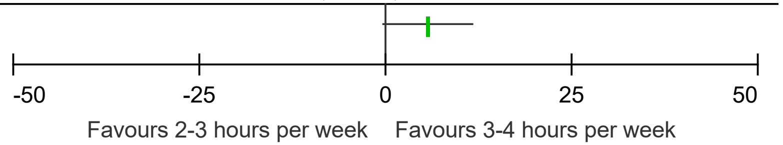
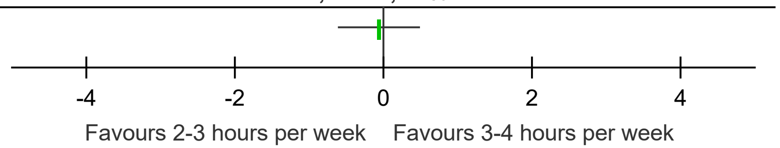


Figure 212: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			2-3 hours per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	0.7	2.3662	178	0.76	1.8001	73	-0.06 [-0.60, 0.48]	



G.3.9 Speech and Language Therapy (communication difficulties) – 3-4 hours per week compared to up to 2 hours per week for people after a first or recurrent stroke

Figure 213: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	15.8	35.7372	104	15.85	33.1506	72	-0.05 [-10.34, 10.24]

Mean Difference
IV, Fixed, 95% CI

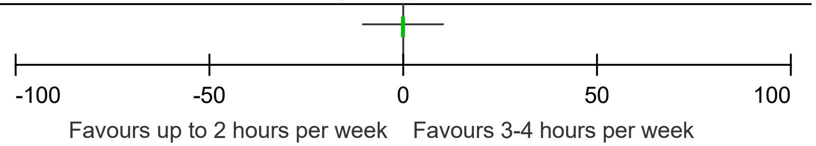


Figure 214: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	9.7	39.8621	127	13.83	16.0872	18	-4.13 [-14.29, 6.03]

Mean Difference
IV, Fixed, 95% CI

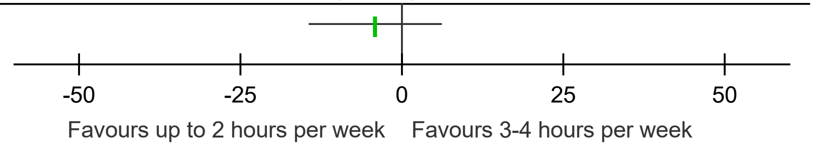


Figure 215: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	6.01	26.5434	112	6.5	9.9173	19	-0.49 [-7.13, 6.15]

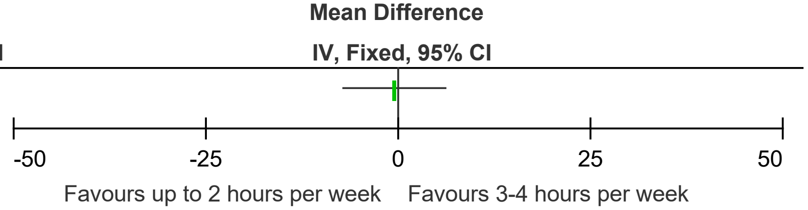
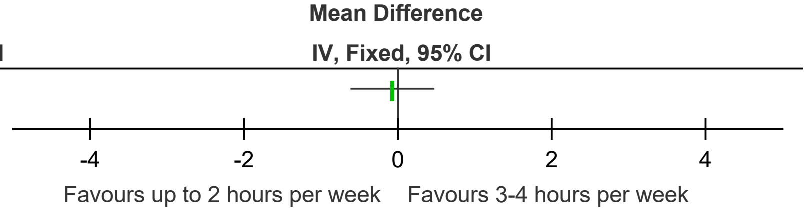


Figure 216: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	3-4 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.7	2.3662	178	0.77	1.8777	83	-0.07 [-0.60, 0.46]



G.3.10 Speech and Language Therapy (communication difficulties) – 2-3 hours per week compared to up to 2 hours per week for people after a first or recurrent stroke

Figure 217: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	2-3 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	10.18	29.862	93	15.85	33.1506	72	-5.67 [-15.44, 4.10]

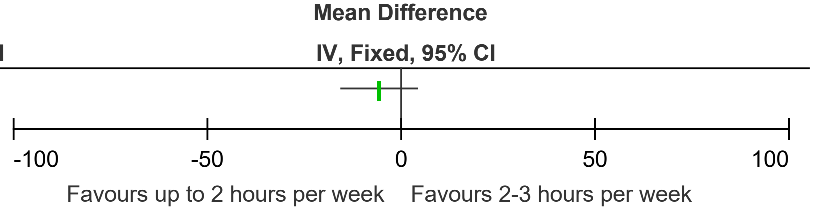


Figure 218: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	2-3 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	6.05	30.9504	101	13.83	16.0872	18	-7.78 [-17.35, 1.79]

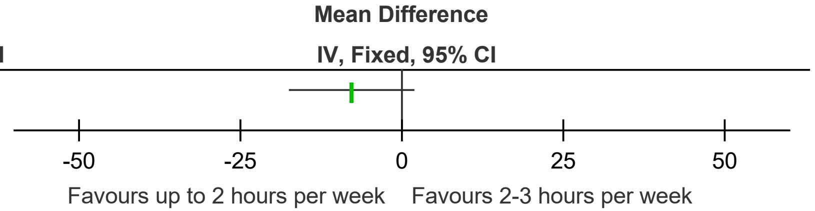


Figure 219: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	2-3 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.32	18.9757	120	6.5	9.9173	19	-6.18 [-11.78, -0.58]

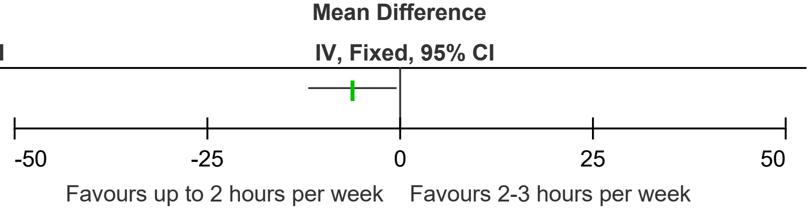
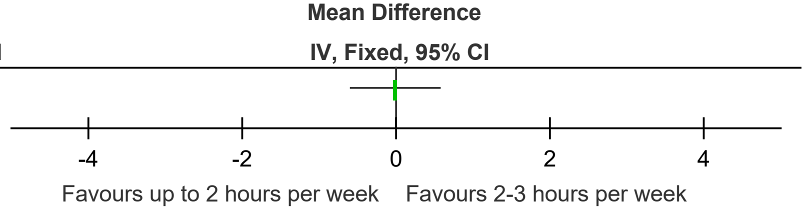


Figure 220: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	2-3 hours per week			Up to 2 hours per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.76	1.8001	73	0.77	1.8777	83	-0.01 [-0.59, 0.57]



G.3.11 Speech and Language Therapy (communication difficulties) – 5+ days per week compared to 5 days per week for people after a first or recurrent stroke

Figure 221: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			5 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	14.14	22.6051	32	14.95	44.3487	194	-0.81 [-10.82, 9.20]

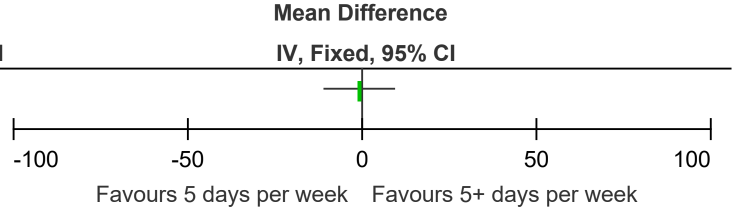


Figure 222: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			5 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	2.38	14.2931	51	4.63	20.8669	171	-2.25 [-7.27, 2.77]

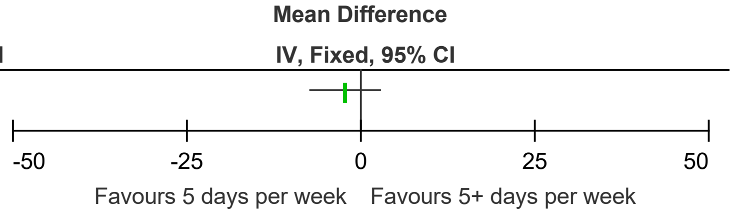
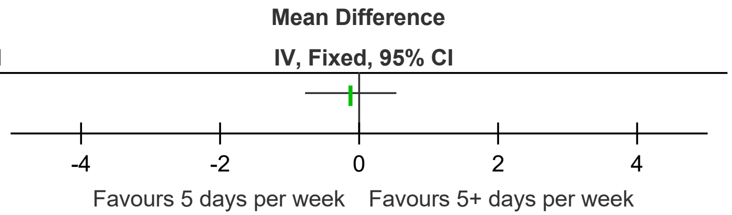


Figure 223: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			5 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.66	0.8716	9	0.78	1.8907	155	-0.12 [-0.76, 0.52]



G.3.12 Speech and Language Therapy (communication difficulties) – 5+ days per week compared to 4 days per week for people after a first or recurrent stroke

Figure 224: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			4 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	14.14	22.6051	32	13.08	33.6091	76	1.06 [-9.82, 11.94]

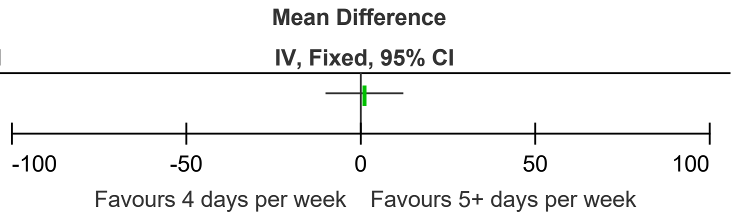


Figure 225: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			4 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	4.07	25.7102	104	7.8	33.6677	103	-3.73 [-11.90, 4.44]

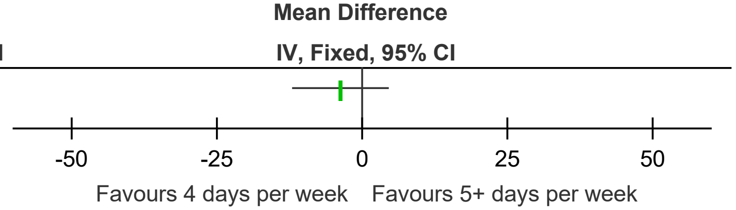


Figure 226: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			4 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	2.38	14.2931	51	5.86	22.7426	114	-3.48 [-9.21, 2.25]

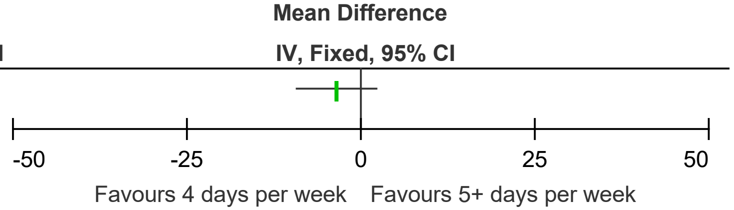
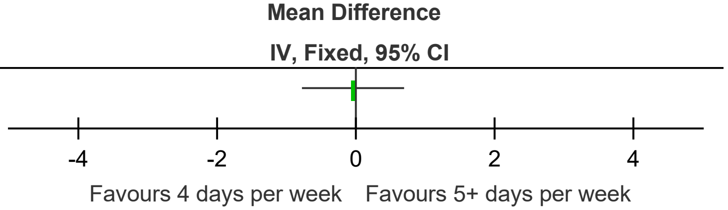


Figure 227: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			4 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.66	0.8716	9	0.7	2.291	102	-0.04 [-0.76, 0.68]



G.3.13 Speech and Language Therapy (communication difficulties) – 5+ days per week compared to 3 days per week for people after a first or recurrent stroke

Figure 228: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			3 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	14.14	22.6051	32	13.35	19.9036	21	0.79 [-10.78, 12.36]

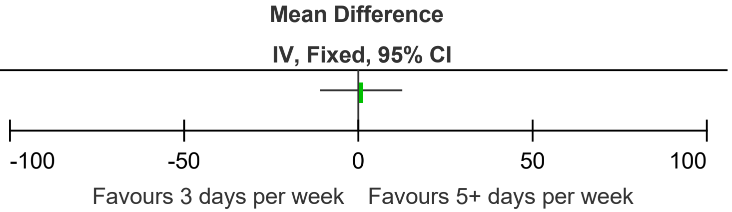


Figure 229: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			3 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	4.07	25.7102	104	6.45	28.6618	84	-2.38 [-10.25, 5.49]	

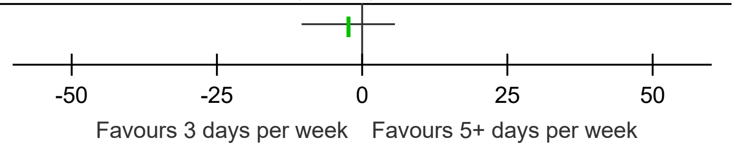


Figure 230: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			3 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	2.38	14.2931	51	1.86	18.6089	89	0.52 [-4.99, 6.03]	

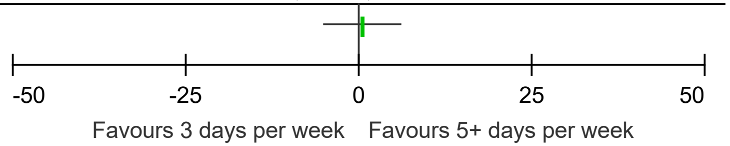
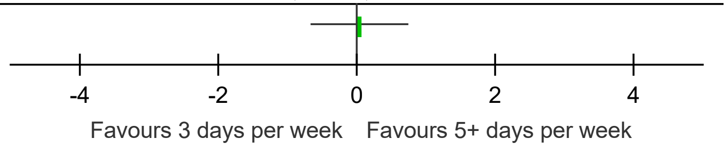


Figure 231: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			3 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	0.66	0.8716	9	0.62	1.9422	93	0.04 [-0.65, 0.73]	



G.3.14 Speech and Language Therapy (communication difficulties) – 5+ days per week compared to up to 2 days per week for people after a first or recurrent stroke

Figure 232: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			Up to 2 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	14.14	22.6051	32	10.24	32.1324	90	3.90 [-6.37, 14.17]	

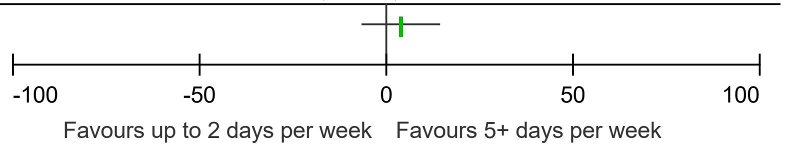


Figure 233: Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			Up to 2 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	4.07	25.7102	104	12.06	20.987	42	-7.99 [-16.03, 0.05]

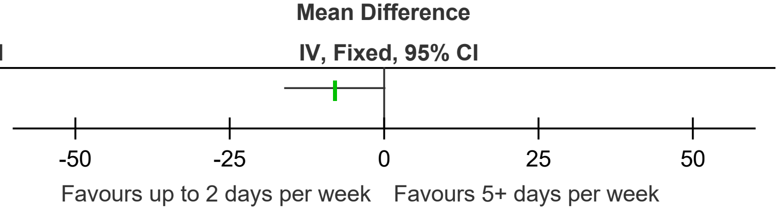


Figure 234: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			Up to 2 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	2.38	14.2931	51	-0.51	14.3319	64	2.89 [-2.37, 8.15]

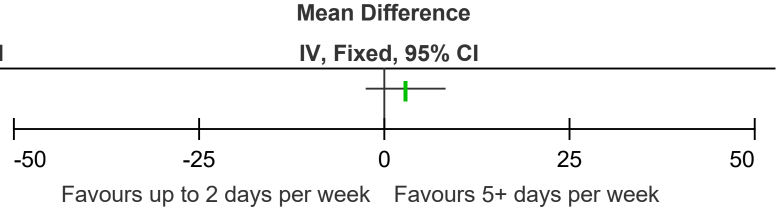
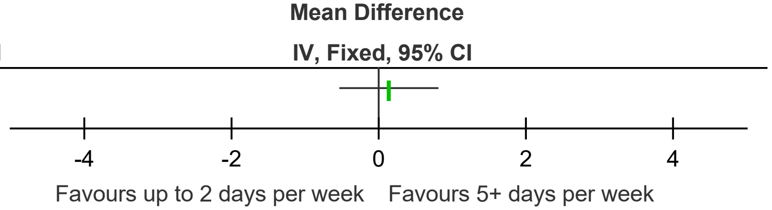


Figure 235: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5+ days per week			Up to 2 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.66	0.8716	9	0.52	1.5474	82	0.14 [-0.52, 0.80]



G.3.15 Speech and Language Therapy (communication difficulties) – 5 days per week compared to 4 days per week for people after a first or recurrent stroke

Figure 236: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			4 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	14.95	44.3487	194	13.08	33.6091	76	1.87 [-7.93, 11.67]

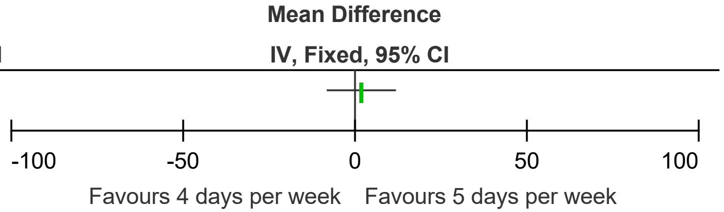


Figure 237: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			4 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	4.63	20.8669	171	5.86	22.7426	114	-1.23 [-6.45, 3.99]

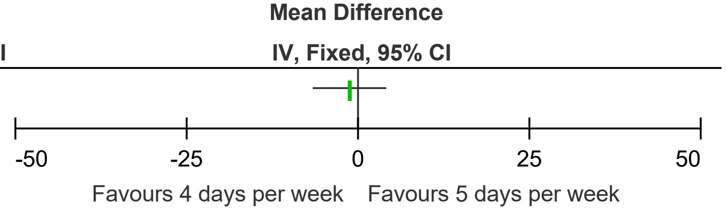
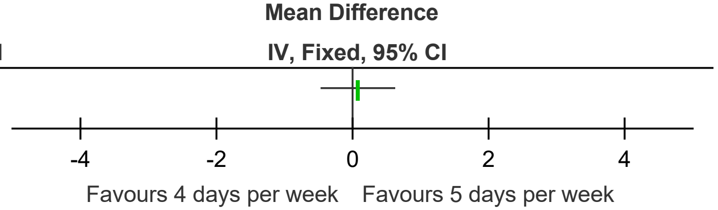


Figure 238: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			4 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	0.78	1.8907	155	0.7	2.291	102	0.08 [-0.46, 0.62]



G.3.16 Speech and Language Therapy (communication difficulties) – 5 days per week compared to 3 days per week for people after a first or recurrent stroke

Figure 239: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			3 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	14.95	44.3487	194	13.35	19.9036	21	1.60 [-8.96, 12.16]

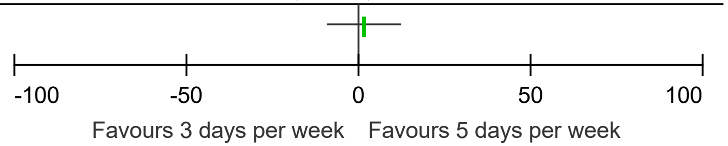


Figure 240: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			3 days per week			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Brady 2021	4.63	20.8669	171	1.86	18.6089	89	2.77 [-2.20, 7.74]

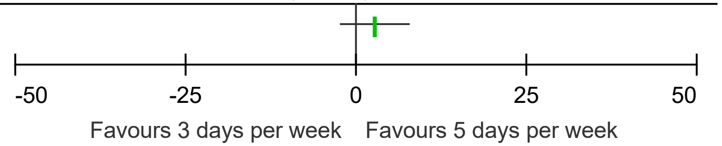
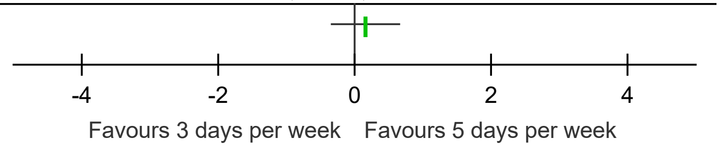


Figure 241: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			3 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	0.78	1.8907	155	0.62	1.9422	93	0.16 [-0.33, 0.65]	



G.3.17 Speech and Language Therapy (communication difficulties) – 5 days per week compared to up to 2 days per week for people after a first or recurrent stroke

Figure 242: Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			Up to 2 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	14.95	44.3487	194	10.24	32.1324	90	4.71 [-4.40, 13.82]	

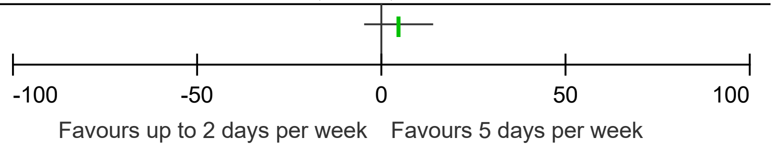


Figure 243: Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			Up to 2 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	4.63	20.8669	171	-0.51	14.3319	64	5.14 [0.44, 9.84]	

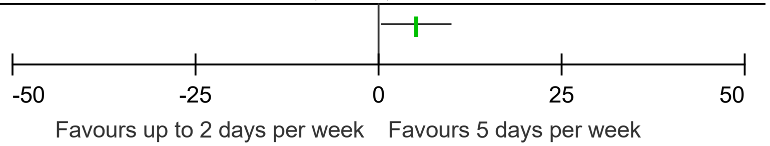
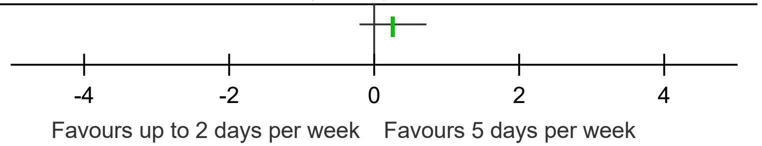


Figure 244: Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

	5 days per week			Up to 2 days per week			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Brady 2021	0.78	1.8907	155	0.52	1.5474	82	0.26 [-0.19, 0.71]	



G.4 Speech and Language Therapy

G.4.1 Speech and Language Therapy (no communication difficulties) - ≤45 minutes, 7 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 245: Swallow function and ability (functional swallow) at ≥6 months

	≤45 min 7 d/wk		>45 min-1 hour <5d/wk		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI	M-H, Fixed, 95% CI
Carnaby 2006	49	102	44	102	1.11 [0.82, 1.50]	

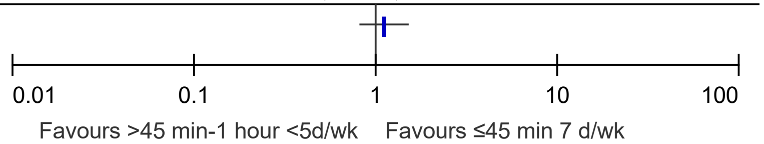
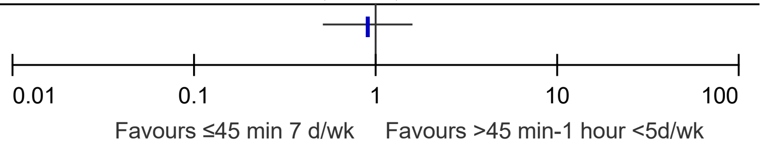


Figure 246: Discontinuation from study at ≥6 months

	≤45 min 7 d/wk		>45 min-1 hour <5d/wk		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI	M-H, Fixed, 95% CI
Carnaby 2006	19	102	21	102	0.90 [0.52, 1.58]	



G.4.2 Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 247: Person/participant health-related quality of life (Stroke and Aphasia Quality of Life Scale-39, 1-5, higher values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Godecke 2020	3.3	0.87	147	3.6	0.76	70	-0.30 [-0.53, -0.07]

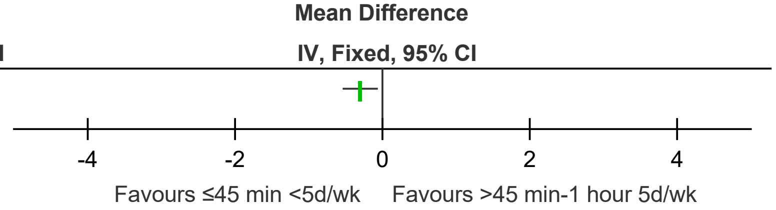


Figure 248: Person/participant health-related quality of life (Stroke and Aphasia Quality of Life Scale-39, 1-5, higher values are better, final values) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Godecke 2020	3.5	0.82	147	3.65	0.75	70	-0.15 [-0.37, 0.07]

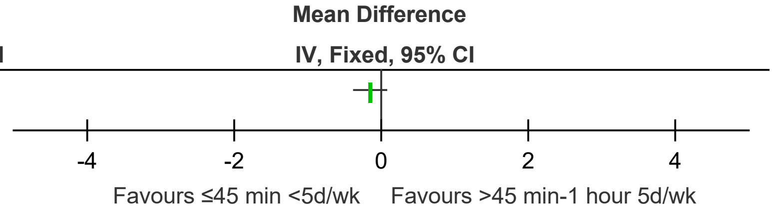


Figure 249: Communication - Overall language ability (Western Aphasia Battery-Revised Aphasia Quotient, 0-100, higher values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Godecke 2020	67.2	29.9	147	70.02	28.7	70	-2.82 [-11.10, 5.46]

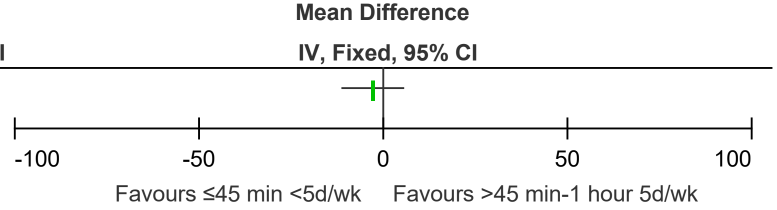


Figure 250: Communication - Overall language ability (Western Aphasia Battery-Revised Aphasia Quotient, 0-100, higher values are better, final values) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Godecke 2020	71.7	28.9	147	75.7	25.3	70	-4.00 [-11.55, 3.55]

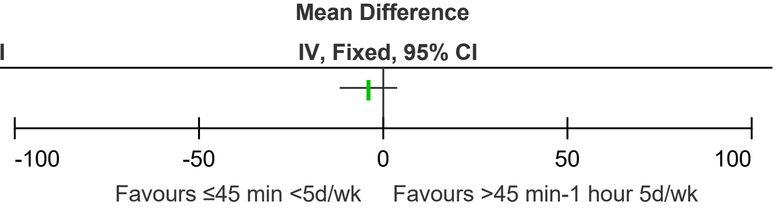


Figure 251: Communication - Impairment specific measures (naming) (Boston Naming Test, number of incorrect names, lower values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Godecke 2020	30.3	20.8	147	31.3	18.8	70	-1.00 [-6.54, 4.54]

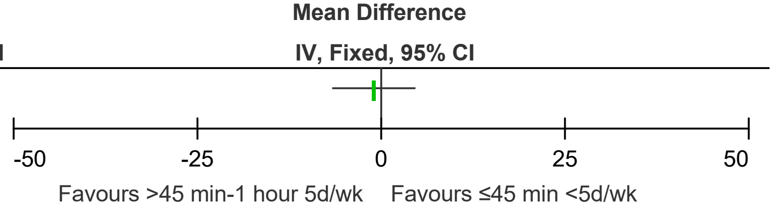


Figure 252: Communication - Impairment specific measures (naming) (Boston Naming Test, number of incorrect names, lower values are better, final values) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Godecke 2020	34.6	20	147	37.5	18	70	-2.90 [-8.21, 2.41]	

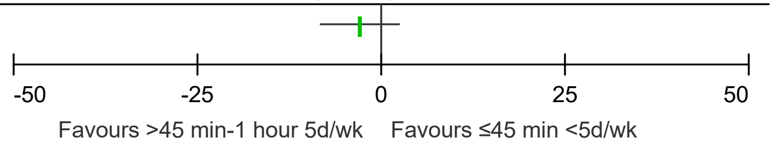


Figure 253: Psychological distress - depression (Aphasia Depression Rating Scale, 0-32, lower values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Godecke 2020	5.6	3.88	147	5.6	3.77	70	0.00 [-1.08, 1.08]	

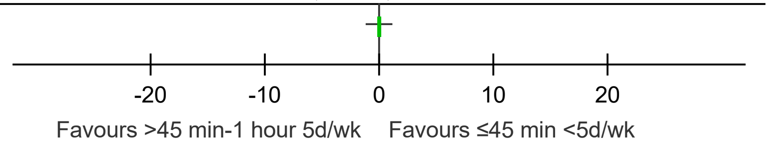


Figure 254: Psychological distress - depression (Aphasia Depression Rating Scale, 0-32, lower values are better, final values) at ≥6 months

	>45 min-1 hour 5d/wk			≤45 min <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Godecke 2020	4.2	3.3	147	4.76	3.8	70	-0.56 [-1.60, 0.48]

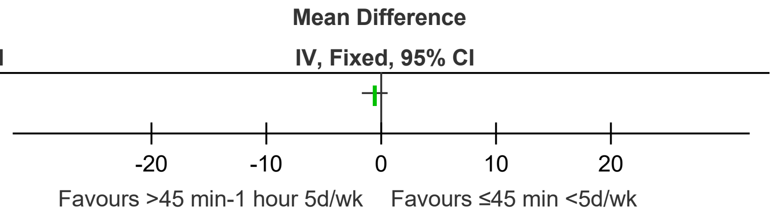


Figure 255: Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min <5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Godecke 2020	46	164	11	81	2.07 [1.13, 3.77]

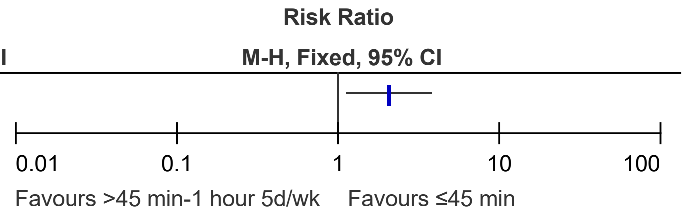
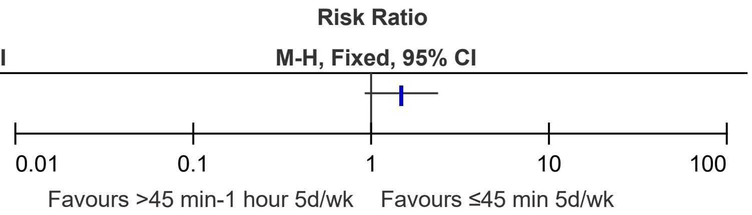


Figure 256: Discontinuation from study at ≥6 months

	>45 min-1 hour 5d/wk		≤45 min <5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Godecke 2020	54	164	18	81	1.48 [0.93, 2.35]



G.4.3 Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Figure 257: Communication - Overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at <6 months

	>45 min to 1 hour 5d/wk			>45 min to 1 hour <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Bakheit 2007	24.8	14.2	51	23.1	15.8	65	1.70 [-3.77, 7.17]

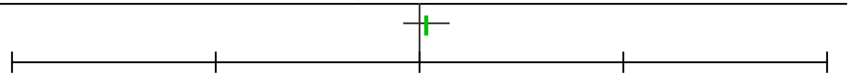


Figure 258: Communication - Overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at ≥6 months

	>45 min to 1 hour 5d/wk			>45 min to 1 hour <5 d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Bakheit 2007	27	16.1	51	26	17.9	65	1.00 [-5.20, 7.20]

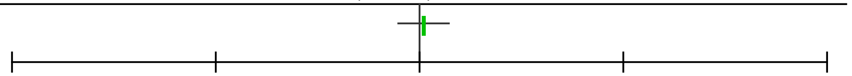


Figure 259: Communication - impairment specific measures (naming) (Aachen Aphasia Test Naming, scale range unclear, higher values are better, change score) at ≥6 months

Study or Subgroup	>45 min-1 hour 5d/wk Mean	>45 min-1 hour 5d/wk SD	>45 min-1 hour 5d/wk Total	>45 min-1 hour <5d/wk Mean	>45 min-1 hour <5d/wk SD	>45 min-1 hour <5d/wk Total	Mean Difference IV, Fixed, 95% CI
Denes 1996	10.2	9.9	8	4.5	4.2	9	5.70 [-1.69, 13.09]

Mean Difference
IV, Fixed, 95% CI

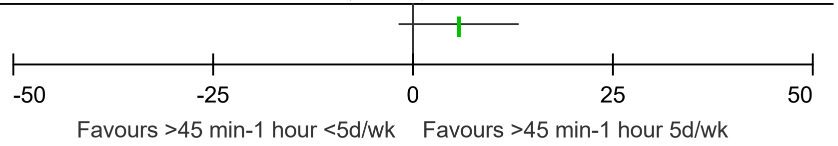


Figure 260: Communication - impairment specific measures (auditory comprehension) (Aachen Aphasia Test Token Test, scale range unclear, higher values are better, change score) at ≥6 months

Study or Subgroup	>45 min-1 hour 5d/wk Mean	>45 min-1 hour 5d/wk SD	>45 min-1 hour 5d/wk Total	>45 min-1 hour <5d/wk Mean	>45 min-1 hour <5d/wk SD	>45 min-1 hour <5d/wk Total	Mean Difference IV, Fixed, 95% CI
Denes 1996	11.4	11.6	8	5.2	7.8	9	6.20 [-3.32, 15.72]

Mean Difference
IV, Fixed, 95% CI

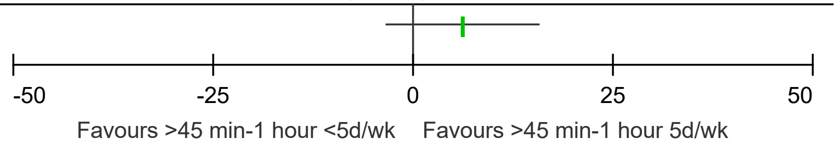


Figure 261: Discontinuation from study at <6 months

Study or Subgroup	>45 min to 1 hour 5d/wk Events	>45 min to 1 hour 5d/wk Total	>45 min to 1 hour <5 d/wk Events	>45 min to 1 hour <5 d/wk Total	Risk Ratio M-H, Fixed, 95% CI
Bakheit 2007	13	51	8	65	2.07 [0.93, 4.61]

Risk Ratio
M-H, Fixed, 95% CI

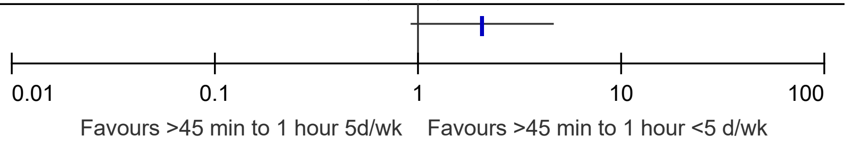
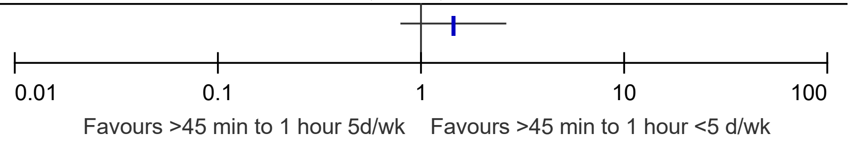


Figure 262: Discontinuation from study at ≥6 months

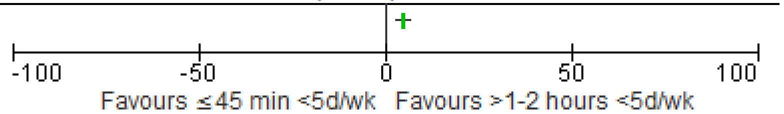
	>45 min to 1 hour 5d/wk		>45 min to 1 hour <5 d/wk		Risk Ratio	Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI	M-H, Fixed, 95% CI
Bakheit 2007	17	51	15	65	1.44 [0.80, 2.60]	



G.4.4 Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Figure 263: Psychological distress - depression (Aphasic Depression Rating Scale, scale range unclear, higher values are better, change score) at <6 months

	>1-2 hours <5d/wk			≤45 min <5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
De Luca 2018	4.8	2.5976	17	-0.1	2.9822	15	4.90 [2.95, 6.85]	



G.4.5 Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Figure 264: Communication - Overall language ability (Western Aphasia Battery-Aphasia Quotient, 0-100, higher values are better, final value) at <6 months

	>1-2 hours <5d/wk			>45 min-1 hour <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kesav 2017	67.6	32.7	11	73.3	26.9	9	-5.70 [-31.82, 20.42]

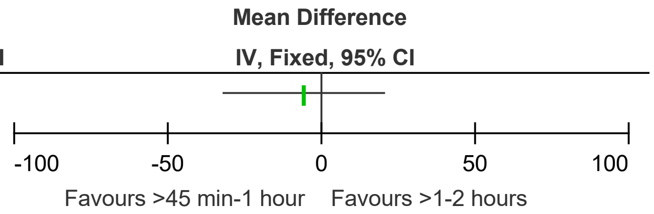
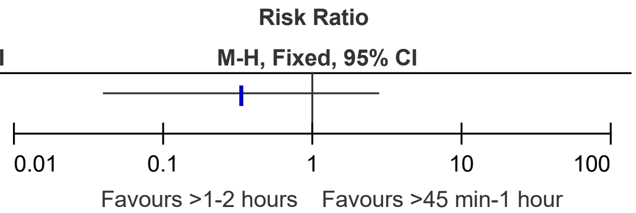


Figure 265: Discontinuation from study at <6 months

	>1-2 hours <5d/wk		>45 min-1 hour <5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Kesav 2017	1	12	3	12	0.33 [0.04, 2.77]



G.4.6 Speech and Language Therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Figure 266: Swallow function and ability (Penetration Aspiration Scale, 1-8, lower values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Jang 2019	-0.86	1.24	18	-0.76	0.97	18	-0.10 [-0.83, 0.63]

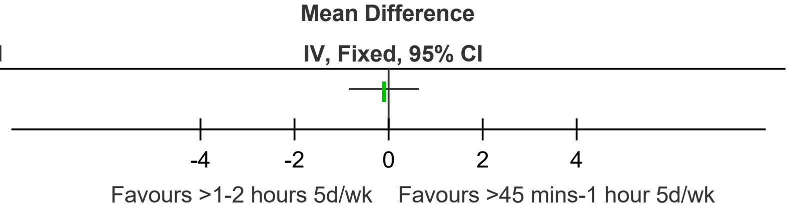
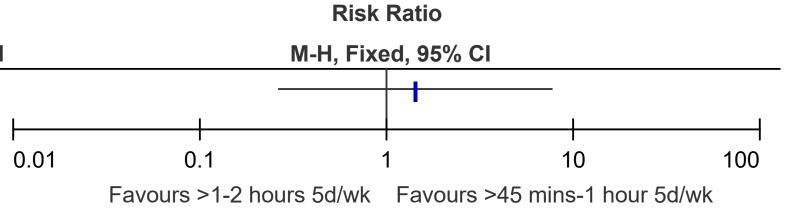


Figure 267: Discontinuation from study at <6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Jang 2019	3	21	2	20	1.43 [0.27, 7.67]



G.4.7 Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Figure 268: Communication - Impairment specific measures, naming (NGA tubtest naming, 0-100, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Øra 2020	50.4	22.4	32	54.1	24.9	30	-3.70 [-15.52, 8.12]

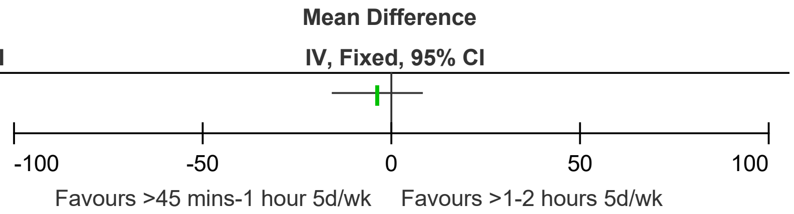


Figure 269: Communication - Impairment specific measures, auditory comprehension (NGA subtest comprehension, 0-100, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Øra 2020	61	24	32	61.5	29.5	30	-0.50 [-13.94, 12.94]

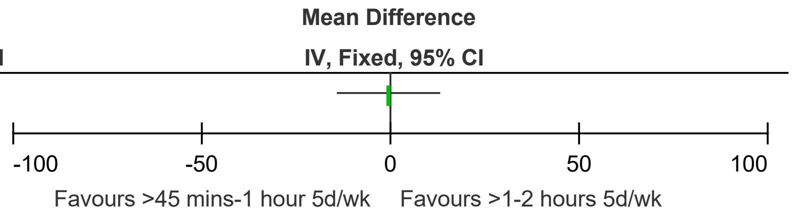


Figure 270: Communication - functional communication (Communicative Effectiveness Index, 0-100, higher values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Øra 2020	61.3	19	32	61.3	21.9	30	0.00 [-10.23, 10.23]

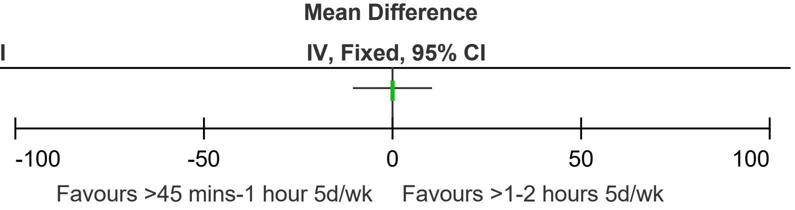
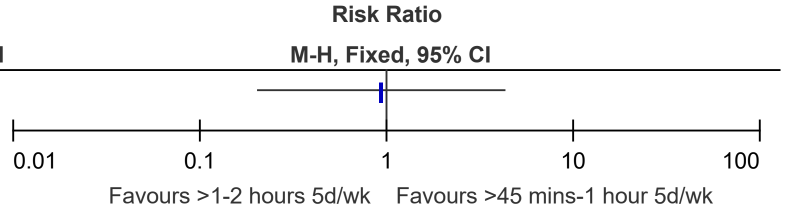


Figure 271: Discontinuation from study at <6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Øra 2020	3	32	3	30	0.94 [0.20, 4.29]



G.4.8 Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, <5 days a week compared to >1 hour to 2 hours, <5 days a week for people after a first or recurrent stroke

Figure 272: Communication - Overall language ability (Action Communication Test, scale range unclear, higher values are better, final value) at <6 months

	>2-4 hours <5d/wk			>1-2 hours <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Stahl 2018	52.7	4.7	15	53.4	4.8	15	-0.70 [-4.10, 2.70]

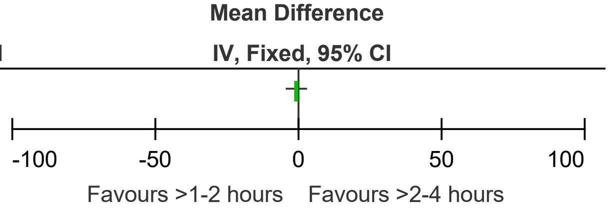


Figure 273: Communication - Functional communication (Aachen Aphasia Test, scale range unclear, higher values are better, final value) at <6 months

	>2-4 hours <5d/wk			>1-2 hours <5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Stahl 2018	50.2	4.9	15	54	5.6	15	-3.80 [-7.57, -0.03]

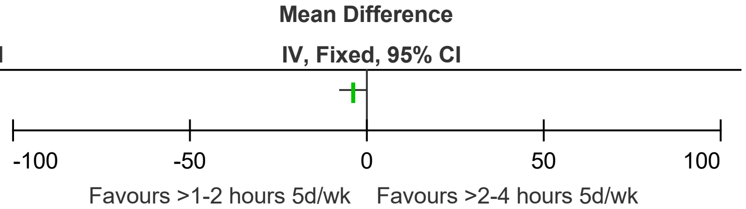
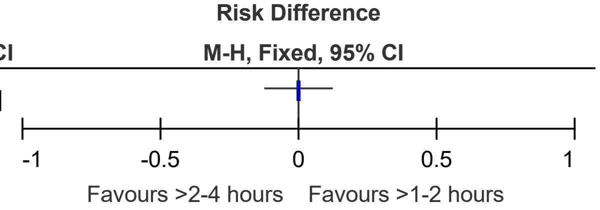


Figure 274: Discontinuation from study at <6 months

	>2-4 hours <5d/wk		>1-2 hours <5d/wk		Risk Difference
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Stahl 2018	0	15	0	15	0.00 [-0.12, 0.12]



G.4.9 Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week compared to usual care for people after a first or recurrent stroke

Figure 275: Person/participant health-related quality of life (SAQOL-39g, 1-5, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Rose 2022	0.03	0.369	133	0.01	0.36	67	0.02 [-0.09, 0.13]

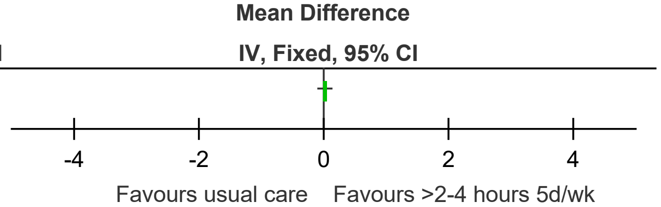


Figure 276: Communication - overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Rose 2022	1.33	5.49	133	3.07	6.58	67	-1.74 [-3.57, 0.09]

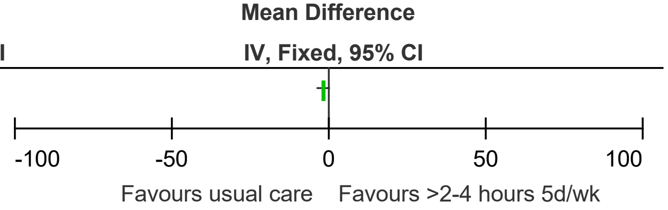


Figure 277: Communication - impairment specific measures, naming (COMPARE naming battery 100 untreated items, 0-100, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Rose 2022	3.35	8.91	133	2.97	6.76	67	0.38 [-1.84, 2.60]

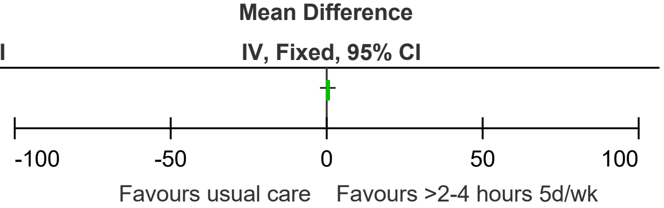


Figure 278: Communication - Functional communication (Communicative Effectiveness Index, 0-100, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Rose 2022	3.24	15.85	133	0.2	13.31	67	3.04 [-1.13, 7.21]

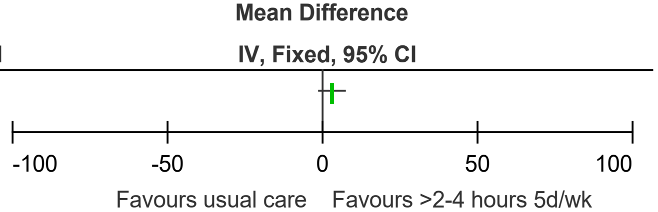
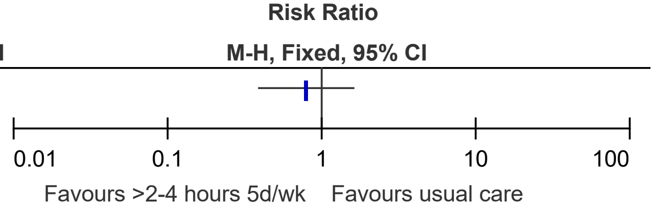


Figure 279: Discontinuation from study at <6 months

	>2-4 hours 5d/wk		Usual care		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Rose 2022	17	146	11	75	0.79 [0.39, 1.61]



G.4.10 Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Figure 280: Communication - Impairment specific measures, naming (Aachen Aphasia Test - Naming Test, scale range unclear, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Woldag 2017	3.5	5.8	40	4	4.11	20	-0.50 [-3.04, 2.04]

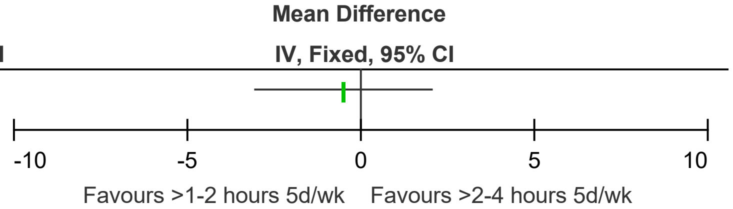


Figure 281: Communication - Impairment specific measures, auditory comprehension (Aachen Aphasia Test - Token Test, scale range unclear, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Woldag 2017	3.75	5.71	40	2.6	3.76	20	1.15 [-1.27, 3.57]	

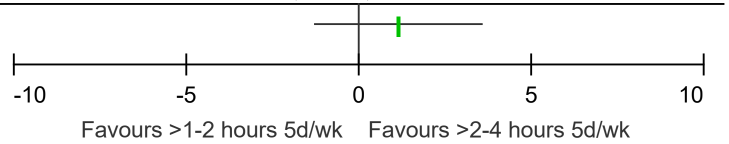


Figure 282: Discontinuation from study at <6 months

	>2-4 hours 5d/wk		>1-2 hours 5d/wk		Peto Odds Ratio	Peto Odds Ratio
Study or Subgroup	Events	Total	Events	Total	Peto, Fixed, 95% CI	Peto, Fixed, 95% CI
Woldag 2017	2	40	0	20	4.60 [0.24, 89.21]	

G.5 Psychology/neuropsychology

G.5.1 Psychology/neuropsychology (communication difficulties) - >45 minutes to 1 hour, <5 days a week compared to usual care for people after a first or recurrent stroke

Figure 283: Carer health-related quality of life (Carer Strain Index, 0-13, lower values are better, final value) at ≥6 months

	>45 min-1 hour <5d/wk			Usual care			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Thomas 2013	6.6	3.1	39	6.3	3.6	44	0.30 [-1.14, 1.74]	

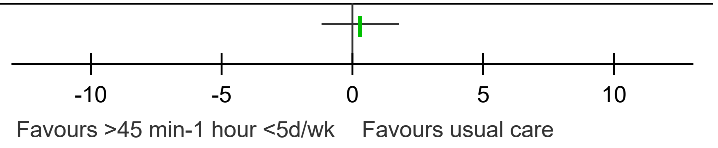


Figure 284: Psychological distress - depression (Stroke Aphasic Depression Questionnaire Hospital version 21, 0-30, lower values are better, final value) at ≥6 months

	>45 min-1 hour <5d/wk			Usual care			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Thomas 2013	17.4	10	39	21.9	9.5	44	-4.50 [-8.71, -0.29]	

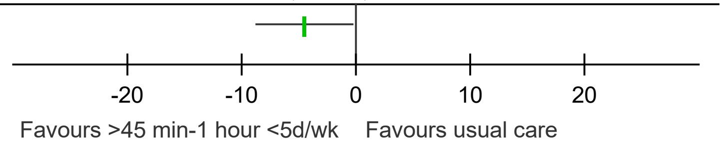


Figure 285: Activities of daily living (Nottingham Leisure Questionnaire, 0-60, higher values are better, final value) at ≥6 months

	>45 min-1 hour <5d/wk			Usual care			Mean Difference	Mean Difference
Study or Subgroup	**Mean**	**SD**	**Total**	**Mean**	**SD**	**Total**	**IV, Fixed, 95% CI**	**IV, Fixed, 95% CI**
Thomas 2013	17	7.6	39	15.9	6.8	44	1.10 [-2.02, 4.22]	

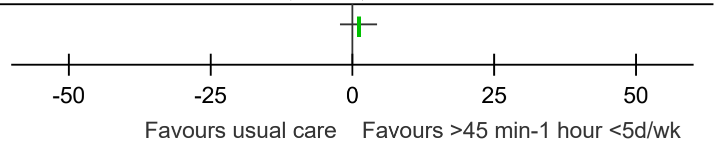
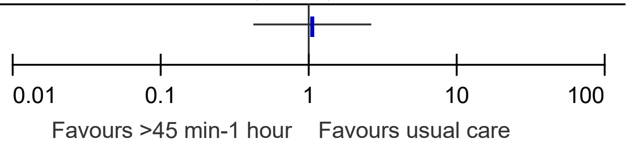


Figure 286: Discontinuation from study at ≥6 months

	>45 min-1 hour <5d/wk		Usual care		Risk Ratio	Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Thomas 2013	8	51	8	54	1.06 [0.43, 2.61]	



G.5.2 Psychology/neuropsychology (no communication difficulties) - >1 hour to 2 hours, <5 days a week compared to usual care for people after a first or recurrent stroke

Figure 287: Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final value) at <6 months

	>1-2 hours <5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Majumdar 2019	0.65	0.26	26	0.7	0.19	27	-0.05 [-0.17, 0.07]

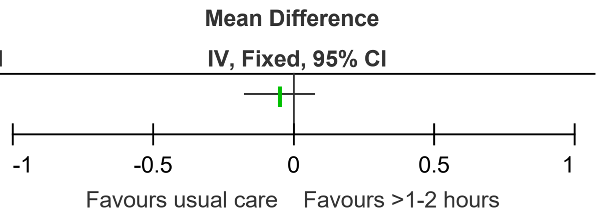


Figure 288: Psychological distress - depression (PHQ-9, 0-27, lower values are better, final value) at <6 months

	>1-2 hours <5 d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Majumdar 2019	8.27	6.5	26	9.74	7.4	27	-1.47 [-5.22, 2.28]

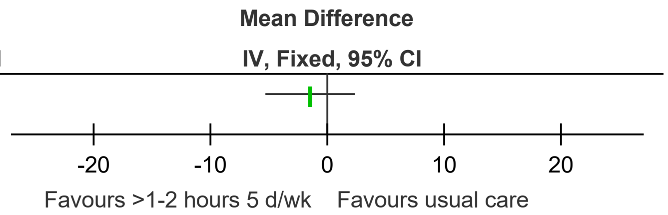
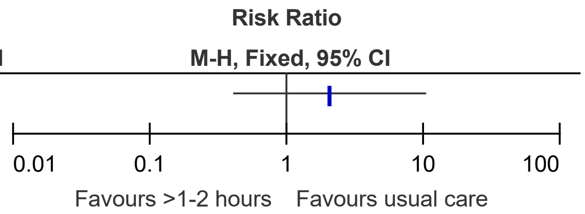


Figure 289: Discontinuation from study at <6 months

	>1-2 hours <5 d/wk		Usual care		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Majumdar 2019	4	26	2	27	2.08 [0.42, 10.39]



G.5.3 Psychology/neuropsychology (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Figure 290: Person/participant health-related quality of life (Pictorial Thai Quality of Life Scale, 0-72, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kongkasuwan 2016	17.5	14.9	54	8.6	11.5	59	8.90 [3.96, 13.84]

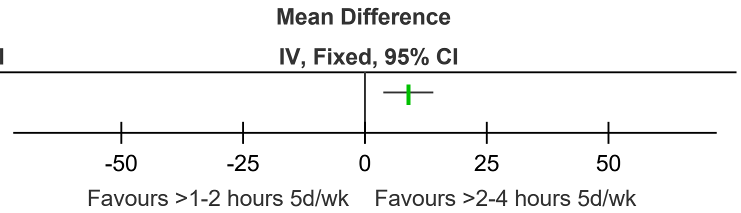


Figure 291: Activities of daily living (Barthel Index, 0-20, higher values are better, change score) at <6 months

	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kongkasuwan 2016	4.7	3.2	54	3.5	2.9	59	1.20 [0.07, 2.33]

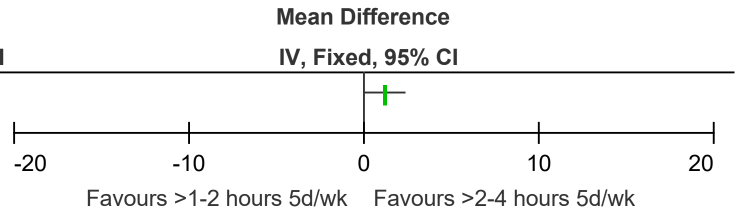


Figure 292: Psychological distress - Depression (HADS depression, 0-21, lower values are better, change score) at <6 months

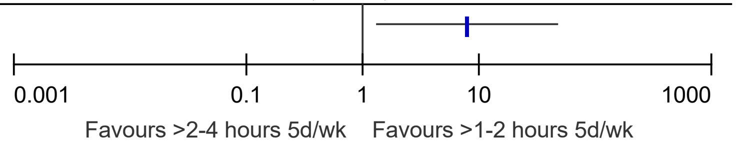
	>2-4 hours 5d/wk			>1-2 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Kongkasuwan 2016	-6.3	6.5	54	-1.8	3.9	59	-4.50 [-6.50, -2.50]

Mean Difference
IV, Fixed, 95% CI

Figure 293: Discontinuation of study at <6 months

	Favours >2-4 hours 5d/wk		>1-2 hours 5d/wk		Peto Odds Ratio
Study or Subgroup	Events	Total	Events	Total	Peto, Fixed, 95% CI
Kongkasuwan 2016	5	59	0	59	7.93 [1.33, 47.21]

Peto Odds Ratio
Peto, Fixed, 95% CI



G.6 Multidisciplinary team

G.6.1 Multidisciplinary team (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Figure 294: Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Smith 1981	10	46	7	43	1.34 [0.56, 3.19]

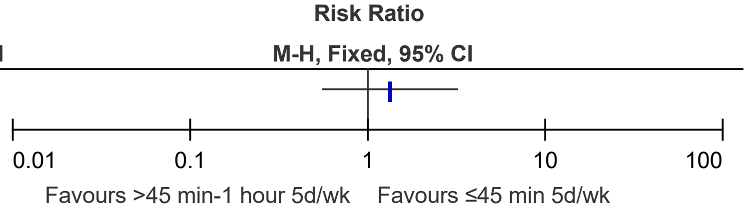
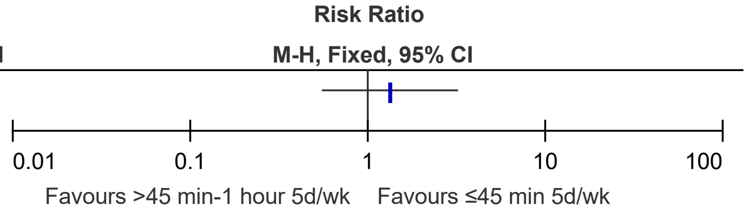


Figure 295: Discontinuation from study at ≥6 months

	>45 min-1 hour 5d/wk		≤45 min 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Smith 1981	10	46	7	43	1.34 [0.56, 3.19]



G.6.2 Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Figure 296: Activities of daily living (Barthel index, activities of daily living and ambulation [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Lin 2020	73.4	22.2	38	71	29	107	55.7%	0.09 [-0.28, 0.46]
Sivenius 1985	21	8.3241	41	16.3	9.7658	33	44.3%	0.52 [0.05, 0.98]
Total (95% CI)			**79**			**140**	**100.0%**	**0.28 [-0.14, 0.70]**

Heterogeneity: Tau² = 0.05; Chi² = 2.00, df = 1 (P = 0.16); I² = 50%

Test for overall effect: Z = 1.30 (P = 0.19)

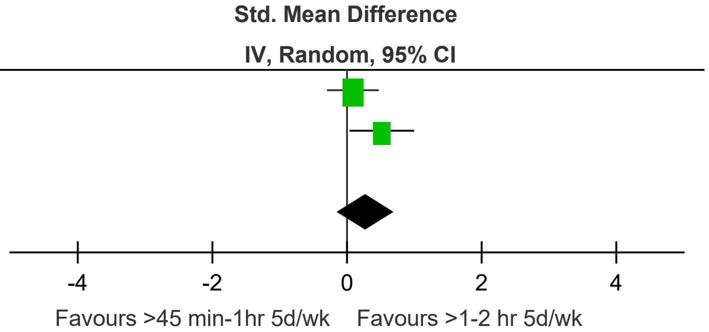


Figure 297: Activities of daily living (Functional Independence Measure upper limb, 0-63, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Burgar 2011	21.5	8.7	17	16.8	7.5	26	4.70 [-0.34, 9.74]

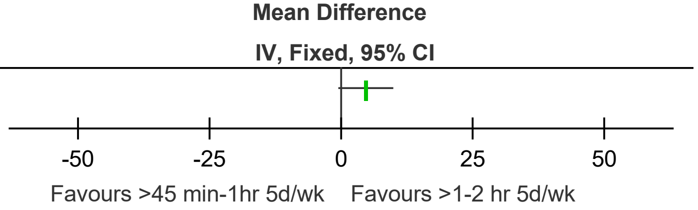


Figure 298: Activities of daily living (Functional independence measure upper limb, 0-63, higher values are better, change score) at ≥6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Burgar 2011	27.5	10	11	25.4	10.9	26	2.10 [-5.14, 9.34]

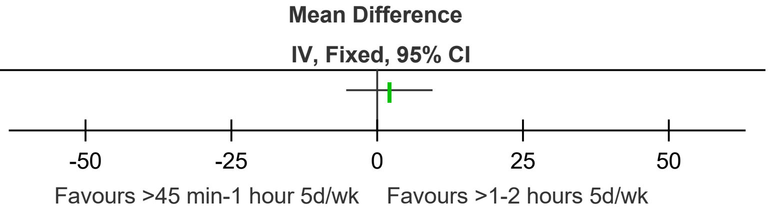


Figure 299: Activities of daily living (Activities of daily living and ambulation, 0-23, higher values are better, final value) at ≥6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Sivenius 1985	21.1	8.425	42	18.4	9.4657	35	2.70 [-1.34, 6.74]

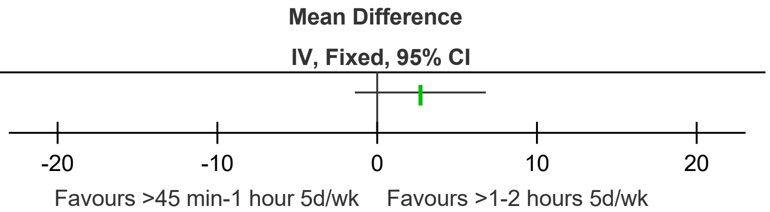


Figure 300: Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, change score) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Burgar 2011	14.4	14.8	17	10.3	12.7	37	4.10 [-4.04, 12.24]	

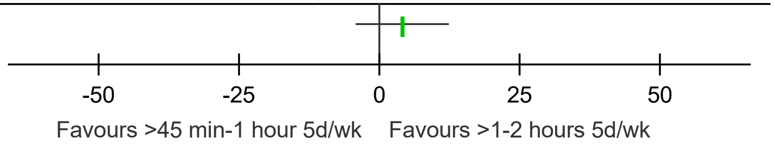


Figure 301: Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, final value) at ≥6 months)

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference	Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI	IV, Fixed, 95% CI
Burgar 2011	23.6	19.2	11	15.6	15	26	8.00 [-4.73, 20.73]	

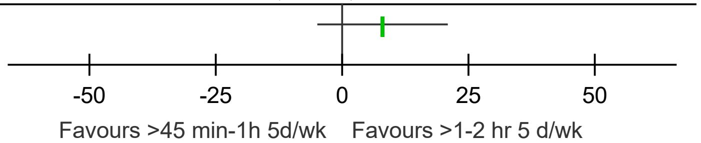


Figure 302: Physical function - lower limb (Postural assessment scale for stroke, motor function test [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Lin 2020	26.8	10.1	38	26.8	11.8	107	56.2%	0.00 [-0.37, 0.37]
Sivenius 1985	26.4	15.411	38	20.2	12.4451	32	43.8%	0.43 [-0.04, 0.91]
Total (95% CI)			**76**			**139**	**100.0%**	**0.19 [-0.23, 0.61]**

Heterogeneity: Tau² = 0.05; Chi² = 1.99, df = 1 (P = 0.16); I² = 50%

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

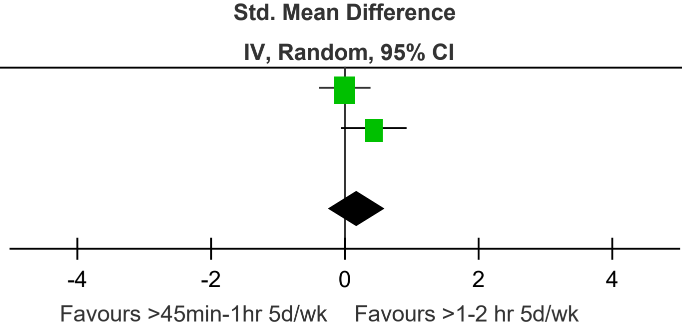


Figure 303: Physical function - lower limb (Motor function test, scale range unclear, higher values are better, final value) at ≥6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Sivenius 1985	26	18.3412	40	21.1	13.607	35	4.90 [-2.35, 12.15]

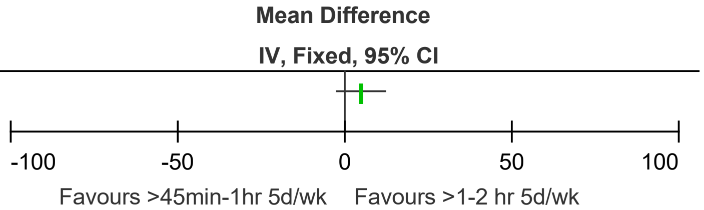


Figure 304: Psychological distress - Depression (HADS depression, 0-21, lower values are better, final value) at <6 months

	>1-2 hours 5d/wk			>45 min-1 hour 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Lin 2020	9.3	3.2	38	10	4.5	107	-0.70 [-2.03, 0.63]

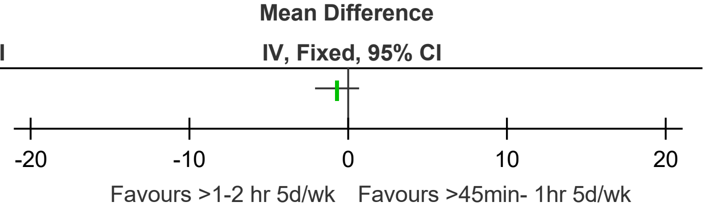


Figure 305: Discontinuation from study at <6 months

	Favours >1-2 hours 5d/wk		>45 min-1 hour 5d/wk			Peto Odds Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	Peto, Fixed, 95% CI
Lin 2020	0	38	9	107	76.9%	0.24 [0.05, 1.10]
Sivenius 1985	0	50	2	45	23.1%	0.12 [0.01, 1.93]
Total (95% CI)		**88**		**152**	**100.0%**	**0.20 [0.05, 0.77]**
Total events	0		11			

Heterogeneity: Chi² = 0.19, df = 1 (P = 0.67); I² = 0%

Test for overall effect: Z = 2.33 (P = 0.02)

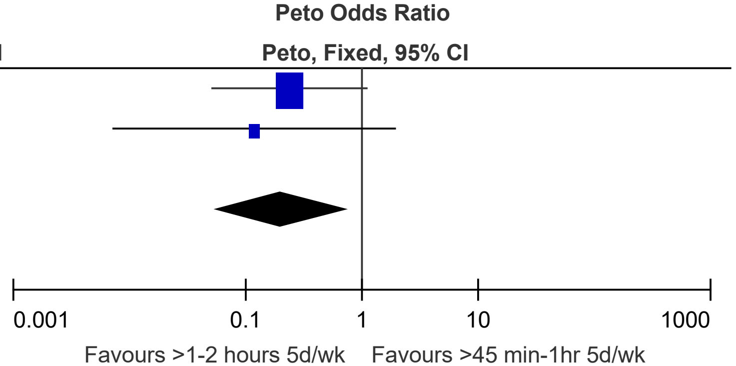
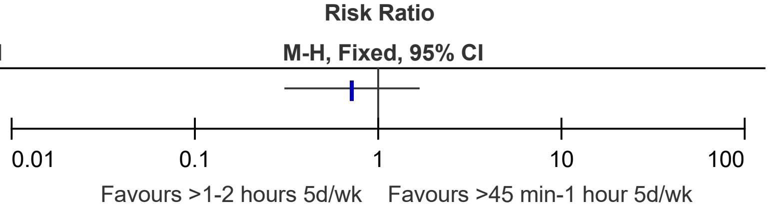


Figure 306: Discontinuation from study at ≥6 months

	>1-2 hours 5d/wk		>45 min-1 hour 5d/wk		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Sivenius 1985	8	50	10	45	0.72 [0.31, 1.66]



G.6.3 Multidisciplinary team (no communication difficulties) - >2 hours to 4 hours, <5 days a week compared to usual care for people after a first or recurrent stroke

Figure 307: Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, change score) at ≥6 months

	>2-4 hours <5d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Pálsdóttir 2020	0.04	0.5339	47	0.04	1.1043	40	0.00 [-0.37, 0.37]

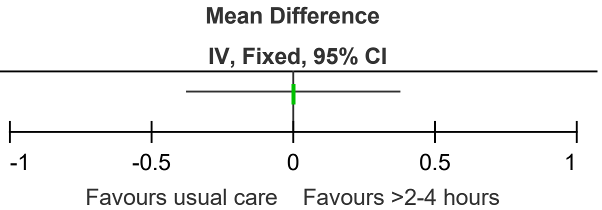


Figure 308: Stroke outcome - modified Rankin Scale (modified Rankin scale, 0-5, lower values are better, change score) at ≥6 months

	>2-4 hours <5d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Pálsdóttir 2020	-0.46	0.939	45	-0.21	0.9484	41	-0.25 [-0.65, 0.15]

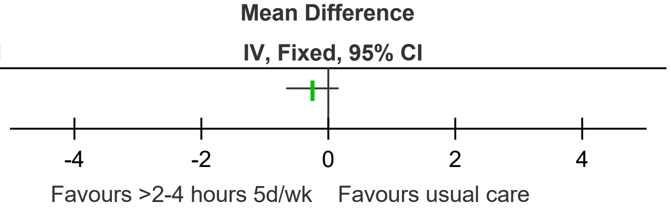


Figure 309: Psychological distress - depression (HADS depression, 0-21, lower values are better, change score) at ≥6 months

	>2-4 hours <5d/wk			Usual care			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Pálsdóttir 2020	-0.63	7.3943	47	-0.96	2.7139	41	0.33 [-1.94, 2.60]

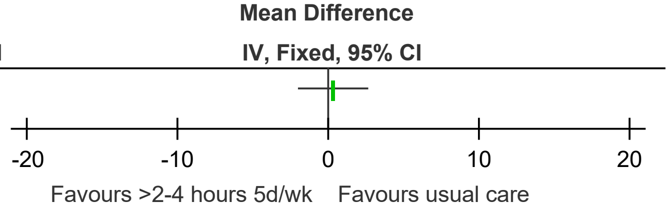
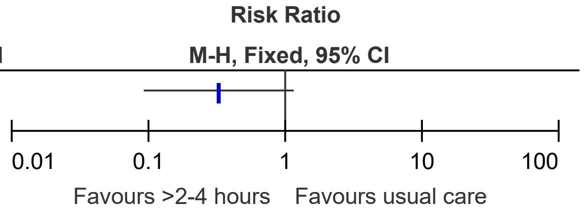


Figure 310: Discontinuation from study at ≥6 months

	>2-4 hours <5d/wk		Usual care		Risk Ratio
Study or Subgroup	Events	Total	Events	Total	M-H, Fixed, 95% CI
Pálsdóttir 2020	3	51	9	50	0.33 [0.09, 1.14]



G.6.4 Multidisciplinary team (no communication difficulties) - >4 hours, 5 days a week compared to >2 hours to 4 hours, 5 days a week for people after a first or recurrent stroke

Figure 311: Physical function - upper limb (Wolf Motor Function Test, 0-120 seconds, lower values are better, final value) at <6 months

	>4 hours 5d/wk			>2-4 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Khan 2011	33	34.7	13	34.4	42.6	29	-1.40 [-25.82, 23.02]

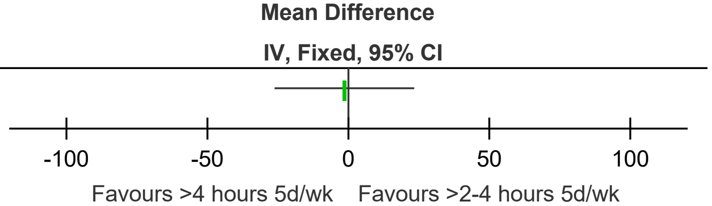


Figure 312: Physical function - upper limb (Wolf Motor Function Test, 0-120 seconds, lower values are better, final value) at ≥6 months

	>4 hours 5d/wk			>2-4 hours 5d/wk			Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	IV, Fixed, 95% CI
Khan 2011	27.9	29.1	13	33	44.1	26	-5.10 [-28.29, 18.09]

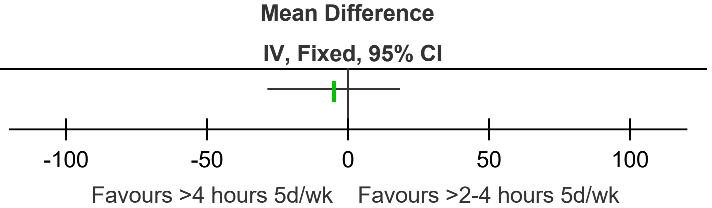


Figure 313: Discontinuation of study at <6 months

Study or Subgroup	>4 hours 5d/wk Events	>4 hours 5d/wk Total	>2-4 hours 5d/wk Events	>2-4 hours 5d/wk Total	Risk Ratio M-H, Fixed, 95% CI
Khan 2011	1	14	1	30	2.14 [0.14, 31.83]

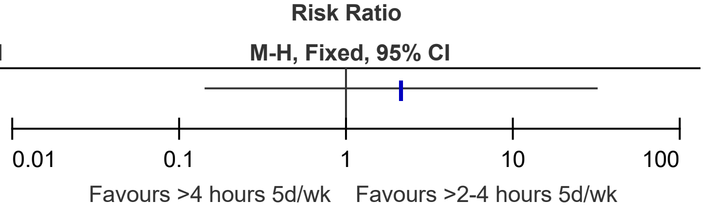
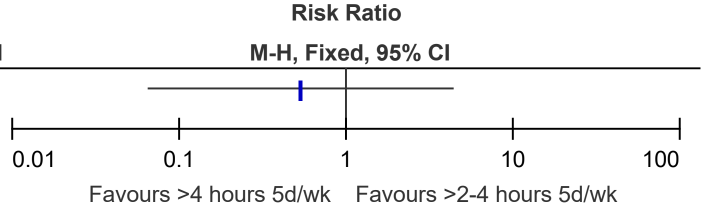


Figure 314: Discontinuation of study at ≥6 months

Study or Subgroup	>4 hours 5d/wk Events	>4 hours 5d/wk Total	>2-4 hours 5d/wk Events	>2-4 hours 5d/wk Total	Risk Ratio M-H, Fixed, 95% CI
Khan 2011	1	14	4	30	0.54 [0.07, 4.36]



Appendix H – Forest plots (mixed methods synthesis)

H.1 Person centred care: Intensity tailored to the individual

Figure 315: Physiotherapy - >45 min-1 hour 5d/wk compared to ≤45 min 5d/wk – Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Hunter 2011	0	18	0	19	48.0%	0.00 [-0.10, 0.10]
Platz 2005	1	20	1	20	52.0%	0.00 [-0.14, 0.14]
Total (95% CI)		**38**		**39**	**100.0%**	**0.00 [-0.09, 0.09]**
Total events	1		1			

Heterogeneity: Chi² = 0.00, df = 1 (P = 1.00); I² = 0%
Test for overall effect: Z = 0.00 (P = 1.00)

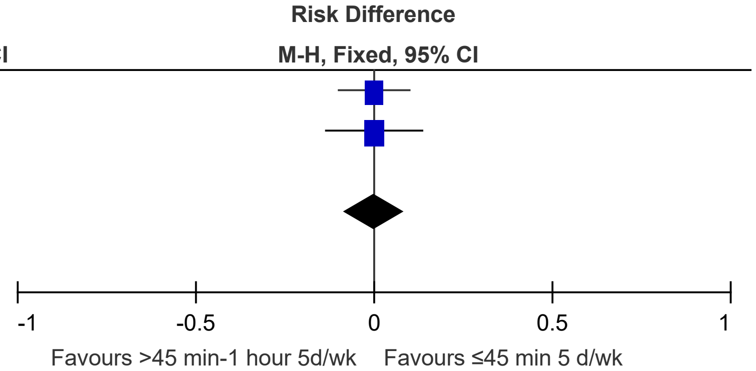


Figure 316: Physiotherapy - >1 hour-2 hours 5d/wk compared to ≤45 min 5d/wk – Discontinuation from study at <6 months

	>1-2 hours 5d/wk		≤45 min 5d/wk			Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Allison 2007	3	17	0	10	55.4%	4.28 [0.24, 75.20]
Hunter 2011	1	19	0	19	44.6%	3.00 [0.13, 69.31]
Total (95% CI)		**36**		**29**	**100.0%**	**3.71 [0.44, 30.90]**
Total events	4		0			

Heterogeneity: Chi² = 0.03, df = 1 (P = 0.87); I² = 0%
Test for overall effect: Z = 1.21 (P = 0.23)

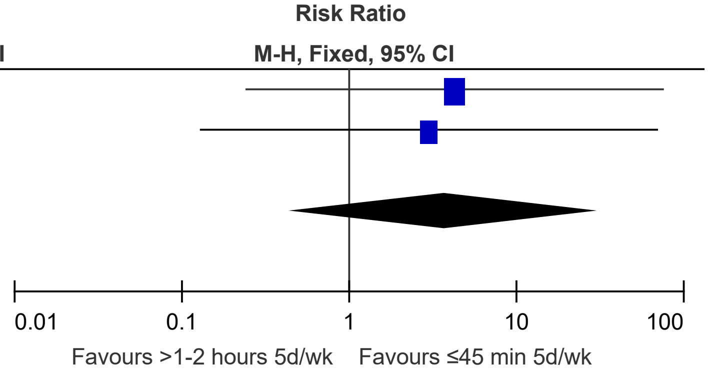


Figure 317: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Hunter 2011	6.6	11.4818	18	6.8	8.9528	18	50.8%	-0.02 [-0.67, 0.63]
Ross 2009	21	23	18	24	26	17	49.2%	-0.12 [-0.78, 0.54]
Total (95% CI)			**36**			**35**	**100.0%**	**-0.07 [-0.53, 0.40]**

Heterogeneity: Chi² = 0.04, df = 1 (P = 0.83); I² = 0%

Test for overall effect: Z = 0.29 (P = 0.77)

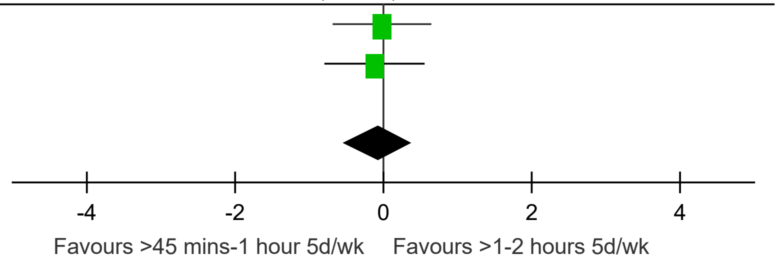
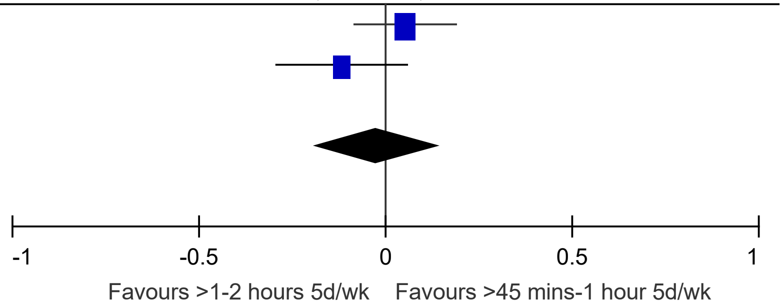


Figure 318: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Discontinuation from study at <6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% CI
Hunter 2011	1	19	0	18	55.2%	0.05 [-0.08, 0.19]
Ross 2009	0	18	2	17	44.8%	-0.12 [-0.29, 0.06]
Total (95% CI)		**37**		**35**	**100.0%**	**-0.02 [-0.19, 0.15]**
Total events	1		2			

Heterogeneity: Tau² = 0.01; Chi² = 2.38, df = 1 (P = 0.12); I² = 58%

Test for overall effect: Z = 0.27 (P = 0.79)



H.2 Person centred care: Intensity tailored to the individual (splitting therapy time during the day)

Figure 319: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Han 2013	19.7	7.09	10	13	6.38	10	43.8%	0.95 [0.02, 1.89]
Hunter 2011	6.6	11.4818	18	6.8	8.9528	18	56.2%	-0.02 [-0.67, 0.63]
Total (95% CI)			**28**			**28**	**100.0%**	**0.41 [-0.54, 1.35]**

Heterogeneity: Tau² = 0.30; Chi² = 2.78, df = 1 (P = 0.10); I² = 64%

Test for overall effect: Z = 0.84 (P = 0.40)

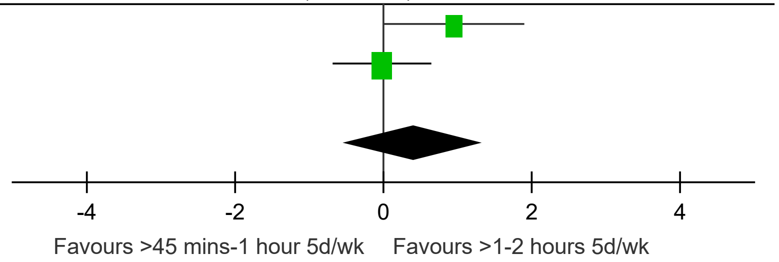
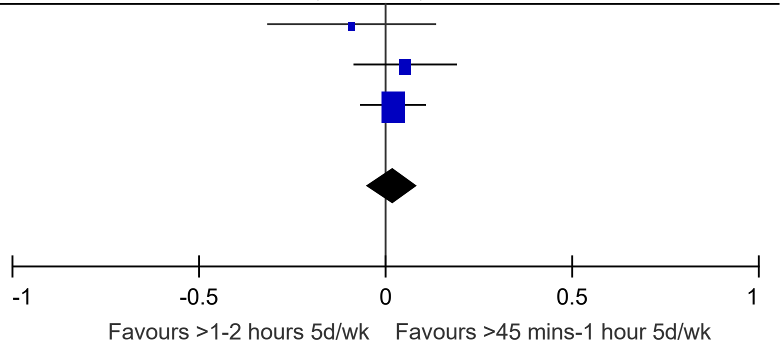


Figure 320: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Discontinuation from study at <6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% CI
Han 2013	0	10	1	11	9.5%	-0.09 [-0.31, 0.13]
Hunter 2011	1	19	0	18	25.9%	0.05 [-0.08, 0.19]
Klassen 2020	1	25	1	50	64.6%	0.02 [-0.07, 0.11]
Total (95% CI)		**54**		**79**	**100.0%**	**0.02 [-0.05, 0.09]**
Total events	2		2			

Heterogeneity: Tau² = 0.00; Chi² = 1.20, df = 2 (P = 0.55); I² = 0%

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



H.3 Person factors: Fatigue

Figure 321: Physiotherapy - >45 min-1 hour 5d/wk compared to ≤45 min 5d/wk – Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk			Risk Difference
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**
Hunter 2011	0	18	0	19	60.6%	0.00 [-0.10, 0.10]
Park 2017	2	12	2	12	39.4%	0.00 [-0.30, 0.30]
Total (95% CI)		**30**		**31**	**100.0%**	**0.00 [-0.13, 0.13]**
Total events	2		2			

Heterogeneity: Chi² = 0.00, df = 1 (P = 1.00); I² = 0%

Test for overall effect: Z = 0.00 (P = 1.00)

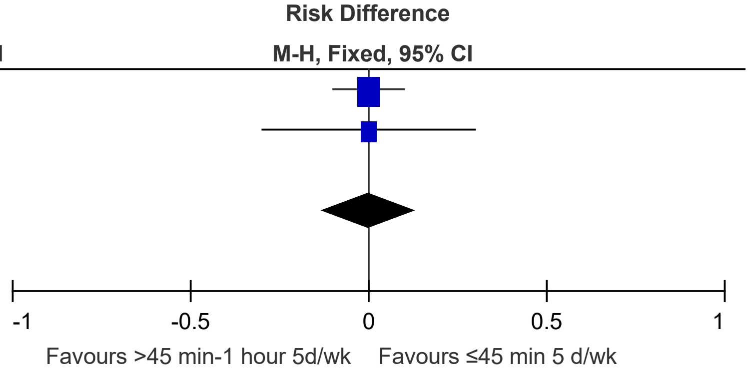


Figure 322: Physiotherapy - >1 hour-2 hours 5d/wk compared to ≤45 min 5d/wk – Discontinuation from study at <6 months

	>1-2 hours 5d/wk		≤45 min 5d/wk			Risk Ratio
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**
Allison 2007	3	17	0	10	55.4%	4.28 [0.24, 75.20]
Hunter 2011	1	19	0	19	44.6%	3.00 [0.13, 69.31]
Total (95% CI)		**36**		**29**	**100.0%**	**3.71 [0.44, 30.90]**
Total events	4		0			

Heterogeneity: Chi² = 0.03, df = 1 (P = 0.87); I² = 0%

Test for overall effect: Z = 1.21 (P = 0.23)

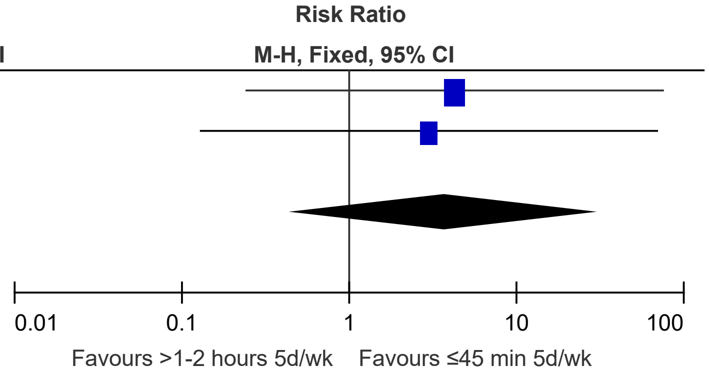


Figure 323: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Han 2013	19.7	7.09	10	13	6.38	10	43.8%	0.95 [0.02, 1.89]
Hunter 2011	6.6	11.4818	18	6.8	8.9528	18	56.2%	-0.02 [-0.67, 0.63]
Total (95% CI)			**28**			**28**	**100.0%**	**0.41 [-0.54, 1.35]**

Heterogeneity: Tau² = 0.30; Chi² = 2.78, df = 1 (P = 0.10); I² = 64%
Test for overall effect: Z = 0.84 (P = 0.40)

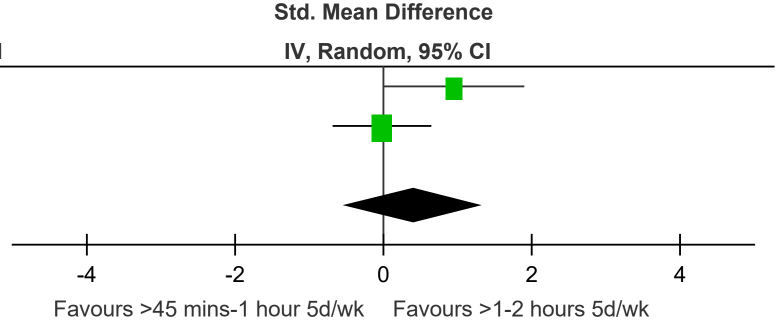
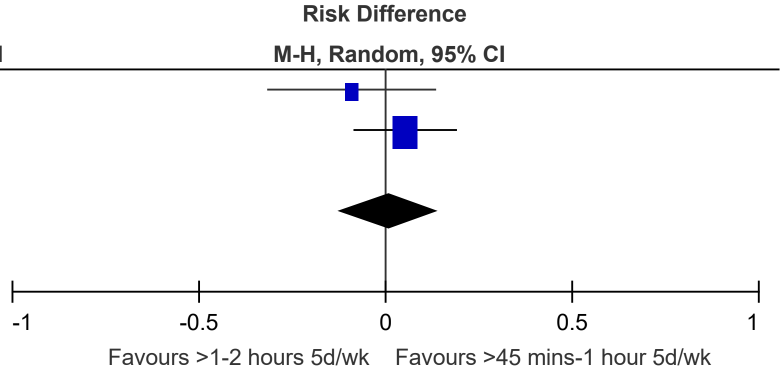


Figure 324: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Discontinuation from study at <6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% CI
Han 2013	0	10	1	11	30.8%	-0.09 [-0.31, 0.13]
Hunter 2011	1	19	0	18	69.2%	0.05 [-0.08, 0.19]
Total (95% CI)		**29**		**29**	**100.0%**	**0.01 [-0.12, 0.14]**
Total events	1		1			

Heterogeneity: Tau² = 0.00; Chi² = 1.20, df = 1 (P = 0.27); I² = 17%
Test for overall effect: Z = 0.12 (P = 0.90)



H.4 Intervention factors – Methods of achieving more intense rehabilitation: Telerehabilitation, assistive technology and computer-based tools

Figure 325: Physiotherapy - >45 min-1 hour 5d/wk compared to ≤45 min 5d/wk – Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, Berg Balance Scale [different scale ranges], higher values are better, final values) at <6 months

	>45 min-1 hour 5d/wk			≤45 min 5 d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Lee 2014	49.9	6	10	42.4	6.3	11	35.7%	1.17 [0.23, 2.11]
Min 2020	25.73	4.36	19	19.42	5.5	19	64.3%	1.24 [0.54, 1.95]
Total (95% CI)			**29**			**30**	**100.0%**	**1.22 [0.66, 1.78]**

Heterogeneity: Chi² = 0.02, df = 1 (P = 0.90); I² = 0%

Test for overall effect: Z = 4.24 (P < 0.0001)

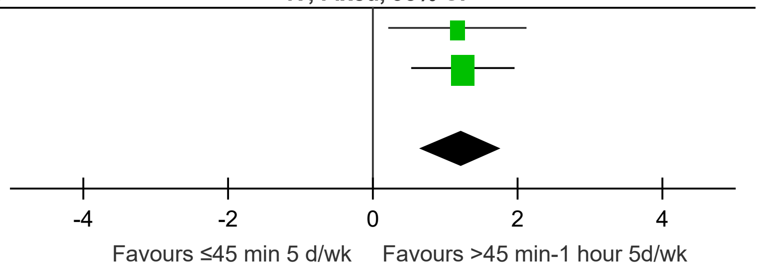


Figure 326: Physiotherapy - >45 min-1 hour 5d/wk compared to ≤45 min 5d/wk – Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Lee 2014	2	10	1	11	16.5%	0.11 [-0.19, 0.41]
Min 2020	0	19	0	19	29.9%	0.00 [-0.10, 0.10]
Park 2017	2	12	2	12	18.9%	0.00 [-0.30, 0.30]
Park 2021	0	22	0	22	34.7%	0.00 [-0.08, 0.08]
Total (95% CI)		**63**		**64**	**100.0%**	**0.02 [-0.07, 0.10]**
Total events	4		3			

Heterogeneity: Chi² = 0.68, df = 3 (P = 0.88); I² = 0%

Test for overall effect: Z = 0.41 (P = 0.68)

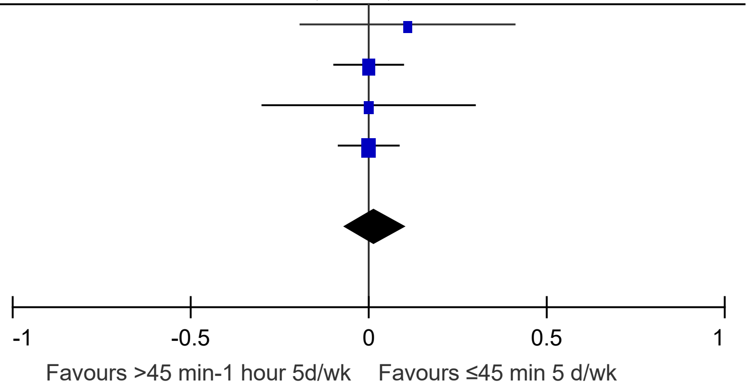


Figure 327: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Activities of daily living (Barthel Index, Canadian Occupational Performance Measure [different scale ranges], higher values are better, final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Lee 2012	70.4	18	20	68.1	12.6	20	6.1%	0.15 [-0.48, 0.77]
Rodgers 2019	15.7	3.4	468	15.3	3.8	207	88.2%	0.11 [-0.05, 0.28]
Taravati 2021	96.47	23.55	17	93.15	21.99	20	5.6%	0.14 [-0.50, 0.79]
Total (95% CI)			**505**			**247**	**100.0%**	**0.12 [-0.04, 0.27]**

Heterogeneity: Chi² = 0.02, df = 2 (P = 0.99); I² = 0%

Test for overall effect: Z = 1.49 (P = 0.14)

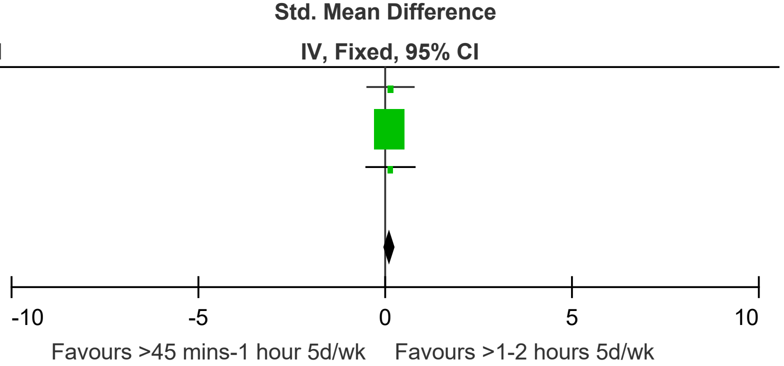


Figure 328: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, change score and final values) at <6 months

	>1-2 hours 5d/wk			>45 mins-1 hour 5d/wk				Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Fixed, 95% CI
Lee 2012	45.7	7.8	20	41.7	6.9	20	4.2%	4.00 [-0.56, 8.56]
Tollar 2021	6.8	6.28	286	4.2	6	355	95.8%	2.60 [1.64, 3.56]
Total (95% CI)			**306**			**375**	**100.0%**	**2.66 [1.72, 3.60]**

Heterogeneity: Chi² = 0.35, df = 1 (P = 0.56); I² = 0%

Test for overall effect: Z = 5.55 (P < 0.00001)

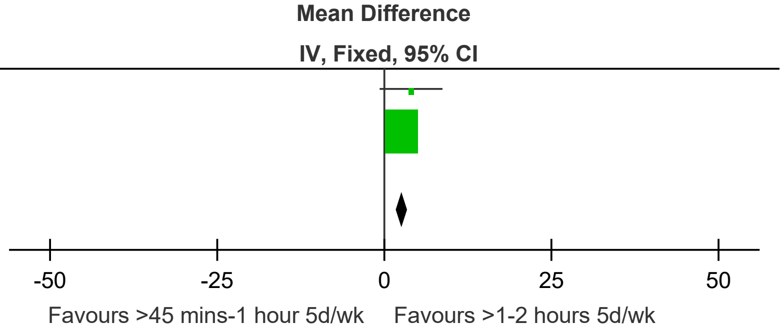


Figure 329: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Discontinuation from study at <6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk			Risk Difference
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Coskunsu 2022	1	12	3	12	2.8%	-0.17 [-0.46, 0.12]
Ikbali Afsar 2018	2	21	5	21	4.9%	-0.14 [-0.36, 0.08]
Kim 2022	4	28	2	14	4.4%	0.00 [-0.22, 0.22]
Lee 2012	0	20	0	20	4.7%	0.00 [-0.09, 0.09]
Rodgers 2019	31	516	31	244	77.9%	-0.07 [-0.11, -0.02]
Taravati 2021	5	22	3	23	5.3%	0.10 [-0.13, 0.32]
Total (95% CI)		**619**		**334**	**100.0%**	**-0.06 [-0.10, -0.02]**
Total events	43		44			

Heterogeneity: Chi² = 4.90, df = 5 (P = 0.43); I² = 0%
Test for overall effect: Z = 2.75 (P = 0.006)

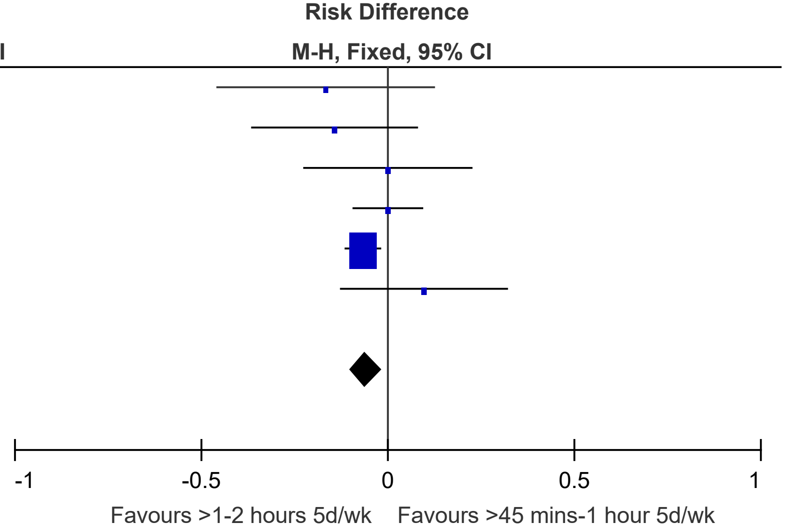
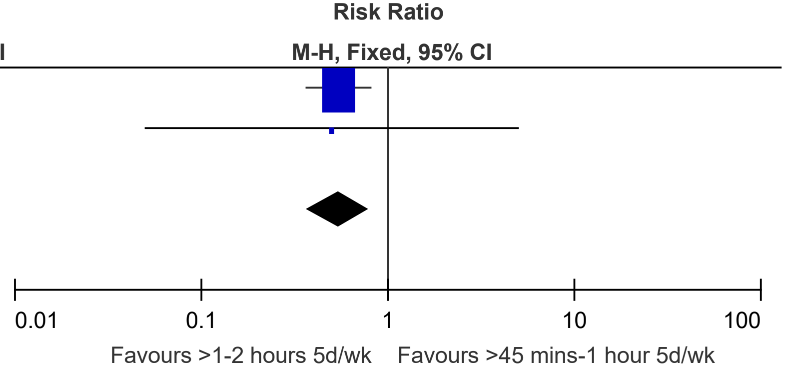


Figure 330: Physiotherapy - >1 hour-2 hours 5d/wk compared to >45 min-1 hour 5d/wk – Discontinuation from study at ≥6 months

	>1-2 hours 5d/wk		>45 mins-1 hour 5d/wk			Risk Ratio
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Fixed, 95% CI
Rodgers 2019	46	516	40	244	96.4%	0.54 [0.37, 0.81]
Wall 2020	1	16	2	16	3.6%	0.50 [0.05, 4.98]
Total (95% CI)		**532**		**260**	**100.0%**	**0.54 [0.37, 0.80]**
Total events	47		42			

Heterogeneity: Chi² = 0.00, df = 1 (P = 0.94); I² = 0%
Test for overall effect: Z = 3.08 (P = 0.002)



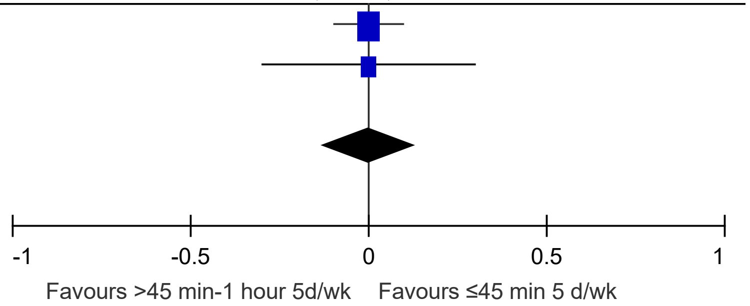
H.5 Intervention factors: Variety in activities and choice

Figure 331: Physiotherapy - >45 min-1 hour 5d/wk compared to ≤45 min 5d/wk – Discontinuation from study at <6 months

	>45 min-1 hour 5d/wk		≤45 min 5 d/wk			Risk Difference	Risk Difference
Study or Subgroup	**Events**	**Total**	**Events**	**Total**	**Weight**	**M-H, Fixed, 95% CI**	**M-H, Fixed, 95% CI**
Min 2020	0	19	0	19	61.3%	0.00 [-0.10, 0.10]	
Park 2017	2	12	2	12	38.7%	0.00 [-0.30, 0.30]	
Total (95% CI)		**31**		**31**	**100.0%**	**0.00 [-0.13, 0.13]**	
Total events	2		2				

Heterogeneity: Chi² = 0.00, df = 1 (P = 1.00); I² = 0%

Test for overall effect: Z = 0.00 (P = 1.00)



Appendix I – GRADE tables

I.1 Physiotherapy

I.1.1 ≤45 minutes

Table 1: Clinical evidence profile: Physiotherapy (no communication difficulties) - ≤45 minutes, <5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, <5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	28	31	-	MD **4.63 higher** (3.99 lower to 13.25 higher)	⊕⊕◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 6.5 weeks)												
2	randomised trials	serious[a]	serious[c]	not serious	serious[d]	none	3/53 (5.7%)	3/50 (6.0%)	**RD 0.00** (-0.10 to 0.09)	**0 fewer per 1,000** (from 100 fewer to 90 more)[e]	⊕◯◯◯ Very low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 12 months)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	8/36 (22.2%)	6/34 (17.6%)	**RR 1.26** (0.49 to 3.25)	**46 more per 1,000** (from 90 fewer to 397 more)	⊕◯◯◯ Very low	CRITICAL

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

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to missing outcome data)

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

d. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 57: Clinical evidence profile: Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale mobility subscale, 0-100, higher values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	31	28	-	MD **8.6 higher** (2.19 lower to 19.39 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (SF-36 physical component, 0-100, higher values are better, final value) at <6 months (follow-up: 3 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	very serious[b]	none	20	15	-	MD **0.01 higher** (6.85 lower to 6.87 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (SF-36 mental component, 0-100, higher values are better, final value) at <6 months (follow-up: 3 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	serious[b]	none	20	15	-	MD **13.6 higher** (4.87 higher to 22.33 higher)	⨁◯◯◯ Very low	CRITICAL
Carer generic health-related quality of life (Carer Quality of Life, 0-14, lower values are better, final value) at <6 months (follow-up: 12 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	31	28	-	MD **0.44 lower** (1.51 lower to 0.63 higher)	⊕◯◯◯ Very low	CRITICAL
Stroke outcome - modified Rankin Scale (modified Rankin Scale, 0-5, lower values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	31	28	-	MD **0.21 lower** (0.8 lower to 0.38 higher)	⊕◯◯◯ Very low	CRITICAL
Activities of daily living (Barthel index, 0-100, higher values are better, change score) at <6 months (follow-up: 3 weeks)												
1	randomised trials	very serious[d]	not serious	not serious	not serious	none	16	16	-	MD **23.5 higher** (14.3 higher to 32.7 higher)	⊕⊕◯◯ Low	CRITICAL
Activities of daily living (Barthel Index, [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 10 weeks)												
2	randomised trials	very serious[e]	not serious	not serious	serious[b]	none	51	48	-	SMD **0.48 SD higher** (0.08 higher to 0.88 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at <6 months (follow-up: 3 weeks)												
1	randomised trials	very serious[f]	not serious	not serious	not serious	none	20	15	-	MD **0** (3.05 lower to 3.05 higher)	⊕⊕◯◯ Low	CRITICAL
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, 0-34, higher values are better, change score) at <6 months (follow-up: 8 weeks)												
1	randomised trials	not serious	not serious	not serious	serious[b]	none	20	20	-	MD **7.75 higher** (2.61 higher to 12.89 higher)	⊕⊕⊕◯ Moderate	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (Berg Balance Scale, Rivermead Mobility Index [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 6 weeks)												
3	randomised trials	very serious[g]	serious[h]	not serious	serious[b]	none	73	70	-	SMD **0.64 SD higher** (0.14 higher to 1.14 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 8 weeks)												
3	randomised trials	very serious[i]	serious[j]	not serious	very serious[b]	none	5/71 (7.0%)	11/74 (14.9%)	**RR 0.50** (0.19 to 1.29)	**74 fewer per 1,000** (from 120 fewer to 43 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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 at very high risk of bias (due to bias arising from the randomisation process, bias due to missing outcome data and bias in measurement of the outcome)

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

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

f. 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 missing outcome data and bias in measurement of the outcome)

g. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to a mixture of bias arising from the randomisation process, risk of 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 1 or 2 increments because heterogeneity, unexplained by subgroup analysis

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

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

Table 60: Clinical evidence profile: Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Discontinuation from study at <6 months (follow up: 6 weeks)												
1	randomised trials	serious [a]	not serious	not serious	very serious [b]	none	0/15 (0.0%)	0/15 (0.0%)	**RD 0.00** (-0.12 to 0.12)	**0 fewer per 1,000** (from 120 fewer to 120 more) [c]	⨁◯◯◯ VERY LOW	CRITICAL

CI: Confidence interval

Explanations

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

b. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 61: Clinical evidence profile: Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (Trunk Impairment Scale, 0-23, higher values are better, final value) at <6 months (follow up: 3 weeks)												
1	randomised trials	very serious [a]	not serious	not serious	not serious	none	10	10	-	MD **4.23 higher** (3.08 higher to 5.38 higher)	⨁⨁◯◯ LOW	CRITICAL

CI: Confidence interval; **MD:** Mean difference

Explanations

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

Table 62: Clinical evidence profile: Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (SF-36 physical function subscale, 0-100, higher values are better, final value) at <6 months (follow-up: 10 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	6	6	-	MD **20 higher** (1.86 higher to 38.14 higher)	⨁◯◯◯ Very low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (6-minute walk test, meters, higher values are better, final value) at <6 months (follow-up: 10 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	serious[b]	none	6	6	-	MD **56.8 higher** (74.94 lower to 188.54 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 10 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[d]	none	0/6 (0.0%)	0/6 (0.0%)	**RD 0.00** (-0.27 to 0.27)	**0 fewer per 1,000** (from 270 fewer to 270 more)[e]	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process, bias in measurement of the outcome and bias in selection of the reported result)

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 at very high risk of bias (due to bias arising from the randomisation process and bias in measurement of the outcome)

d. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 64: Clinical evidence profile: Physiotherapy (no communication difficulties) - ≤45 minutes, 7 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - ≤45 minutes, 7 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Discontinuation from study at ≥6 months (follow up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious [a]	none	9/96 (9.4%)	6/94 (6.4%)	**RR 1.47** (0.54 to 3.96)	**30 more per 1,000** (from 29 fewer to 189 more)	⨁⨁◯◯ LOW	CRITICAL

CI: Confidence interval; **RR:** Risk ratio

Explanations

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

I.1.2 >45 minutes to 1 hour

Table 66: Clinical evidence profile: Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at <6 months (follow up: 6 weeks)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	20	8	-	MD **2.3 lower** (14.88 lower to 10.28 higher)	⨁⨁◯◯ LOW	CRITICAL
Discontinuation from study at <6 months (follow up: 6 weeks)												
1	randomised trials	serious [a]	not serious	not serious	very serious [b]	none	6/20 (30.0%)	5/10 (50.0%)	**RR 0.60** (0.24 to 1.49)	**200 fewer per 1,000** (from 380 fewer to 245 more)	⨁◯◯◯ VERY LOW	CRITICAL

CI: Confidence interval; **MD:** Mean difference; **RR:** Risk ratio

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (bias due to missing outcome data)

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

Table 68: Clinical evidence profile: Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months (follow up: 6 weeks)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	15	15	-	MD **4.8 higher** (0.93 higher to 8.67 higher)	⨁⨁◯◯ LOW	CRITICAL
Discontinuation from study at <6 months (follow up: 6 weeks)												
1	randomised trials	serious [a]	not serious	not serious	very serious [c]	none	0/15 (0.0%)	0/15 (0.0%)	**RD 0.00** (-0.12 to 0.12)	**0 fewer per 1,000** (from 120 fewer to 120 more)	⨁◯◯◯ VERY LOW	CRITICAL

CI: Confidence interval; **MD:** Mean difference

Explanations

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

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 to 2 increments for imprecision due to zero events and small sample size

Table 73: Clinical evidence profile: Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale - hand, 5-25, higher values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	29	29	-	MD **2.94 higher** (0.18 higher to 5.7 higher)	⨁⨁◯◯ Low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - hand, 5-25, higher values are better, final value) at ≥6 months (follow-up: 12 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	29	29	-	MD **2.41 higher** (0.16 lower to 4.98 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Modified Barthel Index, 0-100, higher values are better, final values) at <6 months (follow-up: mean 6 weeks)												
2	randomised trials	very serious[c]	not serious	not serious	serious[b]	none	41	41	-	MD **7.39 higher** (0.56 lower to 15.34 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 6 weeks)												
5	randomised trials	serious[d]	not serious	not serious	not serious	none	60	61	-	SMD **0.08 higher** (0.28 lower to 0.43 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at ≥6 months (follow-up: 24 weeks)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	29	29	-	MD **3.21 higher** (1.83 lower to 8.25 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, Berg Balance Scale [different scale ranges], higher values are better, change scores) at <6 months (follow-up: mean 5 weeks)												
2	randomised trials	serious[e]	not serious	not serious	serious[b]	none	26	26	-	SMD **0.91 higher** (0.33 higher to 1.48 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, Berg Balance Scale [different scale ranges], higher values are better, final values) at <6 months (follow-up: 6 weeks)												
3	randomised trials	very serious[c]	not serious	not serious	not serious	none	44	45	-	SMD **1.14 higher** (0.69 higher to 1.6 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Timed walk, units unclear, lower values are better, final values) at <6 months (follow-up: 6 weeks)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	33	22	-	MD **9.3 higher** (7.29 lower to 25.89 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Timed walk, units unclear, lower values are better, final values) at ≥6 months (follow-up: 6 months)												
1	randomised trials	serious[e]	not serious	not serious	serious[b]	none	27	33	-	MD **13.6 lower** (26.2 lower to 1 lower)	⨁⨁◯◯ Low	CRITICAL
Psychological distress - depression (HADS depression, 0-42, lower values are better, final values) at <6 months (follow-up: 6 weeks)												
1	randomised trials	serious[e]	not serious	not serious	not serious	none	46	46	-	MD **0.3 lower** (3.31 lower to 2.71 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Psychological distress - depression (HADS depression, 0-42, lower values are better, final values) at ≥6 months (follow-up: 6 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious[e]	not serious	not serious	not serious	none	43	43	-	MD **0** (3.15 lower to 3.15 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Discontinuation from study at <6 months (follow-up: 5 weeks)												
10	randomised trials	serious[f]	serious[g]	not serious	very serious[h,i]	none	11/212 (5.2%)	6/209 (2.9%)	**RD 0.02** (-0.02 to 0.07)	**20 more per 1,000** (from 20 fewer to 70 more)[i]	⊕◯◯◯ Very low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 6 months)												
2	randomised trials	serious[e]	serious[g]	not serious	very serious[b]	none	13/89 (14.6%)	10/83 (12.0%)	**RR 1.17** (0.56 to 2.44)	**20 more per 1,000** (from 80 fewer to 120 more)[i]	⊕◯◯◯ Very low	CRITICAL

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

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to bias in selection of the reported result)

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 at very high risk of bias (due to a mixture of bias arising from the randomisation process and bias in measurement of the outcome)

d. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to a mixture of bias arising from the randomisation process and bias in measurement of the outcome)

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

f. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to a mixture of bias arising from the randomisation process and bias in measurement of the outcome)

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

h. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 76: Clinical evidence profile: Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Functional Independence Measure - Upper and Lower Limbs, 0-77, higher values are better, final value) at <6 months (follow-up: 3.5 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	30	26	-	MD **9.9 higher** (3.7 higher to 16.1 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Functional Independence Measure - Upper limb Self-Care, 0-42, higher values are better, final value) at <6 months (follow-up: 3.5 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	30	26	-	MD **4.9 higher** (1.14 higher to 8.66 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Functional Independence Measure - cognitive, 0-35, higher values are better, final value) at <6 months (follow-up: 3.5 weeks)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	30	26	-	MD **7.2 higher** (4.37 higher to 10.03 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment, 0-66, higher values are better, final value) at <6 months (follow-up: 3.5 weeks)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	30	26	-	MD **0.6 lower** (7.83 lower to 6.63 higher)	⨁◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

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

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

Table 77: Clinical evidence profile: Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 7 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 7 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale, 0-100, higher values are better, final value) at ≥6 months (follow-up: 18 months)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	186	194	-	MD **0.7 lower** (7.98 lower to 6.58 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Stroke outcome - modified Rankin scale (modified Rankin scale, 0-6, lower values are better, final value) at ≥6 months (follow-up: 18 months)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	186	194	-	MD **0.05 lower** (0.37 lower to 0.27 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Activities of daily living (Barthel Index, 0-100, higher values are better, final value) at ≥6 months (follow-up: 18 months)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	186	194	-	MD **0** (0.47 lower to 0.47 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Physical function - lower limb (Berg Balance Scale item 14, 0-4, higher values are better, final value) at ≥6 months (follow-up: 18 months)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	186	194	-	MD **0.08 lower** (0.39 lower to 0.23 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 18 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 7 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious[a]	not serious	not serious	not serious	none	42/186 (22.6%)	9/194 (4.6%)	**RR 4.87** (2.44 to 9.72)	**180 more per 1,000** (from 67 more to 405 more)	⨁⨁⨁◯ Moderate	CRITICAL

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

Explanations

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

I.1.3 >1 hour to 2 hours

Table 79: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (grip strength, kg, higher values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b,c]	none	22	22	-	MD **7.3 higher** (2.39 higher to 12.21 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months (follow-up: 4 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[d]	not serious	not serious	serious[b,c]	none	12	12	-	MD **2.92 higher** (0.38 lower to 6.22 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - lower limb (timed up and go, seconds, lower values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b,c]	none	22	22	-	MD **5.8 lower** (13.4 lower to 1.8 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - lower limb (sit-to-stand test, seconds, lower values are better, final value) at <6 months (follow-up: 8 weeks)												
1	randomised trials	serious[e]	not serious	not serious	very serious[b,c]	none	14	12	-	MD **0.6 higher** (1.18 lower to 2.38 higher)	⊕◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 10 weeks)												
2	randomised trials	serious[e]	serious[f]	not serious	very serious[g,h]	none	2/39 (5.1%)	2/40 (5.0%)	**RD 0.00** (-0.10 to 0.11)	**0 fewer per 1,000** (from 100 fewer to 110 more)[g]	⊕◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process)

b. MID = 0.5 SMD

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

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

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

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

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

h. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

Table 80: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Patient/participant generic health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	71	38	-	MD **0** (0.11 lower to 0.11 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - lower limb (Modified Rivermead mobility index, 0-40, higher values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	71	38	-	MD **1.4 lower** (4.12 lower to 1.32 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Physical function - lower limb (6-minute walk test, meters, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	serious[b]	none	10	10	-	MD **46.3 meters higher** (10.83 higher to 81.77 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - lower limb (Timed up and go, 0-3, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	serious[b]	none	15	15	-	MD **0.4 higher** (0.14 lower to 0.94 higher)	⨁⨁⨁◯ Moderate	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Discontinuation from study at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[d,e]	none	0/15 (0.0%)	0/15 (0.0%)	**RD 0.00** (-0.12 to 0.12)	**0 fewer per 1,000** (from 120 fewer to 120 more)[e]	⊕⊕◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to bias due to missing outcome data)

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 at very high risk of bias (due to bias arising from the randomisation process, bias due to missing outcome data and bias in measurement of the outcome)

d. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 81: Clinical evidence profile: Physiotherapy (communication difficulties) - >1 hour to 2 hours, <5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Functional Independence Measure, 1-7, higher values are better, final value) at <6 months (follow-up: 7 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	not serious	serious[a]	none	10	10	-	MD **0.4 higher** (0.19 lower to 0.99 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months (follow-up: 7 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	10	10	-	MD **0.3 lower** (5.51 lower to 4.91 higher)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: 7 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	0/10 (0.0%)	0/10 (0.0%)	**RD 0.00** (-0.17 to 0.17)	**0 fewer per 1,000** (from 170 fewer to 170 more)[c]	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

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

b. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 83: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, motor function, 0-66, higher values are better, change score) at <6 months (follow-up: 6 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	40	20	-	MD **8.3 higher** (2.95 higher to 13.65 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, motor function, 0-66, higher values are better, change score) at ≥6 months (follow-up: 9 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	29	15	-	MD **2.83 lower** (9.12 lower to 3.46 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 6 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	1/40 (2.5%)	3/20 (15.0%)	**RR 0.17** (0.02 to 1.50)	**124 fewer per 1,000** (from 147 fewer to 75 more)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 9 months)												
1	randomised trials	serious[c]	not serious	not serious	not serious	none	6/40 (15.0%)	14/20 (70.0%)	**RR 0.21** (0.10 to 0.47)	**553 fewer per 1,000** (from 630 fewer to 371 fewer)	⨁⨁⨁◯ Moderate	CRITICAL

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

Explanations

a. Downgraded by 2 increments as the majority of the evidence was of very high risk of bias (due to bias in measurement of the outcome and bias in selection of the reported result)

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 due to missing outcome data)

Table 84: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Wolf Motor Function Test Performance Time, 0-120 seconds, lower values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	15	14	-	MD **6.4 lower** (19.09 lower to 6.29 higher)	⊕⊕◯◯ Low	CRITICAL
Stroke-related scale of cognition - spatial attention (Motor-free visual perception test, 0-46, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	15	14	-	MD **2.9 higher** (0.04 higher to 5.76 higher)	⊕⊕◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	1/16 (6.3%)	1/15 (6.7%)	**RR 0.94** (0.06 to 13.68)	**4 fewer per 1,000** (from 63 fewer to 845 more)	⊕◯◯◯ Very low	CRITICAL

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

Explanations

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

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

Table 86: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (EuroQol, 0-100, higher values are better, change score) at ≥6 months (follow-up: 6 months)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	30	34	-	MD **11.78 higher** (1.27 lower to 24.83 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Barthel Index, 0-100, higher values are better, change score and final value) at <6 months (follow-up: mean 9 weeks)												
3	randomised trials	very serious[a]	not serious	not serious	not serious	none	69	69	-	MD **0.27 higher** (0.69 lower to 1.23 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Barthel Index, 0-100, higher values are better, change score) at ≥6 months (follow-up: 6 months)												
2	randomised trials	very serious[a]	not serious	not serious	not serious	none	52	58	-	MD **0.18 lower** (1.44 lower to 1.08 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - upper limb (Action Research Arm Test, Wolf Motor Function [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 5 weeks)												
3	randomised trials	serious[c]	not serious	not serious	serious[b]	none	40	41	-	SMD **0.26 SD higher** (0.19 lower to 0.7 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - upper limb (functional reach test, cm, higher values are better, final value) at <6 months (follow-up: 5 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	6	6	-	MD **4.9 cm higher** (1.66 lower to 11.46 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (Rivermead Mobility Index, 0-15, higher values are better, change score) at <6 months (follow-up: 3 months)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	32	34	-	MD **1.2 higher** (0.15 lower to 2.55 higher)	⊕⊕◯◯ Low	CRITICAL
Physical function - lower limb (Postural Assessment Scale for Stroke patients, 0-36, higher values are better, final value) at <6 months (follow-up: 5 weeks)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	6	6	-	MD **0.17 higher** (2.52 lower to 2.86 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - lower limb (Rivermead Mobility Index, 0-15, higher values are better, change score) at ≥6 months (follow-up: 6 months)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	30	34	-	MD **0.7 higher** (0.75 lower to 2.15 higher)	⊕⊕◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 6 weeks)												
6	randomised trials	serious[c]	serious[d]	not serious	very serious[b,e]	none	19/178 (10.7%)	10/171 (5.8%)	**RD 0.05** (-0.01 to 0.10)	**50 more per 1,000** (from 10 fewer to 100 more)[e]	⊕◯◯◯ Very low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 6 months)												
2	randomised trials	very serious[a]	serious[f]	not serious	serious[b]	none	13/64 (20.3%)	8/66 (12.1%)	**RR 1.70** (0.76 to 3.81)	**85 more per 1,000** (from 29 fewer to 341 more)	⊕◯◯◯ Very low	CRITICAL

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

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to bias due to missing outcome data)

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 at high risk of bias (due to a mixture of bias arising from the randomisation process and bias due to missing outcome data)

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

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

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

Table 89: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, 7 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, 7 days a week	Relative (95% CI)	Absolute (95% CI)		
Discontinuation from study at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	9/93 (9.7%)	9/96 (9.4%)	**RR 1.03** (0.43 to 2.49)	**3 more per 1,000** (from 53 fewer to 140 more)	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **RR:** risk ratio

Explanations

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

Table 90: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final values) at <6 months (follow-up: mean 8 weeks)												
2	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	492	256	-	MD **0.06 higher** (0.02 higher to 0.09 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (EQ-5D, 5-25, higher values are better, change score) at <6 months (follow-up: 5 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	serious[b]	none	286	355	-	MD **4.65 higher** (3.32 higher to 5.98 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale Social Participation, 0-100, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[d]	not serious	not serious	serious[b]	none	11	11	-	MD **8.24 higher** (1.83 higher to 14.65 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant health-related quality of life (stroke specific quality of life, 49-245, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[e]	not serious	not serious	very serious[b]	none	17	20	-	MD **2.21 lower** (23.36 lower to 18.94 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final values) at ≥6 months (follow-up: mean 9 months)												
2	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	466	227	-	MD **0.03 higher** (0.01 lower to 0.06 higher)	⨁◯◯◯ Very low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Stroke outcome - modified Rankin scale (modified Rankin Scale, 0-6, lower values are better, change score) at <6 months (follow-up: 5 weeks)												
1	randomised trials	very serious[f]	not serious	not serious	serious[b]	none	286	355	-	MD **0.56 lower** (0.7 lower to 0.42 lower)	⨁◯◯◯ Very low	CRITICAL
Activities of daily living (Barthel Index, Functional Independence Measure - self-care score [different scale ranges], higher values are better, change scores) at <6 months (follow-up: mean 5 weeks)												
4	randomised trials	very serious[g]	very serious[h]	not serious	serious[b]	none	355	421	-	SMD **0.49 SD higher** (0 to 0.99 higher)	⨁◯◯◯ Very low	CRITICAL
Activities of daily living (Barthel Index, Functional Independence Measure, Canadian Occupational Performance Measure [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 6 weeks)												
6	randomised trials	very serious[a]	not serious	not serious	not serious	none	556	296	-	SMD **0.15 SD higher** (0.01 higher to 0.29 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Barthel Index, 0-100, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[i]	not serious	not serious	not serious	none	445	190	-	MD **0.5 higher** (0.17 lower to 1.17 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, change scores) at <6 months (follow-up: mean 4 weeks)												
2	randomised trials	very serious[j]	serious[h]	not serious	very serious[b]	none	30	25	-	SMD **0.21 SD higher** (0.72 lower to 1.15 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 7 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
6	randomised trials	very serious[k]	not serious	not serious	serious[b]	none	554	294	-	SMD **0.17 SD higher** (0.02 higher to 0.31 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Upper Extremity - shoulder, elbow and forearm, 0-36, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[l]	not serious	not serious	serious[b]	none	24	12	-	MD **1.87 higher** (1.22 lower to 4.96 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Upper Extremity - wrist, 0-10, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[l]	not serious	not serious	serious[b]	none	24	12	-	MD **1.29 higher** (0.19 higher to 2.39 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Upper Extremity - hand, 0-14, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[l]	not serious	not serious	serious[b]	none	24	12	-	MD **1.25 higher** (0.16 higher to 2.34 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Upper Extremity - coordination, 0-6, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[l]	not serious	not serious	serious[b]	none	24	12	-	MD **0.12 higher** (0.53 lower to 0.77 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-120, higher values are better, final value) at ≥6 months (follow-up: 6 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[i]	not serious	not serious	not serious	none	445	190	-	MD **0.9 higher** (3.06 lower to 4.86 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, change score and final values) at <6 months (follow-up: mean 4 weeks)												
4	randomised trials	not serious	not serious	not serious	serious[b]	none	370	463	-	MD **5.12 higher** (0.83 higher to 9.4 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, 0-36, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[m]	not serious	not serious	serious[b]	none	10	10	-	MD **1 lower** (4.33 lower to 2.33 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (6-minute walk test, meters, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[m]	not serious	not serious	serious[b]	none	13	12	-	MD **43.25 meters higher** (0.48 lower to 86.98 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (10 meter walk test, m/s, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[m]	not serious	not serious	serious[b]	none	11	11	-	MD **0.12 higher** (0.01 higher to 0.23 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (fast walking speed, m/s, higher values are better, change score) at <6 months (follow-up: 18 weeks)												
1	randomised trials	very serious[j]	not serious	not serious	serious[b]	none	12	12	-	MD **0.24 m/s higher** (0.08 higher to 0.4 higher)	⨁◯◯◯ Very low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - lower limb (Dynamic Balance Ability, scale range unclear, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	very serious[b]	none	10	10	-	MD **0.2 higher** (0.85 lower to 1.25 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - lower limb (Rivermead Motor Assessment Gross motor function subscale, 0-13, higher values are better, final value) at <6 months (follow-up: 3 weeks)												
1	randomised trials	serious[n]	not serious	not serious	serious[b]	none	37	10	-	MD **2.1 higher** (0.17 lower to 4.37 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Rivermead Motor Assessment leg and trunk subscale, 0-13, higher values are better, final value) at <6 months (follow-up: 3 weeks)												
1	randomised trials	serious[n]	not serious	not serious	serious[b]	none	37	10	-	MD **2.4 higher** (0.5 higher to 4.3 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Rivermead Motor Assessment Gross motor function subscale, 0-13, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	serious[n]	not serious	not serious	serious[b]	none	35	10	-	MD **2 higher** (0.21 higher to 3.79 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Rivermead Motor Assessment leg and trunk subscale, 0-13, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	serious[n]	not serious	not serious	serious[b]	none	35	10	-	MD **2 higher** (0.28 higher to 3.72 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (6-minute walk test, meters, higher values are better, final value) at ≥6 months (follow-up: 12 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious[o]	not serious	not serious	very serious[b]	none	21	36	-	MD **1 meters lower** (83.98 lower to 81.98 higher)	⨁◯◯◯ Very low	CRITICAL
Psychological distress - depression (PHQ-9, Center for Epidemiological Studies - Depression [different scale ranges], lower values are better, final values) at <6 months (follow-up: mean 4 weeks)												
2	randomised trials	not serious	serious[h]	not serious	serious[b]	none	24	48	-	SMD **0.41 SD lower** (1.08 lower to 0.27 higher)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 6 weeks)												
16	randomised trials	serious[p]	serious[q]	not serious	not serious[r]	none	59/827 (7.1%)	59/535 (11.0%)	**RD -0.03** (-0.06 to 0.00)	**30 fewer per 1,000** (from 60 fewer to 0 fewer)[r]	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: mean 8 months)												
4	randomised trials	serious[s]	not serious	not serious	not serious	none	59/600 (9.8%)	59/323 (18.3%)	**RR 0.56** (0.40 to 0.80)	**80 fewer per 1,000** (from 110 fewer to 37 fewer)	⨁⨁⨁◯ Moderate	CRITICAL

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

Explanations

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

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 at very high risk of bias (due to bias arising from the randomisation process and bias in measurement of outcome)

d. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process and bias in selection of the reported result)

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

f. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process)

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

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

i. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias due to missing outcome data and bias in measurement of outcome)

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

k. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to a mixture of 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 outcome)

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

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

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

o. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to bias due to missing outcome data)

p. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to a mixture of bias arising from the randomisation process and bias due to missing outcome data)

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

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

s. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to a mixture of bias due to missing outcome data and bias in measurement of outcome)

Table 94: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale - Mobility subscale, 0-100, higher values are better, final value) at ≥6 months (follow-up: 26 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious[a]	not serious	not serious	not serious	none	30	32	-	MD **1.5 higher** (8.27 lower to 11.27 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Recovery subscale, 0-100, higher values are better, final value) at ≥6 months (follow-up: 26 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	30	32	-	MD **2.9 higher** (6.63 lower to 12.43 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Barthel index, 0-100, higher values are better, final value) at ≥6 months (follow-up: 26 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	30	32	-	MD **1.1 higher** (5.71 lower to 7.91 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at ≥6 months (follow-up: 26 weeks)												
1	randomised trials	not serious	not serious	not serious	serious[b]	none	30	32	-	MD **1.8 higher** (3.73 lower to 7.33 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 26 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[b,c]	none	2/30 (6.7%)	0/32 (0.0%)	**OR 8.18** (0.50 to 133.94)	**70 fewer per 1,000** (from 40 fewer to 170 more)[c]	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference; **OR:** odds ratio

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to bias in selection of the reported result)

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

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

Table 95: Clinical evidence profile: Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week compared to >45 minutes to 1 hour, 6 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	>45 minutes to 1 hour, 6 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale - Strength subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	9	9	-	MD **12.2 lower** (27.37 lower to 2.97 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Memory subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	9	9	-	MD **3.9 higher** (9.24 lower to 17.04 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Mood subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	9	9	-	MD **4.8 lower** (19.01 lower to 9.41 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Communication subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	9	9	-	MD **0.7 higher** (17.77 lower to 19.17 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Activities of daily living subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	>45 minutes to 1 hour, 6 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	9	9	-	MD **9 lower** (22.76 lower to 4.76 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Mobility subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	9	9	-	MD **4.8 lower** (17.36 lower to 7.76 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Hand use subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	9	9	-	MD **5.3 lower** (28.53 lower to 17.93 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke Impact Scale - Activities subscale, 0-80, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	9	9	-	MD **17.5 lower** (33.26 lower to 1.74 lower)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	serious[c]	not serious	not serious	very serious[b]	none	9	9	-	MD **3 lower** (18.9 lower to 12.9 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 6 months)												
1	randomised trials	serious[c]	not serious	not serious	very serious[b]	none	1/9 (11.1%)	2/11 (18.2%)	**RR 0.61** (0.07 to 5.70)	**71 fewer per 1,000** (from 169 fewer to 855 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at very high risk of bias (due to bias due to missing outcome data and bias in measurement of the outcome)

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 at high risk of bias (due to bias due to missing outcome data)

I.1.4 >2 hours to 4 hours

Table 98: Clinical evidence profile: Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at <6 months (follow-up: 14 days)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	20	19	-	MD **3.3 higher** (4.36 lower to 10.96 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Discontinuation from study at <6 months (follow-up: 14 days)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	0/20 (0.0%)	0/19 (0.0%)	**RD 0.00** (-0.09 to 0.09)	**0 fewer per 1,000** (from 90 fewer to 90 more)[c]	⨁◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to bias due to missing outcome data)

b. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 99: Clinical evidence profile: Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 4 weeks)												
2	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	21	21	-	SMD **0.24 SD higher** (0.37 lower to 0.85 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months (follow-up: 4 weeks)												
2	randomised trials	serious[c]	very serious[d]	not serious	serious[b]	none	30	28	-	SMD **0.83 SD higher** (0.4 lower to 2.06 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - lower limb (Wolf Motor Function Test Performance Time, 0-120 seconds, lower values are better, final values) at <6 months (follow-up: 2 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	11	11	-	MD **5.3 seconds lower** (18.67 lower to 8.07 higher)	⊕◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 3 weeks)												
3	randomised trials	serious[c]	serious[e]	not serious	very serious[g]	none	3/46 (6.5%)	1/40 (2.5%)	**RD 0.04** (-0.06 to 0.14)	**40 more per 1,000** (from 60 fewer to 140 more)[f]	⊕◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference; **SMD:** standardised mean difference

Explanations

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

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 at high risk of bias (due to bias arising from the randomisation process)

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

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

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

g. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

Table 100: Clinical evidence profile: Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at <6 months (follow-up: 7 weeks)												
3	randomised trials	very serious[a]	very serious[b]	not serious	serious[c]	none	48	40	-	SMD **0.75 SD higher** (0.3 lower to 1.81 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm Test [different scale ranges], higher values are better, final values) at <6 months (follow-up: 3 weeks)												
3	randomised trials	serious[d]	not serious	not serious	serious[c]	none	47	37	-	SMD **0.45 SD higher** (0.01 higher to 0.89 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final values) at <6 months (follow-up: 12 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[e]	not serious	not serious	not serious	none	21	21	-	MD **23.6 higher** (15.83 higher to 31.37 higher)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: 7 weeks)												
3	randomised trials	serious[d]	not serious	not serious	very serious[f,g]	none	1/52 (1.9%)	1/50 (2.0%)	**RD 0.00** (-0.08 to 0.08)	**0 fewer per 1,000** (from 80 fewer to 80 more)[g]	⨁◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference; **SMD:** standardised mean difference

Explanations

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

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

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

d. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to a mixture of bias arising from the randomisation process and bias due to missing outcome data)

e. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process and bias in measurement of the outcome)

f. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 103: Clinical evidence profile: Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 6 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 6 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical Function - upper limb (Action Research Arm Test, 0-57, higher values are better, change score) at <6 months (follow-up: 3 months)												
1	randomised trials	not serious	not serious	not serious	not serious	none	53	50	-	MD **4.7 higher** (0.63 higher to 8.77 higher)	⨁⨁⨁⨁ High	CRITICAL
Discontinuation from study at <6 months (follow-up: 3 months)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	3/53 (5.7%)	6/50 (12.0%)	**RR 0.47** (0.12 to 1.79)	**64 fewer per 1,000** (from 106 fewer to 95 more)	⨁⨁◯◯ Low	CRITICAL

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

Explanations

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

I.1.5 >4 hours

Table 104: Clinical evidence profile: Physiotherapy (no communication difficulties) - >4 hours, 5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >4 hours, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke impact scale hand function, scale range unclear, higher values are better, change score) at ≥6 months (follow-up: 12 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	106	116	-	MD **0.3 higher** (0.04 higher to 0.56 higher)	⨁◯◯◯ Very low	CRITICAL
Person/participant generic health-related quality of life (Stroke impact scale physical function, scale range unclear, higher values are better, change score) at ≥6 months (follow-up: 12 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	106	116	-	MD **7.04 higher** (0.6 lower to 14.68 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - lower limb (Wolf Motor Function Test Log Performance Time, higher values are better, change score) at ≥6 months (follow-up: 12 months)												
1	randomised trials	very serious[a]	not serious	not serious	not serious	none	106	116	-	MD **1.14 higher** (4.86 lower to 7.14 higher)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: 2 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	8/106 (7.5%)	11/116 (9.5%)	**RR 0.80** (0.33 to 1.90)	**19 fewer per 1,000** (from 64 fewer to 85 more)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 12 months)												
1	randomised trials	serious[c]	not serious	not serious	very serious[b]	none	23/106 (21.7%)	30/116 (25.9%)	**RR 0.84** (0.52 to 1.35)	**41 fewer per 1,000** (from 124 fewer to 91 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

a. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias due to missing outcome data and bias in selection of the reported result)

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 at high risk of bias (due to bias due to missing outcome data)

Table 105: Clinical evidence profile: Physiotherapy (no communication difficulties) - >4 hours, 5 days a week compared to >2 hours to 4 hours, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy (no communication difficulties) - >4 hours, 5 days a week	>2 hours to 4 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-66, higher values are better, final value) at <6 months (follow-up: 3 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	30	30	-	MD **3.64 higher** (1.48 higher to 5.8 higher)	⊕◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 8 weeks)												
2	randomised trials	very serious[c]	serious[d]	not serious	very serious[f]	none	2/45 (4.4%)	3/45 (6.7%)	**RD -0.02** (-0.12 to 0.08)	**20 fewer per 1,000** (from 120 fewer to 80 more)[e]	⊕◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process and bias in measurement of the outcome)

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 at very high risk of bias (due to bias arising from the randomisation process and risk of bias due to deviations from the intended interventions)

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

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

f. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

I.2 Occupational Therapy

I.2.1 ≤45 minutes

Table 55: Clinical evidence profile: Occupational therapy (no communication difficulties) - ≤45 minutes, <5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - ≤45 minutes, <5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale total, 0-100, higher values are better, final value) at <6 months (follow-up: 8 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	9	9	-	MD **2.3 higher** (10.96 lower to 15.56 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment - Upper Extremity, 0-66, higher values are better, final value) at <6 months (follow-up: 8 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	9	9	-	MD **0.4 lower** (13.35 lower to 12.55 higher)	⊕◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 8 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - ≤45 minutes, <5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	3/67 (4.5%)	2/71 (2.8%)	**RR 1.59** (0.27 to 9.22)	**17 more per 1,000** (from 21 fewer to 232 more)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 6 months)												
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	7/67 (10.4%)	8/71 (11.3%)	**RR 0.93** (0.36 to 2.42)	**8 fewer per 1,000** (from 72 fewer to 160 more)	⨁⨁◯◯ Low	CRITICAL

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

Explanations

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

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

Table 58: Clinical evidence profile: Occupational therapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months (follow-up: 6 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	7	7	-	MD **10.18 higher** (4.02 lower to 24.38 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months (follow-up: 6 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	serious[b]	none	18	17	-	MD **4.36 higher** (1.19 higher to 7.53 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 6 weeks)												
1	randomised trials	serious[d]	not serious	not serious	very serious[b]	none	2/20 (10.0%)	3/20 (15.0%)	**RR 0.67** (0.12 to 3.57)	**49 fewer per 1,000** (from 132 fewer to 385 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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 in measurement of the outcome)

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)

Table 59: Clinical evidence profile: Occupational therapy (communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (communication difficulties) - ≤45 minutes, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Korean Shoulder Disability Questionnaire, 0-100, lower values are better, final value) at <6 months (follow-up: 8 weeks)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	18	18	-	MD **17 lower** (22.39 lower to 11.61 lower)	⨁⨁⨁◯ Moderate	CRITICAL
Discontinuation from study at <6 months (follow-up: 8 weeks)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	1/19 (5.3%)	1/19 (5.3%)	**RR 1.00** (0.07 to 14.85)	**0 fewer per 1,000** (from 49 fewer to 729 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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

I.2.2 >45 minutes to 1 hour

Table 67: Clinical evidence profile: Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months (follow up: 6 weeks)												
1	randomised trials	very serious [a]	not serious	not serious	serious [b]	none	7	7	-	MD **10.18 higher** (4.02 lower to 24.38 higher)	⨁◯◯◯ VERY LOW	CRITICAL

CI: Confidence interval; **MD:** Mean difference

Explanations

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

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

Table 71: Clinical evidence profile: Multidisciplinary team (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months (follow-up: 3 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	17	18	-	MD **14.5 higher** (5.67 higher to 23.33 higher)	⨁◯◯◯ Very low	CRITICAL
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at ≥6 months (follow-up: 8 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	17	18	-	MD **14.4 higher** (6.04 higher to 22.76 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment - Shoulder/elbow and coordination subsections, 0-42, higher values are better, final value) at <6 months (follow-up: 3 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	17	18	-	MD **9.9 higher** (5.01 higher to 14.79 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment - Shoulder/elbow and coordination subsections, 0-42, higher values are better, final value) at ≥6 months (follow-up: 8 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	17	18	-	MD **9.5 higher** (2.4 higher to 16.6 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment - Wrist/hand subsections, 0-24, higher values are better, final value) at <6 months (follow-up: 3 months)												
1	randomised trials	very serious[a]	not serious	not serious	not serious	none	17	18	-	MD **0.3 lower** (2.35 lower to 1.75 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Fugl Meyer Assessment - Wrist/hand subsections, 0-24, higher values are better, final value) at ≥6 months (follow-up: 8 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	17	18	-	MD **0.2 higher** (2.12 lower to 2.52 higher)	⨁◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

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

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

Table 74: Clinical evidence profile: Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months (follow-up: mean 10 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
2	randomised trials	serious[a]	very serious[b]	serious[c]	not serious	none	68	46	-	MD **1.46 higher** (1.92 lower to 4.84 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at ≥6 months (follow-up: 12 months)												
1	randomised trials	serious[d]	not serious	serious[c]	serious[e]	none	60	30	-	MD **6.52 higher** (5.01 higher to 8.03 higher)	⨁◯◯◯ Very low	CRITICAL
Swallow function and ability (Penetration Aspiration Scale, 1-8, lower values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	very serious[f]	not serious	not serious	serious[e]	none	9	9	-	MD **1.56 lower** (2.45 lower to 0.67 lower)	⨁◯◯◯ Very low	CRITICAL
Discontinuation at <6 months (follow-up: 10 weeks)												
2	randomised trials	serious[g]	not serious	serious[c]	serious[h,i]	none	0/69 (0.0%)	0/39 (0.0%)	**RD 0.0** (-0.6 to 0.6)	**0 fewer per 1,000** (from 60 fewer to 60 more)[j]	⨁◯◯◯ Very low	CRITICAL
Discontinuation at ≥6 months (follow-up: 12 months)												
1	randomised trials	serious[d]	not serious	serious[c]	serious[h,i]	none	0/60 (0.0%)	0/30 (0.0%)	**RD 0.00** (-0.05 to 0.05)	**0 fewer per 1,000** (from 50 fewer to 50 more)[j]	⨁◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

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

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

c. Downgraded by 1 increment due to comparator indirectness (due to the comparator group not including a passive component of the intervention that was available to a portion of the population combined in the intervention group of one study)

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

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

f. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process and bias in measurement of the outcome)

g. Downgraded by 1 increment as the majority of the evidence was of high risk of bias (due to a mixture of bias arising from the randomisation process and bias due to deviations from the intended interventions)

h. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

I.2.3 >1 hour to 2 hours

Table 85: Clinical evidence profile: Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale-16, 0-100, higher values are better, change score) at <6 months (follow-up: 8 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	not serious	none	12	9	-	MD **9.58 higher** (7.27 higher to 11.89 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-66, higher values are better, change score) at <6 months (follow-up: 8 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[a]	not serious	not serious	not serious	none	12	9	-	MD **2.1 higher** (1.27 higher to 2.93 higher)	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

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

Table 87: Clinical evidence profile: Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant health-related quality of life (stroke-specific quality of life, 49-245, higher values are better, final value) at <6 months (follow-up: 8 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	25	25	-	MD **3.2 higher** (10 lower to 16.4 higher)	⨁◯◯◯ Very low	CRITICAL
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months (follow-up: 8 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	25	25	-	MD **1.3 higher** (3.57 lower to 6.17 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl-Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months (follow-up: 8 weeks)												
1	randomised trials	very serious[c]	not serious	not serious	not serious	none	8	16	-	MD **2.5 higher** (0.2 higher to 4.8 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress - depression (Beck Depression Inventory, 0-63, lower values are better, final value) at <6 months (follow-up: 8 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	25	25	-	MD **2.4 lower** (5.27 lower to 0.47 higher)	⨁◯◯◯ Very low	CRITICAL
Swallow function and ability (Functional Oral Intake Scale, 1-7, higher values are better, final value) at <6 months (follow-up: 8 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	25	25	-	MD **1 higher** (0.39 higher to 1.61 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 3 weeks)												
1	randomised trials	serious[d]	not serious	not serious	very serious[b]	none	5/30 (16.7%)	3/30 (10.0%)	**RR 1.67** (0.44 to 6.36)	**67 more per 1,000** (from 56 fewer to 536 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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 at 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 at very high risk of bias (due to bias arising from the randomisation process)

Table 91: Clinical evidence profile: Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Stroke Impact Scale - Upper Limb Items, 5-25, higher values are better, final value) at <6 months (follow-up: 15 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	70	35	-	MD **1.2 lower** (4.19 lower to 1.79 higher)	⊕⊕◯◯ Low	CRITICAL
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months (follow-up: 15 weeks)												
1	randomised trials	serious[a]	not serious	not serious	not serious	none	70	35	-	MD **7.3 lower** (14.84 lower to 0.24 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, change score and final value) at <6 months (follow-up: mean 12 weeks)												
2	randomised trials	very serious[c]	serious[d]	not serious	not serious	none	78	43	-	MD **1.14 higher** (3.94 lower to 6.22 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - upper limb (Motor Assessment Scale, 0-18, higher values are better, final value) at <6 months (follow-up: 7 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	not serious	very serious[b]	none	23	22	-	MD **1.3 higher** (1.71 lower to 4.31 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, change score and final value) at <6 months (follow-up: 5 weeks)												
2	randomised trials	not serious	not serious	not serious	not serious	none	21	21	-	MD **1.24 higher** (0.5 higher to 1.97 higher)	⨁⨁⨁⨁ High	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 9 weeks)												
3	randomised trials	serious[a]	serious[e]	not serious	very serious[b]	none	8/106 (7.5%)	5/71 (7.0%)	**RD 0.00** (-0.08 to 0.08)	**0 fewer per 1,000** (from 80 fewer to 80 more)[f]	⨁◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

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

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 at very high risk of bias (due to bias arising from the randomisation process and bias due to missing outcome data)

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

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

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

I.2.4 >2 hours to 4 hours

Table 102: Clinical evidence profile: Occupational therapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Occupational therapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Functional Independence Measure, 13-91, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	24	24	-	MD **8.9 higher** (3.96 higher to 13.84 higher)	⨁⨁◯◯ Low	CRITICAL
Acitivities of daily living (Barthel Index, 0-20, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	24	24	-	MD **1.2 higher** (0.07 higher to 2.33 higher)	⨁⨁◯◯ Low	CRITICAL
Psychological distress - Depression (HADS depression, 0-21, lower values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	24	24	-	MD **4.5 lower** (6.5 lower to 2.5 lower)	⨁⨁◯◯ Low	CRITICAL
Discontinuation of study at <6 months (follow-up: 4 weeks)												
2	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	3/27 (11.1%)	4/28 (14.3%)	**RR 0.78** (0.19 to 3.16)	**31 fewer per 1,000** (from 116 fewer to 309 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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

I.3 Speech and Language Therapy

I.3.1 Individual patient data meta-analysis results – Hours per week

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - 9+ hours per week compared to 4-9 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	9+ hours per week	4-9 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	96	50	-	MD **3.42 higher** (6.45 lower to 13.29 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	46	41	-	MD **2.84 lower** (12.45 lower to 6.77 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	141	103	-	MD **4.83 higher** (0.17 higher to 9.49 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	9+ hours per week	4-9 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	serious[a]	not serious	none	60	59	-	MD **0.16 higher** (0.37 lower to 0.69 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - 9+ hours per week compared to 3-4 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	9+ hours per week	3-4 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	96	104	-	MD **0.16 lower** (9.56 lower to 9.24 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	9+ hours per week	3-4 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	serious[a]	not serious	none	46	127	-	MD **6.83 lower** (15.96 lower to 2.3 higher)	⨁⨁⨁◯ Moderate	CRITICAL

Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)

1	randomised trials	not serious	not serious	serious[a]	not serious	none	141	112	-	MD **1.29 higher** (4.57 lower to 7.15 higher)	⨁⨁⨁◯ Moderate	CRITICAL

Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)

1	randomised trials	not serious	not serious	serious[a]	not serious	none	60	178	-	MD **0.01 lower** (0.51 lower to 0.49 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - 9+ hours per week compared to 2-3 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	9+ hours per week	2-3 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	96	93	-	MD **5.46 higher** (3.37 lower to 14.29 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	46	101	-	MD **3.18 lower** (11.65 lower to 5.29 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	141	120	-	MD **6.98 higher** (2.33 higher to 11.63 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	60	73	-	MD **0.07 lower** (0.61 lower to 0.47 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - 9+ hours per week compared to up to 2 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	9+ hours per week	up to 2 hours of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	96	72	-	MD **0.21 lower** (10.2 lower to 9.78 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	46	18	-	MD **10.96 lower** (20.48 lower to 1.44 lower)	⨁⨁◯◯ Low	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	141	19	-	MD **0.8 higher** (4.68 lower to 6.28 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	60	83	-	MD **0.08 lower** (0.62 lower to 0.46 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 4-9 hours per week compared to 3-4 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	4-9 hours per week	3-4 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	50	104	-	MD **3.58 lower** (13.75 lower to 6.59 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	41	127	-	MD **3.99 lower** (14.24 lower to 6.26 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	103	112	-	MD **3.54 lower** (9.52 lower to 2.44 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	59	178	-	MD **0.17 lower** (0.69 lower to 0.35 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 4-9 hours per week compared to 2-3 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	4-9 hours per week	2-3 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	50	93	-	MD **2.04 higher** (7.61 lower to 11.69 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	41	101	-	MD **0.34 lower** (10.01 lower to 9.33 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	103	120	-	MD **2.15 higher** (2.65 lower to 6.95 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	59	73	-	MD **0.23 lower** (0.8 lower to 0.34 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 4-9 hours per week compared to up to 2 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	4-9 hours per week	up to 2 hours of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	50	72	-	MD **3.63 lower** (14.35 lower to 7.09 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	41	18	-	MD **8.12 lower** (18.72 lower to 2.48 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	103	19	-	MD **4.03 lower** (9.64 lower to 1.58 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	59	83	-	MD **0.24 lower** (0.8 lower to 0.32 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 3-4 hours per week compared to 2-3 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	3-4 hours per week	2-3 hours per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	104	93	-	MD **5.62 higher** (3.55 lower to 14.79 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	127	101	-	MD **3.65 higher** (5.54 lower to 12.84 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	112	120	-	MD **5.69 higher** (0.28 lower to 11.66 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	178	73	-	MD **0.06 lower** (0.6 lower to 0.48 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 3-4 hours per week compared to up to 2 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	3-4 hours per week	up to 2 hours of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	104	72	-	MD **0.05 lower** (10.34 lower to 10.24 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	127	18	-	MD **4.13 lower** (14.29 lower to 6.03 higher)	⊕⊕◯◯ Low	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	very serious[b]	none	112	19	-	MD **0.49 lower** (7.13 lower to 6.15 higher)	⊕◯◯◯ Very low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	178	83	-	MD **0.07 lower** (0.6 lower to 0.46 higher)	⊕⊕⊕◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 2-3 hours per week compared to up to 2 hours per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	2-3 hours per week	up to 2 hours of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	93	72	-	MD **5.67 lower** (15.44 lower to 4.1 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	101	18	-	MD **7.78 lower** (17.35 lower to 1.79 higher)	⊕⊕◯◯ Low	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	120	19	-	MD **6.18 lower** (11.78 lower to 0.58 lower)	⊕⊕◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	73	83	-	MD **0.01 lower** (0.59 lower to 0.57 higher)	⊕⊕⊕◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (interventions provided for hours per week rather than hours per day, outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

I.3.2 Individual patient data meta-analysis results – Days per week

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 5+ days per week compared to 5 days per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5+ days per week	5 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	32	194	-	MD **0.81 lower** (10.82 lower to 9.2 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	51	171	-	MD **2.25 lower** (7.27 lower to 2.77 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	9	155	-	MD **0.12 lower** (0.76 lower to 0.52 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 5+ days per week compared to 4 days per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5+ days per week	4 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	32	76	-	MD **1.06 higher** (9.82 lower to 11.94 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	104	103	-	MD **3.73 lower** (11.9 lower to 4.44 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	51	114	-	MD **3.48 lower** (9.21 lower to 2.25 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	9	102	-	MD **0.04 lower** (0.76 lower to 0.68 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 5+ days per week compared to 3 days per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5+ days per week	3 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	very serious[b]	none	32	21	-	MD **0.79 higher** (10.78 lower to 12.36 higher)	⨁◯◯◯ Very low	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	104	84	-	MD **2.38 lower** (10.25 lower to 5.49 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	51	89	-	MD **0.52 higher** (4.99 lower to 6.03 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	9	93	-	MD **0.04 higher** (0.65 lower to 0.73 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 5+ days per week compared to up to 2 days per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5+ days per week	up to 2 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	32	90	-	MD **3.9 higher** (6.37 lower to 14.17 higher)	⊕⊕⊕◯ Moderate	CRITICAL
Communication - Naming (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	104	42	-	MD **7.99 lower** (16.03 lower to 0.05 higher)	⊕⊕◯◯ Low	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	51	64	-	MD **2.89 higher** (2.37 lower to 8.15 higher)	⊕⊕◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5+ days per week	up to 2 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	serious[a]	not serious	none	9	82	-	MD **0.14 higher** (0.52 lower to 0.8 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 5 days per week compared to 4 days per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days per week	4 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	194	76	-	MD **1.87 higher** (7.93 lower to 11.67 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days per week	4 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	serious[a]	not serious	none	171	114	-	MD **1.23 lower** (6.45 lower to 3.99 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	155	102	-	MD **0.08 higher** (0.46 lower to 0.62 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 5 days per week compared to 3 days per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days per week	3 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	194	21	-	MD **1.6 higher** (8.96 lower to 12.16 higher)	⨁⨁◯◯ Low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days per week	3 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	171	89	-	MD **2.77 higher** (2.2 lower to 7.74 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	155	93	-	MD **0.16 higher** (0.33 lower to 0.65 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

Table 63: Clinical evidence profile: Speech and Language Therapy (communication difficulties) – 5 days per week compared to up to 2 days per week of speech and language therapy for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	5 days per week	up to 2 days per week of speech and language therapy	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	194	90	-	MD **4.71 higher** (4.4 lower to 13.82 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Auditory Comprehension (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	serious[b]	none	171	64	-	MD **5.14 higher** (0.44 higher to 9.84 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)												
1	randomised trials	not serious	not serious	serious[a]	not serious	none	155	82	-	MD **0.26 higher** (0.19 lower to 0.71 higher)	⨁⨁⨁◯ Moderate	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. Downgraded by 1 increment for indirectness (outcomes reported for an undefined period of time, comparisons included in the network meta analysis include no treatment comparisons which would otherwise be excluded from this review. Given the importance of these variations it was decided to downgraded by 1 increment only.)

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

I.3.3 ≤45 minutes

Table 63: Clinical evidence profile: Speech and Language Therapy (no communication difficulties) - ≤45 minutes, 7 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (no communication difficulties) - ≤45 minutes, 7 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Swallow function and ability (functional swallow) at ≥6 months (follow up: 6 months)												
1	randomised trials	not serious	not serious	serious [a]	serious [b]	none	49/102 (48.0%)	44/102 (43.1%)	**RR 1.11** (0.82 to 1.50)	**47 more per 1,000** (from 78 fewer to 216 more)	⊕⊕◯◯ LOW	CRITICAL
Discontinuation from study at ≥6 months (follow up: 6 months)												
1	randomised trials	not serious	not serious	not serious	very serious [b]	none	19/102 (18.6%)	21/102 (20.6%)	**RR 0.90** (0.52 to 1.58)	**21 fewer per 1,000** (from 99 fewer to 119 more)	⊕⊕◯◯ LOW	CRITICAL

CI: Confidence interval; **RR:** Risk ratio

Explanations

a. Downgraded by 1 or 2 increments because of outcome indirectness (Downgraded for outcome indirectness as the outcome is a dichotomous outcome when the protocol specified continuous outcomes)

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

I.3.4 >45 minutes to 1 hour

Table 69: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant health-related quality of life (Stroke and Aphasia Quality of Life Scale-39, 1-5, higher values are better, final values) at <6 months (follow up: 12 weeks)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	147	70	-	MD **0.3 lower** (0.53 lower to 0.07 lower)	⨁⨁◯◯ LOW	CRITICAL
Person/participant health-related quality of life (Stroke and Aphasia Quality of Life Scale-39, 1-5, higher values are better, final values) at ≥6 months (follow up: 26 weeks)												
1	randomised trials	serious [a]	not serious	not serious	not serious	none	147	70	-	MD **0.15 lower** (0.37 lower to 0.07 higher)	⨁⨁⨁◯ MODERATE	CRITICAL
Communication - Overall language ability (Western Aphasia Battery-Revised Aphasia Quotient, 0-100, higher values are better, final values) at <6 months (follow up: 12 weeks)												
1	randomised trials	serious [a]	not serious	not serious	not serious	none	147	70	-	MD **2.82 lower** (11.1 lower to 5.46 higher)	-	CRITICAL
Communication - Overall language ability (Western Aphasia Battery-Revised Aphasia Quotient, 0-100, higher values are better, final values) at ≥6 months (follow up: 26 weeks)												
1	randomised trials	serious [a]	not serious	not serious	not serious	none	147	70	-	MD **4 lower** (11.55 lower to 3.55 higher)	⨁⨁⨁◯ MODERATE	CRITICAL
Communication - Impairment specific measures (naming) (Boston Naming Test, number of incorrect names, lower values are better, final values) at <6 months (follow up: 12 weeks)												
1	randomised trials	serious [a]	not serious	not serious	not serious	none	147	70	-	MD **1 lower** (6.54 lower to 4.54 higher)	⨁⨁⨁◯ MODERATE	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Communication - Impairment specific measures (naming) (Boston Naming Test, number of incorrect names, lower values are better, final values) at >6 months (follow up: 26 weeks)												
1	randomised trials	serious [a]	not serious	not serious	not serious	none	147	70	-	MD **2.9 lower** (8.21 lower to 2.41 higher)	⨁⨁⨁◯ MODERATE	CRITICAL
Psychological distress - depression (Aphasia Depression Rating Scale, 0-32, lower values are better, final values) at <6 months (follow up: 12 weeks)												
1	randomised trials	serious [a]	not serious	not serious	not serious	none	147	70	-	MD **0** (1.08 lower to 1.08 higher)	⨁⨁⨁◯ MODERATE	CRITICAL
Psychological distress - depression (Aphasia Depression Rating Scale, 0-32, lower values are better, final values) at ≥6 months (follow up: 26 weeks)												
1	randomised trials	serious [a]	not serious	not serious	not serious	none	147	70	-	MD **0.56 lower** (1.6 lower to 0.48 higher)	⨁⨁⨁◯ MODERATE	CRITICAL
Discontinuation from study at <6 months (follow up: 12 weeks)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	46/164 (28.0%)	11/81 (13.6%)	**RR 2.07** (1.13 to 3.77)	**145 more per 1,000** (from 18 more to 376 more)	⨁⨁◯◯ LOW	CRITICAL
Discontinuation from study at ≥6 months (follow up: 26 weeks)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	54/164 (32.9%)	18/81 (22.2%)	**RR 1.48** (0.93 to 2.35)	**107 more per 1,000** (from 16 fewer to 300 more)	⨁⨁◯◯ LOW	CRITICAL

CI: Confidence interval; **MD:** Mean difference; **RR:** Risk ratio

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to bias due to missing outcome data)

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

Table 70: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at <6 months (follow-up: 12 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	not serious	none	51	65	-	MD **1.7 higher** (3.77 lower to 7.17 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - Overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at ≥6 months (follow-up: 24 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	not serious	none	51	65	-	MD **1 higher** (5.2 lower to 7.2 higher)	⨁⨁◯◯ Low	CRITICAL
Communication - impairment specific measures (naming) (Aachen Aphasia Test Naming, scale range unclear, higher values are better, change score) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	8	9	-	MD **5.7 higher** (1.69 lower to 13.09 higher)	⨁◯◯◯ Very low	CRITICAL
Communication - impairment specific measures (auditory comprehension) (Aachen Aphasia Test Token Test, scale range unclear, higher values are better, change score) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	8	9	-	MD **6.2 higher** (3.32 lower to 15.72 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 12 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	13/51 (25.5%)	8/65 (12.3%)	**RR 2.07** (0.93 to 4.61)	**132 more per 1,000** (from 9 fewer to 444 more)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 24 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	17/51 (33.3%)	15/65 (23.1%)	**RR 1.44** (0.80 to 2.60)	**102 more per 1,000** (from 46 fewer to 369 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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

I.3.5 >1 hour to 2 hours

Table 82: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week compared to ≤45 minutes, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	≤45 minutes, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Psychological distress - depression (Aphasic Depression Rating Scale, scale range unclear, higher values are better, change score) at <6 months (follow-up: 20 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	17	15	-	MD **4.9 higher** (2.95 higher to 6.85 higher)	⊕◯◯◯ Very low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

a. 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 selection of the reported result)

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

Table 82: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week compared to >45 minutes to 1 hour, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	>45 minutes to 1 hour, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (Western Aphasia Battery-Aphasia Quotient, 0-100, higher values are better, final value) at <6 months (follow-up: 12 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	11	9	-	MD **5.7 lower** (31.82 lower to 20.42 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 12 weeks)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	1/12 (8.3%)	3/12 (25.0%)	**RR 0.33** (0.04 to 2.77)	**167 fewer per 1,000** (from 240 fewer to 443 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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

Table 92: Clinical evidence profile: Speech and Language Therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Swallow function and ability (Penetration Aspiration Scale, 1-8, lower values are better, change score) at <6 months (follow-up: 2 weeks)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	18	18	-	MD **0.1 lower** (0.83 lower to 0.63 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation at <6 months (follow-up: 2 weeks)												
1	randomised trials	serious[a]	not serious	not serious	very serious[b]	none	3/21 (14.3%)	2/20 (10.0%)	**RR 1.43** (0.27 to 7.67)	**43 more per 1,000** (from 73 fewer to 667 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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

Table 92: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Communication - Impairment specific measures, naming (NGA tubtest naming, 0-100, higher values are better, final value) at <6 months (follow-up: 4 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	32	30	-	MD **3.7 lower** (15.52 lower to 8.12 higher)	⨁◯◯◯ Very low	CRITICAL
Communication - Impairment specific measures, auditory comprehension (NGA subtest comprehension, 0-100, higher values are better, final value) at <6 months (follow-up: 4 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	32	30	-	MD **0.5 lower** (13.94 lower to 12.94 higher)	⨁◯◯◯ Very low	CRITICAL
Communication - functional communication (Communicative Effectiveness Index, 0-100, higher values are better, final value) at <6 months (follow-up: 4 months)												
1	randomised trials	very serious[a]	not serious	not serious	not serious	none	32	30	-	MD **0** (10.23 lower to 10.23 higher)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: 4 months)												
1	randomised trials	very serious[c]	not serious	not serious	very serious[b]	none	3/32 (9.4%)	3/30 (10.0%)	**RR 0.94** (0.20 to 4.29)	**6 fewer per 1,000** (from 80 fewer to 329 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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 at very high risk of bias (due to bias from the randomisation process)

I.3.6 >2 hours to 4 hours

Table 97: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, <5 days a week compared to >1 hour to 2 hours, <5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, <5 days a week	>1 hour to 2 hours, <5 days a week	Relative (95% CI)	Absolute (95% CI)		
Communication - Overall language ability (Action Communication Test, scale range unclear, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	15	15	-	MD **0.7 lower** (4.1 lower to 2.7 higher)	⊕⊕◯◯ Low	CRITICAL
Communication - Functional communication (Aachen Aphasia Test, scale range unclear, higher values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	serious[a]	none	15	15	-	MD **3.8 lower** (7.57 lower to 0.03 lower)	⊕⊕⊕◯ Moderate	CRITICAL
Discontinuation from study at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[b,c]	none	0/15 (0.0%)	0/15 (0.0%)	**RD 0.00** (-0.12 to 0.12)	**0 fewer per 1,000** (from 120 fewer to 120 more)[c]	⊕⊕◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference

Explanations

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

b. Downgraded by 1 to 2 increments for imprecision due to zero events and small sample size

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

Table 101: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Person/participant health-related quality of life (SAQOL-39g, 1-5, higher values are better, change score) at <6 months (follow-up: 14 weeks)												
1	randomised trials	not serious	not serious	not serious	not serious	none	133	67	-	MD **0.02 higher** (0.09 lower to 0.13 higher)	⨁⨁⨁⨁ High	CRITICAL
Communication - overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at <6 months (follow-up: 14 weeks)												
1	randomised trials	not serious	not serious	not serious	not serious	none	133	67	-	MD **1.74 lower** (3.57 lower to 0.09 higher)	⨁⨁⨁⨁ High	CRITICAL
Communication - impairment specific measures, naming (COMPARE naming battery 100 untreated items, 0-100, higher values are better, change score) at <6 months (follow-up: 14 weeks)												
1	randomised trials	not serious	not serious	not serious	not serious	none	133	67	-	MD **0.38 higher** (1.84 lower to 2.6 higher)	⨁⨁⨁⨁ High	CRITICAL
Communication - Functional communication (Communicative Effectiveness Index, 0-100, higher values are better, change score) at <6 months (follow-up: 14 weeks)												
1	randomised trials	not serious	not serious	not serious	not serious	none	133	67	-	MD **3.04 higher** (1.13 lower to 7.21 higher)	⨁⨁⨁⨁ High	CRITICAL
Discontinuation at <6 months (follow-up: 14 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	17/146 (11.6%)	11/75 (14.7%)	**RR 0.79** (0.39 to 1.61)	**31 fewer per 1,000** (from 89 fewer to 89 more)	⨁⨁◯◯ Low	CRITICAL

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

Explanations

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

Table 101: Clinical evidence profile: Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Communication - Impairment specific measures, naming (Aachen Aphasia Test - Naming Test, scale range unclear, higher values are better, change score) at <6 months (follow-up: 2 weeks)												
1	randomised trials	not serious	not serious	not serious	serious[a]	none	40	20	-	MD **0.5 lower** (3.04 lower to 2.04 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Communication - Impairment specific measures, auditory comprehension (Aachen Aphasia Test - Token Test, scale range unclear, higher values are better, change score) at <6 months (follow-up: 2 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	not serious	not serious	not serious	serious[a]	none	40	20	-	MD **1.15 higher** (1.27 lower to 3.57 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Discontinuation from study at <6 months (follow-up: 2 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	2/40 (5.0%)	0/20 (0.0%)	**OR 4.60** (0.24 to 89.21)	**50 more per 1,000** (from 50 fewer to 150 more)[b]	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference; **OR:** odds ratio

Explanations

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

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

I.4 Psychology/neuropsychology

I.4.1 >45 minutes to 1 hour

Table 65: Clinical evidence profile: Psychology/neuropsychology (communication difficulties) - >45 minutes to 1 hour, <5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychology/neuropsychology (communication difficulties) - >45 minutes to 1 hour, <5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Carer health-related quality of life (Carer Strain Index, 0-13, lower values are better, final value) at ≥6 months (follow up: 6 months)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	39	44	-	MD **0.3 higher** (1.14 lower to 1.74 higher)	⊕⊕◯◯ LOW	CRITICAL
Psychological distress - depression (Stroke Aphasic Depression Questionnaire Hospital version 21, 0-30, lower values are better, final value) at ≥6 months (follow up: 6 months)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	39	44	-	MD **4.5 lower** (8.71 lower to 0.29 lower)	⊕⊕◯◯ LOW	CRITICAL
Activities of daily living (Nottingham Leisure Questionnaire, 0-60, higher values are better, final value) at ≥6 months (follow up: 6 months)												
1	randomised trials	serious [a]	not serious	not serious	serious [b]	none	39	44	-	MD **1.1 higher** (2.02 lower to 4.22 higher)	⊕⊕◯◯ LOW	CRITICAL
Discontinuation from study at ≥6 months (follow up: 6 months)												
1	randomised trials	not serious	not serious	not serious	very serious [b]	none	8/51 (15.7%)	8/54 (14.8%)	**RR 1.06** (0.43 to 2.61)	**9 more per 1,000** (from 84 fewer to 239 more)	⊕⊕◯◯ LOW	CRITICAL

CI: Confidence interval; **MD:** Mean difference; **RR:** Risk ratio

Explanations

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

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

I.4.2 >1 hour to 2 hours

Table 78: Clinical evidence profile: Psychology/neuropsychology (no communication difficulties) - >1 hour to 2 hours, <5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychology/neuropsychology (no communication difficulties) - >1 hour to 2 hours, <5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final value) at <6 months (follow-up: 2 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	26	27	-	MD **0.05 lower** (0.17 lower to 0.07 higher)	⨁◯◯◯ Very low	CRITICAL
Psychological distress - depression (PHQ-9, 0-27, lower values are better, final value) at <6 months (follow-up: 2 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	26	27	-	MD **1.47 lower** (5.22 lower to 2.28 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at <6 months (follow-up: 2 months)												
1	randomised trials	serious[c]	not serious	not serious	very serious[b]	none	4/26 (15.4%)	2/27 (7.4%)	**RR 2.08** (0.42 to 10.39)	**80 more per 1,000** (from 43 fewer to 696 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

a. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to bias arising from the randomisation process and bias in measurement of the outcome)

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 at high risk of bias (due to bias arising from the randomisation process)

I.4.3 >2 hours to 4 hours

Table 102: Clinical evidence profile: Psychology/neuropsychology (no communication difficulties) - >2 hours to 4 hours, 5 days a week compared to >1 hour to 2 hours, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychology/neuropsychology (no communication difficulties) - >2 hours to 4 hours, 5 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (Pictorial Thai Quality of Life Scale, 0-72, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	54	59	-	MD **8.9 higher** (3.96 higher to 13.84 higher)	⊕⊕◯◯ Low	CRITICAL
Acitivities of daily living (Barthel Index, 0-20, higher values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	54	59	-	MD **1.2 higher** (0.07 higher to 2.33 higher)	⊕⊕◯◯ Low	CRITICAL
Psychological distress - Depression (HADS depression, 0-21, lower values are better, change score) at <6 months (follow-up: 4 weeks)												
1	randomised trials	serious[a]	not serious	not serious	serious[b]	none	54	59	-	MD **4.5 lower** (6.5 lower to 2.5 lower)	⊕⊕◯◯ Low	CRITICAL
Discontinuation of study at <6 months (follow-up: 4 weeks)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychology/neuropsychology (no communication difficulties) - >2 hours to 4 hours, 5 days a week	>1 hour to 2 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	serious[a]	not serious	not serious	not serious	none	5/59 (8.5%)	0/59 (0.0%)	**OR 7.93** (1.33 to 47.21)	**80 more per 1,000** (from 10 more to 160 more)[d]	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **MD:** mean difference; **OR:** odds ratio

Explanations

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

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

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

I.5 Multidisciplinary Team

I.5.1 >45 minutes to 1 hour

Table 75: Clinical evidence profile: Multidisciplinary team (no communication difficulties) - >45 minutes to 1 hour, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary team (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Discontinuation from study at <6 months (follow-up: 3 months)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	10/46 (21.7%)	7/43 (16.3%)	**RR 1.34** (0.56 to 3.19)	**55 more per 1,000** (from 72 fewer to 357 more)	⨁⨁◯◯ Low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 6 months)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	10/46 (21.7%)	7/43 (16.3%)	**RR 1.34** (0.56 to 3.19)	**55 more per 1,000** (from 72 fewer to 357 more)	⨁⨁◯◯ Low	CRITICAL

CI: confidence interval; **RR:** risk ratio

Explanations

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

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I.5.2 >1 hour to 2 hours

Table 88: Clinical evidence profile: Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to ≤45 minutes, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week	≤45 minutes, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Discontinuation from study at <6 months (follow up: 3 weeks)												
1	randomised trials	serious [a]	not serious	not serious	very serious [b,c]	none	5/30 (16.7%)	3/30 (10.0%)	**RR 1.67** (0.44 to 6.36)	**67 more per 1,000** (from 56 fewer to 536 more)	⨁◯◯◯ VERY LOW	CRITICAL

CI: Confidence interval; **RR:** Risk ratio

Explanations

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

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

c. MID (precision) = RR 0.8-1.25. MID (clinical importance): 50 per 1,000.

Table 93: Clinical evidence profile: Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week compared to >45 minutes to 1 hour, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Activities of daily living (Barthel index, activities of daily living and ambulation [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 7 weeks)												
2	randomised trials	serious[a]	serious[b]	not serious	serious[c]	none	79	140	-	SMD **0.28 SD higher** (0.14 lower to 0.7 higher)	⨁◯◯◯ Very low	CRITICAL
Activities of daily living (Functional independence measure upper limb, 0-63, higher values are better, change score) at <6 months (follow-up: 3 weeks)												
1	randomised trials	serious[d]	not serious	not serious	serious[c]	none	17	26	-	MD **4.7 higher** (0.34 lower to 9.74 higher)	⨁⨁◯◯ Low	CRITICAL
Activities of daily living (Functional independence measure upper limb, 0-63, higher values are better, change score) at ≥6 months (follow-up: 6 months)												
1	randomised trials	very serious[e]	not serious	not serious	very serious[c]	none	11	26	-	MD **2.1 higher** (5.14 lower to 9.34 higher)	⨁◯◯◯ Very low	CRITICAL
Activities of daily living (Activities of daily living and ambulation, 0-23, higher values are better, final value) at ≥6 months (follow-up: 12 months)												
1	randomised trials	very serious[e]	not serious	not serious	serious[c]	none	42	35	-	MD **2.7 higher** (1.34 lower to 6.74 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, change score) at <6 months (follow-up: 3 weeks)												
1	randomised trials	very serious[f]	not serious	not serious	serious[c]	none	17	37	-	MD **4.1 higher** (4.04 lower to 12.24 higher)	⨁◯◯◯ Very low	CRITICAL
Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, change score) at ≥6 months) (follow-up: 6 months)												

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week	>45 minutes to 1 hour, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
1	randomised trials	very serious[e]	not serious	not serious	serious[c]	none	11	15	-	MD **8 higher** (4.73 lower to 20.73 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - lower limb (Postural assessment scale for stroke, motor function test [different scale ranges], higher values are better, final values) at <6 months (follow-up: mean 7 weeks)												
2	randomised trials	very serious[e]	serious[b]	not serious	serious[c]	none	76	139	-	SMD **0.19 SD higher** (0.23 lower to 0.61 higher)	⊕◯◯◯ Very low	CRITICAL
Physical function - lower limb (Motor function test, scale range unclear, higher values are better, final value) at ≥6 months (follow-up: mean 12 months)												
1	randomised trials	very serious[e]	not serious	not serious	serious[c]	none	40	35	-	MD **4.9 higher** (2.35 lower to 12.15 higher)	⊕◯◯◯ Very low	CRITICAL
Psychological distress - Depression (HADS depression, 0-21, lower values are better, final value) at <6 months (follow-up: 14 days)												
1	randomised trials	serious[d]	not serious	not serious	serious[c]	none	38	107	-	MD **0.7 lower** (2.03 lower to 0.63 higher)	⊕⊕◯◯ Low	CRITICAL
Discontinuation from study at <6 months (follow-up: mean 6 weeks)												
2	randomised trials	serious[d]	not serious	not serious	not serious[g]	none	0/88 (0.0%)	11/152 (7.2%)	**OR 0.20** (0.05 to 0.77)	**70 fewer per 1,000** (from 110 fewer to 20 fewer)[g]	⊕⊕⊕◯ Moderate	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 12 months)												
1	randomised trials	serious[d]	not serious	not serious	very serious[c]	none	8/50 (16.0%)	10/45 (22.2%)	**RR 0.72** (0.31 to 1.66)	**62 fewer per 1,000** (from 153 fewer to 147 more)	⊕◯◯◯ Very low	CRITICAL

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

Explanations

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (due to a mixture of bias arising from the randomisation process and bias due to missing outcome data)

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

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

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

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

f. Downgraded by 2 increments as the majority of the evidence was at very high risk of bias (due to a mixture of bias arising from the randomisation process)

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

I.5.3 >2 hours to 4 hours

Table 96: Clinical evidence profile: Multidisciplinary team (no communication difficulties) - >2 hours to 4 hours, <5 days a week compared to usual care for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary team (no communication difficulties) - >2 hours to 4 hours, <5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Person/participant generic health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, change score) at ≥6 months (follow-up: 14 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	47	40	-	MD **0** (0.37 lower to 0.37 higher)	⨁◯◯◯ Very low	CRITICAL

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary team (no communication difficulties) - >2 hours to 4 hours, <5 days a week	usual care	Relative (95% CI)	Absolute (95% CI)		
Stroke outcome - modified Rankin Scale (modified Rankin scale, 0-5, lower values are better, change score) at ≥6 months (follow-up: 14 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	45	41	-	MD **0.25 lower** (0.65 lower to 0.15 higher)	⨁◯◯◯ Very low	CRITICAL
Psychological distress - depression (HADS depression, 0-21, lower values are better, change score) at ≥6 months (follow-up: 14 months)												
1	randomised trials	very serious[a]	not serious	not serious	very serious[b]	none	47	41	-	MD **0.33 higher** (1.94 lower to 2.6 higher)	⨁◯◯◯ Very low	CRITICAL
Discontinuation from study at ≥6 months (follow-up: 14 months)												
1	randomised trials	very serious[a]	not serious	not serious	serious[b]	none	3/51 (5.9%)	9/50 (18.0%)	**RR 0.33** (0.09 to 1.14)	**121 fewer per 1,000** (from 164 fewer to 25 more)	⨁◯◯◯ Very low	CRITICAL

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

Explanations

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

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

I.5.4 >4 hours

Table 106: Clinical evidence profile: Multidisciplinary team (no communication difficulties) - >4 hours, 5 days a week compared to >2 hours to 4 hours, 5 days a week for people after a first or recurrent stroke

Certainty assessment							№ of patients		Effect		Certainty	Importance
№ of studies	Study design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Multidisciplinary team (no communication difficulties) - >4 hours, 5 days a week	>2 hours to 4 hours, 5 days a week	Relative (95% CI)	Absolute (95% CI)		
Physical function - upper limb (Wolf Motor Function Test, 0-120 seconds, lower values are better, final value) at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	13	29	-	MD **1.4 lower** (25.82 lower to 23.02 higher)	⨁⨁◯◯ Low	CRITICAL
Physical function - upper limb (Wolf Motor Function Test, 0-120 seconds, lower values are better, final value) at ≥6 months (follow-up: 6 months)												
1	randomised trials	not serious	not serious	not serious	serious[a]	none	13	26	-	MD **5.1 lower** (28.29 lower to 18.09 higher)	⨁⨁⨁◯ Moderate	CRITICAL
Discontinuation of study at <6 months (follow-up: 4 weeks)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	1/14 (7.1%)	1/30 (3.3%)	**RR 2.14** (0.14 to 31.83)	**38 more per 1,000** (from 29 fewer to 1,000 more)	⨁⨁◯◯ Low	CRITICAL
Discontinuation of study at ≥6 months (follow-up: 6 months)												
1	randomised trials	not serious	not serious	not serious	very serious[a]	none	1/14 (7.1%)	4/30 (13.3%)	**RR 0.54** (0.07 to 4.36)	**61 fewer per 1,000** (from 124 fewer to 448 more)	⨁⨁◯◯ Low	CRITICAL

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

Explanations

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

Appendix J – GRADE-CERQual tables

J.1 Key principles

Table 2: Clinical evidence profile: Key principles: More therapy is better

Study design and sample size		Finding	Quality assessment		
No of studies contributing to the finding	**Design**		**Criteria**	**Rating**	**Overall assessment of confidence**
Key principles: More therapy is better					
15[6, 7, 16-18, 31, 48, 68, 86, 87, 90, 116, 121, 131, 137]	Combination of focus groups (n=1), semi-structured interviews (n=12), observations and semi-structured interviews (n=1) and focus groups and semi-structured interviews (n=1)	Stroke survivors and family members believe that the more therapy they received the better. Some healthcare professionals agreed, while others (and some stroke survivors) thought the quality of the therapy was more important. “I was only aware of 1 person in the DOSE study when I got there and he was very active and he was recovering very rapidly, much more rapidly than the other patients that were around, and that was kind of an indicator to me that it might be worth doing this if I could get some similar type of recovery, it would be worth a try.”[48] “An additional therapy session per week will always be good” (clinician 01)[90] “We’ve got to get out of this habit that just because a patient needs physiotherapy	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	Minor concerns about coherence[a]	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	No concerns about adequacy	

Study design and sample size			Quality assessment		
No of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
		that the more they have, the better it is, that's completely wrong thinking. (Physiotherapist, Unit 5)"[16]			

a. Minor concerns about coherence between studies, as while the majority of studies agreed that more therapy was better, two discussed that the quality of rehabilitation was more important
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

Table 3: Clinical evidence profile: Key principles: Person centred care: Intensity tailored to the individual

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Key principles: Person centred care: Intensity tailored to the individual					
17[6, 7, 16, 19, 51, 68, 79-81, 86, 87, 107, 109, 121, 123, 125, 137]	Combination of focus groups (n=3), semi-structured interviews (n=11), observations and semi-structured interviews (n=2) and focus groups and semi-structured interviews (n=1)	The amount of rehabilitation should be tailored to the individual. Where people find it difficult to complete rehabilitation in the time block, this should be delivered as more frequent shorter sessions. “There are patients who can’t concentrate for that length of time so they’d be better being trained in two or three 10-minute sessions throughout the day which we might try to do. (Occupational therapist, Unit 2)”[16]	Limitations	No or very minor concerns about methodological limitations	HIGH
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	No concerns about adequacy	

Table 4: Clinical evidence profile: Key principles: Duration of therapy

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Key principles: Duration of therapy					
5[80, 81, 84, 107, 113]	Combination of focus groups (n=1), semi-structured interviews (n=3) and focus groups and semi-structured interviews (n=1)	Stroke survivors and family members believed that therapy duration was too short. Some healthcare professionals agreed while others were sceptical about the benefits of continued rehabilitation. "It [the therapy] really needs to be 2 weeks, 4 weeks, 6 weeks longer to really get the most benefits out of it [be]cause right now I'm at the point where I have the endurance. I built up the endurance, and now I'm there. I'm there, let's take it to the next level, and now I [have to] go home.... It's hard work, but it's well worth it, and it's not long enough.... You're feeling really good by the end of the second week, and you can get through the 3 hours, and then, poof, it's gone."[80]	Limitations	No or very minor concerns about methodological limitations	LOW
			Coherence	Minor concerns about coherence[a]	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns about adequacy[c]	

a. Minor concerns about coherence as there was disagreement between healthcare professionals about the usefulness of long term therapy
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy due to the limited number of studies reporting the theme

J.2 Person factors

Table 5: Clinical evidence profile: Person factors: Medical status

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person factors: Medical status					
8[16, 18, 22, 31, 40, 81, 90, 109]	Combination of focus groups (n=1), semi-structured interviews (n=5), observations and semi-structured interviews (n=1) and focus groups and semi-structured interviews (n=1)	Medical status or comorbidities may be a barrier to engaging in rehabilitation. Interventions may need to be adapted for co-morbidities. "If someone is bed bound (sic), you know the interaction is very minimal… you often walk past and you see them alone in their room… you wonder what happens during those periods of time where they're just in their room and they don't have family. (OT2)"[22] 'The kind of patients who are well motivated and if they don't have any cognitive impairment and things like that, they're obviously going to improve.' (Physio B1)[31]	Limitations	Moderate 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. Moderate concerns about methodological limitations (due to limitations in considering the relationship between the participant and the researcher)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

Table 6: Clinical evidence profile: Person factors: Fatigue

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person factors: Fatigue					
11[6, 16, 32, 68, 79-81, 90, 107, 121, 128]	Combination of semi-structured interviews (n=8), observations and semi-structured interviews (n=1) and focus groups and semi-structured interviews (n=2)	Fatigue is a barrier for delivering more intense rehabilitation. "If we feel patients can do more then we'll try and push them, if we feel a patient is too fatigued, then we like to end on a good note because that's the carry over they're going to get. So, we're restricted by patients' fatigue rather than NICE guidelines or staffing levels. (Physiotherapist, Unit 2)"[16] "The patients that are less motivated, more frail and have more significant deficits. . .came to me exhausted on a Monday, or I came to see them on the weekend and "I just can't do it". They found that it was too much for them. (Participant 14)"[121]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[a]	
			Adequacy	No concerns about adequacy	

a. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

Table 7: Clinical evidence profile: Person factors: Physical factors

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person factors: Physical factors					
5[48, 90, 109, 113, 121]	Semi-structured interviews (n=5)	People with higher previous activity levels may find it easier to engage with more intense rehabilitation. People with a reduced capacity who need lots of support may find it harder. "I guess it's just the logistics of trying to be able to do that [vary the approach for the individual within a group] in a group setting, but be able to provide enough assistance as you need it to a number of people at the same time. . . we found it hard, especially if patients weren't great on their feet. . .it was sometimes hard to feel safe to challenge them all at the same time."[121]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[a]	
			Adequacy	No concerns about adequacy	

a. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

Table 8: Clinical evidence profile: Person factors: Psychological factors

Study design and sample size			**Quality assessment**		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person factors: Psychological factors					
11[6, 17, 48, 51, 68, 81, 87, 92, 109, 114, 128]	Combination of focus groups (n=1) and semi-structured interviews (n=10)	Psychological factors can be moderators for participation in intensive rehabilitation, including: sense of security, concentration, mood and behaviour challenges, personal achievement and sense of purpose. 'Everything starting to look bright, forget the past, I want to move forward with my life. No time to think about what I went through and how it hurt me.'[87] ''... they may have been able to get me focussing sooner, not going through that denial to such an extreme'' (Participant 1, 51 y, female, CCT).[6] ''There was always something going on that would take your attention and it breaks your concentration; with the group... they would distract your attention...'' (Participant 10, 77 y, male, 7D).[6] "they started timing them (activities) to show you the difference in time from when you start to when you finish…to see before and after was just amazing to be honest. It	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[a]	

Study design and sample size			Quality assessment		
No of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
		was like day and night" "It was just a confidence booster to see you were getting quicker" Participant 9[114]			

a. Minor concerns about adequacy (due to a limited number of studies reporting each subtheme included in the theme)

Table 9: Clinical evidence profile: Person factors: Motivation

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person factors: Motivation					
11[13, 51, 68, 80, 84, 107, 109, 113, 114, 125, 131]	Combination of focus groups (n=2), semi-structured interviews (n=8) and focus groups and semi-structured interviews (n=1)	Intensity can be a source of motivation for engagement in rehabilitation. Other sources of motivation for intensive rehabilitation includes: self-motivation, motivation from family and therapists, having an altruistic view towards research, other stroke survivors in the group and using novel techniques (such as robot assisted therapy). Motivation may decrease as duration after stroke increases. "It was different from what your normal occupational therapy was and, because of that I think it was probably a bit more enjoyable" Participant 1[114] "Initially, I was motivated. After several months, I don't feel that excited anymore." (S8)[84]	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 concerns about methodological limitations (due to limitations in considering the relationship between the participant and the researcher and for not considering limitations in some studies)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy (due to a limited number of studies reporting each subtheme included in the theme)

Table 10: Clinical evidence profile: Person factors: Social factors

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person factors: Social factors					
14[6, 7, 22, 48, 51, 68, 76, 81, 92, 109, 113, 123, 128, 137]	Combination of focus groups (n=2), semi-structured interviews (n=11) and focus groups and semi-structured interviews (n=1)	Observing and interacting with other stroke survivors can provide hope and enhanced self-motivation. The relationship with the therapist is an important moderator for the success of the intervention. For some, faith was an important moderator. "Now this chappie could lay on the deck, on the ground and actually get himself up which he could never do before. Now when you see the look on that chappie's face. God! You know there is something going on. And to me that was the biggest motivation for me."[92] 'I praise the Lord that I'm still alive, because what I went through, not many people would [be].'[87]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			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 as some studies were conducted in a healthcare setting outside of the United Kingdom
b. Minor concerns about adequacy (due to a limited number of studies reporting each subtheme included in the theme)

Table 11: Clinical evidence profile: Person factors: Education

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Person factors: Education					
6[25, 51, 68, 81, 84, 123]	Combination of focus groups (n=4) and semi-structured interviews (n=2)	There was a low awareness among patients and their families regarding optimum rehabilitation that can be a barrier to rehabilitation, while education can be used to increase motivation. Stroke survivors and family members will seek information about technology from any source. They would prefer this to be healthcare professionals, but healthcare professionals may not provide this information. "You do feel you are going mad because you just don't understand why this happened… I think for me, if I had to go back, it would be just for someone to explain, you know, you've had a stroke and as part of your stroke you may feel tired or you may find it hard to concentrate, or you might find it difficult to process information, or you may find it difficult to do things [SS01]."[81] "It has meant a whole lot to gain knowledge also about how the brain works to keep the motivation and stimulation	Limitations	Minor concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Moderate concerns about adequacy[c]	

Study design and sample size		Finding	Quality assessment		
No of studies contributing to the finding	Design		Criteria	Rating	Overall assessment of confidence
		going and …it is the effort that counts. It has carried me a lot. Hmm, especially when it doesn't work."[123] "I think their (health professionals') time is very constrained anyway, and that's why they have this problem with actually sort of using new equipment. That's my personal opinion. And it's funding. It's the biggest issue of all. We (patients) might know what we want; we know what we'd like (yep, yep, yep), it's actually getting it, you know. And all right, some people can fund it themselves, but they still need to be able to get to the right people to actually give them that equipment…(its knowing) what you can and can't get…it's a matter of education."[25]			

a. Minor concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, not exploring the limitation of the study sufficiently and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Moderate concerns about adequacy (due to a limited number of studies throughout the theme with even more limited evidence reporting each subtheme included in the theme)

J.3 People requiring specific consideration

Table 12: Clinical evidence profile: People requiring specific consideration: People with communication difficulties

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
People requiring specific consideration: People with communication difficulties					
1[22]	Combination of focus groups and semi-structured interviews (n=1)	People with communication difficulties may require additional opportunities for improving communication outside of formal rehabilitation sessions, which may be difficult to achieve in a hospital setting. “They (speech pathologists) do their bit and we do ours… we don’t have time to practice speech with them because we really do have to get all of our jobs filled in the time and it’s specifically rostered for us to do our work, not to help with someone else’s. (Rehabilitation nurse (RehabN)1)”[22]	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Moderate concerns about adequacy[c]	

a. Moderate concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant); no or very minor concerns about coherence
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Moderate concerns about adequacy (due to a limited number of studies throughout the theme with even more limited evidence reporting each subtheme included in the theme)

Table 13: Clinical evidence profile: People requiring specific consideration: People with cognitive difficulties

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
People requiring specific consideration: people with cognitive difficulties					
3[32, 81, 86]	Combination of focus groups (n=1), semi-structured interviews (n=1) and focus groups and semi-structured interviews (n=1)	People with cognitive difficulties may have 'hidden needs' that require consideration to ensure they can be involved in intense rehabilitation. Rehabilitation may need to be delivered later on after stroke to support them to engage in activities for longer and more intense period of time. 'Cognitive impairment would be a huge factor in the carry-over and instructions' (Physio A4)[31]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[a]	

a. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

J.4 Carer/family member factors

Table 14: Clinical evidence profile: Carer/family member factors: Support of family and friends

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Carer/family member factors: Support of family and friends					
13[13, 19, 22, 32, 48, 68, 87, 107, 109, 113, 121, 123, 132]	Combination of focus groups (n=1), semi-structured interviews (n=10) and focus groups and semi-structured interviews (n=2)	Family provide motivation and support which can be a contributory factor for the success of the intervention. However, wanting to spend time with families at the weekend instead of therapy may be a barrier to therapy seven days a week. "I had a really good support system because I scared everybody.—laughs—I had a good friend, … and he did not let me sulk—none of that. So my scheduling—he would send me a text, "Okay, you have to go the gym this, this, and this day." And I'll say, "No, I don't want to." "Hey, either you call the bus or I'll come get you."—laughs—So, that was my scheduling. You just have to have a good support system. Do not talk yourself out of exercise."[48]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence[a]	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns about adequacy[c]	

a. No or very minor concerns about coherence (while the two statements shows that family member involvement can be a facilitator or barrier, it was decided that this was the nature of the moderate and so was not an inherent sign of a lack of coherence, just a different perspective of the theme)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 15: Clinical evidence profile: Carer/family member factors: Continuity of care

Study design and sample size			Quality assessment		
No of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Carer/family member factors: Continuity of care					
3[81, 84, 107]	Combination of focus groups (n=1) and semi-structured interviews (n=2)	A potential approach to increase the continuity of rehabilitation was to involve family members and carers to conduct therapy at home. However, family of stroke survivors may not be given adequate support throughout the process to achieve this. 'Yes I help Timo once the study physiotherapist shows us what to do and she has 393 advised me how far you can go. And which muscles can em ... .'[107]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence[a]	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[b]	

a. No or very minor concerns about coherence (while the two statements shows that family member involvement can be a facilitator or barrier, it was decided that this was the nature of the moderate and so was not an inherent sign of a lack of coherence, just a different perspective of the theme)
b. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

J.5 Healthcare professional factors

Table 16: Clinical evidence profile: Healthcare professional factors: Beliefs about intensity of rehabilitation

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Healthcare professional factors: Beliefs about intensity of rehabilitation					
5[16, 19, 40, 116, 121]	Combination of semi-structured interviews (n=3) and observations and semi-structured interviews (n=2)	Beliefs about intensity of rehabilitation were varied between professionals, including a conflict between quality and quantity of rehabilitation and knowledge of the evidence for increased frequency and intensity of therapy. Therapists want to be able to adapt their approaches to the needs of the patient rather than fitting a specific model. Most therapists had a positive attitude about 7-day rehabilitation but one had a negative attitude that the quality of therapy over the weekend may not match weekday services. "'I thought it was a good idea that they were getting extra practice, one of my initial concerns was the quality of the movement because we are always so concerned that we want to get them to move as biomechanically proper as possible…' #PT2"[19] ". . .you do it and it works and even though it's not an RCT in a reputable journal, you	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[a]	
			Adequacy	Minor concerns about adequacy[b]	

Study design and sample size		Finding	Quality assessment		
No of studies contributing to the finding	Design		Criteria	Rating	Overall assessment of confidence
		do that because you know it works. (Participant 15)"[121] "I know what kind of treatment techniques are done on the weekend versus probably during the week. And it does tend to be the bare essentials a little bit. So I don't know if people are really being challenged so much during their weekend sessions because you don't know the patients. (Participant 6)"[121]			

a. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
b. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 17: Clinical evidence profile: Healthcare professional factors: Communication

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Healthcare professional factors: Communication					
6[7, 31, 87, 92, 109, 137]	Combination of semi-structured interviews (n=5) and focus groups and semi-structured interviews (n=1)	People after stroke benefited from encouragement, motivation and honesty. They wanted therapists to discourage overoptimistic expectations. "And they know a little bit about you more than just—you build a relationship that's deeper than purely a clinical one. That helps a lot, especially for me during the recovery process, you—stroke tends to remove some of your feelings of humanity, if that means anything and you feel less of a person, and part of the rebuilding is coming to terms with the changes that you are going through, accepting that some of them will to some degree and other be permanent, and having people around you that you feel actually care helps in during the recovery and helps you start regaining a sense of being a worthwhile person again, if that makes sense."[48]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[a]	

a. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 18: Clinical evidence profile: Healthcare professional factors: Feedback

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Healthcare professional factors: Feedback					
11[6, 7, 9, 13, 25, 48, 68, 76, 92, 114, 137]	Combination of focus groups (n=1) and semi-structured interviews (n=10)	Stroke survivors may benefit from receiving feedback during therapy sessions (whether from a therapist or another source, though therapist input was seen to hold validity due to professional status). "It was very straight which I appreciated, because she was very critical. If she didn't like something she told me straight away and I appreciated that because I knew where I was going wrong, like to improve myself..."[6]	Limitations	No or very minor concerns about methodological limitations	HIGH
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	No concerns about adequacy	

Table 19: Clinical evidence profile: Healthcare professional factors: Confidence

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Healthcare professional factors: Confidence					
3[18, 51, 123]	Combination of focus groups (n=2) and semi-structured interviews (n=1)	Therapists require signs from the patient that the therapy is tolerable and that research supports the intensive approach to feel confident delivering the therapy. In turn, stroke survivors had to trust the therapists to feel confident supporting them with the therapy. "Very um . . . helpful she'd [the therapist] point out where you were going wrong and, and finding you . . . how to get it right . . . just build your confidence up so where, where you think 'oh, I can't do that word,' just, just try a different way or . . . work out what you could say instead, take out words you couldn't say y'know so y'know like when they say, oh, I use three words instead of one it's because you can't do the one (laughs) so use three, it's easier. (Speech and language therapy)"[137]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			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 as some studies were conducted in a healthcare setting outside of the United Kingdom
b. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 20: Clinical evidence profile: Healthcare professional factors: Safety

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Healthcare professional factors: Safety					
2[19, 121]	Semi-structured interviews (n=2)	Therapists needed to balance the intensity against the safety of the intervention for the patient. Safety can be a barrier to prescribing unsupervised exercises. "I guess it's just the logistics of trying to be able to do that [vary the approach for the individual within a group] in a group setting, but be able to provide enough assistance as you need it to a number of people at the same time. . . we found it hard, especially if patients weren't great on their feet. . .it was sometimes hard to feel safe to challenge them all at the same time. (Participant 10)"[121]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			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 as some studies were conducted in a healthcare setting outside of the United Kingdom
b. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 21: Clinical evidence profile: Healthcare professional factors: Prioritisation

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Healthcare professional factors: Prioritisation					
1[79]	Semi-structured interviews (n=1)	Prioritisation was used to plan therapy with people perceived to have higher priority being more likely to be seen regularly and for a length of time and time of day relating to achieving their goals. This included: newly admitted patients, patients demonstrating potential to rehabilitate, patients who are complaint and motivated, patients who missed out on therapy the previous day, patients at risk of deteriorating and patients requiring imminent discharge. "Alright. The next double is XXXX. He's got to be able to do stairs, so we need to get to him. Are you free this afternoon at all?"[79]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Moderate concerns about adequacy[a]	

a. Moderate concerns about adequacy (due to a limited number of studies reporting the subtheme which was explanatory in nature)

Table 22: Clinical evidence profile: Healthcare professional factors: Consistency in care

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Healthcare professional factors: Consistency in care					
1[81]	Semi-structured interviews (n=1)	Carers expressed that care could be improved if the stroke survivor was consistently seen by the same healthcare professional who was familiar with the stroke survivor and their condition. "Common across all interviewee groups was the need for regularity and consistency, which SS06 described as providing "an anchor", with others suggesting it would reduce the risk of regression"[81]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Moderate concerns about adequacy[a]	

a. Moderate concerns about adequacy (due to a limited number of studies reporting the subtheme)

J.6 Intervention factors

Table 23: Clinical evidence profile: Intervention factors: Methods of achieving more intense rehabilitation

Study design and sample size		Finding	Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Methods of achieving more intense rehabilitation					
20[6, 7, 9, 12-14, 16, 18, 19, 25, 68, 84, 92, 107, 109, 113, 114, 121, 123, 128]	Combination of focus groups (n=3), semi-structured interviews (n=15) and observations and semi-structured interviews (n=2)	Methods proposed included: individual therapy (2 studies), group-based therapy (6 studies), 'homework'/self management interventions (4 studies), telerehabilitation, assistive technology and computer-based tools (7 studies), seven-day working (1 study) and longer term rehabilitation (1 study).	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence[a]	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Moderate concerns about adequacy[b]	

a. No or very minor concerns about coherence (as while there are conflicting methods of delivering rehabilitation highlighted, multiple of these could be used as part of someone's rehabilitation and so they were not considered to conflict the nature of the subtheme)
b. Moderate concerns about adequacy (due to a very limited number of studies reporting some of the methods highlighted above)

Table 24: Clinical evidence profile: Intervention themes: Increased opportunity for social stimulation

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Increased opportunity for social stimulation					
5[6, 13, 68, 81, 92]	Semi-structured interviews (n=5)	Group based therapies had more opportunities for social interaction with other stroke survivors allowing for exchange of shared experiences and coping strategies. However, carers expressed some reservation that group activity accessibility may be reduced due to noise and lacking confidence to be involved. Telerehabilitation allowed for video-conferencing with the therapist when needed which could make them feel more connected. "When they was coming, call me to go to the physio, I was happy because I get to see another friend, you know, talk together"[6]	Limitations	No or very minor concerns about methodological limitations	LOW
			Coherence	Minor concerns about coherence[a]	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Moderate concerns about adequacy[c]	

a. Minor concerns about coherence (due to disagreement between populations)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Moderate concerns about adequacy (due to only one study discussing the use of computer-based therapies)

Table 25: Clinical evidence profile: Intervention themes: Variety in activities and choice

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Variety in activities and choice					
8[6, 12-14, 25, 90, 114, 128]	Combination of focus groups (n=1), semi-structured interviews (n=6) and observations and semi-structured interviews (n=1)	Computer based therapies and group based therapies may provide opportunities for variety in activities and choice. Computer based therapies could provide more enjoyable, challenging and fun exercises than conventional therapy. Group based therapies with varied staff rotations may provide a change in routine and challenges that are of benefit. "[While] my wife watched [me playing Wii], she said, 'Oh yes, it looks like a lot of fun. We should probably have one like that at home, also for our grandchildren.'"[12] "There was some of the games, you could say were a bit tedious. That was maybe because they didn't tax you enough"[114]	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Moderate concerns about adequacy[c]	

a. Moderate concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, not exploring the limitation of the study sufficiently, study ethics not being considered in a study and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Moderate concerns about adequacy (due to only one study discussing the use of group-based therapies)

Table 26: Clinical evidence profile: Intervention themes: Level of person centred care

Study design and sample size			**Quality assessment**		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Level of person centred care					
5[6, 37, 81, 92, 109]	Semi-structured interviews (n=5)	People with group based therapies have a mixed level of person centred care, where some found that it met their needs while others noted it was a balance between the needs of the group and the needs of the individual that was not always met. Some computer based therapies may be adapted to the needs of the individual. “We’ve tried to do some group sessions in the past and it can be quite hard, just depending on how patients are medically. And how different patients are at different times. So it’s hard to get a group of patients at the same level… if there’s a vast difference, if you have a mild and a severe [mix] I don’t think a group setting would fit for that… [But] if you could get a group of patients with similar levels of difficulty that would be really useful, and patients may learn more in that setting.”[81] ‘‘I like the one to one... I think they would do a little bit more with trying to walk or keep your balance’’[6]	Limitations	No or very minor concerns about methodological limitations	LOW
			Coherence	Minor concerns about coherence[a]	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Moderate concerns about adequacy[c]	

a. Minor concerns about coherence (due to varied experiences in the group-based therapy group)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Moderate concerns about adequacy (due to only one study discussing the use of computer-based therapies)

Table 27: Clinical evidence profile: Intervention themes: Provision of feedback

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Provision of feedback					
6[9, 12, 13, 92, 114, 128]	Semi-structured interviews (n=6)	Computer based therapies could give immediate feedback to the participant which could help provide motivation to improve on previous scores. Telerehabilitation can lead to sufficient feedback from professionals. Feedback from the trainer was seen as important for group based therapies, and depended on the personality of the trainer. "You get motivated to go down there [to play Wii], and there you have a faster result. You can see if you win or what you can do. It motivates you for the next session, for example in bowling, to beat your own record and get more and more points"[12] "[Trainer]) was a great encourager and that was his great benefit and he just encouraged us to do more and more. He saw that you were willing to be pushed and he pushed and so the two together worked."[92]	Limitations	Minor concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Moderate concerns about adequacy[c]	

a. Minor concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Moderate concerns about adequacy (due to a very limited number of studies reporting the subtheme)

Table 28: Clinical evidence profile: Intervention themes: Travel time

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Travel time					
6[14, 25, 37, 81, 90, 109]	Combination of focus groups (n=1), semi-structured interviews (n=4) and observations and semi-structured interviews (n=1)	Home-based therapies (including computer based therapies) were seen as positive due to the smaller amount of travel time for stroke survivors, which could leave them more fatigued after the difficulties of reaching the place of therapy. Non-home based therapies could be accessible if in the local community, such as community centres, hospital and outpatient clinics. ‘‘We’d have to go to Decatur [Georgia] from here and that’s a good 4 hours with travel time. Normally when we have a doctor’s appointment, we’d leave at around 4 in the morning so that we can get down there’’. Another patient explained, ‘‘I wouldn’t have done the therapy if I had to go down there’’[14] “Very often they (the patients) might just have one question. Then they waste perhaps one or one and a half hours just getting here and then going back … It feels like it would be easier if we could communicate in some other way!”[37]	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 concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, not exploring the limitation of the study sufficiently, study ethics not being considered in a study and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 29: Clinical evidence profile: Intervention themes: Need for technical support and training

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Need for technical support and training					
6[9, 13, 14, 25, 37, 90]	Combination of focus groups (n=1), semi-structured interviews (n=4) and observations and semi-structured interviews (n=1)	Technical support and training is necessary for some types of therapy (in particular computer-based therapy). ''Ya'll got a software problem with the machine ... the screen would just lock up on me and I'd have to unplug it and then reboot it up''[14] "To try to find a way that makes it work … being able to continue using your mobile phone, computer and tablet and anything you could have used before you became ill."[37]	Limitations	Moderate 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. Moderate concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, not exploring the limitation of the study sufficiently, study ethics not being considered in a study and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

Table 30: Clinical evidence profile: Intervention themes: Physical environment

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Physical environment					
3[14, 25, 90]	Combination of focus groups (n=1), semi-structured interviews (n=1) and observations and semi-structured interviews (n=1)	Physical environment can be a barrier to home-based therapy if technology which requires a fair amount of space is required. While inpatient facilities which were adapted to the needs of the person were seen as facilitators for rehabilitation. "Make them (robots) much more user-friendly. I think they are such big bits of kit. You can imagine, it's like taking an X-ray machine onto a ward…We've only got in a day, 20 minutes, twice, to work on a limb. I prefer to give them exercises and go, "just keep working, keep working""[25]	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 concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, not exploring the limitation of the study sufficiently, study ethics not being considered in a study and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 31: Clinical evidence profile: Intervention themes: Goal setting

Study design and sample size			Quality assessment		
No of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Intervention factors: Goal setting					
4[51, 68, 76, 87]	Combination of focus groups (n=1) and semi-structured interviews (n=3)	Setting personalised and functional goals assisted with engagement in rehabilitation programs. Goals were identified by the participants, as motivation during intensive training. 'Here's your thing – this is individualised, tailored to you, your needs, your goal.'[51]	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	Minor concerns about adequacy[b]	

a. Moderate concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant and limited applicability of the evidence)
b. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 32: Clinical evidence profile: Intervention themes: Use of expensive/additional equipment

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Use of expensive/additional equipment					
4[9, 18, 25, 37]	Combination of focus groups (n=1) and semi-structured interviews (n=3)	Computers and specialist equipment requires extra funding. This may be achievable depending on the local context (including charity funding). "Personally, myself as a manager, I think it's [computer software] costly, as an investment, in the licenses, for a small department like us"[9]	Limitations	Minor concerns about methodological limitations[a]	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[b]	

a. Minor concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant and not exploring the limitation of the study sufficiently)
b. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 33: Clinical evidence profile: Intervention themes: Meaningful activities

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Intervention factors: Meaningful activities					
6[68, 81, 107, 109, 125, 131]	Semi-structured interviews (n=6)	Tasks which were deemed to be meaningful or related to patients' personal goals led to increased motivation and adherence to therapy. "I'm . . . football fanatic so most of the things she [the therapist] got me to read and do was over football and that's where . . . the letter 'M' came into it. I found I struggled saying [inaudible] . . . [Manchester] United, she did football teams to make it interesting for me. She'd pick my interests out and put it into a way of teaching me that I enjoyed. I think that's why I enjoyed the speech therapy so much. (Speech and language therapy)"[137]	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 concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, it being unclear if data analysis was sufficiently rigorous in one study and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

J.7 Environmental factors

Table 34: Clinical evidence profile: Environmental factors: Hospital care

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Environmental factors: Hospital care					
1[22]	Combination of focus groups and semi-structured interviews (n=1)	Hospital environments do not encourage socialisation which can be a barrier to people with communication difficulties. Shared rooms can give more opportunities for socialisation to help with this. "They (patients) can hear other people talking… there is (sic) a lot of voices going on which is going to impact on their understanding as well."[22] "We used to co-locate our stroke patients (sic) and often using our shared rooms. That's when people had more opportunities for interacting with one another."[22]	Limitations	Moderate concerns about methodological limitations[a]	LOW
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Moderate concerns about adequacy[c]	

a. Moderate concerns about methodological limitations (due to lack of exploration of the relationship between the researcher and the participant)
b. Minor concerns about relevance (as the findings from this outcome are specific to only one part of the population, people with communication difficulties)
c. Moderate concerns about adequacy (due to only one study reporting the subtheme)

Table 35: Clinical evidence profile: Environmental factors: Home

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Environmental factors: Home					
5[13, 17, 25, 81, 125]	Combination of focus groups (n=1), semi-structured interviews (n=4)	Rehabilitation in the home environment was seen to be more cost-effective and less demanding while being perceived as more focussed towards the individual. However, a lack of supervision and space at home may be a barrier to engagement. "if you've got any questions … you could ask them, whereas when you're in a hospital, I feel that I can't take up the people's time because they haven't really got time"[17]	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 concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, not exploring the limitation of the study sufficiently, it being unclear if the data analysis was sufficiently rigorous in a study and limited applicability of the evidence)
b. Minor concerns about coherence (as there was disagreement with one person in one study)
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 36: Clinical evidence profile: Environmental factors: Enriched/adapted environment

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Environmental factors: Enriched/adapted environment					
3[51, 76, 123]	Combination of focus groups (n=2), semi-structured interviews (n=1)	Training in specially adapted and well-resourced environments was found to be stimulated and facilitated the success of the intervention. "This clearly means a lot. Positive surroundings. I only see the colours, the ocean… Most of us have been ill for a long time and have perhaps not experienced many other things during this time. Maybe you've had to give up travelling or other things that you used to do."[123]	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 concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 37: Clinical evidence profile: Environmental factors: Accessible therapy

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Environmental factors: Accessible therapy					
8[9, 13, 25, 37, 51, 81, 84, 109]	Combination of focus groups (n=3), semi-structured interviews (n=5)	Therapy in person was seen as accessible if delivered in a location that could be accessed in the local community. Remote therapy can be delivered remotely to improve geographic accessibility and reduce the effort to the stroke survivor and caregivers, but can produce barriers dependent on the person's use of computers. "It's not easy for them [the patients] to pay to come by cab…so expensive. Now they have to pay about 30 ringgit or more. So, transportation becomes a problem."[84]	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 concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, not exploring the limitation of the study sufficiently and limited applicability of the evidence)
b. Minor concerns about coherence (as there was disagreement when discussing remote delivery of therapy)
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 38: Clinical evidence profile: Environmental factors: Supervision

Study design and sample size		Finding	Quality assessment		
No of studies contributing to the finding	**Design**		**Criteria**	**Rating**	**Overall assessment of confidence**
Environmental factors: Supervision					
8[6, 13, 19, 76, 90, 92, 107, 125]	Semi-structured interviews (n=8)	Lack of supervision was cited as a barrier to intensive therapy by stroke survivors and healthcare professionals. For exercise, barriers to completing exercise without supervision included therapists' beliefs about patients' ability to correctly complete exercises, patient safety awareness, cognitive impairment and a lack of family support. Remote communications via telerehabilitation may increase adherence. "[The therapist] went away and left me on my own and I have to keep walking ....you can't stop it, and I was just going for too long"[6]	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 concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant, it being unclear if the data analysis was sufficiently rigorous in a study and limited applicability of the evidence)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

J.8 Service factors

Table 39: Clinical evidence profile: Service factors: Time spent in information exchange

Study design and sample size			Quality assessment		
No of studies contributing to the finding	Design	Finding	Criteria	Rating	Overall assessment of confidence
Service factors: Time spent in information exchange					
3[16, 79, 86]	Combination of focus groups (n=1), semi-structured interviews (n=1) and observations and semi-structured interviews (n=1)	Therapist time spent in information exchange activities (for example: daily handovers or board rounds) limits the time they have to deliver more intense therapy. Some view these activities as useful or essential if all of the multidisciplinary team was involved and if the process is based on exchange of information and not simply receipt. "There's often nothing new to report and sometimes that does seem a waste of time to sit and hear the same thing as the day before. (Stroke co-ordinator, Unit 6)"[16] "Some days it may feel as though the information that we get is not appropriate, but it's important that we have handover, as the therapy team, we have our input as well as taking information from them. (Physiotherapist, Unit 4)"[16]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[a]	

a. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 40: Clinical evidence profile: Service factors: Time spent in other non-patient contact activities

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: Time spent in other non-patient contact activities					
4[9, 16, 79, 116]	Combination of semi-structured interviews (n=2) and observations and semi-structured interviews (n=2)	Other administrative tasks may reduce time therapists have to deliver more intense therapy (including planning and documenting therapy, discharge planning, ordering equipment and transport, training stroke survivors, family/carer and staff and producing information packages). Some therapists consider this a part of therapy time as they facilitating discharge was their therapy priority and so was a valuable use of time. “We have a large indirect role; because indirect isn’t included in your 45minutes therapy it’s not part of [achieving] your target, but it is a vital part of somebody’s treatment with us. Sometimes it can take 30minutes to fill out a bed-rail risk assessment. (Occupational therapist, Unit 4)”[16]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[a]	

a. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 41: Clinical evidence profile: Service factors: Staffing levels and deployment

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: Staffing levels and deployment					
13[9, 16, 18, 22, 40, 41, 68, 79, 84, 86, 87, 121, 132]	Combination of focus groups (n=2), semi-structured interviews (n=8), observations and semi-structured interviews (n=1), focus groups and semi-structured interviews (n=1) and a survey, focus groups and semi-structured interviews (n=1).	Lack of staff availability may make it difficult to deliver more intense therapy. Participants viewed limited resources in the current healthcare system as a major barrier. “We [local NHS speech and language therapy service] don’t have the staffing any more to provide that kind of 1:1 therapy that we used to...”[9] “I think it’s the system more than the people, and I think the system just doesn’t work for intensive therapy… I think there’s been a real lack of intensive therapy…. at least for the first three months we needed way more therapy. There was a lot of assessing, therapy minimal at times…frustrating.”[40]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	Minor concerns about relevance[a]	
			Adequacy	No concerns about adequacy	

a. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

Table 42: Clinical evidence profile: Service factors: Seven day working

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: Seven day working					
4[6, 16, 68, 121]	Combination of semi-structured interviews (n=3) and observations and semi-structured interviews (n=1)	The majority of healthcare professionals had a positive view on seven day services. Managers perceived the benefits in preventing patient deterioration over the weekend while therapists viewed it at improving function. An alternative view was that seven day services may not increase intensity if existing staff taken weekdays off in lieu, depleting number of healthcare professionals available during the week. "I think seven-day working is exactly what we should be doing but not how this Trust is doing it because you're making five day working less effective because you're just spreading it [therapists] too thinly to tick a box. (Speech and language therapist, Unit 1"[16]	Limitations	No or very minor concerns about methodological limitations	LOW
			Coherence	Minor concerns about coherence[a]	
			Relevance	Minor concerns about relevance[b]	
			Adequacy	Minor concerns about adequacy[c]	

a. Minor concerns about coherence (due to disagreement between professionals)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom
c. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 43: Clinical evidence profile: Service factors: Influence of external audit

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: Influence of external audit					
3[16, 20, 116]	Combination of semi-structured interviews (n=1) and observations and semi-structured interviews (n=2)	Auditing may make it more likely for targets to be met and provide evidence for additional staffing requirements. However, this can shape therapists' behaviour, making them focus on increasing recorded therapy minutes rather than providing more patients with more therapy. "It's better to have some standard about the amount of therapy that patients should be receiving, because that gives a target to work towards and you're more likely to give patients adequate therapy […]. That is measured and known throughout your region and to the public, and the Trust is going to be judged upon it. (Stroke co-ordinator, Unit 6)"[16] "We count [group activity] as contact time, sometimes it feels like a bit of a cheat because I know it's not therapy, we're just seeing the patients, making sure they're okay and seeing them from a mental point of view, trying to perk their moods up. (Physiotherapist, Unit 6)"[16]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	Minor concerns about coherence[a]	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[b]	

a. Minor concerns about coherence (due to disagreement between professionals)
b. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 44: Clinical evidence profile: Service factors: Use of therapy timetabling

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: Use of therapy timetabling					
4[16, 18, 79, 86]	Combination of focus groups (n=1), semi-structured interviews (n=2) and observations and semi-structured interviews (n=1)	Daily or weekly timetabling of therapist activity may help nurses to prioritise their workload and for staff not involved in timetabling to use the schedules to work around planned therapy. "If the day before, they [therapists] could let us know who they're going to first in the morning, then obviously nursing staff would be able to prepare for that. (Registered nurse, Unit 2)"[16]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[a]	

a. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 45: Clinical evidence profile: Service factors: Dedicated stroke care, staff training and expertise

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: Dedicated stroke care, staff training and expertise					
1[86]	Focus groups (n=1)	Dedicated stroke services allowed staff to develop expertise in stroke care, which provided benefits for patients and carers. When there were physical or professional separations in the service, problems occurred. '... the therapists are very used to the stroke patients, I think that's a positive thing for them, ...'[86] '... there are two philosophies of care in place, and ... it's made people incredibly anxious and defensive in their practice and quite a blaming culture has grown up ... ... so there seems to be a kind of reciprocal relationship of blame between THE nurses and THE therapy team ...'[86]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Moderate concerns about adequacy[a]	

a. Moderate concerns about adequacy (due to a very limited number of studies reporting the subtheme)

Table 46: Clinical evidence profile: Service factors: An emphasis on discharge planning versus treatment

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: An emphasis on discharge planning versus treatment					
2[16, 116]	Observations and semi-structured interviews (n=2)	A shift of emphasis from treatment to discharge planning was acknowledged by clinical leaders. Discharge planning for patients increased administration, which therapists often prioritised over face-to-face therapy. "We don't use the word 'rehab' in relation to inpatient stroke services at [NHS organisation] anymore because the concept is about community. Rehab happens in the community… I think I'm very clear… yes, the therapists don't do therapy, but they get their patients home."[116]	Limitations	No or very minor concerns about methodological limitations	MODERATE
			Coherence	No or very minor concerns about coherence	
			Relevance	No or very minor concerns about relevance	
			Adequacy	Minor concerns about adequacy[a]	

a. Minor concerns about adequacy (due to a limited number of studies reporting the subtheme)

Table 47: Clinical evidence profile: Service factors: Transitioning from hospital care to community-based stroke rehabilitation

Study design and sample size			Quality assessment		
No of studies contributing to the finding	**Design**	**Finding**	**Criteria**	**Rating**	**Overall assessment of confidence**
Service factors: Transitioning from hospital care to community-based stroke rehabilitation					
6[17, 25, 40, 48, 81, 84]	Combination of focus groups (n=2) and semi-structured interviews (n=4)	Stroke survivors, carers and healthcare professionals all felt that transitions between services were a source of challenge and could lead to a lack of support. Assistive technologies were seen as a possible way of bridging this gap. Community-based rehabilitation centres are greatly needed to manage long term stroke patients. Stroke recovery groups may attempt to be a substitute for the problem by providing an environment where people could obtain therapy services and emotional support. '... all of a sudden it's like, 'Oh, we've referred you to the hospital again to get the physio,' which has took, like, three months. So I've had intense physio for six weeks and then, for three months, I've had nothing'[17] "I think that it (assistive technology use) has got to start before you are, before you are discharged, to be able to carry it home, and then do whatever it is you need to do afterwards."[25]	Limitations	Moderate 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. Moderate concerns about methodological limitations (due to problems in considering the relationship between the researcher and participant and not exploring the limitations of the study sufficiently)
b. Minor concerns about relevance as some studies were conducted in a healthcare setting outside of the United Kingdom

Appendix K – Excluded studies

Effectiveness studies

Table 48: Quantitative studies excluded from the clinical review

Study	Code [Reason]
(2008) The Effectiveness of Mental Practice: With Motor Imagery in the Neurological Rehabilitation of Stroke Patients *for the improvement of UE function. JBI library of systematic reviews 6suppl8s: 1-8	- Duplicate reference
(2017) Effect of cathodal transcranial direct current stimulation on upper limb motor function in patients with stroke. Chinese journal of cerebrovascular diseases 14(12): 622-627	- Study not reported in English
(2020) Evaluation of the enhanced upper limb therapy programme within the Robot-Assisted Training for the Upper Limb after Stroke trial: descriptive analysis of intervention fidelity, goal selection and goal achievement. Clinical rehabilitation: 269215520953833	- Study design not relevant to this review protocol
(2013) Characteristics of exercise training interventions to improve cardiorespiratory fitness after stroke: A systematic review with meta-analysis. Neurorehabilitation and Neural Repair 27(9): 775-88.	- Study does not contain an intervention relevant to this review protocol
(2018) Effects of high-frequency repetitive transcranial magnetic stimulation combined with task-oriented mirror therapy training on hand rehabilitation of acute stroke patients. Medical science monitor 24(pp743750)	- Comparator in study does not match that specified in this review protocol
(2018) Effects of electromechanical assisted gait training with Exowalk on walking ability of chronic stroke patients: a randomized controlled trial. Annals of physical and rehabilitation medicine	- Conference abstract
(2020) Effect of Low-Frequency rTMS and Intensive Speech Therapy Treatment on Patients With Nonfluent Aphasia After Stroke. Neurologist 26(1): 6-9	- Study does not contain an intervention relevant to this review protocol
Abbasian, S. and Rastegar, Mm M. (2018) Is the Intensity or Duration of Treadmill Training Important for Stroke Patients? A Meta-Analysis. Journal of Stroke and Cerebrovascular Diseases 27(1): 32-43	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Abdullahi, A. (2017) Number of repetition versus hours of shaping practice duringconstraint-induced movement therapy in acute stroke: a randomised controlled trial protocol. European Journal of Physiotherapy 19(3): 173-176	- Protocol only
Abdullahi, Auwal, Pedlow, Katy, Lennon, Sheila et al. (2014) Is time spent using constraint induced movement therapy an appropriate measure of dose? A critical literature review. International Journal of Therapy & Rehabilitation 21(3): 140-146	- Study does not contain an intervention relevant to this review protocol
Abo, M. (2020) Dose-response of repetitive peripheral magnetic stimulation therapy combined with intensive occupational therapy for upper limb hemiparesis after stroke: a multi-center randomized controlled study.	- Trial registry data only
Actrn (2017) BRAIN Training Trial: balance, Resistance, or INterval Training Trial: a Randomised Controlled Trial of Three Exercise Modalities in Mild Cognitive Impairment.	- Trial registry data only
Agrawal, K; Suchetha, PS; Mallikarjunaiah, HS. (2013) A comparative study on quantity of caregiver support for upper limb functional recovery in post stroke. International Journal of Physiotherapy and Research 3: 77-82	- Data not reported in an extractable format or a format that can be analysed
Aguilar-Ferrandiz, M. E., Toledano-Moreno, S., Garcia-Rios, M. C. et al. (2021) Effectiveness of a Functional Rehabilitation Program for Upper Limb Apraxia in Poststroke Patients: A Randomized Controlled Trial. Archives of Physical Medicine & Rehabilitation 102(5): 940-950	- Comparator in study does not match that specified in this review protocol
Aguirrezabal, A, Duarte, E, Rueda, N et al. (2013) Effects of information and training provision in satisfaction of patients and carers in stroke rehabilitation. Neurorehabilitation 33(4): 639-47.	- Full text paper not available
Akabogu, J., Nnamani, A., Otu, M. S. et al. (2019) Efficacy of cognitive behavior language therapy for aphasia following stroke: Implications for language education research. Medicine 98(18): e15305	- Comparator in study does not match that specified in this review protocol
Alberts, J. L.; Butler, A. J.; Wolf, S. L. (2004) The effects of constraint-induced therapy on precision grip: a preliminary study. Neurorehabilitation and neural repair 18(4): 250-258	- Study design not relevant to this review protocol
Alingh, J. F., Groen, B. E., van Asseldonk, E. H. F. et al. (2020) Effectiveness of rehabilitation interventions to improve paretic propulsion in individuals with stroke -- a systematic review. Clinical Biomechanics 2020 Jan;71:176-188	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Altin Ertekin, O., Gelecek, N., Yildirim, Y. et al. (2009) Supervised versus home physiotherapy outcomes in stroke patients with unilateral visual neglect: A randomized controlled follow-up study. Journal of Neurological Sciences 26(3): 325-334	- Comparator in study does not match that specified in this review protocol
An, M. and Shaughnessy, M. (2011) The effects of exercise-based rehabilitation on balance and gait for stroke patients: a systematic review. The Journal of neuroscience nursing : journal of the American Association of Neuroscience Nurses 43(6): 298-307	- Study does not contain an intervention relevant to this review protocol
Ang, K. K., Chua, K. S., Phua, K. S. et al. (2015) A Randomized Controlled Trial of EEG-Based Motor Imagery Brain-Computer Interface Robotic Rehabilitation for Stroke. Clinical EEG and neuroscience 46(4): 310-320	- Study does not contain an intervention relevant to this review protocol
Ardestani, M. M., Henderson, C. E., Mahtani, G. et al. (2020) Locomotor Kinematics and Kinetics Following High-Intensity Stepping Training in Variable Contexts Poststroke. Neurorehabilitation & Neural Repair 34(7): 652-660	- Comparator in study does not match that specified in this review protocol
Arulmozhe, A. and Sivakumar, V. P. R. (2016) Comparison of embedded versus added motor imagery training for improving balance and gait in individuals with stroke. International Journal of Pharmaceutical and Clinical Research 8(9): 1331-1338	- Study design not relevant to this review protocol
Arya, K. N., Pandian, S., Sharma, A. et al. (2020) Interlimb coupling in poststroke rehabilitation: a pilot randomized controlled trial. Topics in Stroke Rehabilitation 27(4): 272-289	- Study does not contain an intervention relevant to this review protocol
Asano, M., Tai, B. C., Chen, C. et al. (2018) Home-based tele-rehabilitation presents comparable and positive impact on self-reported functional outcomes as center-based rehabilitation: singapore tele-technology aided rehabilitation in stroke (STARS) trial. Annals of physical and rehabilitation medicine	- Conference abstract
Asghar, M., Fatima, A., Warner, S. et al. (2021) Effectiveness of proprioceptive neuromuscular facilitation on balance in chronic stroke patients. Rawal Medical Journal 46(1): 212-215	- Comparator in study does not match that specified in this review protocol
Ashizawa, R., Yamashita, K., Take, K. et al. (2021) Nonleisure-Time Physical Activity Guidance Following Minor Ischemic Stroke: a Randomized Clinical Trial. Adapted physical activity quarterly 38(2): 329-347	- Study does not contain an intervention

Study	Code [Reason]
	relevant to this review protocol
Atteya, A. A. (2004) Effects of modified constraint induced therapy on upper limb function in subacute stroke patients. Neurosciences 9(1): 24-9	- Comparator in study does not match that specified in this review protocol
Au-Yeung, S. S. and Hui-Chan, C. W. (2014) Electrical acupoint stimulation of the affected arm in acute stroke: a placebo-controlled randomized clinical trial. Clinical Rehabilitation 28(2): 149-58	- Study does not contain an intervention relevant to this review protocol
Azab, M., Al-Jarrah, M., Nazzal, M. et al. (2009) Effectiveness of constraint-induced movement therapy (CIMT) as home-based therapy on Barthel Index in patients with chronic stroke. Topics in Stroke Rehabilitation 16(3): 207-11	- Comparator in study does not match that specified in this review protocol
Babbar, P., Vijaya Kumar, K., Joshua, A. et al. (2021) Adherence to home-based neuro-rehabilitation exercise program in stroke survivors. Bangladesh Journal of Medical Science 20(1): 145-153	- Study design not relevant to this review protocol
Baer, G. (2007) An investigation into the efficacy of a home-based physiotherapy rehabilitation programme for late-stage stroke. A pilot randomised controlled trial. National research register	- Trial registry data only
Baer, G. D., Salisbury, L. G., Smith, M. T. et al. (2018) Treadmill training to improve mobility for people with sub-acute stroke: a phase II feasibility randomized controlled trial. Clinical Rehabilitation 32(2): 201-212	- Comparator in study does not match that specified in this review protocol
Bagley, P., Hudson, M., Forster, A. et al. (2005) A randomized trial evaluation of the Oswestry Standing Frame for patients after stroke. Clinical Rehabilitation 19(4): 354-64	- Comparator in study does not match that specified in this review protocol
Bai, Y., Hu, Y., Chen, W. et al. (2008) Effects of three stage rehabilitation therapy on neurological deficit scores and ADL in ischemic stroke patients. Journal of rehabilitation medicine: 109	- Conference abstract
Bai, Y., Hu, Y., Wu, Y. et al. (2012) A prospective, randomized, single-blinded trial on the effect of early rehabilitation on daily activities and motor function of patients with hemorrhagic stroke. Journal of Clinical Neuroscience 19(10): 1376-9	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Bank, J.; Charles, K.; Morgan, P. (2016) What is the effect of additional physiotherapy on sitting balance following stroke compared to standard physiotherapy treatment: a systematic review. Topics in stroke rehabilitation 23(1): 1945511915y0000000005	- Systematic review used as source of primary studies
Barclay, R. E., Stevenson, T. J., Poluha, W. et al. (2015) Interventions for improving community ambulation in individuals with stroke. Cochrane Database of Systematic Reviews 3(3): cd010200	- Study does not contain an intervention relevant to this review protocol
Barclay, R. E., Stevenson, T. J., Poluha, W. et al. (2020) Mental practice for treating upper extremity deficits in individuals with hemiparesis after stroke (Cochrane review) [with consumer summary]. Cochrane Database of Systematic Reviews 2020;Issue 5	- Study does not contain an intervention relevant to this review protocol
Barzel, A., Ketels, G., Stark, A. et al. (2015) Home-based constraint-induced movement therapy for patients with upper limb dysfunction after stroke (HOMECIMT): a cluster-randomised, controlled trial. Lancet Neurology 14(9): 893-902	- Comparator in study does not match that specified in this review protocol
Barzel, A., Liepert, J., Haevernick, K. et al. (2009) Comparison of two types of Constraint-Induced Movement Therapy in chronic stroke patients: A pilot study. Restorative Neurology & Neuroscience 27(6): 673-80	- Study design not relevant to this review protocol
Bayindir, Ozun; Akyuz, Gulseren; Sekban, Nimet (2022) The effect of adding robot-assisted hand rehabilitation to conventional rehabilitation program following stroke: A randomized-controlled study. Turkish journal of physical medicine and rehabilitation 68(2): 254-261	- Data not reported in an extractable format or a format that can be analysed *Medians and interquartile ranges*
Bergfeldt, U., Ingolfsdottir, E., Berthold-Lindstedt, M. et al. (2019) Effects of aerobic training on memory, attention, and working memory in patients with stroke and traumatic brain injury. European stroke journal 4 (Supplement 1): 793	- Conference abstract
Bergheim, A (2010) Modified constraint induced movement therapy versus traditional physiotherapy after cerebral stroke: A pilot study. Fysioterapeuten 77(2): 16-22.	- Study not reported in English
Bernhardt, J., Churilov, L., Ellery, F. et al. (2016) Prespecified dose-response analysis for A Very Early Rehabilitation Trial (AVERT). Neurology 86(23): 2138-2145	- Very early mobilisation

Study	Code [Reason]
Bhogal, S. K.; Teasell, R.; Speechley, M. (2003) Intensity of aphasia therapy, impact on recovery. Stroke; a journal of cerebral circulation 34(4): 987-992	- Comparator in study does not match that specified in this review protocol
Bjorkdahl, A., Nilsson, A. L., Grimby, G. et al. (2006) Does a short period of rehabilitation in the home setting facilitate functioning after stroke? A randomized controlled trial. Clinical Rehabilitation 20(12): 1038-49	- Comparator in study does not match that specified in this review protocol
Bjorklund, A. and Fecht, A. (2006) The effectiveness of contraint-induced therapy as a stroke intervention: A meta-analysis. Occupational Therapy in Health Care 2006;20(2):31-49	- Study does not contain an intervention relevant to this review protocol
Blennerhassett, J. and Dite, W. (2004) Additional task-related practice improves mobility and upper limb function early after stroke: a randomised controlled trial. Australian Journal of Physiotherapy 50(4): 219-24	- Comparator in study does not match that specified in this review protocol
Borschmann, K., Hayward, K. S., Raffelt, A. et al. (2018) Rationale for Intervention and Dose Is Lacking in Stroke Recovery Trials: A Systematic Review. Stroke research and treatment 2018: 8087372	- Comparator in study does not match that specified in this review protocol
Borstad, Alexandra, Nichols-Larsen, Deborah, Uswatte, Gitendra et al. (2022) Tactile Sensation Improves Following Motor Rehabilitation for Chronic Stroke: The VIGoROUS Randomized Controlled Trial. Neurorehabilitation and neural repair 36(8): 525-534	- Comparator in study does not match that specified in this review protocol *Time-matched comparison*
Bosomworth, H., Rodgers, H., Shaw, L. et al. (2021) Evaluation of the enhanced upper limb therapy programme within the Robot-Assisted Training for the Upper Limb after Stroke trial: descriptive analysis of intervention fidelity, goal selection and goal achievement. Clinical Rehabilitation 35(1): 119-134	- Study design not relevant to this review protocol
Bowden, M. G., Monsch, E. D., Middleton, A. et al. (2020) Lessons Learned: The Difficulties of Incorporating Intensity Principles Into Inpatient Stroke Rehabilitation. Archives of Rehabilitation Research and Clinical Translation 2(2): 100052	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
	Did not appear to necessarily receive a more intense therapy in terms of time than the control group based on the reporting in the study
Bower, K. J., Louie, J., Landesrocha, Y. et al. (2015) Clinical feasibility of interactive motion-controlled games for stroke rehabilitation. Journal of Neuroengineering and Rehabilitation 12: 63	- Comparator in study does not match that specified in this review protocol
Brady, M. C., Kelly, H., Godwin, J. et al. (2012) Speech and language therapy for aphasia following stroke. Cochrane Database of Systematic Reviews: cd000425	- More recent systematic review included that covers the same topic
Brady, M. C., Kelly, H., Godwin, J. et al. (2016) Speech and language therapy for aphasia following stroke. Cochrane Database of Systematic Reviews: cd000425	- Comparator in study does not match that specified in this review protocol
Braley, M., Pierce, J. S., Saxena, S. et al. (2021) A Virtual, Randomized, Control Trial of a Digital Therapeutic for Speech, Language, and Cognitive Intervention in Post-stroke Persons With Aphasia. Frontiers in neurology 12	- Comparator in study does not match that specified in this review protocol
Breitenstein, C., Grewe, T., Floel, A. et al. (2017) Intensive speech and language therapy in patients with chronic aphasia after stroke: a randomised, open-label, blinded-endpoint, controlled trial in a health-care setting. Lancet 389(10078): 1528-1538	- Comparator in study does not match that specified in this review protocol
Brogardh, C. and Sjolund, B. H. (2006) Constraint-induced movement therapy in patients with stroke: A pilot study on effects of small group training and of extended miit use. Clinical Rehabilitation 20(3): 218-227	- Comparator in study does not match that specified in this review protocol
Byun, S. D., Jung, T. D., Kim, C. H. et al. (2011) Effects of the sliding rehabilitation machine on balance and gait in chronic stroke patients - a controlled clinical trial. Clinical rehabilitation 25(5): 408-415	- Study design not relevant to this review protocol

Study	Code [Reason]
Cabanas-Valdes, R., Bagur-Calafat, C., Girabent-Farres, M. et al. (2017) Long-term follow-up of a randomized controlled trial on additional core stability exercises training for improving dynamic sitting balance and trunk control in stroke patients. Clinical Rehabilitation 31(11): 1492-1499	- Comparator in study does not match that specified in this review protocol
Calayan, Ludmina Svetlana M. and Dizon, Janine Margarita R. (2008) The Effectiveness of Mental Practice With Motor Imagery in the Neurological Rehabilitation of Stroke Patients for the improvement of UE function. JBI Library of Systematic Reviews 6(8): 21-28	- Study does not contain an intervention relevant to this review protocol
Calisgan, E. (2018) The effects of somatosensory and vestibular rehabilitation additional conventional therapy on balance in patients with acute stroke.	- Trial registry data only
Calugi, S., Taricco, M., Rucci, P. et al. (2016) Effectiveness of adaptive physical activity combined with therapeutic patient education in stroke survivors at twelve months: a non-randomized parallel group study. European journal of physical and rehabilitation medicine 52(1): 72-80	- Study design not relevant to this review protocol
Campbell, F. M., Ashburn, A. M., Pickering, R. M. et al. (2001) Head and pelvic movements during a dynamic reaching task in sitting: Implications for physical therapists. Archives of Physical Medicine and Rehabilitation 82(12): 1655-1660	- Study design not relevant to this review protocol
Campbell, H. M. (2004) Review: therapy based rehabilitation services reduce the risk of deterioration in patients who have had a stroke. Evidence Based Nursing 7(4): 117-117	- Commentary only
Cano-Manas, M. J., Collado-Vazquez, S., Rodriguez Hernandez, J. et al. (2020) Effects of Video-Game Based Therapy on Balance, Postural Control, Functionality, and Quality of Life of Patients with Subacute Stroke: A Randomized Controlled Trial. Journal of Healthcare Engineering 2020: 5480315	- Comparator in study does not match that specified in this review protocol
Carmeli, E., Peleg, S., Bartur, G. et al. (2011) HandTutor TM enhanced hand rehabilitation after stroke--a pilot study. Physiotherapy Research International 16(4): 191-200	- Comparator in study does not match that specified in this review protocol
Cha, H. G.; Shin, Y. J.; Kim, M. K. (2017) Effects of the Bad Ragaz Ring Method on muscle activation of the lower limbs and balance ability in chronic stroke: A randomised controlled trial. Hong Kong Physiotherapy Journal 37: 39-45	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Chan, B. (2015) Effect of Increased Intensity of Physiotherapy on Patient Outcomes After Stroke: An Economic Literature Review and Cost-Effectiveness Analysis. Ontario Health Technology Assessment Series 15(7): 1-43	- Health economic analysis only
Chan, B. (2015) Effect of increased intensity of physiotherapy on patient outcomes after stroke: an economic literature review and cost-effectiveness analysis [with consumer summary]. Ontario Health Technology Assessment Series 2015 Mar;15(7):1-43	- Health economic analysis only
Chan, W. C. and Au-Yeung, S. S. Y. (2018) Recovery in the Severely Impaired Arm Post-Stroke After Mirror Therapy: a Randomized Controlled Study. American journal of physical medicine & rehabilitation 97(8): 572-577	- Comparator in study does not match that specified in this review protocol
Chang, K. W., Lin, C. M., Yen, C. W. et al. (2021) The Effect of Walking Backward on a Treadmill on Balance, Speed of Walking and Cardiopulmonary Fitness for Patients with Chronic Stroke: A Pilot Study. International Journal of Environmental Research & Public Health [Electronic Resource] 18(5): 01	- Comparator in study does not match that specified in this review protocol
Chatterjee, K., Stockley, R. C., Lane, S. et al. (2019) PULSE-I - Is rePetitive Upper Limb SEnsory stimulation early after stroke feasible and acceptable? A stratified single-blinded randomised controlled feasibility study. Trials [Electronic Resource] 20(1): 388	- Study does not contain an intervention relevant to this review protocol
Chen, C. H., Hung, K. S., Chung, Y. C. et al. (2019) Mind-body interactive qigong improves physical and mental aspects of quality of life in inpatients with stroke: A randomized control study. European Journal of Cardiovascular Nursing 18(8): 658-666	- Comparator in study does not match that specified in this review protocol
Chen, C. X., Mao, R. H., Li, S. X. et al. (2015) Effect of visual training on cognitive function in stroke patients. International Journal of Nursing Sciences 2(4): 329-333	- Data not reported in an extractable format or a format that can be analysed
Chen, J., Jin, W., Zhang, X. X. et al. (2015) Telerehabilitation Approaches for Stroke Patients: Systematic Review and Meta-analysis of Randomized Controlled Trials. Journal of stroke and cerebrovascular diseases : the official journal of National Stroke Association 24(12): 2660-8	- Study does not contain an intervention relevant to this review protocol
Chen, Jc, Lin, Ch, Wei, Yc et al. (2011) Facilitation of motor and balance recovery by thermal intervention for the paretic lower limb of acute stroke: A single-blind randomized clinical trial. Clinical Rehabilitation 25(9): 823-32.	- Study does not contain an intervention

Study	Code [Reason]
	relevant to this review protocol
Chen, W. H. (2006) Three-stage rehabilitation program on acute stroke patients and relevant cost-effectiveness analysis. Neurorehabilitation and neural repair 20(1): 220	- Conference abstract
Chen, X., Gan, Z., Tian, W. et al. (2020) Effects of rehabilitation training of core muscle stability on stroke patients with hemiplegia. Pakistan Journal of Medical Sciences 36(3): 461-466	- Study does not contain an intervention relevant to this review protocol
Cherney, L. R. (2010) Oral reading for language in aphasia (ORLA): evaluating the efficacy of computer-delivered therapy in chronic nonfluent aphasia. Topics in Stroke Rehabilitation 17(6): 423-31	- Study design not relevant to this review protocol
Choi, HyeJung, Kim, YeonSoo, Park, DooSoon et al. (2012) Effects of wheelchair-based rehabilitation on the physical functions and health perception of stroke patients. Personal and ubiquitous computing: 1-8	- Comparator in study does not match that specified in this review protocol
Choi, Y. H. and Paik, N. J. (2018) Mobile Game-based Virtual Reality Program for Upper Extremity Stroke Rehabilitation. Journal of Visualized Experiments 133(03): 08	- Study does not contain an intervention relevant to this review protocol
Chow T; Chan C; Tong J (2013) Effectiveness of virtual reality in balance training in stroke rehabilitation: a pilot study. Cerebrovascular Diseases 36: 17-8	- Conference abstract
Chumbler, N. R., Quigley, P., Li, X. et al. (2012) Effects of telerehabilitation on physical function and disability for stroke patients: a randomized, controlled trial. Stroke; a journal of cerebral circulation 43(8): 2168-2174	- Study does not contain an intervention relevant to this review protocol
Chung, S. H., Kim, J. H., Yong, S. Y. et al. (2019) Effect of Task-Specific Lower Extremity Training on Cognitive and Gait Function in Stroke Patients: A Prospective Randomized Controlled Trial. Annals of Rehabilitation Medicine 43(1): 1-10	- Study does not contain an intervention relevant to this review protocol
Church, G., Parker, J., Powell, L. et al. (2019) The effectiveness of group exercise for improving activity and participation in adult stroke survivors: a systematic review [with consumer summary]. Physiotherapy 2019 Dec;105(4):399-411	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Cikajlo, I., Rudolf, M., Mainetti, R. et al. (2020) Multi-Exergames to Set Targets and Supplement the Intensified Conventional Balance Training in Patients With Stroke: A Randomized Pilot Trial. Frontiers in Psychology 11: 572	- Study does not contain an intervention relevant to this review protocol
Clark, B., Whitall, J., Kwakkel, G. et al. (2017) Time spent in rehabilitation and effect on measures of activity after stroke. Cochrane Database of Systematic Reviews 2017 (3)	- Protocol only
Clark, Beth, Whitall, Jill, Kwakkel, Gert et al. (2021) The effect of time spent in rehabilitation on activity limitation and impairment after stroke. The Cochrane database of systematic reviews 10: cd012612	- Systematic review used as source of primary studies *Cochrane review that was published after this review was started. This also looks at intensity, but only looks at physiotherapy, includes a limited number of outcomes, separates by more or less time of rehabilitation rather than by specific amounts of time.*
Conroy, S. S. (2016) Translating Intensive Arm Rehabilitation in Stroke to a Telerehabilitation Format (TeleBATRAC).	- Trial registry data only
Cooke, E. V., Mares, K., Clark, A. et al. (2010) The effects of increased dose of exercise-based therapies to enhance motor recovery after stroke: a systematic review and meta-analysis. BMC medicine 8(nopagination): 60	- Systematic review used as source of primary studies
Cooke, E., Tallis, R., Miller, S. et al. (2007) The effects of type and intensity of physiotherapy on lower limb strength and function after stroke. UK stroke forum conference 2007: 25-26	- Conference abstract
Corbetta, D.; Imeri, F.; Gatti, R. (2015) Rehabilitation that incorporates virtual reality is more effective than standard rehabilitation for improving walking speed, balance and mobility after stroke: a systematic review [with consumer summary]. Journal of Physiotherapy 2015 Jul;61(3):117-124	- Systematic review used as source of primary studies
Corbetta, D.; Imeri, F.; Gatti, R. (2015) Rehabilitation that incorporates virtual reality is more effective than standard rehabilitation for improving walking speed, balance and mobility after stroke: a systematic review. Journal of Physiotherapy 61(3): 117-24	- Systematic review used as source of primary studies

Study	Code [Reason]
Corbetta, D., Sirtori, V., Castellini, G. et al. (2015) Constraint-induced movement therapy for upper extremities in people with stroke. Cochrane Database of Systematic Reviews 10(10): cd004433	- Study does not contain an intervention relevant to this review protocol
Coroian, F., Jourdan, C., Bakhti, K. et al. (2017) Upper Limb Isokinetic Strengthening Versus Passive Mobilization in Patients With Chronic Stroke: a Randomized Controlled Trial. Archives of physical medicine and rehabilitation	- Comparator in study does not match that specified in this review protocol
Corr, S. and Bayer, A. (1995) Occupational therapy for stroke patients after hospital discharge - a randomized controlled trial. Clinical rehabilitation 9(4): 291-296	- Comparator in study does not match that specified in this review protocol
Correia, A., Pimenta, C., Alves, M. et al. (2020) Better balance: a randomised controlled trial of oculomotor and gaze stability exercises to reduce risk of falling after stroke. Clinical rehabilitation: 269215520956338	- Study does not contain an intervention relevant to this review protocol
Costa, Valton da Silva, Melo, Luciana Protásio de, Bezerra, Viviane Tavares et al. (2014) Effects of Bobath Method and Treadmill Training with Partial Body WeightSupport in Gait Rehabilitation after Stroke: A Systematic Review. Rev. bras. ciênc. saúde 18(2): 161-166	- Study not reported in English
Costantino, C., Petraglia, F., Sabetta, L. L. et al. (2018) Effects of Single or Multiple Sessions of Whole Body Vibration in Stroke: Is There Any Evidence to Support the Clinical Use in Rehabilitation?. Rehabilitation Research & Practice Print 2018: 8491859	- Study does not contain an intervention relevant to this review protocol
Cozean, C. D.; Pease, W. S.; Hubbell, S. L. (1988) Biofeedback and functional electric stimulation in stroke rehabilitation. Archives of Physical Medicine & Rehabilitation 69(6): 401-5	- Study does not contain an intervention relevant to this review protocol
Cramer, S. C., Dodakian, L., Le, V. et al. (2020) A Feasibility Study of Expanded Home-Based Telerehabilitation After Stroke. Frontiers in neurology [electronic resource]. 11: 611453	- Study design not relevant to this review protocol
Cui, B. J., Wang, D. Q., Qiu, J. Q. et al. (2015) Effects of a 12-hour neuromuscular electrical stimulation treatment program on the recovery of upper extremity function in sub-acute stroke patients: a randomized controlled pilot trial. Journal of Physical Therapy Science 27(7): 2327-31	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Cullen, B., Pownall, J., Cummings, J. et al. (2018) Positive PsychoTherapy in ABI Rehab (PoPsTAR): a pilot randomised controlled trial. Neuropsychological rehabilitation 28(1): 17-33	- Study does not contain an intervention relevant to this review protocol
Cunningham, P., Turton, A. J., Van Wijck, F. et al. (2016) Task-specific reach-to-grasp training after stroke: development and description of a home-based intervention. Clinical Rehabilitation 30(8): 731-40	- Study design not relevant to this review protocol
Da Campo, L., Hauck, M., Marcolino, M. A. Z. et al. (2019) Effects of aerobic exercise using cycle ergometry on balance and functional capacity in post-stroke patients: a systematic review and meta-analysis of randomised clinical trials. Disability and rehabilitation: 1-7	- Study does not contain an intervention relevant to this review protocol
da Silva Cameirao, M., Bermudez, I. Badia S., Duarte, E. et al. (2011) Virtual reality based rehabilitation speeds up functional recovery of the upper extremities after stroke: a randomized controlled pilot study in the acute phase of stroke using the rehabilitation gaming system. Restorative Neurology & Neuroscience 29(5): 287-98	- Comparator in study does not match that specified in this review protocol
Da Silva, R. H.; Moore, S. A.; Price, C. I. (2018) Self-directed therapy programmes for arm rehabilitation after stroke: a systematic review. Clinical Rehabilitation 32(10): 1412-1411	- Study does not contain an intervention relevant to this review protocol
Da Silva, R.; Moore, S. A.; Price, C. I. M. (2017) A systematic review of self-directed therapy programmes for upper limb rehabilitation after stroke. International Journal of Stroke: 29	- Study does not contain an intervention relevant to this review protocol
Daly, J. J., McCabe, J. P., Holcomb, J. et al. (2019) Long-Dose Intensive Therapy Is Necessary for Strong, Clinically Significant, Upper Limb Functional Gains and Retained Gains in Severe/Moderate Chronic Stroke. Neurorehabilitation and neural repair 33(7): 523-537	- Comparator in study does not match that specified in this review protocol
Davidson, I., Hillier, V. F., Waters, K. et al. (2005) A study to assess the effect of nursing interventions at the weekend for people with stroke. Clinical Rehabilitation 19(2): 126-37	- Data not reported in an extractable format or a format that can be analysed
de Araujo Freitas Moreira, K. L., Abalos-Medina, G. M., Villaverde-Gutierrez, C. et al. (2018) Effectiveness of two home ergonomic programs in reducing pain and enhancing quality of life in informal caregivers of post-stroke	- Comparator in study does not match that

Study	Code [Reason]
patients: A pilot randomized controlled clinical trial. Disability & Health Journal 11(3): 471-477	specified in this review protocol
de Jong, L. D.; Nieuwboer, A.; Aufdemkampe, G. (2006) Contracture preventive positioning of the hemiplegic arm in subacute stroke patients: a pilot randomized controlled trial. Clinical rehabilitation 20(8): 656-667	- Study does not contain an intervention relevant to this review protocol
de Rooij, I. J.; van de Port, I. G.; Meijer, J. G. (2016) The Effect of Virtual Reality Training on Balance and Gait Ability in Patients With Stroke: A Systematic Review and Meta-Analysis. Physical therapy 96(12): 1905-1918	- Study does not contain an intervention relevant to this review protocol
de, Seze M, Wiart, L, Bon-Saint-Come, A et al. (2001) Rehabilitation of postural disturbances of hemiplegic patients by using trunk control retraining during exploratory exercises. Archives of Physical Medicine and Rehabilitation 82(6): 793-800.	- Comparator in study does not match that specified in this review protocol
Dean, S. G., Poltawski, L., Forster, A. et al. (2016) Community-based Rehabilitation Training after stroke: protocol of a pilot randomised controlled trial (ReTrain). BMJ open 6(10): e012375	- Protocol only
Dean, S. G., Poltawski, L., Forster, A. et al. (2018) Community-based rehabilitation training after stroke: results of a pilot randomised controlled trial (ReTrain) investigating acceptability and feasibility. BMJ Open 8(2): e018409	- Comparator in study does not match that specified in this review protocol
Desrosiers, J., Bourbonnais, D., Corriveau, H. et al. (2005) Effectiveness of unilateral and symmetrical bilateral task training for arm during the subacute phase after stroke: a randomized controlled trial. Clinical rehabilitation 19(6): 581-593	- Comparator in study does not match that specified in this review protocol
Dickstein, R., Hocherman, S., Pillar, T. et al. (1986) Stroke rehabilitation. Three exercise therapy approaches. Physical therapy 66(8): 1233-1238	- Comparator in study does not match that specified in this review protocol
Dogan-Aslan, M., Nakipoglu-Yuzer, G. F., Dogan, A. et al. (2012) The effect of electromyographic biofeedback treatment in improving upper extremity functioning of patients with hemiplegic stroke. Journal of Stroke & Cerebrovascular Diseases 21(3): 187-92	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Dromerick, A. W.; Edwards, D. F.; Hahn, M. (2000) Does the application of constraint-induced movement therapy during acute rehabilitation reduce arm impairment after ischemic stroke?. Stroke; a journal of cerebral circulation 31(12): 2984-2988	- Comparator in study does not match that specified in this review protocol
Dromerick, A. W., Lang, C. E., Birkenmeier, R. L. et al. (2009) Very Early Constraint-Induced Movement during Stroke Rehabilitation (VECTORS): A single-center RCT. Neurology 73(3): 195-201	- Very early mobilisation
Druzbicki, M., Kwolek, A., Depa, A. et al. (2010) The use of a treadmill with biofeedback function in assessment of relearning walking skills in post-stroke hemiplegic patients--a preliminary report. Neurologia i Neurochirurgia Polska 44(6): 567-73	- Comparator in study does not match that specified in this review protocol
Duncan, P. W., Sullivan, K. J., Behrman, A. L. et al. (2011) Body-weight-supported treadmill rehabilitation after stroke. New England Journal of Medicine 364(21): 2026-36	- Comparator in study does not match that specified in this review protocol
Duncan, P., Richards, L., Wallace, D. et al. (1998) A randomized, controlled pilot study of a home-based exercise program for individuals with mild and moderate stroke. Stroke; a journal of cerebral circulation 29(10): 2055-2060	- Comparator in study does not match that specified in this review protocol
Duncan, P., Studenski, S., Richards, L. et al. (2003) Randomized clinical trial of therapeutic exercise in subacute stroke. Stroke; a journal of cerebral circulation 34(9): 2173-2180	- Comparator in study does not match that specified in this review protocol
Edinger, K., Herbold, J., Mohr, D. et al. (2003) Value of a fitness program after completion of rehabilitation therapy poststroke. Archives of physical medicine and rehabilitation 84: a10	- Conference abstract
Edinger, K., Herbold, J., Mohr, D. et al. (2003) Value of a fitness program following completion of rehabilitation therapy poststroke. Neurorehabilitation and neural repair 17(4): 237	- Conference abstract
Ellis-Hill, C., Thomas, S., Gracey, F. et al. (2019) HeART of Stroke: randomised controlled, parallel-arm, feasibility study of a community-based arts and health intervention plus usual care compared with usual care to increase psychological well-being in people following a stroke. BMJ open 9(3): e021098	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
English, C., Shields, N., Brusco, N. K. et al. (2016) Additional weekend therapy may reduce length of rehabilitation stay after stroke: a meta-analysis of individual patient data. Journal of Physiotherapy 62(3): 124-9	- Systematic review used as source of primary studies
Eom, M. J., Chang, M. Y., Oh, D. H. et al. (2017) Effects of resistance expiratory muscle strength training in elderly patients with dysphagic stroke. NeuroRehabilitation 41(4): 747-752	- Comparator in study does not match that specified in this review protocol
Ertel, K. A., Glymour, M. M., Glass, T. A. et al. (2007) Frailty modifies effectiveness of psychosocial intervention in recovery from stroke. Clinical Rehabilitation 21(6): 511-22	- Study does not contain an intervention relevant to this review protocol
Eser, F., Yavuzer, G., Karakus, D. et al. (2008) The effect of balance training on motor recovery and ambulation after stroke: a randomized controlled trial. European journal of physical & rehabilitation medicine. 44(1): 19-25	- Comparator in study does not match that specified in this review protocol
Fan, W.; Hu, Y.; Wu, Y. (2006) Clinical study of standardized three stages' rehabilitation program in promoting motor function in stroke patients with hemiplegia. Chinese journal of rehabilitation medicine 21(6): 484-487	- Study not reported in English
Fang, J., Chen, L., Ma, R. et al. (2016) Comprehensive rehabilitation with integrative medicine for subacute stroke: A multicenter randomized controlled trial. Scientific Reports 6: 25850	- Study does not contain an intervention relevant to this review protocol
Fang, Y., Chen, X., Li, H. et al. (2003) A study on additional early physiotherapy after stroke and factors affecting functional recovery. Clinical Rehabilitation 17(6): 608-17	- Comparator in study does not match that specified in this review protocol
Fang, Y., Chen, X., Li, H. et al. (2003) A study on additional early physiotherapy after stoke and factors affecting functional recovery. Clinical Rehabilitation 17(6): 608-617	- Comparator in study does not match that specified in this review protocol
Fang, Z., Wu, T., Lv, M. et al. (2021) Effect of Traditional plus Virtual Reality Rehabilitation on Prognosis of Stroke Survivors: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. American Journal of Physical Medicine & Rehabilitation 28: 28	- Systematic review used as source of primary studies

Study	Code [Reason]
Faulkner, J., Tzeng, Y. C., Lambrick, D. et al. (2017) A randomized controlled trial to assess the central hemodynamic response to exercise in patients with transient ischaemic attack and minor stroke. Journal of Human Hypertension 31(3): 172-177	- Population not relevant to this review protocol
Faure, C., Duret, C., Dobrev, N. et al. (2019) Mirror Therapy Rehabilitation of the Upper Limb After Stroke (NEURO-MIROIR 2).	- Trial registry data only
Fazekas, G., Horvath, M., Troznai, T. et al. (2007) Robot-mediated upper limb physiotherapy for patients with spastic hemiparesis: a preliminary study. Journal of Rehabilitation Medicine 39(7): 580-2	- Population not relevant to this review protocol
Feng, S. Z.; Zhang, M. Y.; Dai, Z. H. (2005) Impacts of rehabilitative therapy on post-stroke depression and the ability of daily life. Chinese Journal of Clinical Rehabilitation 9(13): 154-155	- Study not reported in English
Ferrarello, F., Baccini, M., Rinaldi, L. A. et al. (2011) Efficacy of physiotherapy interventions late after stroke: a meta-analysis. Journal of neurology, neurosurgery, and psychiatry 82(2): 136-43	- Comparator in study does not match that specified in this review protocol
Ferreira, Fmrm, Chaves, M. E. A., Oliveira, V. C. et al. (2018) Effectiveness of robot therapy on body function and structure in people with limited upper limb function: A systematic review and meta-analysis. PLoS ONE [Electronic Resource] 13(7): e0200330	- Systematic review used as source of primary studies
Feys, H. M., De Weerdt, W. J., Selz, B. E. et al. (1998) Effect of a therapeutic intervention for the hemiplegic upper limb in the acute phase after stroke: a single-blind, randomized, controlled multicenter trial. Stroke 29(4): 785-92	- Study does not contain an intervention relevant to this review protocol
Feys, H., De Weerdt, W., Verbeke, G. et al. (2004) Early and repetitive stimulation of the arm can substantially improve the long-term outcome after stroke: a 5-year follow-up study of a randomized trial. Stroke 35(4): 924-9	- Study does not contain an intervention relevant to this review protocol
Fiori, V., Coccia, M., Marinelli, C. V. et al. (2011) Transcranial direct current stimulation improves word retrieval in healthy and nonfluent aphasic subjects. Journal of cognitive neuroscience 23(9): 2309-2323	- Study does not contain an intervention relevant to this review protocol
Fjaertoft, H., Indredavik, B., Johnsen, R. et al. (2004) Acute stroke unit care combined with early supported discharge. Long-term effects on quality of life. A randomized controlled trial. Clinical Rehabilitation 18(5): 580-6	- Very early mobilisation

Study	Code [Reason]
Fletcher-Smith, Jc, Walker, Mf, Cobley, Cs et al. (2013) Occupational therapy for care home residents with stroke. Cochrane Database of Systematic Reviews	- Study design not relevant to this review protocol
Flowers, H. L., Skoretz, S. A., Silver, F. L. et al. (2016) Poststroke Aphasia Frequency, Recovery, and Outcomes: A Systematic Review and Meta-Analysis. Archives of Physical Medicine & Rehabilitation 97(12): 2188-2201.e8	- Study does not contain an intervention relevant to this review protocol
Franceschini, M., Carda, S., Agosti, M. et al. (2009) Walking after stroke: what does treadmill training with body weight support add to overground gait training in patients early after stroke?: a single-blind, randomized, controlled trial. Stroke 40(9): 3079-85	- Comparator in study does not match that specified in this review protocol
Freeman, J. (2015) Stroke Self-Management Delivered by Rehabilitation Assistants Within an Early Supported Discharge Service.	- Trial registry data only
French, B., Thomas, L. H., Coupe, J. et al. (2016) Repetitive task training for improving functional ability after stroke (Cochrane review) [with consumer summary]. Cochrane Database of Systematic Reviews 2016;Issue 11	- Study does not contain an intervention relevant to this review protocol
French, B, Thomas, Lh, Coupe, J et al. (2016) Repetitive task training for improving functional ability after stroke. Cochrane Database of Systematic Reviews	- Study does not contain an intervention relevant to this review protocol
Fu, Jianming, Zeng, Ming, Shen, Fang et al. (2017) Effects of action observation therapy on upper extremity function, daily activities and motion evoked potential in cerebral infarction patients. Medicine 96(42): e8080	- Comparator in study does not match that specified in this review protocol
Fuzaro, A. C., Dos Santos, T. P., Mucciaroni, T. S. et al. (2014) Modified forced used therapy versus classic physiotherapy in the rehabilitation of paretic lower limb post-stroke. Cerebrovascular diseases (Basel, Switzerland) 37(suppl1): 316	- Conference abstract
Galloway, M., Marsden, D. L., Callister, R. et al. (2019) What Is the Dose-Response Relationship Between Exercise and Cardiorespiratory Fitness After Stroke? A Systematic Review. Physical therapy 99(7): 821-832	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Galvao, M. L. C., Gouvea, P. M., Ocamoto, G. N. et al. (2015) Virtual Reality effect on upper limb Motor function paretic in post stroke. Revista neurociencias 23(4): 493-498	- Study not reported in English
Gauthier, Lynne V, Nichols-Larsen, Deborah S, Uswatte, Gitendra et al. (2022) Video game rehabilitation for outpatient stroke (VIGoROUS): A multi-site randomized controlled trial of in-home, self-managed, upper-extremity therapy. EClinicalMedicine 43: 101239	- Comparator in study does not match that specified in this review protocol *Time matched comparator*
Ghasemi, E., Khademi-Kalantari, K., Khalkhali-Zavieh, M. et al. (2018) The effect of functional stretching exercises on functional outcomes in spastic stroke patients: a randomized controlled clinical trial. Journal of bodywork and movement therapies 22(4): 1004-1012	- Study does not contain an intervention relevant to this review protocol
Ghaziani, E., Couppe, C., Siersma, V. et al. (2018) Electrical Somatosensory Stimulation in Early Rehabilitation of Arm Paresis After Stroke: A Randomized Controlled Trial. Neurorehabilitation & Neural Repair 32(10): 899-912	- Study does not contain an intervention relevant to this review protocol
Girard, V., Bellavance-Tremblay, H., Gaudet-Drouin, G. et al. (2020) Cardiorespiratory strain during stroke rehabilitation: Are patients trained enough? A systematic review. Annals of Physical & Rehabilitation Medicine: 101443	- Study does not contain an intervention relevant to this review protocol
Givon, N., Zeilig, G., Weingarden, H. et al. (2016) Video-games used in a group setting is feasible and effective to improve indicators of physical activity in individuals with chronic stroke: a randomized controlled trial. Clinical Rehabilitation 30(4): 383-92	- Comparator in study does not match that specified in this review protocol
Glanz, M., Klawansky, S., Stason, W. et al. (1995) Biofeedback therapy in poststroke rehabilitation: a meta-analysis of the randomized controlled trials. Archives of Physical Medicine & Rehabilitation 76(6): 508-15	- Study does not contain an intervention relevant to this review protocol
Gobert, D.; Merring, C.; Dugan, K. (2013) Somatosensory stimulation combined with moderate intensity therapeutic exercise significantly improves motor function in chronic stroke survivors. Stroke; a journal of cerebral circulation 44	- Conference abstract
Godecke, E. (2013) Very Early Rehabilitation in Speech in patients with aphasia following stroke.	- Trial registry data only

Study	Code [Reason]
Goliwas, M., Kocur, P., Furmaniuk, L. et al. (2015) Effects of sensorimotor foot training on the symmetry of weight distribution on the lower extremities of patients in the chronic phase after stroke. Journal of Physical Therapy Science 27(9): 2925-30	- Comparator in study does not match that specified in this review protocol
Golla, A., Muller, T., Wohlfarth, K. et al. (2018) Home-based balance training using Wii Fitâ„¢: a pilot randomised controlled trial with mobile older stroke survivors. Pilot and feasibility studies 4(1)	- Study does not contain an intervention relevant to this review protocol
Goodwin, N. and Sunderland, A. (2003) Intensive, time-series measurement of upper limb recovery in the subacute phase following stroke. Clinical Rehabilitation 17(1): 69-82	- Study design not relevant to this review protocol
Gracies, J. M., Pradines, M., Ghedira, M. et al. (2019) Guided Self-rehabilitation Contract vs conventional therapy in chronic stroke-induced hemiparesis: NEURORESTORE, a multicenter randomized controlled trial. BMC Neurology 19(1): 39	- Study does not contain an intervention relevant to this review protocol
Grasel, E., Biehler, J., Schmidt, R. et al. (2005) Intensification of the transition between inpatient neurological rehabilitation and home care of stroke patients. Controlled clinical trial with follow-up assessment six months after discharge. Clinical Rehabilitation 19(7): 725-36	- Study design not relevant to this review protocol
Grasel, E., Schmidt, R., Biehler, J. et al. (2006) Long-term effects of the intensification of the transition between inpatient neurological rehabilitation and home care of stroke patients. Clinical Rehabilitation 20(7): 577-83	- Study design not relevant to this review protocol *Non-randomised study that does not adjust for all confounders in the analysis*
Grau-Pellicer, M., Lalanza, J. F., Jovell-Fernandez, E. et al. (2020) Impact of mHealth technology on adherence to healthy PA after stroke: a randomized study. Topics in Stroke Rehabilitation 27(5): 354-368	- Comparator in study does not match that specified in this review protocol
Graven, C., Brock, K., Hill, K. et al. (2011) From rehabilitation to recovery: protocol for a randomised controlled trial evaluating a goal-based intervention to reduce depression and facilitate participation post-stroke. BMC neurology 11: 73	- Protocol only

Study	Code [Reason]
Green, J., Forster, A., Bogle, S. et al. (2002) Physiotherapy for patients with mobility problems more than 1 year after stroke: a randomised controlled trial. Lancet 359(9302): 199-203	- Comparator in study does not match that specified in this review protocol
Guan, Y., Guo, N., Gao, H. et al. (2019) Study on application of continuous nursing in rehabilitation period of stroke patients. Acta Medica Mediterranea 35: 539-543	- Study does not contain an intervention relevant to this review protocol
Gurcan, A., Selcuk, B., Onder, B. et al. (2015) Evaluation of clinical and electrophysiological effects of electrical stimulation on spasticity of plantar flexor muscles in patients with stroke. Turkiye fiziksel tip ve rehabilitasyon dergisi 61(4): 307-313	- Study does not contain an intervention relevant to this review protocol
Gómez Martínez M, Tomas Aguirre F, Torregrosa Castellanos C et al. (2014) The family as a therapeutic collaborator in modified constraint-induced movement therapy. WFOT Bulletin 70: 54-61	- Study not reported in English
Hammer, A. M. and Lindmark, B. (2009) Effects of forced use on arm function in the subacute phase after stroke: a randomized, clinical pilot study. Physical Therapy 89(6): 526-39	- Study does not contain an intervention relevant to this review protocol
Hanschke, Z. F. (2016) The use of transcranial direct current stimulation and therapeutic exercise for rehabilitation of individuals after stroke.	- Trial registry data only
Harel-Katz, H., Adar, T., Milman, U. et al. (2020) Examining the feasibility and effectiveness of a culturally adapted participation-focused stroke self-management program in a day-rehabilitation setting: A randomized pilot study. Topics in Stroke Rehabilitation 27(8): 577-589	- Study does not contain an intervention relevant to this review protocol
Harvey, S., Carragher, M., Dickey, M. W. et al. (2020) Dose effects in behavioural treatment of post-stroke aphasia: a systematic review and meta-analysis. Disability and rehabilitation: 1-12	- Study does not contain an intervention relevant to this review protocol
Hatem, S. M., Saussez, G., della Faille, M. et al. (2016) Rehabilitation of motor function after stroke: A multiple systematic review focused on techniques to stimulate upper extremity recovery. Frontiers in Human Neuroscience 10(sep2016): 442	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Hayward, K. S. (2016) Higher-dose, higher-repetition upper limb motor rehabilitation program after stroke is not superior to dose-matched or usual-dose customary occupational therapy. Journal of physiotherapy 62(4): 226	- Commentary only
Hayward, K. S., Barker, R. N., Carson, R. G. et al. (2014) The effect of altering a single component of a rehabilitation programme on the functional recovery of stroke patients: a systematic review and meta-analysis. Clinical Rehabilitation 28(2): 107-17	- Systematic review used as source of primary studies
Hayward, K. S., Barker, R. N., Carson, R. G. et al. (2014) The effect of altering a single component of a rehabilitation programme on the functional recovery of stroke patients: a systematic review and meta-analysis [with consumer summary]. Clinical Rehabilitation 2014 Feb;28(2):107-117	- Systematic review used as source of primary studies
Hayward, K. S. and Brauer, S. G. (2015) Dose of arm activity training during acute and subacute rehabilitation post stroke: a systematic review of the literature. Clinical Rehabilitation 29(12): 1234-43	- Comparator in study does not match that specified in this review protocol
Hellstrom, K. (2016) Effect of intensified physical activity for patients with stroke - a combined physical and behavioural approach.	- Trial registry data only
Hesse, S., Eich, H. J., Mach, H. et al. (2005) Aerobic treadmill training plus physiotherapy improves walking speed and capacity in subacute, moderately affected patients after stroke. Neurologie und rehabilitation 11(1): 7-12	- Comparator in study does not match that specified in this review protocol
Hesse, S., Welz, A., Werner, C. et al. (2011) Comparison of an intermittent high-intensity vs continuous low-intensity physiotherapy service over 12 months in community-dwelling people with stroke: a randomized trial. Clinical Rehabilitation 25(2): 146-56	- Study does not contain an intervention relevant to this review protocol
Hildebrandt, H.; Bussmann-Mork, B.; Schwendemann, G. (2006) Group therapy for memory impaired patients: a partial remediation is possible. Journal of Neurology 253(4): 512-9	- Population not relevant to this review protocol
Hill, V., Dunn, L., Dunning, K. et al. (2011) A pilot study of rhythm and timing training as a supplement to occupational therapy in stroke rehabilitation. Topics in stroke rehabilitation 18(6): 728-737	- Comparator in study does not match that specified in this review protocol
Hillier, S. (2010) Circuit class therapy for rehabilitation after stroke. A pragmatic randomised controlled trial (CIRCIT). Australian new zealand clinical trials registry (ANZCTR) http://www.anzctr.org.au/	- Trial registry data only

Study	Code [Reason]
Hillier, S., English, C., Berhardt, J. et al. (2014) Circuit class and 7-day week therapy for increasing rehabilitation intensity of therapy after stroke (CIRCIT): six month follow-up and cost analysis of the CIRCIT RCT. International journal of stroke 9(suppl3): 22	- Conference abstract
Hines, S.; Kynoch, K.; Munday, J. (2014) Identification and nursing management of dysphagia in individuals with acute neurological impairment: a systematic review (new update). JBI Database of Systematic Reviews and Implementation Reports 12(5): 195-236	- Study does not contain an intervention relevant to this review protocol
Hiraoka, K. (2001) Rehabilitation effort to improve upper extremity function in post-stroke patients: a meta-analysis. Journal of Physical Therapy Science 13(1): 5-9	- Study does not contain an intervention relevant to this review protocol
Hoeg Dembrower, K. E., von Heijne, A., Laska, A. C. et al. (2017) Patients with aphasia and an infarct in Wernicke's area benefit from early intensive speech and language therapy. Aphasiology 31(1): 122-128	- Comparator in study does not match that specified in this review protocol
Hoffmann, T., Bennett, S., Koh, C. L. et al. (2010) Occupational therapy for cognitive impairment in stroke patients. Cochrane database of systematic reviews (Online): cd006430	- Study does not contain an intervention relevant to this review protocol
Hofstad, H., Naess, H., Moe-Nilssen, R. et al. (2013) Early supported discharge after stroke in Bergen (ESD Stroke Bergen): a randomized controlled trial comparing rehabilitation in a day unit or in the patients' homes with conventional treatment. International Journal of Stroke 8(7): 582-7	- Comparator in study does not match that specified in this review protocol
Horn, S. D., DeJong, G., Smout, R. J. et al. (2005) Stroke rehabilitation patients, practice, and outcomes: is earlier and more aggressive therapy better?. Archives of physical medicine and rehabilitation 86(12): S101-14	- Study design not relevant to this review protocol
Hornby, T. G., Holleran, C. L., Hennessy, P. W. et al. (2015) Variable Intensive Early Walking Poststroke (VIEWS). Neurorehabilitation and Neural Repair 30(5): 440-450	- Duplicate reference
Hornby, T. G., Holleran, C. L., Hennessy, P. W. et al. (2016) Variable Intensive Early Walking Poststroke (VIEWS): A Randomized Controlled Trial. Neurorehabilitation & Neural Repair 30(5): 440-50	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Horsley, Sa; Herbert, Rd; Ada, L (2007) Four weeks of daily stretch has little or no effect on wrist contracture after stroke: a randomised controlled trial. Australian Journal of Physiotherapy 53(4): 239-45.	- Study does not contain an intervention relevant to this review protocol
Host, H. H., Lang, C. E., Hildebrand, M. W. et al. (2014) Patient Active Time During Therapy Sessions in Postacute Rehabilitation: Development and Validation of a New Measure. Physical & Occupational Therapy in Geriatrics 32(2): 169-178	- Study design not relevant to this review protocol
Hsieh, H. C. (2019) Training by Using an Adaptive Foot Switch and Video Games to Improve Balance and Mobility Following Stroke: A Randomised Controlled Trial. Brain Impairment 20(1): 16-23	- Comparator in study does not match that specified in this review protocol
Hsieh, R. L., Wang, L. Y., Lee, W. C. et al. (2008) Additional therapeutic effects of electroacupuncture in conjunction with conventional rehabilitation for patients with first-ever ischaemic stroke. Deutsche zeitschrift fur akupunktur 51(1): 56-57	- Study does not contain an intervention relevant to this review protocol
Hsieh, Y. W., Wu, C. Y., Lin, K. C. et al. (2012) Dose-response relationship of robot-assisted stroke motor rehabilitation: the impact of initial motor status. Stroke 43(10): 2729-34	- Study does not contain an intervention relevant to this review protocol
Hu, Y. S. (2007) Clinical study of standardized tertiary rehabilitation program in promoting upper and lower limbs motor function in stroke patients. Zhonghua yi xue za zhi 87(33): 2358-2360	- Study not reported in English
Hu, Z.; Hu, Y.; Lu, Q. (2003) Impact of early rehabilitation therapy on post stroke depression. Chinese journal of clinical rehabilitation 7(5): 849	- Study not reported in English
Huang, Q., Wu, W., Chen, X. et al. (2019) Evaluating the effect and mechanism of upper limb motor function recovery induced by immersive virtual-reality-based rehabilitation for subacute stroke subjects: study protocol for a randomized controlled trial. Trials [Electronic Resource] 20(1): 104	- Protocol only
Huang, Y-C, Chuang, C-Y, Leong, C-P et al. (2018) Effect of Comprehensive Postural Instructions and Range of Motion Exercises Via Educational Videos on Motor Function and Shoulder Injury in Stroke Patients With Hemiplegia: A Preliminary Study. Journal of Manipulative and Physiological Therapeutics 41(8): 665-671.	- Study design not relevant to this review protocol

Study	Code [Reason]
Huh, J. S., Lee, Y. S., Kim, C. H. et al. (2015) Effects of Balance Control Training on Functional Outcomes in Subacute Hemiparetic Stroke Patients. Ann rehabil med 39(6): 995-1001	- Comparator in study does not match that specified in this review protocol
Hui-Chan, C. W.; Ng, S. S.; Mak, M. K. (2009) Effectiveness of a home-based rehabilitation programme on lower limb functions after stroke. Hong Kong Medical Journal 15(3suppl4): 42-6	- Study does not contain an intervention relevant to this review protocol
Huijben-Schoenmakers, M., Rademaker, A., van Rooden, P. et al. (2014) The effects of increased therapy time on cognition and mood in frail patients with a stroke who rehabilitate on rehabilitation units of nursing homes in the Netherlands: a protocol of a comparative study. BMC Geriatrics 14: 68	- Protocol only
Hung, J. W., Yu, M. Y., Chang, K. C. et al. (2016) Feasibility of Using Tetrax Biofeedback Video Games for Balance Training in Patients With Chronic Hemiplegic Stroke. Pm & R 8(10): 962-970	- Comparator in study does not match that specified in this review protocol
Hunter, Sm, Hammett, L, Ball, S et al. (2011) Dose-response study of mobilisation and tactile stimulation therapy for the upper extremity early after stroke: A phase 1 trial. Neurorehabilitation and Neural Repair 25(4): 314-22.	- Duplicate reference
Hwang, N. K., Kim, H. H., Shim, J. M. et al. (2019) Tongue stretching exercises improve tongue motility and oromotor function in patients with dysphagia after stroke: a preliminary randomized controlled trial. Archives of oral biology 108: 104521	- Study does not contain an intervention relevant to this review protocol
Iliescu, A. M., McIntyre, A., Wiener, J. et al. (2020) Evaluating the effectiveness of aquatic therapy on mobility, balance, and level of functional independence in stroke rehabilitation: a systematic review and meta-analysis. Clinical rehabilitation 34(1): 269215519880955	- Study does not contain an intervention relevant to this review protocol
Immadi, S. K., Achyutha, K. K., Reddy, A. et al. (2015) Effectiveness of the Motor Relearning Approach in Promoting Physical Function of the Upper Limb after a Stroke. International journal of physiotherapy: 386-390	- Comparator in study does not match that specified in this review protocol
Immink, M. (2009) A pilot study on yoga and meditation as an adjunct to fitness rehabilitation programs for stroke patients with chronic hemiparesis. Australian new zealand clinical trials registry (ANZCTR) http://www.anzctr.org.au/	- Trial registry data only

Study	Code [Reason]
Immink, M. A.; Hillier, S.; Petkov, J. (2014) Randomized controlled trial of yoga for chronic poststroke hemiparesis: motor function, mental health, and quality of life outcomes. Topics in Stroke Rehabilitation 21(3): 256-71	- Comparator in study does not match that specified in this review protocol
In, T.; Lee, K.; Song, C. (2016) Virtual Reality Reflection Therapy Improves Balance and Gait in Patients with Chronic Stroke: Randomized Controlled Trials. Medical Science Monitor 22: 4046-4053	- Comparator in study does not match that specified in this review protocol
Ivey, F. M., Stookey, A. D., Hafer-Macko, C. E. et al. (2015) Higher Treadmill Training Intensity to Address Functional Aerobic Impairment after Stroke. Journal of Stroke & Cerebrovascular Diseases 24(11): 2539-46	- Comparator in study does not match that specified in this review protocol
Izumi, S. I. (2001) Stroke rehabilitation at University hospitals (1): early rehabilitative intervention for stroke, a randomized control study. Japanese journal of rehabilitation medicine 38(7): 535	- Study not reported in English
Jackie, Winter, Susan, Hunter, Julius, Sim et al. (2011) Hands-on therapy interventions for upper limb motor dysfunction following stroke. Cochrane Database of Systematic Reviews: cd006609	- Study does not contain an intervention relevant to this review protocol
Jandaghi, S.; Tahan, N.; Baghban, A. A. (2016) Comparing the efficacy of balance training exercises with visual cue deprivation and balance training on unstable surface after stroke. Journal of mazandaran university of medical sciences 26(143): 62-70	- Comparator in study does not match that specified in this review protocol
Jang, W. H., Kwon, H. C., Yoo, K. J. et al. (2016) The effect of a wrist-hand stretching device for spasticity in chronic hemiparetic stroke patients. European journal of physical and rehabilitation medicine 52(1): 65-71	- Comparator in study does not match that specified in this review protocol
Jeon, H. S., Woo, Y. K., Yi, C. H. et al. (2012) Effect of intensive training with a pring-assisted hand orthosis on movement smoothness in upper extremity following stroke: A pilot clinical trial. Topics in Stroke Rehabilitation 19(4): 320-328	- Comparator in study does not match that specified in this review protocol *People wore the orthosis for the same amount of time which could be a form of*

Study	Code [Reason]
	therapy and so would make it difficult to draw a comparison
Jiang, C.; Hu, Y.; Wu, Y. (2006) The cost-effectiveness analysis of early rehabilitation of cerebral vascular accident patients. Chinese journal of rehabilitation medicine 21(11): 973-976	- Study not reported in English
Jiang, S., You, H., Zhao, W. et al. (2021) Effects of short-term upper limb robot-assisted therapy on the rehabilitation of sub-acute stroke patients. Technology & Health Care 29(2): 295-303	- Duplicate reference
Jianjun, Yu, Yongshan, Hu, Wu, Y. et al. (2009) The effects of community-based rehabilitation on stroke patients in China: a single-blind, randomized controlled multicentre trial. Clinical Rehabilitation 23(5): 408-17	- Comparator in study does not match that specified in this review protocol
Jin, M., Zhang, Z., Bai, Z. et al. (2019) Timing-dependent interaction effects of tDCS with mirror therapy on upper extremity motor recovery in patients with chronic stroke: A randomized controlled pilot study. Journal of the Neurological Sciences 405: 116436	- Study does not contain an intervention relevant to this review protocol
Johansson, T. and Wild, C. (2011) Telerehabilitation in stroke care--a systematic review. Journal of telemedicine and telecare 17(1): 1-6	- Study does not contain an intervention relevant to this review protocol
Jones, F. and Riazi, A. (2011) Self-efficacy and self-management after stroke: a systematic review. Disability and rehabilitation 33(10): 797-810	- Study does not contain an intervention relevant to this review protocol
Jonsdottir, J., Baglio, F., Gindri, P. et al. (2021) Virtual Reality for Motor and Cognitive Rehabilitation From Clinic to Home: A Pilot Feasibility and Efficacy Study for Persons With Chronic Stroke. Frontiers in Neurology 12 (no pagination)	- Comparator in study does not match that specified in this review protocol
Joo, S.; Shin, D.; Song, C. (2015) The Effects of Game-Based Breathing Exercise on Pulmonary Function in Stroke Patients: A Preliminary Study. Medical Science Monitor 21: 1806-11	- No outcomes of interest
Jung, S. E., Han, M. A., Park, J. et al. (2015) Effects of Tongue-Holding Maneuver Compared with Mendelsohn Maneuver on Swallowing Function in Stroke Patients. Korean j health promot 15(2): 83-90	- Study not reported in English

Study	Code [Reason]
Karapolat, H. (2019) Effects of computer assisted cognitive rehabilitation on patients with stroke.	- Trial registry data only
Katic, M. (1973) Rehabilitation of speech disorders in the patient after cerebrovascular stroke. Neuropsihijatrija 21(1): 166-167	- Study not reported in English
Kaur, H., Kumaran, S., Chopra, S. et al. (2018) Effectiveness of intensive cognitive-linguistic therapy in post-stroke aphasia patients: a randomized, open-label, controlled trial in low-resource health-care setting. International stroke conference 2018	- Conference abstract
Kawahira, K., Shimodozono, M., Etoh, S. et al. (2010) Effects of intensive repetition of a new facilitation technique on motor functional recovery of the hemiplegic upper limb and hand. Brain Injury 24(10): 1202-1213	- Crossover trials (for people after acute/subacute stroke only)
Keeling, A. B., Piitz, M., Semrau, J. A. et al. (2021) Robot enhanced stroke therapy optimizes rehabilitation (RESTORE): a pilot study. Journal of NeuroEngineering and Rehabilitation 18 (1)	- Study design not relevant to this review protocol
Kenny, M.; Gilmartin, J.; Thompson, C. (2020) Video-guided exercise after stroke: a feasibility randomised controlled trial. Physiotherapy theory and practice: 1-12	- Comparator in study does not match that specified in this review protocol
Keskin, Y., Gurcan Atci, A., Urkmez, B. et al. (2020) Efficacy of a video-based physical therapy and rehabilitation system in patients with post-stroke hemiplegia: A randomized, controlled, pilot study. Turk Geriatri Dergisi 23(1): 118-128	- Study does not contain an intervention relevant to this review protocol
Khalid, S., Alnajjar, F., Gochoo, M. et al. (2021) Robotic assistive and rehabilitation devices leading to motor recovery in upper limb: a systematic review. Disability and rehabilitation. Assistive technology: 1-15	- Study does not contain an intervention relevant to this review protocol
Khorvash, F., Shahnazi, H., Saadatnia, M. et al. (2020) Implementation of home-based health promotion program to improve flow-mediated dilation among patients with subacute stroke. Journal of Education & Health Promotion 9: 41	- Comparator in study does not match that specified in this review protocol
Kim, B. R., Chun, M. H., Kim, L. S. et al. (2011) Effect of virtual reality on cognition in stroke patients. Annals of Rehabilitation Medicine 35(4): 450-9	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Kim, C. Y., Lee, J. S., Kim, H. D. et al. (2015) Effects of the combination of respiratory muscle training and abdominal drawing-in maneuver on respiratory muscle activity in patients with post-stroke hemiplegia: a pilot randomized controlled trial. Topics in Stroke Rehabilitation 22(4): 262-70	- No outcomes of interest
Kim, J. H. and Lee, B. H. (2013) Action observation training for functional activities after stroke: a pilot randomized controlled trial. NeuroRehabilitation 33(4): 565-574	- Comparator in study does not match that specified in this review protocol
Kim, J.; Park, J. H.; Yim, J. (2014) Effects of respiratory muscle and endurance training using an individualized training deviceon pulmonary function and exercise capacity in stroke patients. Medical Science Monitor 20: 2543-2549	- Duplicate reference
Kim, S. H., Park, J. H., Jung, M. Y. et al. (2016) Effects of Task-Oriented Training as an Added Treatment to Electromyogram-Triggered Neuromuscular Stimulation on Upper Extremity Function in Chronic Stroke Patients. Occupational Therapy International 23(2): 165-74	- Study does not contain an intervention relevant to this review protocol
Kim, S. S. and Lee, B. H. (2015) Motor imagery training improves upper extremity performance in stroke patients. Journal of Physical Therapy Science 27(7): 2289-91	- Study does not contain an intervention relevant to this review protocol
Kim, Y. H. (2017) Effect of intensive cognitive rehabilitation in subacute stroke patient.	- Trial registry data only
Kim, Y. H. (2017) Effect of intensive language therapy in subacute stroke patients.	- Trial registry data only
Klassen, T. D., Eng, J. J., Bayley, M. et al. (2015) Implementing an extra hour of intensive, task-specific, physical therapy daily for individuals post-stroke during inpatient rehabilitation: feasibility data from the DOSE study. International journal of stroke 10(suppl4): 86	- Conference abstract
Knight, A., Langhorne, P., Stott, D. et al. (2007) Very early rehabilitation or intensive telemetry after stroke (VERITAS): a pilot randomised trial. 16th european stroke conference 2007	- Conference abstract
Ko, E. J., Chun, M. H., Kim, D. Y. et al. (2016) The Additive Effects of Core Muscle Strengthening and Trunk NMES on Trunk Balance in Stroke Patients. Annals of Rehabilitation Medicine 40(1): 142-51	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Koganemaru, S., Mima, T., Thabit, M. N. et al. (2010) Recovery of upper-limb function due to enhanced use-dependent plasticity in chronic stroke patients. Brain 133(11): 3373-3384	- Study does not contain an intervention relevant to this review protocol
Koolstra, M., Veerbeek, J. M., van Wegen, E. E. et al. (2012) Het effect van additionele oefentherapie op het lopen en aan lopen gerelateerde activiteiten in de eerste 6 maanden na een beroerte; een meta-analyse (Effects of augmented exercise therapy on outcome of gait and gait-related activities in the first six months after stroke: a meta-analysis) [Dutch]. Nederlands Tijdschrift voor Fysiotherapie [Dutch Journal of Physical Therapy] 2012 Oct;122(3):116-122	- Study not reported in English
Korkmaz, N., Gurcay, E., Demir, Y. et al. (2021) The effectiveness of high-intensity laser therapy in the treatment of post-stroke patients with hemiplegic shoulder pain: a prospective randomized controlled study. Lasers in Medical Science 08: 08	- Study does not contain an intervention relevant to this review protocol
Kotov, S. V., Belova, Y. A., Shcherbakova, M. M. et al. (2018) Restoration of Speech Functions in Patients with Aphasia in the Early Rehabilitation Period of Ischemic Stroke. Neuroscience and Behavioral Physiology 48(5): 646-649	- Study does not contain an intervention relevant to this review protocol
Kowalczewski, J., Gritsenko, V., Ashworth, N. et al. (2007) Upper-extremity functional electric stimulation-assisted exercises on a workstation in the subacute phase of stroke recovery. Archives of Physical Medicine & Rehabilitation 88(7): 833-9	- Study does not contain an intervention relevant to this review protocol
Kreisel, S. H.; Bazner, H.; ennerici, M. G. (2005) Intensive rehabilitation in the acute phase of stroke: positive or negative effects on outcome?. Cerebrovascular diseases (basel, switzerland) 19 (Suppl 2): 92	- Conference abstract
Kringle, Emily A., Barone Gibbs, Bethany, Campbell, Grace et al. (2020) Influence of Interventions on Daily Physical Activity and Sedentary Behavior after Stroke: A Systematic Review. PM & R: Journal of Injury, Function & Rehabilitation 12(2): 186-201	- Study does not contain an intervention relevant to this review protocol
Krutulyte, G.; Kimtys, A.; Krisciunas, A. (2003) The effectiveness of physical therapy methods (Bobath and motor relearning program) in rehabilitation of stroke patients. Medicina 39(9): 889-895	- Study not reported in English
Kumar, V. K.; Chakrapani, M.; Kedambadi, R. (2016) Motor Imagery Training on Muscle Strength and Gait Performance in Ambulant Stroke Subjects-A Randomized Clinical Trial. Journal of Clinical and Diagnostic Research JCDR 10(3): YC01-4	- Study does not contain an intervention

Study	Code [Reason]
	relevant to this review protocol
Kutlay, S., Genc, A., Gok, H. et al. (2018) Kinaesthetic ability training improves unilateral neglect and functional outcome in patients with stroke: A randomized control trial. Journal of Rehabilitation Medicine 50(2): 159-164	- Comparator in study does not match that specified in this review protocol
Kuzgun, S., Ozgen, M., Armagan, O. et al. (2012) The efficacy of mirror therapy combined with conventional stroke rehabilitation program on motor and functional recovery. Turk beyin damar hastaliklar dergisi 18(3): 77-82	- Study not reported in English
Kwakkel, G.; Kollen, B. J.; Wagenaar, R. C. (2002) Long term effects of intensity of upper and lower limb training after stroke: a randomised trial. Journal of Neurology, Neurosurgery & Psychiatry 72(4): 473-9	- Comparator in study does not match that specified in this review protocol
Kwakkel, G., van Peppen, R., Wagenaar, R. C. et al. (2004) Effects of augmented exercise therapy time after stroke: a meta-analysis. Stroke 35(11): 2529-39	- Systematic review used as source of primary studies
Kwakkel, G., Wagenaar, R. C., Koelman, T. W. et al. (1997) Effects of intensity of rehabilitation after stroke. A research synthesis. Stroke 28(8): 1550-6	- Review article but not a systematic review
Kwakkel, G., Wagenaar, R. C., Twisk, J. W. et al. (1999) Intensity of leg and arm training after primary middle-cerebral-artery stroke: a randomised trial. Lancet 354(9174): 191-6	- Comparator in study does not match that specified in this review protocol
Kwon, J. S., Park, M. J., Yoon, I. J. et al. (2012) Effects of virtual reality on upper extremity function and activities of daily living performance in acute stroke: a double-blind randomized clinical trial. NeuroRehabilitation 31(4): 379-85	- Comparator in study does not match that specified in this review protocol
Laddha, D., Ganesh, G. S., Pattnaik, M. et al. (2016) Effect of Transcutaneous Electrical Nerve Stimulation on Plantar Flexor Muscle Spasticity and Walking Speed in Stroke Patients. Physiotherapy Research International 21(4): 247-256	- Study does not contain an intervention relevant to this review protocol
Lamberti, N., Straudi, S., Malagoni, A. M. et al. (2017) Effects of low-intensity endurance and resistance training on mobility in chronic stroke survivors: a pilot randomized controlled study. European journal of physical and rehabilitation medicine 53(2): 228-239	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Langhammer, B.; Lindmark, B.; Stanghelle, J. K. (2007) Stroke patients and long-term training: is it worthwhile? A randomized comparison of two different training strategies after rehabilitation. Clinical Rehabilitation 21(6): 495-510	- Comparator in study does not match that specified in this review protocol
Langhammer, B.; Lindmark, B.; Stanghelle, J. K. (2014) Physiotherapy and physical functioning post-stroke: exercise habits and functioning 4 years later? Long-term follow-up after a 1-year long-term intervention period: a randomized controlled trial. Brain Injury 28(11): 1396-405	- Comparator in study does not match that specified in this review protocol
Langhammer, B. and Stanghelle, J. K. (2009) Improving gait after stroke-treadmill or walking; quantity or quality. Journal of Cyber Therapy and Rehabilitation 2(3): 191-198	- Comparator in study does not match that specified in this review protocol
Langhammer, B. and Stanghelle, J. K. (2005) Bobath or motor relearning programme? A comparison of two different approaches of physiotherapy in stroke rehabilitation: a randomised controlled trial. Australian journal of physiotherapy 51(4esuppl): 23	- Full text paper not available
Langhammer, B. and Stanghelle, J. K. (2003) Bobath or motor relearning programme? A comparison of two different approaches of physiotherapy in stroke rehabilitation: a randomized controlled trial. 14th international congress of the world confederation for physical therapy	- Conference abstract
Langhammer, B. and Stanghelle, J. K. (2010) Exercise on a treadmill or walking outdoors? A randomized controlled trial comparing effectiveness of two walking exercise programmes late after stroke. Clinical Rehabilitation 24(1): 46-54	- Comparator in study does not match that specified in this review protocol
Langhammer, B.; Stanghelle, J. K.; Lindmark, B. (2008) Exercise and health-related quality of life during the first year following acute stroke. A randomized controlled trial. Brain Injury 22(2): 135-45	- Comparator in study does not match that specified in this review protocol
Langhammer, B.; Stanghelle, J. K.; Lindmark, B. (2009) An evaluation of two different exercise regimes during the first year following stroke: a randomised controlled trial. Physiotherapy Theory & Practice 25(2): 55-68	- Comparator in study does not match that specified in this review protocol
Langhorne, P. (2017) Very Early Rehabilitation or Intensive Telemetry After Stroke (VERITAS).	- Trial registry data only

Study	Code [Reason]
Langhorne, P., Knight, A., Stott, D. J. et al. (2008) Very early rehabilitation or intensive telemetry after stroke (VERITAS): pilot randomised trial. International journal of stroke 3(Suppl 1): 241 (Abst.PO01-546)	- Conference abstract
Langhorne, P., Knight, A., Stott, D. J. et al. (2008) Very early rehabilitation or intensive telemetry after stroke (VERITAS): a pilot randomised trial. Cerebrovascular diseases (basel, switzerland) 25(suppl2): 168	- Conference abstract
Langhorne, P.; Ramachandra, S.; Stroke Unit Trialists, Collaboration (2020) Organised inpatient (stroke unit) care for stroke: network meta-analysis (Cochrane review) [with consumer summary]. Cochrane Database of Systematic Reviews 2020;Issue 4	- Study does not contain an intervention relevant to this review protocol
Langhorne, P., Stott, D., Bernhardt, J. et al. (2002) Very Early Rehabilitation or Intensive Telemetry After Stroke (VERITAS). Chest, heart and stroke scotland research grant application (private communication)	- Commentary only
Langhorne, P.; Wagenaar, R.; Partridge, C. (1996) Physiotherapy after stroke: more is better?. Physiotherapy Research International 1(2): 75-88	- Systematic review used as source of primary studies
Lannin, N. A., Ada, L., Levy, T. et al. (2018) Intensive therapy after botulinum toxin in adults with spasticity after stroke versus botulinum toxin alone or therapy alone: a pilot, feasibility randomized trial. Pilot & Feasibility Studies 4: 82	- Comparator in study does not match that specified in this review protocol
Laska, A. C., Dembrower, K. H., Hellblom, A. et al. (2012) Patients with aphasia and acute cerebral infarction in Wernicke`s area benefit from early intensive speech and language therapy. Cerebrovascular diseases (basel, switzerland) 33(suppl2): 662-663	- Conference abstract
Lauro di, A., Pellegrino, L., Savastano, G. et al. (2003) A randomised trial on the efficacy of intensive rehabilitation in the acute phase of ischemic stroke. Journal neurology 250(10): 1206-1208	- Duplicate reference
Laursen, S. O., Henriksen, I. O., Dons, U. et al. (1995) Intensive rehabilitation following stroke: controlled pilot study. Ugeskrift for laeger 157: 1996-1999	- Study not reported in English
Lauterbach, M., Leal, G., Aguiar, M. et al. (2007) Intensive vs conventional speech therapy in aphasia due to ischaemic stroke: a randomized controlled trial. British aphasiology society 2007 biennial conference.: 67-68	- Conference abstract
Laver, K. E., Lange, B., George, S. et al. (2017) Virtual reality for stroke rehabilitation. Cochrane Database of Systematic Reviews 11: cd008349	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Laver, K. E., Lange, B., George, S. et al. (2017) Virtual reality for stroke rehabilitation (Cochrane review) [with consumer summary]. Cochrane Database of Systematic Reviews 2017;Issue 11	- Study does not contain an intervention relevant to this review protocol
Laver, K., George, S., Thomas, S. et al. (2012) Cochrane review: virtual reality for stroke rehabilitation. European journal of physical and rehabilitation medicine 48(3): 523-30	- More recent systematic review included that covers the same topic
Lee, G. (2015) Does whole-body vibration training in the horizontal direction have effects on motor function and balance of chronic stroke survivors? A preliminary study. Journal of Physical Therapy Science 27(4): 1133-6	- Study does not contain an intervention relevant to this review protocol
Lee, H. S., Lim, J. H., Jeon, B. H. et al. (2020) Non-immersive Virtual Reality Rehabilitation Applied to a Task-oriented Approach for Stroke Patients: aÂ Randomized Controlled Trial. Restorative neurology and neuroscience	- Comparator in study does not match that specified in this review protocol
Lee, J. and Stone, A. J. (2020) Combined Aerobic and Resistance Training for Cardiorespiratory Fitness, Muscle Strength, and Walking Capacity after Stroke: A Systematic Review and Meta-Analysis. Journal of stroke and cerebrovascular diseases : the official journal of National Stroke Association 29(1): 104498	- Study does not contain an intervention relevant to this review protocol
Lee, K. W., Kim, S. B., Lee, J. H. et al. (2016) Effect of Upper Extremity Robot-Assisted Exercise on Spasticity in Stroke Patients. Annals of Rehabilitation Medicine 40(6): 961-971	- Comparator in study does not match that specified in this review protocol
Lee, M. M.; Lee, K. J.; Song, C. H. (2018) Game-Based Virtual Reality Canoe Paddling Training to Improve Postural Balance and Upper Extremity Function: A Preliminary Randomized Controlled Study of 30 Patients with Subacute Stroke. Medical Science Monitor 24: 2590-2598	- Comparator in study does not match that specified in this review protocol
Lennon, O., Carey, A., Stephenson, J. et al. (2006) A single blinded RCT to evaluate the effects of a cardiac rehabilitation programme for the non-acute ischaemic stroke population. UK stroke forum conference 2006: 86-87	- Conference abstract
Letombe, A., Cornille, C., Delahaye, H. et al. (2010) Early post-stroke physical conditioning in hemiplegic patients: A preliminary study. Annals of Physical & Rehabilitation Medicine 53(10): 632-42	- Comparator in study does not match that

Study	Code [Reason]
	specified in this review protocol
Leung, J., Harvey, L. A., Moseley, A. M. et al. (2012) Electrical stimulation and splinting were not clearly more effective than splinting alone for contracture management after acquired brain injury: a randomised trial. Journal of Physiotherapy 58(4): 231-40	- Study does not contain an intervention relevant to this review protocol
Li, F., Zhang, T., Li, B. J. et al. (2018) Motor imagery training induces changes in brain neural networks in stroke patients. Neural Regeneration Research 13(10): 1771-1781	- Study does not contain an intervention relevant to this review protocol
Li, H., Chai, W., Xu, G. et al. (2016) Evaluation on curative effect of modified constraint-induced movement therapy in rehabilitation of activity of daily living in patients with sub-acute stroke. Journal of jilin university medicine edition 42(6): 1183-1188	- Study not reported in English
Lim, Jy; Kang, Ek; Paik, Nj (2010) Repetitive transcranial magnetic stimulation for hemispatial neglect in patients after stroke: An open-label pilot study. Journal of Rehabilitation Medicine 42(5): 447-52.	- Study does not contain an intervention relevant to this review protocol
Lin, J. C. (2018) Robot-assisted hand rehabilitation for patients with stroke.	- Trial registry data only
Lin, K. C., Chang, Y. F., Wu, C. Y. et al. (2009) Effects of constraint-induced therapy versus bilateral arm training on motor performance, daily functions, and quality of life in stroke survivors. Neurorehabilitation and Neural Repair 23(5): 441-8	- Comparator in study does not match that specified in this review protocol
Lin, K. C., Chung, H. Y., Wu, C. Y. et al. (2010) Constraint-induced therapy versus control intervention in patients with stroke: a functional magnetic resonance imaging study. American Journal of Physical Medicine & Rehabilitation 89(3): 177-85	- Comparator in study does not match that specified in this review protocol
Lin, K. C., Wu, C. Y., Wei, T. H. et al. (2007) Effects of modified constraint-induced movement therapy on reach-to-grasp movements and functional performance after chronic stroke: a randomized controlled study. Clinical Rehabilitation 21(12): 1075-86	- Comparator in study does not match that specified in this review protocol
Lin, L. F., Lin, Y. J., Lin, Z. H. et al. (2018) Feasibility and efficacy of wearable devices for upper limb rehabilitation in patients with chronic stroke:	- Comparator in study does not match that

Study	Code [Reason]
a randomized controlled pilot study. European journal of physical & rehabilitation medicine. 54(3): 388-396	specified in this review protocol
Lincoln, N. B.; Parry, R. H.; Vass, C. D. (1999) Randomized, controlled trial to evaluate increased intensity of physiotherapy treatment of arm function after stroke. Stroke 30(3): 573-9	- Data not reported in an extractable format or a format that can be analysed
Linder, S. M., Rosenfeldt, A. B., Bay, R. C. et al. (2015) Improving Quality of Life and Depression After Stroke Through Telerehabilitation. American Journal of Occupational Therapy 69(2): 6902290020p1-10	- Comparator in study does not match that specified in this review protocol
Lindvall, M. A. and Forsberg, A. (2014) Body awareness therapy in persons with stroke: a pilot randomized controlled trial. Clinical Rehabilitation 28(12): 1180-8	- Study does not contain an intervention relevant to this review protocol
Liu, K. P., Balderi, K., Leung, T. L. et al. (2016) A randomized controlled trial of self-regulated modified constraint-induced movement therapy in sub-acute stroke patients. European Journal of Neurology 23(8): 1351-60	- Comparator in study does not match that specified in this review protocol
Liu, K. P., Chan, C. C., Wong, R. S. et al. (2009) A randomized controlled trial of mental imagery augment generalization of learning in acute poststroke patients. Stroke 40(6): 2222-5	- Study does not contain an intervention relevant to this review protocol
Liu, N., Cadilhac, D. A., Andrew, N. E. et al. (2014) Randomized controlled trial of early rehabilitation after intracerebral hemorrhage stroke: difference in outcomes within 6 months of stroke. Stroke 45(12): 3502-7	- Very early mobilisation
Liu, W., Xu, W., Wu, W. et al. (2016) Effects of motor imagery and electromyographic biofeedback therapy on upper limp functions in patients with stroke. Chinese journal of cerebrovascular diseases 13(4): 174-177	- Study not reported in English
Liu-Ambrose, T. and Eng, J. J. (2015) Exercise training and recreational activities to promote executive functions in chronic stroke: a proof-of-concept study. Journal of Stroke & Cerebrovascular Diseases 24(1): 130-7	- Comparator in study does not match that specified in this review protocol
Lloréns, R., Gil-Gómez, J. A., Alcañiz, M. et al. (2015) Improvement in balance using a virtual reality-based stepping exercise: a randomized	- Comparator in study does not match that

Study	Code [Reason]
controlled trial involving individuals with chronic stroke. Clinical rehabilitation 29(3): 261-268	specified in this review protocol
Lo, A. C., Guarino, P. D., Richards, L. G. et al. (2010) Robot-assisted therapy for long-term upper-limb impairment after stroke. New England Journal of Medicine 362(19): 1772-83	- Comparator in study does not match that specified in this review protocol
Lo, A. C., Guarino, P., Krebs, H. I. et al. (2009) Multicenter randomized trial of robot-assisted rehabilitation for chronic stroke: methods and entry characteristics for VA ROBOTICS. Neurorehabilitation & Neural Repair 23(8): 775-83	- Comparator in study does not match that specified in this review protocol
Logan, P. A., Ahern, J., Gladman, J. R. et al. (1997) A randomized controlled trial of enhanced Social Service occupational therapy for stroke patients. Clinical Rehabilitation 11(2): 107-13	- Data not reported in an extractable format or a format that can be analysed
Logan, P. A., Armstrong, S., Avery, T. J. et al. (2014) Rehabilitation aimed at improving outdoor mobility for people after stroke: A multicentre randomized controlled study (the getting out of the house study). Health Technology Assessment 18(29): 1-73	- Duplicate reference
Logan, P. A., Armstrong, S., Avery, T. J. et al. (2014) Rehabilitation aimed at improving outdoor mobility for people after stroke: a multicentre randomised controlled study (the Getting out of the House Study). Health Technology Assessment (Winchester, England) 18(29): vii-viii, 1	- Comparator in study does not match that specified in this review protocol
Logan, P. A., Gladman, J. R., Avery, A. et al. (2004) Randomised controlled trial of an occupational therapy intervention to increase outdoor mobility after stroke. BMJ (Clinical research ed.) 329(7479): 1372-1375	- Comparator in study does not match that specified in this review protocol
Lohse, K. R.; Lang, C. E.; Boyd, L. A. (2014) Is more better? Using metadata to explore dose-response relationships in stroke rehabilitation. Stroke; a journal of cerebral circulation 45(7): 2053-8	- Systematic review used as source of primary studies
Lou, G., Fu, C., Du, Q. et al. (2019) TheraSling Therapy (TST) Combined with Neuromuscular Facilitation Technique on Hemiplegic Gait in Patients with Stroke. Medical Science Monitor 25: 4766-4772	- Study does not contain an intervention relevant to this review protocol
Low, AY; Ng, YS; Chan, Y; Tan, DML; Bok, CW; Fook Chong, SMC; et al. (2012) Effect of virtual reality rehabilitation as an adjunct to conventional	- Conference abstract

Study	Code [Reason]
therapy in people with sub-acute stroke: a randomised controlled pilot trial. Proceedings of Singapore Healthcare 21: S357	
Luft, A. R., Macko, R. F., Forrester, L. W. et al. (2008) Treadmill exercise activates subcortical neural networks and improves walking after stroke: a randomized controlled trial. Stroke 39(12): 3341-50	- Comparator in study does not match that specified in this review protocol
Luo, L., Meng, H., Wang, Z. et al. (2020) Effect of high-intensity exercise on cardiorespiratory fitness in stroke survivors: A systematic review and meta-analysis. Annals of Physical & Rehabilitation Medicine 63(1): 59-68	- Study does not contain an intervention relevant to this review protocol
Luo, Z., Zhou, Y., He, H. et al. (2020) Synergistic Effect of Combined Mirror Therapy on Upper Extremity in Patients With Stroke: A Systematic Review and Meta-Analysis. Frontiers in neurology [electronic resource]. 11: 155	- Study does not contain an intervention relevant to this review protocol
López, N. D., Monge Pereira, E., Centeno, E. J. et al. (2019) Motor imagery as a complementary technique for functional recovery after stroke: a systematic review. Topics in stroke rehabilitation 26(8): 1-12	- Study does not contain an intervention relevant to this review protocol
Mackay-Lyons, M. (2012) Aerobic treadmill training effectively enhances cardiovascular fitness and gait function for older persons with chronic stroke. Journal of Physiotherapy 58(4): 271	- Comparator in study does not match that specified in this review protocol
Mackey, F, Ada, L, Heard, R et al. (1996) Stroke rehabilitation: are highly structured units more conducive to physical activity than less structured units?. Archives of Physical Medicine and Rehabilitation 77(10): 1066-70.	- Study design not relevant to this review protocol *Non-randomised study that does not adjust for confounders*
Macko, R. F., Ivey, F. M., Forrester, L. W. et al. (2005) Treadmill exercise rehabilitation improves ambulatory function and cardiovascular fitness in patients with chronic stroke: a randomized, controlled trial. Stroke 36(10): 2206-11	- Comparator in study does not match that specified in this review protocol
Maeshima, S., Matsumoto, T., Boh-oka, S. et al. (2001) Early rehabilitation program for hemiplegic stroke patients: useful training conducted by patient	- Conference abstract

Study	Code [Reason]
families. 1st international congress of international society of physical and rehabilitation medicine (ISPRM)	
Mahmood, A., Veluswamy, S. K., Hombali, A. et al. (2019) Effect of Transcutaneous Electrical Nerve Stimulation (TENS) on spasticity in adults with stroke: A systematic review and meta-analysis. Archives of physical medicine and rehabilitation 100(4): 751-768	- Study does not contain an intervention relevant to this review protocol
Malik, A. N. and Masood, T. (2017) Virtual reality training improves turning capacity and functional reach in stroke patients. Rawal Medical Journal 42(2): 158-161	- Commentary only
Mallet, K., Shamloul, R., Lecompte-Collin, J. et al. (2017) TeleRehab for patients with post-stroke communication deficits using mobile technology: a randomized controlled trial. International journal of stroke 12(4suppl1): 18	- Conference abstract
Malouin, F., Potvin, M., Prevost, J. et al. (1992) Use of an intensive task-oriented gait training program in a series of patients with acute cerebrovascular accidents. Physical Therapy 72(11): 781-793	- Study design not relevant to this review protocol
Manning, C. D. and Pomeroy, V. M. (2003) Effectiveness of treadmill retraining on gait of hemiparetic stroke patients: systematic review of current evidence. Physiotherapy 89(6): 337-349	- Study does not contain an intervention relevant to this review protocol
Mansfield, A., Inness, E. L., Danells, C. J. et al. (2020) Determining the optimal dose of reactive balance training after stroke: study protocol for a pilot randomised controlled trial. BMJ Open 10(8): e038073	- Protocol only
Marcheschi, E., Von Koch, L., Pessah-Rasmussen, H. et al. (2018) Home setting after stroke, facilitators and barriers: A systematic literature review. Health & social care in the community 26(4): e451-e459	- Study does not contain an intervention relevant to this review protocol
Marquardt, M. K., Oettingen, G., Gollwitzer, P. M. et al. (2017) Mental contrasting with implementation intentions (MCII) improves physical activity and weight loss among stroke survivors over one year. Rehabilitation Psychology 62(4): 580-590	- Study does not contain an intervention relevant to this review protocol
Marquardt, T. (2017) tDCS as an adjuvant to intensive speech therapy for chronic post stroke aphasia.	- Trial registry data only
Marryam, M. and Umar, M. (2017) Effectiveness of task oriented training in improving upper limb function after stroke. Rawal medical journal 42(3): 341-343	- Comparator in study does not match that

Study	Code [Reason]
	specified in this review protocol
Marsden, D., Quinn, R., Pond, N. et al. (2010) A multidisciplinary group programme in rural settings for community-dwelling chronic stroke survivors and their carers: a pilot randomized controlled trial. Clinical Rehabilitation 24(4): 328-41	- Comparator in study does not match that specified in this review protocol
Massie, C. L., Tracy, B. L., Paxton, R. J. et al. (2013) Repeated sessions of functional repetitive transcranial magnetic stimulation increases motor cortex excitability and motor control in survivors of stroke. Neurorehabilitation 33(2): 185-93	- Study does not contain an intervention relevant to this review protocol
Matsumoto, S., Uema, T., Ikeda, K. et al. (2016) Effect of Underwater Exercise on Lower-Extremity Function and Quality of Life in Post-Stroke Patients: A Pilot Controlled Clinical Trial. Journal of Alternative & Complementary Medicine 22(8): 635-41	- Study design not relevant to this review protocol
Matsuo A, Takahara T, Hiraoka N, Hiyamizu M et al. (2013) Effectiveness of interactive video gaming system in stroke rehabilitation. Cerebrovascular Diseases 35(Suppl 3): 779	- Conference abstract
Matsuo, T., Saotome, K., Seino, S. et al. (2014) Effects of a low-volume aerobic-type interval exercise on VO2max and cardiac mass. Medicine & Science in Sports & Exercise 46(1): 42-50	- Population not relevant to this review protocol
Mattioli, F., Ambrosi, C., Mascaro, L. et al. (2014) Early aphasia rehabilitation is associated with functional reactivation of the left inferior frontal gyrus: a pilot study. Stroke 45(2): 545-52	- Comparator in study does not match that specified in this review protocol
Maulet, T., Pouplin, S., Bensmail, D. et al. (2020) Self-rehabilitation combined with botulinum toxin to improve arm function in people with chronic stroke. A randomized controlled trial. Annals of Physical & Rehabilitation Medicine 17: 17	- Comparator in study does not match that specified in this review protocol
Mayo, N., Wood-Dauphinee, S., Tamblyn, R. et al. (1998) There's no place like home: a trial of early discharge and intensive home rehabilitation post stroke. Cerebrovascular diseases (basel, switzerland) 8 (Suppl 4): 94	- Conference abstract
Mayr, A., Quirbach, E., Picelli, A. et al. (2018) Early robot-assisted gait retraining in non-ambulatory patients with stroke: a single blind randomized controlled trial. European journal of physical and rehabilitation medicine 54(6): 819-826	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Mazzini, N. A., Almeida, M. G. R., Pompeu, J. E. et al. (2019) A combination of multimodal physical exercises in real and virtual environments for individuals after chronic stroke: study protocol for a randomized controlled trial. Trials [Electronic Resource] 20(1): 436	- Protocol only
McEwan, D., Taillson-Hobson, A., Bilodeau, M. et al. (2013) Virtual reality exercise therapy in stroke rehabilitation - a randomized study. PM & R : the journal of injury, function, and rehabilitation 5(suppl9): s138-s139	- Conference abstract
McEwen, S., Polatajko, H., Baum, C. et al. (2015) Combined Cognitive-Strategy and Task-Specific Training Improve Transfer to Untrained Activities in Subacute Stroke. Neurorehabilitation and Neural Repair 29(6): 526-536	- Comparator in study does not match that specified in this review protocol
McMeeken, J., Kent, P., Baker, P. et al. (1999) Effects of a lower limb strengthening program during rehabilitation after stroke. 13th international congress of the world confederation of physical therapy: 135	- Conference abstract
Mehrholz, J., Pohl, M., Platz, T. et al. (2018) Electromechanical and robot-assisted arm training for improving activities of daily living, arm function, and arm muscle strength after stroke. The Cochrane database of systematic reviews 9: cd006876	- Study does not contain an intervention relevant to this review protocol
Mehrholz, J., Pohl, M., Platz, T. et al. (2015) Electromechanical and robot-assisted arm training for improving activities of daily living, arm function, and arm muscle strength after stroke. Cochrane Database of Systematic Reviews 11(11): cd006876	- More recent systematic review included that covers the same topic
Mehrholz, J., Thomas, S., Kugler, J. et al. (2020) Electromechanical-assisted training for walking after stroke. The Cochrane database of systematic reviews 10: cd006185	- Study does not contain an intervention relevant to this review protocol
Mehrholz, Jan, Pohl, Marcus, Kugler, Joachim et al. (2018) The Improvement of Walking Ability Following Stroke: A Systematic Review and Network Meta-Analysis of Randomized Controlled Trials. Deutsches Aerzteblatt International 115(39): 639-677	- Study does not contain an intervention relevant to this review protocol
Mekbib, D. B., Han, J., Zhang, L. et al. (2020) Virtual reality therapy for upper limb rehabilitation in patients with stroke: a meta-analysis of randomized clinical trials. Brain Injury 34(4): 456-465	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Melo, A. S. (2016) Virtual rehabilitation and therapeutic exercise in the treatment of post-stroke hemiparetic.	- Trial registry data only
Mendigutia-Gomez, A., Quintana-Garcia, M. T., Martin-Sevilla, M. et al. (2020) Post-needling soreness and trigger point dry needling for hemiplegic shoulder pain following stroke. Acupuncture in Medicine 38(3): 150-157	- Study does not contain an intervention relevant to this review protocol
Merians, A. S., Fluet, G. G., Qiu, Q. et al. (2020) Hand Focused Upper Extremity Rehabilitation in the Subacute Phase Post-stroke Using Interactive Virtual Environments. Frontiers in Neurology 11 (no pagination)	- Comparator in study does not match that specified in this review protocol
Merkert, J., Butz, S., Nieczaj, R. et al. (2011) Combined whole body vibration and balance training using Vibrosphere. Improvement of trunk stability, muscle tone, and postural control in stroke patients during early geriatric rehabilitation. Zeitschrift fur Gerontologie und Geriatrie 44(4): 256-261	- Study does not contain an intervention relevant to this review protocol
Meythaler, J. M.; Vogtle, L.; Brunner, R. C. (2009) A preliminary assessment of the benefits of the addition of botulinum toxin a to a conventional therapy program on the function of people with longstanding stroke. Archives of physical medicine and rehabilitation 90(9): 1453-1461	- Comparator in study does not match that specified in this review protocol
Mitchell, C., Bowen, A., Tyson, S. et al. (2018) A feasibility randomized controlled trial of ReaDySpeech for people with dysarthria after stroke. Clinical Rehabilitation 32(8): 1037-1046	- Study does not contain an intervention relevant to this review protocol
Mohamed Faisal, C. K.; Prakash, P. N. O.; Ajith, S. (2012) Efficacy of functional neuromuscular electrical Stimulation (FNMES) in the improvement of hand Functions in acute stroke survivals. Nitte University Journal of Health Science 2(4): 16-21	- Study does not contain an intervention relevant to this review protocol
Mohapatra, S., Eviota, A. C., Ringquist, K. L. et al. (2012) Compelled Body Weight Shift Technique to Facilitate Rehabilitation of Individuals with Acute Stroke. Isrn Rehabilitation Print 01: 01	- Study does not contain an intervention relevant to this review protocol
Molier, B. I., Van Asseldonk, E. H., Hermens, H. J. et al. (2010) Nature, timing, frequency and type of augmented feedback; does it influence motor relearning of the hemiparetic arm after stroke? A systematic review. Disability and rehabilitation 32(22): 1799-809	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Molteni, F., Guanziroli, E., Goffredo, M. et al. (2021) Gait Recovery with an Overground Powered Exoskeleton: A Randomized Controlled Trial on Subacute Stroke Subjects. Brain Sciences 11(1): 14	- Comparator in study does not match that specified in this review protocol
Momsen, A. M., Rasmussen, J. O., Nielsen, C. V. et al. (2012) Multidisciplinary team care in rehabilitation: on overview of reviews. Journal of Rehabilitation Medicine 2012 Nov 5;44(11):901-912	- Study design not relevant to this review protocol
Moon, J. H., Hong, D. G., Kim, K. H. et al. (2017) Effects of lingual strength training on lingual strength and articulator function in stroke patients with dysarthria. Journal of Physical Therapy Science 29(7): 1201-1204	- No outcomes of interest
Moon, Y. and Bae, Y. (2019) Backward walking observational training improves gait ability in patients with chronic stroke: randomised controlled pilot study. International journal of rehabilitation research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue internationale de recherches de readaptation 42(3): 217-222	- Comparator in study does not match that specified in this review protocol
Moore, J. L., Nordvik, J. E., Erichsen, A. et al. (2020) Implementation of High-Intensity Stepping Training during Inpatient Stroke Rehabilitation Improves Functional Outcomes. Stroke. (pp 563-570), 2020. Date of publication: 2020.: 563-570	- Study design not relevant to this review protocol
Moore, J. L., Roth, E. J., Killian, C. et al. (2010) Locomotor training improves daily stepping activity and gait efficiency in individuals poststroke who have reached a "plateau" in recovery. Stroke 41(1): 129-35	- Comparator in study does not match that specified in this review protocol
Morris, J. H., John, A., Wedderburn, L. et al. (2019) Dynamic Lycra R orthoses as an adjunct to arm rehabilitation after stroke: a single-blind, two-arm parallel group, randomized controlled feasibility trial. Clinical Rehabilitation 33(8): 1331-1343	- Study does not contain an intervention relevant to this review protocol
Morris, J. H., Kelly, C., Joice, S. et al. (2019) Art participation for psychosocial wellbeing during stroke rehabilitation: a feasibility randomised controlled trial. Disability & Rehabilitation 41(1): 9-18	- Comparator in study does not match that specified in this review protocol
Morris, J., Kelly, C., John, A. et al. (2015) Is evaluation of psychosocial effects of an arts based creative engagement intervention during in-patient stroke rehabilitation possible? A feasibility randomised controlled trial (RCT). International journal of stroke 10(suppl5): 7	- Conference abstract

Study	Code [Reason]
Morris, S. L.; Dodd, K. J.; Morris, M. E. (2004) Outcomes of progressive resistance strength training following stroke: a systematic review. Clinical rehabilitation 18(1): 27-39	- Study does not contain an intervention relevant to this review protocol
Morén, C., Welmer, A. K., Hagströmer, M. et al. (2016) The Effects of "Physical Activity on Prescription" in Persons With Transient Ischemic Attack: a Randomized Controlled Study. Journal of neurologic physical therapy 40(3): 176-183	- Population not relevant to this review protocol
Moucheboeuf, G., Griffier, R., Gasq, D. et al. (2020) Effects of robotic gait training after stroke: A meta-analysis. Annals of Physical & Rehabilitation Medicine 63(6): 518-534	- Study does not contain an intervention relevant to this review protocol
Mulder, Marijn, Nijland, Rinske H M, Vloothuis, Judith D M et al. (2022) Comparing two identically protocolized, multicentre, randomized controlled trials on caregiver-mediated exercises poststroke: Any differences across countries?. PloS one 17(1): e0263013	- Comparator in study does not match that specified in this review protocol *Compared differences between two countries delivering the same protocolised treatment*
Munawar, A., Seemal, P., Afzal, H. et al. (2022) Effects of Hand-Arm Bimanual Intensive Training on Fine Motor Skills in Patients of Chronic Stroke. Pakistan Journal of Medical and Health Sciences 16(11): 49-51	- Comparator in study does not match that specified in this review protocol *Two physiotherapy interventions at a matched intensity*
Myint, J. M., Yuen, G. F., Yu, T. K. et al. (2008) A study of constraint-induced movement therapy in subacute stroke patients in Hong Kong. Clinical Rehabilitation 22(2): 112-24	- Comparator in study does not match that specified in this review protocol
Nakao, M., Banno, M., Kataoka, Y. et al. (2020) Commentary: High Intensity Physical Rehabilitation Later Than 24 h Post Stroke Is Beneficial in Patients: A Pilot Randomized Controlled Trial (RCT) Study in Mild to Moderate Ischemic Stroke. Frontiers in neurology [electronic resource]. 11: 182	- Commentary only

Study	Code [Reason]
Ng, S. S. (2005) Effectiveness of an innovative home-based rehabilitation program on lower limb functions in subjects with chronic stroke: a randomized, controlled trial. Dissertation/ thesis: 281p	- Thesis paper
Nguyen, S., Wong, D., McKay, A. et al. (2019) Cognitive behavioural therapy for post-stroke fatigue and sleep disturbance: a pilot randomised controlled trial with blind assessment. Neuropsychological rehabilitation 29(5): 723-738	- Study does not contain an intervention relevant to this review protocol
Nindorera, F., Nduwimana, I., Thonnard, J. L. et al. (2021) Effectiveness of walking training on balance, motor functions, activity, participation and quality of life in people with chronic stroke: a systematic review with meta-analysis and meta-regression of recent randomized controlled trials. Disability and rehabilitation: 1-12	- Study does not contain an intervention relevant to this review protocol
Nir, Z.; Zolotogorsky, Z.; Sugarman, H. (2004) Structured nursing intervention versus routine rehabilitation after stroke. American Journal of Physical Medicine & Rehabilitation 83(7): 522-9	- Study does not contain an intervention relevant to this review protocol
Norouzi-Gheidari, N.; Archambault, P. S.; Fung, J. (2012) Effects of robot-assisted therapy on stroke rehabilitation in upper limbs: Systematic review and meta-analysis of the literature. Journal of rehabilitation research and development 49(4): 479-96	- Study does not contain an intervention relevant to this review protocol
Norouzi-Gheidari, N; Archambault, Ps; Fung, J (2012) Effects of robot-assisted therapy on stroke rehabiliiation in upper limbs: Systematic review and meta-analysis of the literature. Journal of Rehabilitation Research and Development 49(4): 479-96.	- Duplicate reference
Nouwens, F., Dippel, D. W., de Jong-Hagelstein, M. et al. (2013) Rotterdam Aphasia Therapy Study (RATS)-3: "The efficacy of intensive cognitive-linguistic therapy in the acute stage of aphasia"; design of a randomised controlled trial. Trials 14: 24	- Protocol only
Oh, E. Y. and Jung, M. S. (2017) Effects of a Cognitive Training Program on Cognitive Function and Activities of Daily Living in Patients with Acute Ischemic Stroke. Journal of korean academy of nursing 47(1): 1-13	- Study not reported in English
Olawale, O. A., Jaja, S. I., Anigbogu, C. N. et al. (2011) Exercise training improves walking function in an African group of stroke survivors: a randomized controlled trial. Clinical Rehabilitation 25(5): 442-50	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Olukolade, O. and Osinowo, H. O. (2017) Efficacy of Cognitive Rehabilitation Therapy on Poststroke Depression among Survivors of First Stroke Attack in Ibadan, Nigeria. Behavioural Neurology 2017: 4058124	- Study does not contain an intervention relevant to this review protocol
Ooi, H. K.; Chai, S. C.; Kadar, M. (2020) Effects of pressure garment on spasticity and function of the arm in the early stages after stroke: a randomized controlled trial. Clinical Rehabilitation 34(4): 515-523	- Study does not contain an intervention relevant to this review protocol
Outermans, J. C., van Peppen, R. P., Wittink, H. et al. (2010) Effects of a high-intensity task-oriented training on gait performance early after stroke: a pilot study. Clinical Rehabilitation 24(11): 979-87	- Comparator in study does not match that specified in this review protocol
Outpatient Service, Trialists (2003) Therapy-based rehabilitation services for stroke patients at home. Cochrane Database of Systematic Reviews: cd002925	- Study does not contain an intervention relevant to this review protocol
Page, S. J. (2000) Imagery improves upper extremity motor function in chronic stroke patients: A pilot study. Occupational Therapy Journal of Research 20(3): 200-215	- Study does not contain an intervention relevant to this review protocol
Page, S. J., Dunning, K., Hermann, V. et al. (2011) Longer versus shorter mental practice sessions for affected upper extremity movement after stroke: a randomized controlled trial. Clinical Rehabilitation 25(7): 627-37	- Study does not contain an intervention relevant to this review protocol
Page, S. J.; Levine, P.; Leonard, A. C. (2005) Modified constraint-induced therapy in acute stroke: a randomized controlled pilot study. Neurorehabilitation & Neural Repair 19(1): 27-32	- Comparator in study does not match that specified in this review protocol
Page, S. J., Levine, P., Leonard, A. et al. (2008) Modified constraint-induced therapy in chronic stroke: results of a single-blinded randomized controlled trial. Physical therapy 88(3): 333-340	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Page, S. J., Sisto, S. A., Levine, P. et al. (2001) Modified constraint induced therapy: a randomized feasibility and efficacy study. Journal of Rehabilitation Research & Development 38(5): 583-90	- Comparator in study does not match that specified in this review protocol
Page, S. J., Sisto, S., Johnston, M. V. et al. (2002) Modified constraint-induced therapy after subacute stroke: a preliminary study. Neurorehabilitation and neural repair 16(3): 290-295	- Comparator in study does not match that specified in this review protocol
Page, S. J., Sisto, S., Levine, P. et al. (2004) Efficacy of modified constraint-induced movement therapy in chronic stroke: a single-blinded randomized controlled trial. Archives of Physical Medicine and Rehabilitation 85(1): 14-8	- Comparator in study does not match that specified in this review protocol
Pak, S. and Patten, C. (2008) Strengthening to promote functional recovery poststroke: an evidence-based review. Topics in Stroke Rehabilitation 15(3): 177-99	- Study does not contain an intervention relevant to this review protocol
Palmcrantz, S., Wall, A., Vreede, K. S. et al. (2021) Impact of Intensive Gait Training With and Without Electromechanical Assistance in the Chronic Phase After Stroke-A Multi-Arm Randomized Controlled Trial With a 6 and 12 Months Follow Up. Frontiers in Neuroscience 15: 660726	- Comparator in study does not match that specified in this review protocol
Pan, R., Zhou, M., Cai, H. et al. (2018) A randomized controlled trial of a modified wheelchair arm-support to reduce shoulder pain in stroke patients. Clinical Rehabilitation 32(1): 37-47	- Study does not contain an intervention relevant to this review protocol
Pan, X. L. (2018) Efficacy of early rehabilitation therapy on movement ability of hemiplegic lower extremity in patients with acute cerebrovascular accident. Medicine 97(2): e9544	- Comparator in study does not match that specified in this review protocol
Park, C.; Son, H.; Yeo, B. (2021) The effects of lower extremity cross-training on gait and balance in stroke patients: a double-blinded randomized controlled trial. European journal of physical & rehabilitation medicine. 57(1): 4-12	- Comparator in study does not match that specified in this review protocol
Park, D., Lee, J. H., Kang, T. W. et al. (2018) Effects of a 4-Week Self-Ankle Mobilization with Movement Intervention on Ankle Passive Range of Motion,	- Comparator in study does not

Study	Code [Reason]
Balance, Gait, and Activities of Daily Living in Patients with Chronic Stroke: A Randomized Controlled Study. Journal of Stroke & Cerebrovascular Diseases 27(12): 3451-3459	match that specified in this review protocol
Park, D., Lee, J. H., Kang, T. W. et al. (2019) Four-week training involving ankle mobilization with movement versus static muscle stretching in patients with chronic stroke: a randomized controlled trial. Topics in Stroke Rehabilitation 26(2): 81-86	- Comparator in study does not match that specified in this review protocol
Park, H. K., Lee, H. J., Lee, S. J. et al. (2019) Land-based and aquatic trunk exercise program improve trunk control, balance and activities of daily living ability in stroke: a randomized clinical trial. European journal of physical and rehabilitation medicine 55(6): 687-694	- Comparator in study does not match that specified in this review protocol
Park, J. (2019) The effects of time-use intervention on the quality of life of outpatients with chronic stroke. Journal of Physical Therapy Science 31(1): 36-38	- Comparator in study does not match that specified in this review protocol
Park, J. H. and Lee, J. H. (2015) The effects of mental practice on unilateral neglect in patients with chronic stroke: a randomized controlled trial. Journal of Physical Therapy Science 27(12): 3803-5	- Study does not contain an intervention relevant to this review protocol
Park, J., Lee, N., Cho, M. et al. (2015) Effects of mental practice on stroke patients' upper extremity function and daily activity performance. Journal of Physical Therapy Science 27(4): 1075-7	- Study does not contain an intervention relevant to this review protocol
Park, M. O. and Lee, S. H. (2018) Effects of cognitive-motor dual-Task training combined with auditory motor synchronization training on cognitive functioning in individuals with chronic stroke. Medicine (United States) 97 (22)	- Comparator in study does not match that specified in this review protocol
Park, S. H., Koh, E. J., Choi, H. Y. et al. (2013) A double-blind, sham-controlled, pilot study to assess the effects of the concomitant use of transcranial direct current stimulation with the computer assisted cognitive rehabilitation to the prefrontal cortex on cognitive functions in patients with stroke. Journal of Korean Neurosurgical Society 54(6): 484-488	- Comparator in study does not match that specified in this review protocol
Parke, H. L., Epiphaniou, E., Pearce, G. et al. (2015) Self-Management Support Interventions for Stroke Survivors: A Systematic Meta-Review. PLoS ONE [Electronic Resource] 10(7): e0131448	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Parry, R. H.; Lincoln, N. B.; Vass, C. D. (1999) Effect of severity of arm impairment on response to additional physiotherapy early after stroke. Clinical Rehabilitation 13(3): 187-98	- Data not reported in an extractable format or a format that can be analysed
Patel, J., Fluet, G., Qiu, Q. et al. (2019) Intensive virtual reality and robotic based upper limb training compared to usual care, and associated cortical reorganization, in the acute and early sub-acute periods post-stroke: a feasibility study. Journal of Neuroengineering & Rehabilitation 16(1): 92	- Comparator in study does not match that specified in this review protocol
Patterson, K. K., Wong, J. S., Prout, E. C. et al. (2018) Dance for the rehabilitation of balance and gait in adults with neurological conditions other than Parkinson's disease: A systematic review. Heliyon 4(3): e00584	- Study does not contain an intervention relevant to this review protocol
Phonthee, S., Amatachaya, P., Sooknuan, T. et al. (2020) Stepping training with external feedback relating to lower limb support ability effectively improved complex motor activity in ambulatory patients with stroke: a randomized controlled trial. European journal of physical and rehabilitation medicine 56(1): 14-23	- Comparator in study does not match that specified in this review protocol
Platz, T., Eickhof, C., van Kaick, S. et al. (2005) Impairment-oriented training or Bobath therapy for severe arm paresis afer stroke: A single-blind, multicentre randomized controlled trial. Clinical Rehabilitation 19(7): 714-724	- Duplicate reference
Platz, T., van Kaick, S., Mehrholz, J. et al. (2009) Best conventional therapy versus modular impairment-oriented training for arm paresis after stroke: a single-blind, multicenter randomized controlled trial. Neurorehabilitation and neural repair 23(7): 706-716	- Study does not contain an intervention relevant to this review protocol
Ploughman, M. and Corbett, D. (2004) Can forced-use therapy be clinically applied after stroke? An exploratory randomized controlled trial. Archives of physical medicine and rehabilitation 85(9): 1417-1423	- Comparator in study does not match that specified in this review protocol
Ploumis, A., Papadopoulou, S. L., Theodorou, S. J. et al. (2018) Cervical isometric exercises improve dysphagia and cervical spine malalignment following stroke with hemiparesis: a randomized controlled trial. European journal of physical and rehabilitation medicine 54(6): 845-852	- Comparator in study does not match that specified in this review protocol
Plummer, P. and Iyigun, G. (2018) Effects of physical exercise interventions on dual-task gait speed after stroke: A systematic review and meta-analysis. Archives of physical medicine and rehabilitation 99(12): 2548-2560	- Study does not contain an intervention

Study	Code [Reason]
	relevant to this review protocol
Pollock, A. S., Durward, B. R., Rowe, P. J. et al. (2002) The effect of independent practice of motor tasks by stroke patients: a pilot randomized controlled trial. Clinical Rehabilitation 16(5): 473-80	- Comparator in study does not match that specified in this review protocol
Pollock, A., Baer, G., Campbell, P. et al. (2014) Physical rehabilitation approaches for the recovery of function and mobility following stroke. Cochrane Database of Systematic Reviews: cd001920	- Study does not contain an intervention relevant to this review protocol
Pulvermüller, F., Neininger, B., Elbert, T. et al. (2001) Constraint-induced therapy of chronic aphasia after stroke. Stroke; a journal of cerebral circulation 32(7): 1621-1626	- Data not reported in an extractable format or a format that can be analysed
Qian, K. L. and Wang, T. (2004) Effect of early rehabilitation therapy on short and long term functional assessment in hemiplegic patients after stroke. Chinese journal of clinical rehabilitation 8(25): 5210-5211	- Study not reported in English
Radajewska, A., Opara, J. A., Kucio, C. et al. (2013) The effects of mirror therapy on arm and hand function in subacute stroke in patients. International Journal of Rehabilitation Research 36(3): 268-74	- Comparator in study does not match that specified in this review protocol
Raglio, A., Oasi, O., Gianotti, M. et al. (2016) Improvement of spontaneous language in stroke patients with chronic aphasia treated with music therapy: a randomized controlled trial. International Journal of Neuroscience 126(3): 235-42	- Data not reported in an extractable format or a format that can be analysed
Ran, M. S.; Ye, J. J.; Ma, D. B. (2013) Effects and changes of brain functional MRI of motor imagery therapy on acute cerebral infarction patients with upper limb paralysis. Journal of clinical neurology (china) 26(2): 102-104	- Study not reported in English
Ranzani, R., Lambercy, O., Metzger, J. C. et al. (2020) Neurocognitive robot-assisted rehabilitation of hand function: a randomized control trial on motor recovery in subacute stroke. Journal of Neuroengineering & Rehabilitation 17(1): 115	- Comparator in study does not match that specified in this review protocol
Remy-Neris, O., Le Jeannic, A., Dion, A. et al. (2021) Additional, Mechanized Upper Limb Self-Rehabilitation in Patients With Subacute Stroke: The REM-AVC Randomized Trial. Stroke 52(6): 1938-1947	- Comparator in study does not match that

Study	Code [Reason]
	specified in this review protocol
Remy-Neris, O., Medee, B., Bensmail, D. et al. (2018) Rehabilitation robotics of the upper limb after stroke. The REM_AVC trial. Annals of physical and rehabilitation medicine	- Conference abstract
Reynolds, H., Steinfort, S., Tillyard, J. et al. (2021) Feasibility and adherence to moderate intensity cardiovascular fitness training following stroke: a pilot randomized controlled trial. BMC neurology 21(1)	- Comparator in study does not match that specified in this review protocol
Riccio, I., Iolascon, G., Barillari, M. R. et al. (2010) Mental practice is effective in upper limb recovery after stroke: a randomized single-blind cross-over study. European journal of physical & rehabilitation medicine. 46(1): 19-25	- Crossover trials (for people after acute/subacute stroke only)
Richards, C. L., Malouin, F., Wood-Dauphinee, S. et al. (1993) Task-specific physical therapy for optimization of gait recovery in acute stroke patients. Archives of Physical Medicine & Rehabilitation 74(6): 612-20	- Comparator in study does not match that specified in this review protocol
Richards, L., Gonzalez Rothi, L. J., Davis, S. et al. (2006) Limited dose response to constraint-induced movement therapy in patients with chronic stroke. Clinical rehabilitation 20(12): 1066-1074	- Comparator in study does not match that specified in this review protocol
Rimmer, J. H., Rauworth, A. E., Wang, E. C. et al. (2009) A preliminary study to examine the effects of aerobic and therapeutic (nonaerobic) exercise on cardiorespiratory fitness and coronary risk reduction in stroke survivors. Archives of Physical Medicine & Rehabilitation 90(3): 407-12	- No outcomes of interest
Robinson, W., Smith, R., Aung, O. et al. (2008) No difference between wearing a night splint and standing on a tilt table in preventing ankle contracture early after stroke: a randomised trial. Australian Journal of Physiotherapy 54(1): 33-8	- Comparator in study does not match that specified in this review protocol
Rodgers, H., Mackintosh, J., Price, C. et al. (2003) Does an early increased-intensity interdisciplinary upper limb therapy programme following acute stroke improve outcome?. Clinical Rehabilitation 17(6): 579-89	- Comparator in study does not match that specified in this review protocol
Rosbergen, I. C., Grimley, R. S., Hayward, K. S. et al. (2019) The impact of environmental enrichment in an acute stroke unit on how and when patients undertake activities. Clinical rehabilitation 33(4): 784-795	- Study does not contain an intervention

Study	Code [Reason]
	relevant to this review protocol
Rose, M. L., Copland, D., Nickels, L. et al. (2019) Constraint-induced or multi-modal personalized aphasia rehabilitation (COMPARE): A randomized controlled trial for stroke-related chronic aphasia. International Journal of Stroke 14(9): 972-976	- Protocol only
Rose, M. L., Rai, T., Copland, D. et al. (2021) Statistical analysis plan for the COMPARE trial: a 3-arm randomised controlled trial comparing the effectiveness of Constraint-induced Aphasia Therapy Plus and Multi-modality Aphasia Therapy to usual care in chronic post-stroke aphasia (COMPARE). Trials [Electronic Resource] 22(1): 303	- Protocol only
Rosulescu, E., Rusu, L., Zavaleanu, M. et al. (2008) Intensive physical therapy in the management of lower limb spasticity in hemiparetic stroke. International journal of stroke 3(suppl1): 353	- Conference abstract
Rothgangel, As, Morton, Ar, van, den Hout Jw et al. (2004) Mirror therapy in stroke patients. Nederlands Tijdschrift fur Fysioterapie 114(2): 36-40.	- Conference abstract
Rozental-Iluz, C., Zeilig, G., Weingarden, H. et al. (2016) Improving executive function deficits by playing interactive video-games: secondary analysis of a randomized controlled trial for individuals with chronic stroke. European journal of physical and rehabilitation medicine 52(4): 508-515	- Secondary analysis of a trial
Ruff, R. M.; Yarnell, S.; Marinos, J. M. (1999) Are stroke patients discharged sooner if in-patient rehabilitation services are provided seven v six days per week?. American Journal of Physical Medicine & Rehabilitation 78(2): 143-6	- Study design not relevant to this review protocol *Non-randomised study that does not adjust for confounders*
Ryan, T.; Enderby, P.; Rigby, A. S. (2006) A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age: Results at 12-month followup. International Journal on Disability and Human Development 5(1): 83-89	- Population not relevant to this review protocol
Ryan, T.; Enderby, P.; Rigby, A. S. (2006) A randomized controlled trial to evaluate intensity of community-based rehabilitation provision following stroke or hip fracture in old age. Clinical Rehabilitation 20(2): 123-31	- Population not relevant to this review protocol *the study investigates 6 or more treatment contacts per week to 3 or less treatment contacts per week, but does*

Study	Code [Reason]
	not define the number of minutes/hours of treatment for each contact or if those contacts occur on different days of the week and so cannot be stratified for the purposes of the protocol
Rydwik, E.; Eliasson, S.; Akner, G. (2006) The effect of exercise of the affected foot in stroke patients--a randomized controlled pilot trial. Clinical Rehabilitation 20(8): 645-55	- Comparator in study does not match that specified in this review protocol
Sade, I., Cekmece, C., Inanir, M. et al. (2020) The Effect of Whole Body Vibration Treatment on Balance and Gait in Patients with Stroke. Noropsikiyatri Arsivi 57(4): 308-311	- Study does not contain an intervention relevant to this review protocol
Saeys, W., Vereeck, L., Truijen, S. et al. (2012) Randomized controlled trial of truncal exercises early after stroke to improve balance and mobility. Neurorehabilitation & Neural Repair 26(3): 231-8	- Comparator in study does not match that specified in this review protocol
Sakai, K., Kinoshita, S., Tsuboi, M. et al. (2019) Effects of Nutrition Therapy in Older Stroke Patients Undergoing Rehabilitation: A Systematic Review and Meta-Analysis. Journal of Nutrition, Health & Aging 23(1): 21-26	- Study does not contain an intervention relevant to this review protocol
Sakai, T.; Shimura, Y.; Tanaka, K. (2004) Comparison of the effects of community- and home-based rehabilitation programs for chronic stroke survivors. Journal of aging and physical activity 12(3): 425	- Conference abstract
Samanci, N., Balci, N., Cavuldak, T. et al. (2001) Effectiveness of an outpatient, inpatient and home-based rehabilitation programs for stroke patients. 1st international congress of international society of physical and rehabilitation medicine (ISPRM)	- Conference abstract
Samanci, N., Nilufer, B., Tugba, C. et al. (2001) Effectiveness of an outpatients, inpatient and home-based rehabilitation program for stroke patients. Cerebrovascular diseases (basel, switzerland) 11 (Suppl 4): 46	- Conference abstract

Study	Code [Reason]
Sammut, M., Fini, N., Haracz, K. et al. (2020) Increasing time spent engaging in moderate-to-vigorous physical activity by community-dwelling adults following a transient ischemic attack or non-disabling stroke: a systematic review. Disability & Rehabilitation: 1-16	- Population not relevant to this review protocol
Samuelkamaleshkumar, S., Reethajanetsureka, S., Pauljebaraj, P. et al. (2014) Mirror therapy enhances motor performance in the paretic upper limb after stroke: a pilot randomized controlled trial. Archives of Physical Medicine & Rehabilitation 95(11): 2000-5	- Comparator in study does not match that specified in this review protocol
Sandberg, K., Kleist, M., Falk, L. et al. (2016) Effects of Twice-Weekly Intense Aerobic Exercise in Early Subacute Stroke: a Randomized Controlled Trial. Archives of physical medicine and rehabilitation 97(8): 1244-1253	- Comparator in study does not match that specified in this review protocol
Sandberg, K., Kleist, M., Wijkman, M. et al. (2020) Effects of In-Bed Cycle Exercise in Patients With Acute Stroke: A Randomized Controlled Trial. Archives of Rehabilitation Research and Clinical Translation 2(4): 100085	- Data not reported in an extractable format or a format that can be analysed
Sankaran, R., Kamath, R., Nambiar, V. et al. (2019) A prospective study on the effects of Ayurvedic massage in post-stroke patients. Journal of Ayurveda and integrative medicine 10(2): 126-130	- Study does not contain an intervention relevant to this review protocol
Saposnik, G., Cohen, L. G., Mamdani, M. et al. (2016) Efficacy and safety of non-immersive virtual reality exercising in stroke rehabilitation (EVREST): a randomised, multicentre, single-blind, controlled trial. Lancet Neurology 15(10): 1019-27	- Comparator in study does not match that specified in this review protocol
Savkovic, N. (2017) Effects of combined special education treatment and occupational therapy on upper extremities motor skills in adult patients with hemiplegia. Vojnosanitetski pregled 74(5): 428-434	- Comparator in study does not match that specified in this review protocol
Schneider, E. J.; Ada, L.; Lannin, N. A. (2019) Extra upper limb practice after stroke: a feasibility study. Pilot & Feasibility Studies 5: 156	- Study design not relevant to this review protocol
Schneider, E. J., Lannin, N. A., Ada, L. et al. (2016) Increasing the amount of usual rehabilitation improves activity after stroke: a systematic review [with consumer summary]. Journal of Physiotherapy 2016 Oct;62(4):182-187	- Duplicate reference

Study	Code [Reason]
Schneider, E. J., Lannin, N. A., Ada, L. et al. (2016) Increasing the amount of usual rehabilitation improves activity after stroke: a systematic review. Journal of Physiotherapy 62(4): 182-7	- Systematic review used as source of primary studies
Schnitzler, A., Yelnik, A., Wanepain, M. et al. (2018) Active mobility early after stroke (AMOBES), 1 year follow-up. A randomised controlled trial. Annals of physical and rehabilitation medicine	- Conference abstract
Schroder, J., Truijen, S., van Criekinge, T. et al. (2019) Feasibility and effectiveness of repetitive gait training early after stroke: a systematic review and meta-analysis [with consumer summary]. Journal of Rehabilitation Medicine 2019 Feb;51(2):78-88	- Study does not contain an intervention relevant to this review protocol
Schröder, J., van Criekinge, T., Embrechts, E. et al. (2019) Combining the benefits of tele-rehabilitation and virtual reality-based balance training: a systematic review on feasibility and effectiveness. Disability and rehabilitation. Assistive technology 14(1): 1-9	- Study does not contain an intervention relevant to this review protocol
Schuster, C., Butler, J., Andrews, B. et al. (2009) Comparison of embedded and added motor imagery training in patients after stroke: study protocol of a randomised controlled pilot trial using a mixed methods approach. Trials [Electronic Resource] 10: 97	- Protocol only
Schuster, C., Butler, J., Andrews, B. et al. (2012) Comparison of embedded and added motor imagery training in patients after stroke: results of a randomised controlled pilot trial. Trials [Electronic Resource] 13: 11	- Study does not contain an intervention relevant to this review protocol
Scianni, A.; Teixeira-Salmela, L. F.; Ada, L. (2010) Effect of strengthening exercise in addition to task-specific gait training after stroke: a randomised trial. International Journal of Stroke 5(4): 329-35	- Protocol only
Sehatzadeh, S. (2015) Effect of Increased Intensity of Physiotherapy on Patient Outcomes After Stroke: An Evidence-Based Analysis. Ontario Health Technology Assessment Series 15(6): 1-42	- Systematic review used as source of primary studies
Sen, S. B., Demir, S. O., Ekiz, T. et al. (2015) Effects of the bilateral isokinetic strengthening training on functional parameters, gait, and the quality of life in patients with stroke. International Journal of Clinical and Experimental Medicine 8(9): 16871-16879	- Comparator in study does not match that specified in this review protocol
Seok, H., Kim, S. H., Jang, Y. W. et al. (2010) Effect of Mirror Therapy on Recovery of Upper Limb Function and Strength in Subacute Hemiplegia after Stroke. Journal of korean academy of rehabilitation medicine 34(5): 508-512	- Study not reported in English

Study	Code [Reason]
Shah, S.; Vanclay, F.; Cooper, B. (1990) Efficiency, effectiveness and duration of stroke rehabilitation. Stroke; a journal of cerebral circulation 21(2): 241-246	- Study design not relevant to this review protocol
Sharififar, S.; Shuster, J. J.; Bishop, M. D. (2018) Adding electrical stimulation during standard rehabilitation after stroke to improve motor function. A systematic review and meta-analysis. Annals of physical and rehabilitation medicine 61(5): 339-344	- Study does not contain an intervention relevant to this review protocol
Shaw, L. C., Price, C. I., van Wijck, F. M. et al. (2011) Botulinum Toxin for the Upper Limb after Stroke (BoTULS) Trial: effect on impairment, activity limitation, and pain. Stroke; a journal of cerebral circulation 42(5): 1371-1379	- Comparator in study does not match that specified in this review protocol
Sheehy, L., Taillon-Hobson, A., Sveistrup, H. et al. (2016) Does the addition of virtual reality training to a standard program of inpatient rehabilitation improve sitting balance ability and function after stroke? Protocol for a single-blind randomized controlled trial. BMC neurology 16: 42	- Comparator in study does not match that specified in this review protocol
Sheikh, K., Meade, T. W., Brennan, P. J. et al. (1981) Intensive rehabilitation after stroke: service implications. Community medicine 3: 210-216	- Study design not relevant to this review protocol
Shin, D. C. (2020) Smartphone-based visual feedback trunk control training for gait ability in stroke patients: A single-blind randomized controlled trial. Technology & Health Care 28(1): 45-55	- Study does not contain an intervention relevant to this review protocol
Shin, D. C., Shin, S. H., Lee, M. M. et al. (2016) Pelvic floor muscle training for urinary incontinence in female stroke patients: a randomized, controlled and blinded trial. Clinical Rehabilitation 30(3): 259-67	- Study does not contain an intervention relevant to this review protocol
Shin, D. C. and Song, C. H. (2016) Smartphone-Based Visual Feedback Trunk Control Training Using a Gyroscope and Mirroring Technology for Stroke Patients: Single-blinded, Randomized Clinical Trial of Efficacy and Feasibility. American Journal of Physical Medicine & Rehabilitation 95(5): 319-29	- Comparator in study does not match that specified in this review protocol
Shin, J. H.; Bog Park, S.; Ho Jang, S. (2015) Effects of game-based virtual reality on health-related quality of life in chronic stroke patients: A randomized, controlled study. Computers in Biology & Medicine 63: 92-8	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Shin, J. H.; Ryu, H.; Jang, S. H. (2014) A task-specific interactive game-based virtual reality rehabilitation system for patients with stroke: a usability test and two clinical experiments. Journal of Neuroengineering & Rehabilitation 11: 32	- Comparator in study does not match that specified in this review protocol
Shin, S. H.; Kim, J. S.; Kim, Y. K. (2008) The Effects of a Computer-assisted Cognition Training Program (RehaComÂ®) in Stroke Patients. Brain neurorehabil 1(2): 181-189	- Study not reported in English
Shmonin, A. A., melnikova, E. V., Maltseva, N. N. et al. (2014) The dog-assisted therapy (the kanis-therapy) is the rehabilitation for patients in the later phases of stroke recovery: single-blind study of the efficacy. Cerebrovascular diseases (Basel, Switzerland) 37(suppl1): 310	- Conference abstract
Shutter, L. and Whyte, J. (1999) Increased intensity of physiotherapy after stroke. Stroke; a journal of cerebral circulation 30: 2242	- Commentary only
Silva, S., Borges, L. R., Santiago, L. et al. (2020) Motor imagery for gait rehabilitation after stroke. The Cochrane database of systematic reviews 9(9): cd013019	- Study does not contain an intervention relevant to this review protocol
Singh, P. and Pradhan, B. (2013) Study to assess the effectiveness of modified constraint-induced movement therapy in stroke subjects: A randomized controlled trial. Annals of Indian Academy of Neurology 16(2): 180-4	- Comparator in study does not match that specified in this review protocol
Sit, J. W., Chair, S. Y., Chan Yip, C. W. et al. (2018) Effect of health empowerment intervention for stroke self-management on behaviour and health in stroke rehabilitation patients. Hong Kong Medical Journal 24suppl2(1): 12-15	- Study does not contain an intervention relevant to this review protocol
Sit, J. W., Chair, S. Y., Choi, K. C. et al. (2016) Do empowered stroke patients perform better at self-management and functional recovery after a stroke? A randomized controlled trial. Clinical interventions in aging 11: 1441-1450	- Study does not contain an intervention relevant to this review protocol
Sivertsen, Marianne, Arntzen, Ellen Christin, Alstadhaug, Karl Bjornar et al. (2022) Effect of innovative vs. usual care physical therapy in subacute rehabilitation after stroke. A multicenter randomized controlled trial. Frontiers in rehabilitation sciences 3: 987601	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
	Physiotherapy intervention at a matched intensity
Slade, A.; Tennant, A.; Chamberlain, M. A. (2002) A randomised controlled trial to determine the effect of intensity of therapy upon length of stay in a neurological rehabilitation setting. Journal of Rehabilitation Medicine 34(6): 260-6	- Population not relevant to this review protocol
Smania, N., Gandolfi, M., Paolucci, S. et al. (2012) Reduced-intensity modified constraint-induced movement therapy versus conventional therapy for upper extremity rehabilitation after stroke: a multicenter trial. Neurorehabilitation & Neural Repair 26(9): 1035-45	- Comparator in study does not match that specified in this review protocol
Smolentseva, I. G.; Amosova, N. A.; Maslyluk, O. A. (2013) The use of virtual reality technology in the rehabilitation of patients with acute cerebral stroke. Cerebrovascular diseases (Basel, Switzerland) 35suppl3: 766	- Conference abstract
Son, Sm; Park, Mk; Lee, Nk (2014) Influence of resistance exercise training to strengthen muscles across multiple joints of the lower limbs on dynamic balance functions of stroke patients. Journal of Physical Therapy Science 26(8): 1267-9.	- Comparator in study does not match that specified in this review protocol
Sonde, L., Gip, C., Fernaeus, S. E. et al. (1998) Stimulation with low frequency (1.7 Hz) transcutaneous electric nerve stimulation (low-tens) increases motor function of the post-stroke paretic arm. Scandinavian Journal of Rehabilitation Medicine 30(2): 95-9	- Study does not contain an intervention relevant to this review protocol
Song, Y. B., Chun, M. H., Kim, W. et al. (2014) The effect of virtual reality and tetra-ataxiometric posturography programs on stroke patients with impaired standing balance. Ann rehabil med 38(2): 160-6	- Comparator in study does not match that specified in this review protocol
Sonoda, S, Saitoh, E, Nagai, S et al. (2004) Full-time integrated treatment program, a new system for stroke rehabilitation in Japan: comparison with conventional rehabilitation. American Journal of Physical Medicine and Rehabilitation 83(2): 88-93.	- Study design not relevant to this review protocol
Sorinola, I. O.; Powis, I.; White, C. M. (2014) Does additional exercise improve trunk function recovery in stroke patients? A meta-analysis. Neurorehabilitation 2014;35(2):205-213	- Systematic review used as source of primary studies
Stahl, B. (2015) Intensive Language-Action Therapy (ILAT): how does high training intensity affect speech and language recovery in stroke patients with chronic aphasia?.	- Trial registry data only

Study	Code [Reason]
States, R. A.; Salem, Y.; Pappas, E. (2009) Overground gait training for individuals with chronic stroke: a Cochrane systematic review. Journal of neurologic physical therapy : JNPT 33(4): 179-86	- Study does not contain an intervention relevant to this review protocol
Steen Krawcyk, R., Vinther, A., Petersen, N. C. et al. (2019) Effect of Home-Based High-Intensity Interval Training in Patients With Lacunar Stroke: A Randomized Controlled Trial. Frontiers in neurology [electronic resource]. 10: 664	- Comparator in study does not match that specified in this review protocol
Stern, P. H., McDowell, F., Miller, J. M. et al. (1970) Effects of facilitation exercise techniques in stroke rehabilitation. Archives of Physical Medicine and Rehabilitation 51(9): 526-31	- Comparator in study does not match that specified in this review protocol
Stroke Unit Trialists, Collaboration (1997) Collaborative systematic review of the randomised trials of organised inpatient (stroke unit) care after stroke [with consumer summary]. BMJ 1997 Apr 19;314(7088):1151-1159	- Systematic review used as source of primary studies
Sun, L., Yin, D., Zhu, Y. et al. (2013) Cortical reorganization after motor imagery training in chronic stroke patients with severe motor impairment: a longitudinal fMRI study. Neuroradiology 55(7): 913-25	- Study does not contain an intervention relevant to this review protocol
Sunderland, A., Fletcher, D., Bradley, L. et al. (1994) Enhanced physical therapy for arm function after stroke: a one year follow up study. Journal of neurology, neurosurgery, and psychiatry 57(7): 856-858	- Study does not contain an intervention relevant to this review protocol
Sungkarat, S.; Fisher, B. E.; Kovindha, A. (2011) Efficacy of an insole shoe wedge and augmented pressure sensor for gait training in individuals with stroke: a randomized controlled trial. Clinical Rehabilitation 25(4): 360-9	- Study does not contain an intervention relevant to this review protocol
Suputtitada, A.; Suwanwela, N. C.; Tumvitee, S. (2004) Effectiveness of constraint-induced movement therapy in chronic stroke patients. Journal of the Medical Association of Thailand 87(12): 1482-90	- Comparator in study does not match that specified in this review protocol
Sutbeyaz, S., Yavuzer, G., Sezer, N. et al. (2007) Mirror therapy enhances lower-extremity motor recovery and motor functioning after stroke: a randomized controlled trial. Archives of Physical Medicine & Rehabilitation 88(5): 555-9	- Comparator in study does not match that

Study	Code [Reason]
	specified in this review protocol
Svaerke, K., Niemeijer, M., Mogensen, J. et al. (2019) The effects of computer-based cognitive rehabilitation in patients with visuospatial neglect following stroke: a systematic review. Topics in Stroke Rehabilitation 26(3): 214-225	- Study does not contain an intervention relevant to this review protocol
Swank, C., Trammell, M., Callender, L. et al. (2020) The impact of a patient-directed activity program on functional outcomes and activity participation after stroke during inpatient rehabilitation-a randomized controlled trial. Clinical rehabilitation 34(4): 504-514	- Comparator in study does not match that specified in this review protocol
Szaflarski, J. P., Ball, A. L., Vannest, J. et al. (2015) Constraint-Induced Aphasia Therapy for Treatment of Chronic Post-Stroke Aphasia: A Randomized, Blinded, Controlled Pilot Trial. Medical Science Monitor 21: 2861-9	- Comparator in study does not match that specified in this review protocol
Takebayashi, T., Takahashi, K., Domen, K. et al. (2015) Efficient training intensity of robotic therapy to improve arm function in subacute stroke patients. Cerebrovascular diseases (Basel, Switzerland) 39(suppl2): 260	- Conference abstract
Tanaka, N., Saitou, H., Takao, T. et al. (2012) Effects of gait rehabilitation with a footpad-type locomotion interface in patients with chronic post-stroke hemiparesis: a pilot study. Clinical Rehabilitation 26(8): 686-95	- Comparator in study does not match that specified in this review protocol
Tang, A, Sibley, Km, Thomas, Sg et al. (2009) Effects of an aerobic exercise program on aerobic capacity, spatiotemporal gait parameters, and functional capacity in subacute stroke. Neurorehabilitation and Neural Repair 23(4): 398-406.	- Study design not relevant to this review protocol
Tankisheva, E., Bogaerts, A., Boonen, S. et al. (2014) Effects of intensive whole-body vibration training on muscle strength and balance in adults with chronic stroke: a randomized controlled pilot study. Archives of Physical Medicine & Rehabilitation 95(3): 439-46	- Study does not contain an intervention relevant to this review protocol
Tariah, Ha, Almalty, Am, Sbieh, Z et al. (2010) Constraint induced movement therapy for stroke survivors in Jordan: A home-based model. International Journal of Therapy and Rehabilitation 17(12): 638-45.	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Taub, E., Miller, N. E., Novack, T. A. et al. (1993) Technique to improve chronic motor deficit after stroke. Archives of Physical Medicine and Rehabilitation 74(4): 347-54	- Study does not contain an intervention relevant to this review protocol
Taub, E., Uswatte, G., King, D. K. et al. (2006) A placebo-controlled trial of constraint-induced movement therapy for upper extremity after stroke. Stroke 37(4): 1045-9	- Comparator in study does not match that specified in this review protocol
Taveggia, G., Borboni, A., Salvi, L. et al. (2016) Efficacy of robot-assisted rehabilitation for the functional recovery of the upper limb in post-stroke patients: a randomized controlled study. European journal of physical and rehabilitation medicine 52(6): 767-773	- Study does not contain an intervention relevant to this review protocol
Tavernese, E, Paoloni, M, Mangone, M et al. Segmental muscle vibration improves reaching movement in patients with chronic stroke. A randomized controlled trial. Neurorehabilitation 32(3): 591-9.	- Study does not contain an intervention relevant to this review protocol
Taylor-Piliae, R. E., Hoke, T. M., Hepworth, J. T. et al. (2014) Effect of Tai Chi on physical function, fall rates and quality of life among older stroke survivors. Archives of Physical Medicine & Rehabilitation 95(5): 816-24	- Comparator in study does not match that specified in this review protocol
Tchero, H., Tabue Teguo, M., Lannuzel, A. et al. (2018) Telerehabilitation for Stroke Survivors: Systematic Review and Meta-Analysis. Journal of medical Internet research 20(10): e10867	- Study does not contain an intervention relevant to this review protocol
Tian, Y., Shi, L., Jing, L. et al. (2007) Effects of active and passive training apparatus combined with rehabilitation training on lower limb function of stroke patients during recovery period. Neural Regeneration Research 2(10): 636-640	- Study design not relevant to this review protocol
Tilling, K. and Wolfe, C. (2002) Re: Randomized controlled study of stroke unit versus stroke team care in different stroke subtypes. Stroke 33(7): 1741-2; author reply 1741	- Commentary only
Toledano-Zarhi, A., Tanne, D., Carmeli, E. et al. (2011) Feasibility, safety and efficacy of an early aerobic rehabilitation program for patients after minor ischemic stroke: A pilot randomized controlled trial. Neurorehabilitation 28(2): 85-90	- Comparator in study does not match that specified in this review protocol

Study	Code [Reason]
Tong, Y. (2015) Effect of early and intensive rehabilitation on functional recovery after stroke.	- Trial registry data only
Tong, Y., Forreider, B., Sun, X. et al. (2015) Music-supported therapy (MST) in improving post-stroke patients' upper-limb motor function: a randomised controlled pilot study. Neurological Research 37(5): 434-40	- Comparator in study does not match that specified in this review protocol
Torres-Arreola Ldel, P., Doubova Dubova, S. V., Hernandez, S. F. et al. (2009) Effectiveness of two rehabilitation strategies provided by nurses for stroke patients in Mexico. Journal of Clinical Nursing 18(21): 2993-3002	- Comparator in study does not match that specified in this review protocol
Treger, I., Aidinof, L., Lehrer, H. et al. (2012) Modified constraint-induced movement therapy improved upper limb function in subacute poststroke patients: a small-scale clinical trial. Topics in Stroke Rehabilitation 19(4): 287-93	- Comparator in study does not match that specified in this review protocol
Tretriluxana, J. (2017) Paretic hand function rehabilitative program in individuals with sub-acute stroke: combine effect of low-frequency repetitive transcranial magnetic stimulation with action observation and task oriented training.	- Trial registry data only
Tsuchimoto, S., Shindo, K., Hotta, F. et al. (2019) Sensorimotor Connectivity after Motor Exercise with Neurofeedback in Post-Stroke Patients with Hemiplegia. Neuroscience 416: 109-125	- Study does not contain an intervention relevant to this review protocol
Turton, A. J. and Britton, E. (2005) A pilot randomized controlled trial of a daily muscle stretch regime to prevent contractures in the arm after stroke. Clinical Rehabilitation 19(6): 600-612	- No outcomes of interest
Underwood, J., Clark, P. C., Blanton, S. et al. (2006) Pain, fatigue, and intensity of practice in people with stroke who are receiving constraint-induced movement therapy. Physical therapy 86(9): 1241-1250	- Comparator in study does not match that specified in this review protocol
Uswatte, G. (2005) Constraint-induced movement therapy modified for rehabilitating arm function in stroke survivors with plegic hands. National rehabilitation information center. http://www.naric.com/research/	- Conference abstract
Valero-Cuevas, F. J., Klamroth-Marganska, V., Winstein, C. J. et al. (2016) Robot-assisted and conventional therapies produce distinct rehabilitative	- Secondary analysis of a trial

Study	Code [Reason]
trends in stroke survivors. Journal of neuroengineering and rehabilitation 13(1): 92	
Valkenborghs, S. R., Callister, R., Visser, M. M. et al. (2019) Interventions combined with task-specific training to improve upper limb motor recovery following stroke: a systematic review with meta-analyses. Physical Therapy Reviews 2019;24(3-4):100-117	- Study does not contain an intervention relevant to this review protocol
Van Criekinge, T., Saeys, W., Hallemans, A. et al. (2020) SWEAT² study: effectiveness of trunk training on muscle activity after stroke. A randomized controlled trial. European journal of physical and rehabilitation medicine	- Comparator in study does not match that specified in this review protocol
Van Criekinge, T., Saeys, W., Vereeck, L. et al. (2018) Are unstable support surfaces superior to stable support surfaces during trunk rehabilitation after stroke? A systematic review. Disability and rehabilitation 40(17): 1-8	- Comparator in study does not match that specified in this review protocol
van de Port, I. G., Wevers, L. E., Lindeman, E. et al. (2012) Effects of circuit training as alternative to usual physiotherapy after stroke: randomised controlled trial. BMJ 344: e2672	- Comparator in study does not match that specified in this review protocol
van Delden, A. L., Peper, C. L., Nienhuys, K. N. et al. (2013) Unilateral versus bilateral upper limb training after stroke: the Upper Limb Training After Stroke clinical trial. Stroke 44(9): 2613-6	- Comparator in study does not match that specified in this review protocol
Van Der Meulen, I., Van De Sandt-Koenderman, M. W., Heijenbrok, M. H. et al. (2016) Melodic Intonation Therapy in Chronic Aphasia: Evidence from a Pilot Randomized Controlled Trial. Frontiers in Human Neuroscience 10: 533	- Comparator in study does not match that specified in this review protocol
van der Ploeg, H. P., Streppel, K. R., van der Beek, A. J. et al. (2006) Counselling increases physical activity behaviour nine weeks after rehabilitation. British Journal of Sports Medicine 40(3): 223-9	- No outcomes of interest
van Wijck, F., Alexander, G., Baillie, L. et al. (2020) Early VERsus Later Augmented Physiotherapy compared with usual physiotherapy (EVERLAP): a feasibility randomised controlled trial of arm function after stroke. Physiotherapy (united kingdom) conferencephysiotherapyukconference2019unitedkingdom107(supplement1): e13-e14	- Conference abstract

Study	Code [Reason]
van Wyk, A.; Eksteen, C. A.; Rheeder, P. (2014) The effect of visual scanning exercises integrated into physiotherapy in patients with unilateral spatial neglect poststroke: a matched-pair randomized control trial. Neurorehabilitation & Neural Repair 28(9): 856-73	- Comparator in study does not match that specified in this review protocol
Vanroy, C., Vanlandewijck, Y., Cras, P. et al. (2019) Does a cycling program combined with education and followed by coaching promote physical activity in subacute stroke patients? A randomized controlled trial. Disability and rehabilitation 41(4): 413-421	- Comparator in study does not match that specified in this review protocol
Veerbeek, J. M., Koolstra, M., Ket, J. C. et al. (2011) Effects of augmented exercise therapy on outcome of gait and gait-related activities in the first 6 months after stroke: a meta-analysis. Stroke; a journal of cerebral circulation 42(11): 3311-5	- Systematic review used as source of primary studies
Veerbeek, J. M., van Wegen, E., van Peppen, R. et al. (2014) What is the evidence for physical therapy poststroke? A systematic review and meta-analysis. PLoS ONE [Electronic Resource] 9(2): e87987	- Study does not contain an intervention relevant to this review protocol
Veldema, J. and Jansen, P. (2020) Ergometer training in stroke rehabilitation: systematic review and meta-analysis. Archives of physical medicine and rehabilitation 101(4): 674-689	- Study does not contain an intervention relevant to this review protocol
Veldema, J. and Jansen, P. (2020) Resistance training in stroke rehabilitation: systematic review and meta-analysis [with consumer summary]. Clinical Rehabilitation 2020 Sep;34(9):1173-1197	- Comparator in study does not match that specified in this review protocol
Verbunt, J. A., Seelen, H. A., Ramos, F. P. et al. (2008) Mental practice-based rehabilitation training to improve arm function and daily activity performance in stroke patients: a randomized clinical trial. BMC neurology 8: 7	- Study does not contain an intervention relevant to this review protocol
Villafane, J. H., Taveggia, G., Galeri, S. et al. (2018) Efficacy of Short-Term Robot-Assisted Rehabilitation in Patients With Hand Paralysis After Stroke: A Randomized Clinical Trial. Hand 13(1): 95-102	- Comparator in study does not match that specified in this review protocol
Viswaja, K., Pappala, K. P., Tulasi, P. R. S. et al. (2015) Effectiveness of Trunk Training Exercises Versus Swiss Ball Exercises for Improving Sitting	- Comparator in study does not match that

Study	Code [Reason]
Balance and Gait Parameters in Acute Stroke Subjects. International journal of physiotherapy: 925-932	specified in this review protocol
Vloothuis, J. D., Mulder, M., Veerbeek, J. M. et al. (2016) Caregiver-mediated exercises for improving outcomes after stroke. Cochrane Database of Systematic Reviews 12: cd011058	- Study does not contain an intervention relevant to this review protocol
Vluggen, T. P., van Haastregt, J. C., Verbunt, J. A. et al. (2012) Multidisciplinary transmural rehabilitation for older persons with a stroke: the design of a randomised controlled trial. BMC Neurology 12: 164	- Protocol only
von Koch, L., de Pedro-Cuesta, J., Kostulas, V. et al. (2001) Randomized controlled trial of rehabilitation at home after stroke: one-year follow-up of patient outcome, resource use and cost. Cerebrovascular Diseases 12(2): 131-8	- Comparator in study does not match that specified in this review protocol
von Koch, L., Widen Holmqvist, L., Kostulas, V. et al. (2000) A randomized controlled trial of rehabilitation at home after stroke in Southwest Stockholm: outcome at six months. Scandinavian Journal of Rehabilitation Medicine 32(2): 80-6	- Comparator in study does not match that specified in this review protocol
Wade, D. T., Collen, F. M., Robb, G. F. et al. (1992) Physiotherapy intervention late after stroke and mobility. BMJ 304(6827): 609-13	- Comparator in study does not match that specified in this review protocol
Wagner, T. H., Lo, A. C., Peduzzi, P. et al. (2011) An economic analysis of robot-assisted therapy for long-term upper-limb impairment after stroke. Stroke; a journal of cerebral circulation 42(9): 2630-2632	- Comparator in study does not match that specified in this review protocol
Walker, C.; Brouwer, B. J.; Culham, E. G. (2000) Use of visual feedback in retraining balance following acute stroke. Physical therapy 80(9): 886-895	- Study does not contain an intervention relevant to this review protocol
Wan, C. and Suo, D. (2018) Pulmonary rehabilitation to enhance recovery of patients with moderate or severe stroke in the rehabilitation intensive care unit.	- Trial registry data only
Wang, B., Li, H., Xu, B. et al. (2005) Influence of earlier rehabilitative interventions on the emotions and the ability of daily living of patients	- Study not reported in English

Study	Code [Reason]
following the first onset of acute stroke. Chinese Journal of Clinical Rehabilitation 9(29): 176-178	
Wang, D. S., Lu, Y. Y., Xie, R. M. et al. (2004) Effect of different intensitise of rehabilitation therapy on the prognosis of patients with stroke. Chinese journal of clinical rehabilitation 8(22): 4410-4411	- Study not reported in English
Wang, F., Zhang, S., Zhou, F. et al. (2021) Early physical rehabilitation therapy between 24 and 48 h following acute ischemic stroke onset: a randomized controlled trial. Disability and rehabilitation: 1-6	- Very early mobilisation
Wang, F., Zhang, S., Zhou, F. et al. (2021) Early physical rehabilitation therapy between 24 and 48 h following acute ischemic stroke onset: a randomized controlled trial. Disability & Rehabilitation: 1-6	- Duplicate reference
Wang, H., Zhao, Z., Jiang, P. et al. (2017) Effect and mechanism of mirror therapy on rehabilitation of lower limb motor function in patients with stroke hemiplegia. Biomedical Research (India) 28(22): 10165-10170	- Comparator in study does not match that specified in this review protocol *Matched intensity between study arms*
Wang, L., Chen, C. M., Liao, W. C. et al. (2013) Evaluating a community-based stroke nursing education and rehabilitation programme for patients with mild stroke. International Journal of Nursing Practice 19(3): 249-56	- Comparator in study does not match that specified in this review protocol
Wang, Mian; Liao, Weijing; Chen, Xiaoli (2019) Effects of a Short-term Mindfulness-Based Intervention on Comfort of Stroke Survivors Undergoing Inpatient Rehabilitation. Rehabilitation nursing 44(2): 78-86	- Study design not relevant to this review protocol
Wang, Q., Zhao, J. L., Zhu, Q. X. et al. (2011) Comparison of conventional therapy, intensive therapy and modified constraint-induced movement therapy to improve upper extremity function after stroke. Journal of Rehabilitation Medicine 43(7): 619-25	- Data not reported in an extractable format or a format that can be analysed
Wang, Tingwei, Tai, Jiahui, Hu, Ruiping et al. (2022) Effect of Tongue-Pressure Resistance Training in Poststroke Dysphagia Patients with Oral Motor Dysfunction-A Randomized Controlled Trial. American journal of physical medicine & rehabilitation	- Data not reported in an extractable format or a format that can be analysed *Medians and interquartile ranges*

Study	Code [Reason]
Wang, Y.; Fu, Z.; Su, J. (2006) Effect of early integrated rehabilitation on functional prognosis and complication in acute stroke patients. Chinese journal of rehabilitation medicine 21(12): 1099-1100+1106	- Study not reported in English
Wattchow, K. A.; McDonnell, M. N.; Hillier, S. L. (2018) Rehabilitation interventions for upper limb function in the first four weeks following stroke: a systematic review and meta-analysis of the evidence. Archives of physical medicine and rehabilitation 99(2): 367-382	- Study does not contain an intervention relevant to this review protocol
Wenke, R., Cardell, E., Lawrie, M. et al. (2018) Communication and well-being outcomes of a hybrid service delivery model of intensive impairment-based treatment for aphasia in the hospital setting: a pilot study. Disability & Rehabilitation 40(13): 1532-1541	- Comparator in study does not match that specified in this review protocol
Wentink, M. M., Meesters, J., Berger, M. A. M. et al. (2018) Adherence of stroke patients with an online brain training program: the role of health professionals' support. Topics in Stroke Rehabilitation 25(5): 359-365	- Comparator in study does not match that specified in this review protocol
Werner, R. A. and Kessler, S. (1996) Effectiveness of an intensive outpatient rehabilitation program for postacute stroke patients. American Journal of Physical Medicine & Rehabilitation 75(2): 114-20	- Comparator in study does not match that specified in this review protocol
West, D., Cream, A., Godecke, E. et al. (2009) Intensive aphasia therapy in the early poststroke recovery phase: is group intervention a viable therapy option?. International journal of stroke 4(suppl1): 28abstb30	- Conference abstract
Wiart, L., Côme, A. B., Debelleix, X. et al. (1997) Unilateral neglect syndrome rehabilitation by trunk rotation and scanning training. Archives of Physical Medicine and Rehabilitation 78(4): 424-9	- Comparator in study does not match that specified in this review protocol
Widen Holmqvist, L., von Koch, L., Kostulas, V. et al. (1998) A randomized controlled trial of rehabilitation at home after stroke in southwest Stockholm. Stroke 29(3): 591-7	- Comparator in study does not match that specified in this review protocol
Wiener, J., McIntyre, A., Janssen, S. et al. (2019) Effectiveness of High-Intensity Interval Training for Fitness and Mobility Post Stroke: A Systematic Review. PM & R : the journal of injury, function, and rehabilitation 11(8): 868-878	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
Williams, Courtney (2017) The Effects of Adding Task-Based Activities to Mirror Therapy as Compared to Traditional Mirror Therapy Alone on Upper Extremity Motor Function in Post Stroke Individuals. Effects of Adding Task-Based Activities to Mirror Therapy as Compared to Traditional Mirror Therapy Alone on Upper Extremity Motor Function in Post Stroke Individuals: 1-1	- Thesis paper
Winkens, I., Van Heugten, C. M., Wade, D. T. et al. (2009) Efficacy of time pressure management in stroke patients with slowed information processing: a randomized controlled trial. Archives of Physical Medicine & Rehabilitation 90(10): 1672-9	- Study does not contain an intervention relevant to this review protocol *Usual care received the same amount of therapy as the intervention group*
Winstein, C. J., Wolf, S. L., Dromerick, A. W. et al. (2016) Effect of a Task-Oriented Rehabilitation Program on Upper Extremity Recovery Following Motor Stroke: The ICARE Randomized Clinical Trial. JAMA 315(6): 571-81	- Comparator in study does not match that specified in this review protocol
Winstein, C., Kim, B., Kim, S. et al. (2019) Dosage Matters. Stroke; a journal of cerebral circulation 50(7): 1831-1837	- Duplicate reference
Winstein, C., Kim, B., Kim, S. et al. (2019) Dosage Matters: a Phase IIb Randomized Controlled Trial of Motor Therapy in the Chronic Phase after Stroke. Stroke; a journal of cerebral circulation 50(7): 1831-1837	- Comparator in study does not match that specified in this review protocol
Winstein, Cj, Wolf, Sl, Dromerick, Aw et al. (2016) Effect of a task-oriented rehabilitation program on upper extremity recovery following motor stroke. Journal - American Medical Association 315(6): 571-81.	- Duplicate reference
Wittenberg, G. F., Chen, R., Ishii, K. et al. (2003) Constraint-induced therapy in stroke: magnetic-stimulation motor maps and cerebral activation. Neurorehabilitation & Neural Repair 17(1): 48-57	- Data not reported in an extractable format or a format that can be analysed
Wolf, S. L., Winstein, C. J., Miller, J. P. et al. (2008) Retention of upper limb function in stroke survivors who have received constraint-induced movement therapy: the EXCITE randomised trial. Lancet Neurology 7(1): 33-40	- Crossover trials (for people after acute/subacute stroke only)

Study	Code [Reason]
Wolfe, C. D.; Tilling, K.; Rudd, A. G. (2000) The effectiveness of community-based rehabilitation for stroke patients who remain at home: a pilot randomized trial. Clinical rehabilitation 14(6): 563-569	- Comparator in study does not match that specified in this review protocol
Wray, F.; Clarke, D.; Forster, A. (2018) Post-stroke self-management interventions: a systematic review of effectiveness and investigation of the inclusion of stroke survivors with aphasia. Disability and rehabilitation 40(11): 1-15	- Study does not contain an intervention relevant to this review protocol
Wright, A., Stone, K., Lambrick, D. et al. (2017) A Community-Based, Bionic Leg Rehabilitation Program for Patients with Chronic Stroke: clinical Trial Protocol. Journal of stroke and cerebrovascular diseases	- Protocol only
Wu, C. W. (2013) Effects of intensive robot-assisted therapy in patients with subacute stroke (RT).	- Trial registry data only
Wu, C. Y., Chen, C. L., Tang, S. F. et al. (2007) Kinematic and clinical analyses of upper-extremity movements after constraint-induced movement therapy in patients with stroke: a randomized controlled trial. Archives of Physical Medicine and Rehabilitation 88(8): 964-70	- Comparator in study does not match that specified in this review protocol
Wu, C. Y., Chen, C. L., Tsai, W. C. et al. (2007) A randomized controlled trial of modified constraint-induced movement therapy for elderly stroke survivors: changes in motor impairment, daily functioning, and quality of life. Archives of Physical Medicine & Rehabilitation 88(3): 273-8	- Comparator in study does not match that specified in this review protocol
Wu, C. Y., Chuang, L. L., Lin, K. C. et al. (2011) Randomized trial of distributed constraint-induced therapy versus bilateral arm training for the rehabilitation of upper-limb motor control and function after stroke. Neurorehabilitation & Neural Repair 25(2): 130-9	- Comparator in study does not match that specified in this review protocol
Wu, Cy, Lin, Kc, Chen, Hc et al. (2007) Effects of Modified Constraint-Induced Movement Therapy on Movement Kinematics and Daily Function in Patients With Stroke: A Kinematic Study of Motor Control Mechanisms. Neurorehabilitation and Neural Repair 21(5): 460-6.	- Comparator in study does not match that specified in this review protocol
Wu, D. Y., Guo, M., Gao, Y. S. et al. (2012) Clinical effects of comprehensive therapy of early psychological intervention and rehabilitation training on neurological rehabilitation of patients with acute stroke. Asian Pacific Journal of Tropical Medicine 5(11): 914-6	- Very early mobilisation

Study	Code [Reason]
Wu, J. F., Wang, H. J., Wu, Y. et al. (2016) Efficacy of transcranial alternating current stimulation over bilateral mastoids (tACSbm) on enhancing recovery of subacute post-stroke patients. Topics in Stroke Rehabilitation 23(6): 420-429	- Study does not contain an intervention relevant to this review protocol
Wu, W. X., Zhou, C. Y., Wang, Z. W. et al. (2020) Effect of Early and Intensive Rehabilitation after Ischemic Stroke on Functional Recovery of the Lower Limbs: A Pilot, Randomized Trial. Journal of Stroke & Cerebrovascular Diseases 29(5): 104649	- Data not reported in an extractable format or a format that can be analysed
Wu, X., Guarino, P., Lo, A. C. et al. (2016) Long-term Effectiveness of Intensive Therapy in Chronic Stroke. Neurorehabilitation and neural repair 30(6): 583-590	- Comparator in study does not match that specified in this review protocol
Xia, W. M. and Hu, Y. Q. (2003) Effect of early psychological intervention in rehabilitation of patients with cerebral stroke. Chinese journal of clinical rehabilitation 7(28): 3842-3843	- Study not reported in English
Xiang X, Yu-rong M, Jiang-li Z et al. (2014) Virtual reality enhanced body weight supported treadmill training improved lower limb motor function in patients with cerebral infarction. Chinese Journal of Tissue Engineering Research 18(7): 1143-8	- Study not reported in English
Xiao, W., Wang, J., Luo, Z. et al. (2003) The economic health evaluation to the early intensive rehabilitation of patients with stroke. Chinese journal of clinical rehabilitation 7(3): 372-373+378	- Study not reported in English
Xiao, W., Wang, J., Luo, Z. et al. (2003) The economic health evaluation to the early intensive rehabilitation on patients with stroke. Chinese journal of clinical rehabilitation 7(3): 372-373	- Duplicate reference
Xu, Q., Li, C., Pan, Y. et al. (2020) Impact of smart force feedback rehabilitation robot training on upper limb motor function in the subacute stage of stroke. Neurorehabilitation 47(2): 209-215	- Comparator in study does not match that specified in this review protocol *Matched intensity between study arms*
Xu, Y. and Liu, S. (2003) Effects of early rehabilitation on patients with paralysis after cerebral infarction. Zhongguo linchuang kangfu 7(1): 127	- Study not reported in English

Study	Code [Reason]
Xu, Y. and Liu, S. (2003) Effects of early rehabilitation to patients with paralysis after cerebral infarction. Chinese journal of clinical rehabilitation 7(1): 127	- Duplicate reference
Xuefang, Liu; Guihua, Wang; Fengru, Miao (2021) The effect of early cognitive training and rehabilitation for patients with cognitive dysfunction in stroke. International journal of methods in psychiatric research 30(3): e1882	- No outcomes of interest *Reported global cognitive outcomes or imaging outcomes*
Yagura, H, Miyai, I, Seike, Y et al. (2003) Benefit of inpatient multidisciplinary rehabilitation up to 1 year after stroke. Archives of Physical Medicine and Rehabilitation 84(11): 1687-91.	- Study design not relevant to this review protocol
Yakupov, E. Z., Nalbat, A. V., Semenova, M. V. et al. (2019) Efficacy of music therapy in the rehabilitation of stroke patients. Neuroscience and behavioral physiology 49(1): 121-128	- Comparator in study does not match that specified in this review protocol
Yamada, N., Kakuda, W., Kondo, T. et al. (2014) Local muscle injection of botulinum toxin type a synergistically improves the beneficial effects of repetitive transcranial magnetic stimulation and intensive occupational therapy in post-stroke patients with spastic upper limb hemiparesis. European Neurology 72(56): 290-8	- Comparator in study does not match that specified in this review protocol
Yang, C. L., Lin, K. C., Chen, H. C. et al. (2012) Pilot comparative study of unilateral and bilateral robot-assisted training on upper-extremity performance in patients with stroke. American Journal of Occupational Therapy 66(2): 198-206	- Comparator in study does not match that specified in this review protocol
Yavuzer, G., Eser, F., Karakus, D. et al. (2006) The effects of balance training on gait late after stroke: a randomized controlled trial. Clinical Rehabilitation 20(11): 960-9	- Comparator in study does not match that specified in this review protocol
Yavuzer, G., Geler-Kulcu, D., Sonel-Tur, B. et al. (2006) Neuromuscular electric stimulation effect on lower-extremity motor recovery and gait kinematics of patients with stroke: a randomized controlled trial. Archives of Physical Medicine & Rehabilitation 87(4): 536-40	- Study does not contain an intervention relevant to this review protocol
Yavuzer, G., Selles, R., Sezer, N. et al. (2008) Mirror therapy improves hand function in subacute stroke: a randomized controlled trial. Archives of Physical Medicine & Rehabilitation 89(3): 393-8	- Comparator in study does not match that

Study	Code [Reason]
	specified in this review protocol
Yavuzer, G., Senel, A., Atay, M. B. et al. (2008) "Playstation eyetoy games" improve upper extremity-related motor functioning in subacute stroke: a randomized controlled clinical trial. European journal of physical & rehabilitation medicine. 44(3): 237-44	- Comparator in study does not match that specified in this review protocol
Yelnik, A. P., Quintaine, V., Andriantsifanetra, C. et al. (2017) AMOBES (Active Mobility Very Early After Stroke): A Randomized Controlled Trial. Stroke 48(2): 400-405	- Data not reported in an extractable format or a format that can be analysed
Yih, Wong, Ada, Louise, Wang, Rongrong et al. (2020) Self-administered, home-based, upper limb practice in stroke patients: A systematic review. Journal of Rehabilitation Medicine (Stiftelsen Rehabiliteringsinformation) 52(10): 1-2	- Study does not contain an intervention relevant to this review protocol
Yin, C. W., Sien, N. Y., Ying, L. A. et al. (2014) Virtual reality for upper extremity rehabilitation in early stroke: a pilot randomized controlled trial. Clinical rehabilitation 28(11): 1107-1114	- Comparator in study does not match that specified in this review protocol
Yin, X. J., Wang, Y. J., Ding, X. D. et al. (2021) Effects of motor imagery training on lower limb motor function of patients with chronic stroke: A pilot single-blind randomized controlled trial. International Journal of Nursing Practice: e12933	- Study does not contain an intervention relevant to this review protocol
Yokota, C. (2017) Acute stroke rehabilitation for patients with upper limb motor dysfunction.	- Trial registry data only
Yoo, D. H., Cha, Y. J., Kim, S. Y. et al. (2013) Effects of upper limb robot-assisted therapy in the rehabilitation of stroke patients. Journal of physical therapy science 25: 407-409	- Data not reported in an extractable format or a format that can be analysed
Yoo, D. H. and Kim, S. Y. (2015) Effects of upper limb robot-assisted therapy in the rehabilitation of stroke patients. Journal of physical therapy science 27(3): 677-679	- Duplicate reference
Yoo, I. G. and Yoo, W. G. (2011) Effects of a multidisciplinary supervised exercise program on motor performance and quality of life in community-dwelling chronic stroke survivors in Korean. The Southeast Asian journal of tropical medicine and public health 42(2): 436-443	- Conference abstract

Study	Code [Reason]
You, H., Cheng, Y., Li, H. et al. (2020) The effect of comprehensive rehabilitation nursing on mental state recovery and neurological dysfunction in elderly stroke patients. International Journal of Clinical and Experimental Medicine 13(8): 6216-6223	- Study does not contain an intervention relevant to this review protocol
Young, H. J. and van Wijck, F. (2020) Upper-limb therapy for stroke survivors with severely-limited arm function: analysis of participants' function and goal attainment following an augmented intervention. Physiotherapy (united kingdom) conferencephysiotherapyukconference2019unitedkingdom107(supplement1): e203	- Conference abstract
Yu, Chang Seon; Nam, Yeon-Gyo; Kwon, Bum Sun (2022) Comparison of high-intensive and low-intensive electromechanical-assisted gait training by Exowalk R in patients over 3-month post-stroke. BMC sports science, medicine & rehabilitation 14(1): 126	- Study design not relevant to this review protocol *Study takes intervention arms from two randomised trials and compares them to each others, effectively undoing the randomisation without adjusting for the confounders listed in the protocol*
Yu, J., Hu, Y., Wu, Y. et al. (2008) An analysis about the effects of standardized community-based rehabilitation (CBR) therapy on ADL for patients after stroke in China. Journal of rehabilitation medicine: 110	- Trial registry data only
Yu, J., Hu, Y., Wu, Y. et al. (2008) An analysis of the effects of community-based rehabilitation therapy on activity of daily living performance of the Chinese stroke patients: a single blind, randomized, controlled, multicenter trial. Journal of physical medicine and rehabilitation 30(4): 260-264	- Study not reported in English
Yuan, R. and Wang, H. (2022) TU-173. The effect of upper limb rehabilitation robot training on the motor function and neuroelectrophysiology of stroke patients. Clinical Neurophysiology 141(supplement): 29	- Conference abstract
Zhang, J., Wu, S., Huang, Y. et al. (2008) The effects of standardized three stages rehabilitation program in promoting active function in stroke patients with hemiplegia. Journal of rehabilitation medicine: 111 (Abst. PP002-060)	- Conference abstract
Zhang, Jiaqi, Yu, Jiadan, Bao, Yong et al. (2017) Constraint-induced aphasia therapy in poststroke aphasia rehabilitation: A systematic review and meta-analysis of randomized controlled trials. PLoS ONE 12(8)	- Study does not contain an intervention

Study	Code [Reason]
	relevant to this review protocol
Zhang, Q., Schwade, M., Smith, Y. et al. (2020) Exercise-based interventions for post-stroke social participation: A systematic review and network meta-analysis. International journal of nursing studies 111: 103738	- Study does not contain an intervention relevant to this review protocol
Zhang, Y. M., Fu, W., Hu, J. et al. (2013) Effect of transcranial magnetic stimulation on unilateral spatial neglect and motor functions rehabilitation in patients with stroke. Chinese journal of cerebrovascular diseases 10(2): 74-78	- Study not reported in English
Zheng, L.; Li, Y.; Liu, Y. (2014) The individualized rehabilitation interventions for dysphagia: A multidisciplinary case control study of acute stroke patients. International Journal of Clinical and Experimental Medicine 7(10): 3789-3794	- No outcomes of interest
Zhou, C. X., Su, X. L., Yang, X. Z. et al. (2004) Effect of physiological nursing on the rehabilitation of post-stroke depression. Chinese journal of clinical rehabilitation 8(16): 3008-3009	- Study not reported in English
Zhou, M., Li, F., Lu, W. et al. (2018) Efficiency of Neuromuscular Electrical Stimulation and Transcutaneous Nerve Stimulation on Hemiplegic Shoulder Pain: A Randomized Controlled Trial. Archives of Physical Medicine & Rehabilitation 99(9): 1730-1739	- Study does not contain an intervention relevant to this review protocol
Zhu, G. X., Hu, Y. S., Wu, Y. et al. (2004) Effects of standardized three-stage rehabilitation on recovery of neurological function in stroke patients with hemiplegia. Zhonghua yi xue za zhi 84(23): 1955-1958	- Study not reported in English
Zhu, L., Song, W., Liu, L. et al. (2016) Rehabilitation effect of lower limb rehabilitation training robot combined with task-oriented training on walking ability after stroke. Chinese journal of cerebrovascular diseases 13(5): 240-244 and 248	- Study not reported in English

Qualitative studies

Table 49: Qualitative studies excluded from this clinical review (as the aim is not relevant to this review), but included in review question 1.1 early supported discharge

Study	Code [Reason]
Chouliara, N., Fisher, R. J., Kerr, M. et al. (2014) Implementing evidence-based stroke Early Supported Discharge services: a qualitative study of challenges, facilitators and impact. Clinical Rehabilitation 28(4): 370-7	- Qualitative study (1.1 Early supported discharge)
Collins, Gillian, Breen, Ciara, Walsh, Thomas et al. (2016) An exploration of the experience of early supported discharge from the perspective of stroke survivors. International Journal of Therapy & Rehabilitation 23(5): 207-214	- Qualitative study (1.1 Early supported discharge)
Ellis-Hill, C., Robison, J., Wiles, R. et al. (2009) Going home to get on with life: patients and carers experiences of being discharged from hospital following a stroke. Disability & Rehabilitation 31(2): 61-72	- Qualitative study (1.1 Early supported discharge)
Fisher, R. J., Walker, M. F., Golton, I. et al. (2013) The implementation of evidence-based rehabilitation services for stroke survivors living in the community: the results of a Delphi consensus process. Clinical Rehabilitation 27(8): 741-9	- Qualitative study (1.1 Early supported discharge)
Kjaerhauge Christiansen, L., Rasmussen, A. M., Mouritzen, H. S. et al. (2020) Quickly home again: patients' experiences of early discharge after minor stroke. Scandinavian Journal of Caring Sciences 05: 05	- Qualitative study (1.1 Early supported discharge)
Kjork, E. K., Gunnel, C., Lundgren-Nilsson, A. et al. (2019) 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] 14(10): e0223338	- Qualitative study (1.1 Early supported discharge)
Kraut, Jacey; Singer, Barbara; Singer, Kevin (2016) Clinician and client views of utilising early supported discharge services. International Journal of Therapy & Rehabilitation 23(10): 464-471	- Qualitative study (1.1 Early supported discharge)

Study	Code [Reason]
Lou, S., Carstensen, K., Moldrup, M. et al. (2017) Early supported discharge following mild stroke: a qualitative study of patients' and their partners' experiences of rehabilitation at home. Scandinavian Journal of Caring Sciences 31(2): 302-311	- Qualitative study (1.1 Early supported discharge)
Moule, Pam, Young, Pat, Glogowska, Margaret et al. (2011) Early Stroke Discharge Team: a participatory evaluation. International Journal of Therapy & Rehabilitation 18(6): 319-328	- Qualitative study (1.1 Early supported discharge)
Nordin, A.; Sunnerhagen, K. S.; Axelsson, A. B. (2015) Patients' expectations of coming home with Very Early Supported Discharge and home rehabilitation after stroke - an interview study. BMC Neurology 15: 235	- Qualitative study (1.1 Early supported discharge)
Ringsberg, K. C. and Holmgren, B. (2003) Home rehabilitation of stroke patients from the perspective of the patients and their relatives. Nordisk Fysioterapi 7(3): 21-31	- Qualitative study (1.1 Early supported discharge)
Rochette, A.; Dugas, A.; Morissette-Gravel, A. S. (2021) 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 28(2): 142-152	- Qualitative study (1.1 Early supported discharge)
Taule, T. and Raheim, M. (2014) Life changed existentially: a qualitative study of experiences at 6-8 months after mild stroke. Disability & Rehabilitation 36(25): 2107-19	- Qualitative study (1.1 Early supported discharge)
Taule, Tina, Strand, Liv Inger, Skouen, Jan Sture et al. (2015) Striving for a life worth living: stroke survivors' experiences of home rehabilitation. Scandinavian Journal of Caring Sciences 29(4): 651-661	- Qualitative study (1.1 Early supported discharge)
van der Veen, D. J., Dopp, C. M. E., Siemonsma, P. C. et al. (2019) Factors influencing the implementation of Home-Based Stroke Rehabilitation: Professionals' perspective. PLoS ONE [Electronic Resource] 14(7): e0220226	- Qualitative study (1.1 Early supported discharge)
von Koch, L., Holmqvist, L. W., Wottrich, A. W. et al. (2000) Rehabilitation at home after stroke:	- Qualitative study (1.1 Early supported discharge)

Study	Code [Reason]
a descriptive study of an individualized intervention. Clinical Rehabilitation 14(6): 574-583	
Wottrich, A. W.; von Koch, L.; Tham, K. (2007) 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 87(6): 778-788	- Qualitative study (1.1 Early supported discharge)

Table 50: 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:	- Survey data that only reported descriptive quantitative data

Study	Code [Reason]
findings from the ASPIRE-S study. International Journal of Stroke 10(6): 918-23	
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 Physical Activity: An Exploratory Qualitative Study. American Journal of Occupational Therapy 75(2): 1-6	- No relevant themes to answer the review question
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

Study	Code [Reason]
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. Scandinavian Journal of Caring Sciences 17(3): 215-22	- No relevant themes to answer the review question
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

Study	Code [Reason]
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
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	- Population not relevant to this review protocol

Study	Code [Reason]
developing self-care independence in a rehabilitation ward: a qualitative study. Clinical Rehabilitation 27(6): 538-45	
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. British Journal of Therapy & Rehabilitation 6(1): 32-37	- No relevant themes to answer the review question
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	- Conference abstract

Study	Code [Reason]
services following a stroke: A qualitative evidence synthesis. European Geriatric Medicine 12(suppl1): 296	
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
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	- Survey data that only reported descriptive quantitative data

Study	Code [Reason]
physiotherapist. Topics in Stroke Rehabilitation 22(5): 377-85	
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
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:	- Systematic review used as source of primary studies

Study	Code [Reason]
qualitative meta-synthesis. Journal of Advanced Nursing (John Wiley & Sons, Inc.) 69(3): 514-525	
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 stroke. The FASE qualitative study. British Journal of Occupational Therapy 84(2): 111-121	- Aims of the study are not relevant to the review question
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	- Survey data that only reported descriptive quantitative data

Study	Code [Reason]
functional recovery. Disability & Rehabilitation 34(25): 2132-8	
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 management. International Journal of Language & Communication Disorders 50(4): 547-563	- Aims of the study are not relevant to the review question
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

Study	Code [Reason]
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 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	- Aims of the study are not relevant to the review question *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*

Study	Code [Reason]
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
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	- No relevant themes to answer the review question

Study	Code [Reason]
impact and potential of an innovative arts based therapy. Disability & Rehabilitation 27(22): 1391-8	
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
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

Study	Code [Reason]
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 and relationships between staff and stroke patients on a rehabilitation ward. Journal of Advanced Nursing 26(1): 101-10	- No relevant themes to answer the review question
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

Study	Code [Reason]
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
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*

Study	Code [Reason]
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
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

Study	Code [Reason]
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
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

Study	Code [Reason]
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 and functions. Disability & Rehabilitation 41(4): 396-404	- Aims of the study are not relevant to the review question
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

Study	Code [Reason]
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
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'	- Aims of the study are not relevant to the review question

Study	Code [Reason]
satisfaction with rehabilitation. Clinical Rehabilitation 22(9): 825-35	
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 rehabilitation. PLoS ONE [Electronic Resource] 15(8): e0236831	- Aims of the study are not relevant to the review question
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,	- Population not relevant to this review protocol

Study	Code [Reason]
Canada. Disability & Rehabilitation 40(26): 3120-3126	
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
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

Study	Code [Reason]
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 experience of a stroke family during the first 18 months poststroke. Scandinavian Journal of Caring Sciences 32(1): 270-279	- No relevant themes to answer the review question
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	- Population not relevant to this review protocol

Study	Code [Reason]
during inpatient rehabilitation: a qualitative study. Journal of Physiotherapy 58(4): 261-8	
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
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

Study	Code [Reason]
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 in nursing homes. International Journal of Nursing Studies 37(3): 267-76	- No relevant themes to answer the review question
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

Study	Code [Reason]
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
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	- No relevant themes to answer the review question

Study	Code [Reason]
caregivers and the multidisciplinary team. Journal of Advanced Nursing 73(10): 2351-2360	
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 stakeholder engagement. PLoS ONE [Electronic Resource] 12(5): e0177102	- Aims of the study are not relevant to the review question
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	- No relevant themes to answer the review question

Study	Code [Reason]
stroke: caregiver perceptions. International Journal of Therapy & Rehabilitation 25(7): 353-364	
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 perspective. International Journal of Language & Communication Disorders 54(4): 634-644	- No relevant themes to answer the review question
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	- No relevant themes to answer the review question

Study	Code [Reason]
therapists. British Journal of Occupational Therapy 63(2): 59-64	
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 superiority design of very early supported discharge for patients with stroke. BMC Neurology Vol 13 2013, ArtID 66 13	- Protocol only
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

Study	Code [Reason]
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
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

Study	Code [Reason]
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
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	- Study does not contain an intervention relevant to this review protocol

Study	Code [Reason]
individuals with stroke in the community: the family's experience. Canadian Journal of Neuroscience Nursing 29(2): 5-12	*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 dwelling stroke survivors: a prospective qualitative study. Disability & Rehabilitation 34(16): 1376-1384	- No relevant themes to answer the review question
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	- No relevant themes to answer the review question

Study	Code [Reason]
perspective. Topics in Stroke Rehabilitation 20(6): 478-84	
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 Review. Journal of Stroke and Cerebrovascular Diseases 29 (8)	- No relevant themes to answer the review question
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

Appendix L – Research recommendations – full details

L.1 Research recommendation

What is the clinical and cost-effectiveness of delivering rehabilitation for 7 days a week compared to 5 days a week for people after a stroke?

L.1.1 Why this is important

Access to more intense rehabilitation after stroke is seen as of high importance. The NHS long term plan discusses the importance of delivering stroke services 7 days a week. Currently, there is a lack of access to clinical or therapy services over the weekend which can result in delays to their rehabilitation and may lead to worse clinical outcomes. This is supported by the findings from the qualitative review which showed that people after stroke believe that increasing the amount of therapy delivered led to better recovery after a stroke. One way to deliver this is thought to be through 7 day working. In this review there was evidence relating to the time therapy was delivered. However, there was limited evidence exploring therapy delivered over 7 days per week.

L.1.2 Rationale for research recommendation

Importance to 'patients' or the population	The delivery of rehabilitation services is critical to stroke survivors as any gaps in rehabilitation over the weekend could result in worse health outcomes. In the qualitative review, one of the key findings was 'more therapy is better', and the delivery of therapy over 7 days per week would allow patients to engage in more therapy and achieve rehabilitation goals more quickly.
Relevance to NICE guidance	This research will help determine whether therapy delivered over 7 days is more effective than 5 days per week. This research will enable future guidelines to clearly recommend how many days per week therapy services are most effective and if 7 day working is a feasible way of delivering more intensive rehabilitation.
Relevance to the NHS	This will be particularly relevant to the NHS as 7 day working is part of the NHS long term plan to ensure patients receive consistent high quality care every day of the week. This will help determine if stroke rehabilitation services delivered seven days per week compared to five days lead to better clinical outcomes and to assess if it is cost effective.
National priorities	Implementing 7 day working for stroke rehabilitation is an aim in the NHS Long Term Plan and a national priority.
Current evidence base	Limited evidence was identified investigating 7 days a week services compared to 5 days a week services. There is also limited research into cost effectiveness of 7 day working in post stroke rehabilitation.
Equality considerations	No specific equality considerations were identified. The committee noted that in general throughout the guideline, people with communication and cognitive difficulties, older

	people and people who have had a previous stroke or transient ischaemic attack were excluded from trials but are people that the guideline is for. Therefore, research should aim to include these people where possible.

L.1.3 Modified PICO table

Population	Inclusion: • Adults (age ≥16 years) who have had a first stroke or recurrent stroke (including people after a subarachnoid haemorrhage) Exclusion: • Children (age <16 years) • People who have had a transient ischaemic attack
Intervention	• Rehabilitation delivered by any members of a multidisciplinary team 7 days a week This should otherwise match standard care as recommended within the current NICE guideline (if required, at least 1-2 hours of physiotherapy, at least 45 minutes of occupational therapy and speech and language therapy for each difficulty that a person has)
Comparator	• Rehabilitation delivered by any members of a multidisciplinary team 5 days a week This should otherwise match standard care as recommended within the current NICE guideline (if required, at least 1-2 hours of physiotherapy, at least 45 minutes of occupational therapy and speech and language therapy for each difficulty that a person has)
Outcome	At time period • <6 months • ≥6 months • Person/participant generic health-related quality of life • Carer generic health-related quality of life • Stroke outcome - modified Rankin scale • Activities of daily living • Physical function • Communication • Psychological distress • Stroke-related scales of cognition (continuous outcomes will be prioritised) (including non-spatial attention and working

	memory, spatial attention, memory and executive function scores) • Swallow function and ability • Discontinuation from study
Study design	Randomised controlled trial
Timeframe	6 months
Additional information	Subgroup analyses: • Severity of stroke (NIHSS scale, split into mild 1-5, moderate 5-14, severe 15-24, very severe >25) • Time after stroke on entry to the study (hyperacute <72 hours, acute 72 hours-7 days, subacute 7 days-6 months, chronic >6 months) • Presence of communication difficulty at baseline

L.2 Research recommendation

What is the clinical and cost-effectiveness of more intense psychology/neuropsychology compared to usual care for people after a stroke?

L.2.1 Why this is important

Following a stroke up to 75% of patients will have some form of cognitive impairment[93]. These can include difficulties with attention, language, memory, mood disturbance and depression. Many stroke survivors remain undiagnosed and a large proportion of stroke survivors would benefit from therapy delivered by clinical psychologists or neuropsychologists. As part of the NHS long term plan there is an initiative to deliver higher intensity care models for stroke rehabilitation. Evidence from the clinical review indicated that higher intensities of physiotherapy rehabilitation between 1-2 hours were more clinically and cost effective than therapy delivered at lower intensities. There was very limited evidence looking at different intensities of psychological therapy which showed clinically important benefits of higher intensity therapy in health-related quality of life and psychological distress, but this was based on one study and therefore insufficient to draw any conclusions.

Rationale for research recommendation

Importance to 'patients' or the population	The delivery of psychological services is critical to a large proportion of stroke survivors who may experience difficulties with mood, language, attention and memory. Greater intensities of psychological therapy may lead to better patient outcomes. In the qualitative review one the key findings was 'more therapy is better' indicating that this is a key priority for patients and careers who feel they will benefit from increased intensities of therapy.
Relevance to NICE guidance	The majority of evidence presented in this review looked at rehabilitation delivered by physiotherapists and there was limited evidence for greater intensities of psychological

	interventions. Identifying if increased intensities of psychological rehabilitation improve clinical outcomes and cost-effectiveness will help to answer the initial question from the review and inform future NICE guidance on psychological and cognitive therapy delivery.
Relevance to the NHS	This will be particularly relevant to the NHS as delivering higher intensity care model for stroke rehabilitation is part of the NHS long term plan to ensure patients receive consistent high quality care. This will help determine if psychological therapies delivered at higher intensities result in better clinical outcomes and to assess if it is cost effective.
National priorities	Developing high intensity care models for stroke rehabilitation is an aim in the NHS Long Term Plan and a national priority.
Current evidence base	The evidence identified in this review investigated the intensity of different types of rehabilitation delivered by any member of the MDT team. One study was available specifically looking at greater intensities of psychological or cognitive rehabilitation.
Equality considerations	No specific equality considerations were identified. The committee noted that in general throughout the guideline, people with communication difficulties, older people and people who have had a previous stroke or transient ischaemic attack were excluded from trials but are people that the guideline is for. Therefore, research should aim to include these people where possible.

L.2.2 Modified PICO table

Population	Inclusion: • Adults (age ≥16 years) who have had a first or recurrent stroke (including people after subarachnoid haemorrhage) and would benefit from cognitive or psychological therapies Exclusion: • Children (age <16 years) • People who have had a transient ischaemic attack
Intervention	Psychology/neuropsychology (inpatient and outpatient) delivered by a clinical psychologist or neuropsychologist: • Minutes/Hours of rehabilitation per day (24 hour period) o ≤45 minutes o >45 minutes to 1 hour o >1-2 hours

Comparator	Different numbers of minutes/hours of rehabilitation per day No treatment (waiting list control)
Outcome	At time period • <6 months • ≥6 months • Person/participant generic health-related quality of life • Carer generic health-related quality of life • Stroke outcome - modified Rankin scale • Stroke-related scales of cognition (continuous outcomes will be prioritised) (including non-spatial attention and working memory, spatial attention, memory and executive function scores) • Psychological distress (depression, anxiety and distress) • Discontinuation from study
Study design	Randomised controlled trial
Timeframe	6 months
Additional information	Subgroup analyses: • Time after stroke at the start of the trial: (hyperacute, acute, subacute, chronic)

L.3 Research recommendation

What is the clinical and cost-effectiveness of more intense swallowing therapy compared to usual care for people after a stroke?

L.3.1 Why this is important

Dysphagia affects a large number of stroke survivors and can result in increased morbidity and mortality. Swallowing therapy delivered by speech and language therapists aim to improve swallowing function and reduce the risk of aspiration. As part of the NHS long term plan there is an initiative to deliver higher intensity care models for stroke rehabilitation. Evidence from the clinical review indicated that higher intensities of physiotherapy rehabilitation between 1-2 hours were more clinically and cost effective than therapy delivered at lower intensities. However, there was very limited evidence available which looked at different intensities of speech and language therapy and this was insufficient to draw any conclusions. Higher intensities of rehabilitation were also supported by qualitative evidence which showed that the majority of stroke survivors believed that ‘more therapy is better’.

Rationale for research recommendation

Importance to ‘patients’ or the population	Post-stroke dysphagia affects a large proportion of stroke survivors and can greatly impact health-related quality of life and mortality. Greater intensities of swallowing therapy may lead to better outcomes. In the qualitative review one the key findings was ‘more therapy is better’ indicating that this is a key priority for patients

	and careers who feel they will benefit from increased intensities of therapy.
Relevance to NICE guidance	The majority of evidence presented in this review looked at rehabilitation delivered by physiotherapists and there was very limited evidence for greater intensities of swallowing therapy. Identifying if increased intensities of swallowing therapy improve clinical outcomes and cost effectiveness will help to answer the initial question from the review and help future NICE guidance specify the optimal intensity of swallowing therapy.
Relevance to the NHS	This will be relevant to the NHS as delivering higher intensity care model for stroke rehabilitation is part of the NHS long term plan to ensure patients receive consistent high quality care. This will help determine if swallowing therapy delivered at higher intensities is clinically and cost effective.
National priorities	Developing high intensity care models for stroke rehabilitation is an aim in the NHS Long Term Plan and a national priority.
Current evidence base	The evidence identified in this review investigated the intensity of different types of rehabilitation delivered by any member of the multidisciplinary team. Very limited evidence was available specifically looking at greater intensities of swallowing therapy.
Equality considerations	No specific equality considerations were identified. The committee noted that in general throughout the guideline, people with communication difficulties, older people and people who have had a previous stroke or transient ischaemic attack were excluded from trials but are people that the guideline is for. Therefore, research should aim to include these people where possible.

L.3.2 Modified PICO table

Population	Inclusion: • Adults (age ≥16 years) who have had a first or recurrent stroke (including people after subarachnoid haemorrhage) and require swallowing therapy. Exclusion: • Children (age <16 years) • People who have had a transient ischaemic attack • People with mechanical dysphagia • People with other pre-existing neurological conditions causing dysphagia
Intervention	Swallowing therapy delivered as inpatients or outpatients. This may be delivered by a speech and language therapist, or by speech and

	language therapy assistants, family members or may include patient practice::
	• Minutes/Hours of rehabilitation per day (24 hour period)
	  ○ ≤45 minutes
	  ○ >45 minutes to 1 hour
	  ○ >1-2 hours

Comparator	Different numbers of minutes/hours of rehabilitation per day
Outcome	At time period • <6 months • ≥6 months • Mortality • Person/participant generic health-related quality of life • Carer generic health-related quality of life • Occurrence of chest infections • Occurrence of aspiration • Dysphagia present/Return to normal diet • Discharge to residential service • Length of hospital stay • Re-admission • Nutrition • Hydration • Swallow function and ability • Discontinuation from study
Study design	Randomised controlled trial
Timeframe	6 months
Additional information	Subgroup analyses: • Time after stroke at the start of the trial: (hyperacute, acute, subacute, chronic) • People requiring enteral feeding support at baseline

Appendix M – Mixed methods analysis summary matrices

M.1 Explanation

Summary matrices compare studies reporting a specific intensity of the intervention reported in the quantitative studies (stated on the horizontal header row) and the themes and subthemes identified in the qualitative studies (stated on the vertical first column). Rows in dark grey are themes that relate to the subthemes used for the comparisons. Y is stated when studies appear to consider the qualitative subtheme (with superscript numbers as citations to the relevant quantitative studies). N is stated when there are no studies for this comparison that appear to consider this qualitative subtheme. An asterisk is used when at least one study included in this intensity category are compared to usual care, and therefore the amount of therapy provided may be greater than that stated (as it will be in addition to usual care).

M.2 Physiotherapy

Table 51: Summary matrix comparing the effectiveness evidence for physiotherapy interventions to the themes identified in the qualitative evidence

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Key principles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
More therapy is better	N	N	N	N	N	N	N	N	N	Y*[127]	Y[120]	N	N	N	N	N	N	N	N	N
Person centred care: Intensity	Y*[124, 134]	Y*[30, 122, 138]	Y*[65]	N	N	Y[104]	N	Y[2]	Y[115, 119]	Y*[1, 10, 49, 106, 126,]	Y[3, 120]	N	N	Y[44]	N	N	N	Y[130, 133]	N	N

Number minutes and hours per day and number of days per week of therapy	**≤45 minutes <5 d/wk**	**≤45 minutes 5 d/wk**	**≤45 minutes 6 d/wk**	**≤45 minutes 7 d/wk**	**>45 minutes to 1 hour <5 d/wk**	**>45 minutes to 1 hour 5 d/wk**	**>45 minutes to 1 hour 6 d/wk**	**>45 minutes to 1 hour 7 d/wk**	**>1 hour to 2 hours <5 d/wk**	**>1 hour to 2 hours 5 d/wk**	**>1 hour to 2 hours 6 d/wk**	**>1 hour to 2 hours 7 d/wk**	**>2 hours to 4 hours <5 d/wk**	**>2 hours to 4 hours 5 d/wk**	**>2 hours to 4 hours 6 d/wk**	**>2 hours to 4 hours 7 d/wk**	**>4 hours <5 d/wk**	**>4 hours 5 d/wk**	**>4 hours 6 d/wk**	**>4 hours 7 d/wk**
tailored to the individual										127, 134										
Person centred care: Intensity tailored to the individual (splitting therapy time during the day)	N	N	N	N	N	Y[44, 67]	N	N	N	Y[38, 44, 49, 61]	N	N	N	Y[38, 44, 136]	N	N	N	N	N	N
Duration of therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical status	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Fatigue	N	N	N	N	N	Y[44, 97]	N	N	N	Y[1, 38, 44, 134]	Y[120]	N	N	Y[38, 44, 136]	Y[39]	N	N	N	N	N
Physical factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Psychological factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	**≤45 minutes <5 d/wk**	**≤45 minutes 5 d/wk**	**≤45 minutes 6 d/wk**	**≤45 minutes 7 d/wk**	**>45 minutes to 1 hour <5 d/wk**	**>45 minutes to 1 hour 5 d/wk**	**>45 minutes to 1 hour 6 d/wk**	**>45 minutes to 1 hour 7 d/wk**	**>1 hour to 2 hours <5 d/wk**	**>1 hour to 2 hours 5 d/wk**	**>1 hour to 2 hours 6 d/wk**	**>1 hour to 2 hours 7 d/wk**	**>2 hours to 4 hours <5 d/wk**	**>2 hours to 4 hours 5 d/wk**	**>2 hours to 4 hours 6 d/wk**	**>2 hours to 4 hours 7 d/wk**	**>4 hours <5 d/wk**	**>4 hours 5 d/wk**	**>4 hours 6 d/wk**	**>4 hours 7 d/wk**
Motivation	N	Y*[138]	N	N	N	N	N	N	Y[56]	Y*[127]	N	N	N	N	N	N	N	N	N	N
Social factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Education	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People requiring specific consideration	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
People with communication difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People with cognitive difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Carer/family member factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Support of family and friends	Y*[124]	Y*[30]	N	N	N	Y[44]	N	Y[2]	N	Y[44]	N	N	Y[45]	Y[44]	N	N	N	N	N	N
Continuity of care	Y*[124]	Y*[30]	N	N	N	N	N	Y[2]	N	N	N	N	Y[45]	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Healthcare professional factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Beliefs about intensity of rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Communication	N	N	N	N	N	Y[44]	N	N	N	Y[44]	N	N	N	Y[44]	N	N	N	N	N	N
Feedback	Y*[124]	N	N	N	N	N	N	N	N	Y*[127, 134]	N	N	N	N	N	N	N	Y*[130]	N	N
Confidence	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Safety	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Prioritisation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Consistency in care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors - Methods of achieving more intense rehabilitation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Individual therapy	Y*[34, 124, 135]	Y*[30, 62, 89,]	Y*[65, 75]	Y[28]	Y[27]	Y[29, 44, 55, 67, 69,]	N	Y[2]	Y[5, 21, 43,]	Y[1, 10, 28,]	Y[3, 120]	N	N	Y[38, 44, 45,]	Y[39]	N	N	Y*[102,]	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
		122, 138				82, 83, 89, 97, 100, 101, 104			56, 58, 115, 119	35, 38, 44, 46, 49, 50, 57, 60, 61, 66, 71, 98, 99, 103, 105, 106, 108, 126, 127, 134				47, 136				130, 133		
Group-based therapy	N	N	Y[75]	Y[28]	N	Y[118]	N	N	N	Y[28]	N	N	N	N	N	N	N	N	N	N
‘Homework’/ self management interventions	Y*[124]	Y*[30]	Y[75]	N	N	Y[67]	N	Y[2]	N	N	Y[3, 120]	N	N	Y[45, 136]	Y[39]	N	N	Y[130]	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Telerehabilitation, assistive technology and computer-based tools	Y*[124]	Y*[62, 138]	N	N	N	Y[29, 69, 82, 97, 100]	N	N	Y[5, 56]	Y[46, 49, 50, 71, 105, 118, 126, 134]	N	N	N	N	N	N	N	N	N	N
Seven-day working	N	N	N	Y[28]	N	N	N	Y[2]	N	Y[28]	N	N	N	N	N	N	N	N	N	N
Longer term rehabilitation	N	N	N	N	N	N	N	Y[2]	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Increased opportunity for social stimulation	N	N	N	N	N	N	N	N	N	Y[118]	N	N	N	N	N	N	N	N	N	N
Variety in activities and choice	N	Y*[138]	N	N	N	Y[82, 97]	N	Y[2]	Y[56]	Y[46, 50]	N	N	N	N	N	N	N	N	N	N
Level of person centred care	N	Y*[30]	N	N	N	N	N	N	N	N	N	N	N	Y[45]	N	N	N	N	N	N
Provision of feedback	N	N	N	N	N	N	N	N	Y[43]	Y*[49, 60, 108,]	N	N	N	N	Y[39]	N	N	Y*[130]	N	N

Number minutes and hours per day and number of days per week of therapy	**≤45 minutes <5 d/wk**	**≤45 minutes 5 d/wk**	**≤45 minutes 6 d/wk**	**≤45 minutes 7 d/wk**	**>45 minutes to 1 hour <5 d/wk**	**>45 minutes to 1 hour 5 d/wk**	**>45 minutes to 1 hour 6 d/wk**	**>45 minutes to 1 hour 7 d/wk**	**>1 hour to 2 hours <5 d/wk**	**>1 hour to 2 hours 5 d/wk**	**>1 hour to 2 hours 6 d/wk**	**>1 hour to 2 hours 7 d/wk**	**>2 hours to 4 hours <5 d/wk**	**>2 hours to 4 hours 5 d/wk**	**>2 hours to 4 hours 6 d/wk**	**>2 hours to 4 hours 7 d/wk**	**>4 hours <5 d/wk**	**>4 hours 5 d/wk**	**>4 hours 6 d/wk**	**>4 hours 7 d/wk**
										[127, 134]										
Travel time	Y*[34]	N	N	N	N	N	N	N	N	Y[49]	N	N	N	N	N	N	N	N	N	N
Need for technical support and training	N	Y*[30]	N	N	N	Y[69, 82, 99]	N	N	N	Y[49, 126]	N	N	N	N	N	N	N	Y*[130]	N	N
Physical environment	N	N	N	N	N	Y[82, 99]	N	N	N	Y[46, 49, 50]	N	N	N	N	N	N	N	N	N	N
Goal setting	N	Y*[30]	N	N	N	N	N	Y[2]	N	Y[103]	N	N	N	Y[45]	N	N	N	N	N	N
Use of expensive/additional equipment	N	Y[62, 138]	N	N	N	Y[29, 69, 82, 97, 100]	N	N	Y[5, 56]	Y[46, 49, 50, 60, 71, 105, 108, 118, 126, 134]	N	N	N	N	N	N	N	N	N	N
Meaningful activities	N	N	N	N	N	Y[104]	N	N	N	Y*[105, 127]	N	N	N	N	N	N	N	Y[133]	N	N
Environmental factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Hospital care	Y*[124, 135]	Y*[30, 62, 122, 138]	Y*[65, 75]	Y[28]	Y[27]	Y[29, 44, 55, 67, 82, 83, 89, 97, 100, 101, 104]	N	N	Y[5, 21, 43, 56, 58, 115, 119]	Y*[1, 10, 28, 35, 38, 44, 46, 49, 50, 57, 60, 61, 66, 71, 98, 99, 103, 105, 106, 108, 118, 126, 127, 134]	Y[120]	N	N	Y[38, 44, 45, 47]	Y[39]	N	N	Y*[102, 130, 133]	N	N
Home	Y*[34, 124, 135]	Y*[30]	Y[75]	N	N	N	N	Y[2]	N	N	Y[3, 120]	N	N	Y[45]	Y[39]	N	N	Y*[130]	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Enriched/adapted environment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Accessible therapy	N	N	N	N	N	N	N	N	N	N	Y[3]	N	N	N	N	N	N	N	N	N
Supervision	Y*[135]	Y*[30]	N	N	N	Y[104]	N	N	Y[115]	Y[106, 126, 134]	Y[120]	N	N	Y[136]	N	N	N	N	N	N
Service factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Time spent in information exchange	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Time spent in other non-patient contact activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Staffing levels and deployment	N	N	N	Y[28]	N	N	N	N	N	Y[28]	N	N	N	N	N	N	N	N	N	N
Seven day working	N	N	N	Y[28]	N	N	N	Y[2]	N	Y[28]	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	**≤45 minutes <5 d/wk**	**≤45 minutes 5 d/wk**	**≤45 minutes 6 d/wk**	**≤45 minutes 7 d/wk**	**>45 minutes to 1 hour <5 d/wk**	**>45 minutes to 1 hour 5 d/wk**	**>45 minutes to 1 hour 6 d/wk**	**>45 minutes to 1 hour 7 d/wk**	**>1 hour to 2 hours <5 d/wk**	**>1 hour to 2 hours 5 d/wk**	**>1 hour to 2 hours 6 d/wk**	**>1 hour to 2 hours 7 d/wk**	**>2 hours to 4 hours <5 d/wk**	**>2 hours to 4 hours 5 d/wk**	**>2 hours to 4 hours 6 d/wk**	**>2 hours to 4 hours 7 d/wk**	**>4 hours <5 d/wk**	**>4 hours 5 d/wk**	**>4 hours 6 d/wk**	**>4 hours 7 d/wk**
Influence of external audit	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of therapy timetabling	N	N	N	N	N	Y[44]	N	N	N	Y[44]	N	N	N	Y[44]	N	N	N	N	N	N
Dedicated stroke care, staff training and expertise	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
An emphasis on discharge planning versus treatment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Transition from hospital care to community-based stroke rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

** = At least one of the studies included in this comparison compare to usual care, and so therapy may have been provided for additional time beyond that stated*

M.3 Occupational Therapy

Table 52: Summary matrix comparing the effectiveness evidence for occupational therapy interventions to the themes identified in the qualitative evidence

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Key principles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
More therapy is better	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual	Y*[91]	N	N	N	N	N	N	N	N	Y[63]	N	N	N	N	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual (splitting therapy time during the day)	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Duration of therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	**≤45 minutes <5 d/wk**	**≤45 minutes 5 d/wk**	**≤45 minutes 6 d/wk**	**≤45 minutes 7 d/wk**	**>45 minutes to 1 hour <5 d/wk**	**>45 minutes to 1 hour 5 d/wk**	**>45 minutes to 1 hour 6 d/wk**	**>45 minutes to 1 hour 7 d/wk**	**>1 hour to 2 hours <5 d/wk**	**>1 hour to 2 hours 5 d/wk**	**>1 hour to 2 hours 6 d/wk**	**>1 hour to 2 hours 7 d/wk**	**>2 hours to 4 hours <5 d/wk**	**>2 hours to 4 hours 5 d/wk**	**>2 hours to 4 hours 6 d/wk**	**>2 hours to 4 hours 7 d/wk**	**>4 hours <5 d/wk**	**>4 hours 5 d/wk**	**>4 hours 6 d/wk**	**>4 hours 7 d/wk**
Medical status	N	Y*[59]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Fatigue	Y*[91]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Physical factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Psychological factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Motivation	Y*[91]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Social factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Education	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People requiring specific consideration	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
People with communication difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People with cognitive difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Carer/family member factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Support of family and friends	N	N	N	N	N	N	N	N	N	N	N	N	N	Y[23]	N	N	N	N	N	N
Continuity of care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Healthcare professional factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Beliefs about intensity of rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Communication	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Feedback	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Confidence	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Safety	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Prioritisation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Consistency in care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors - Methods of achieving more intense	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	**≤45 minutes <5 d/wk**	**≤45 minutes 5 d/wk**	**≤45 minutes 6 d/wk**	**≤45 minutes 7 d/wk**	**>45 minutes to 1 hour <5 d/wk**	**>45 minutes to 1 hour 5 d/wk**	**>45 minutes to 1 hour 6 d/wk**	**>45 minutes to 1 hour 7 d/wk**	**>1 hour to 2 hours <5 d/wk**	**>1 hour to 2 hours 5 d/wk**	**>1 hour to 2 hours 6 d/wk**	**>1 hour to 2 hours 7 d/wk**	**>2 hours to 4 hours <5 d/wk**	**>2 hours to 4 hours 5 d/wk**	**>2 hours to 4 hours 6 d/wk**	**>2 hours to 4 hours 7 d/wk**	**>4 hours <5 d/wk**	**>4 hours 5 d/wk**	**>4 hours 6 d/wk**	**>4 hours 7 d/wk**
rehabilitation																				
Individual therapy	Y*[33, 91]	Y*[59, 88]	N	N	N	Y[70, 78, 85, 96]	N	N	N	Y[15, 24, 42, 54, 63, 73, 96]	N	N	N	Y[23]	N	N	N	N	N	N
Group-based therapy	N	N	N	N	N	N	N	N	N	Y[42]	N	N	N	N	N	N	N	N	N	N
'Homework'/ self management interventions	Y*[33]	N	N	N	N	Y[96]	N	N	N	Y[24, 96]	N	N	N	Y[23]	N	N	N	N	N	N
Telerehabilitation, assistive technology and computer-based tools	Y*[91]	Y*[59, 88]	N	N	N	Y[70, 78]	N	N	N	Y[15, 42, 63, 73]	N	N	N	N	N	N	N	N	N	N
Seven-day working	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Longer term rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Increased opportunity for social stimulation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Variety in activities and choice	N	N	N	N	N	Y[70]	N	N	N	Y[15, 63]	N	N	N	N	N	N	N	N	N	N
Level of person centred care	N	N	N	N	N	N	N	N	N	Y[63]	N	N	N	N	N	N	N	N	N	N
Provision of feedback	N	N	N	N	N	N	N	N	N	Y[42]	N	N	N	N	N	N	N	N	N	N
Travel time	N	N	N	N	N	N	N	N	N	N	N	N	N	Y[23]	N	N	N	N	N	N
Need for technical support and training	N	N	N	N	N	N	N	N	N	Y[63]	N	N	N	Y[23]	N	N	N	N	N	N
Physical environment	N	N	N	N	N	Y[78]	N	N	N	Y[15, 63]	N	N	N	Y[23]	N	N	N	N	N	N
Goal setting	Y*[33]	N	N	N	N	Y[96]	N	N	N	Y[96]	N	N	N	N	N	N	N	N	N	N
Use of expensive/additional equipment	Y*[91]	Y*[59, 88]	N	N	N	Y[70, 78]	N	N	N	Y[15, 42, 63, 73]	N	N	N	N	N	N	N	N	N	N
Meaningful activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Environmental factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hospital care	Y*[91]	Y*[59, 88]	N	N	N	Y[70, 78, 85]	N	N	N	Y[15, 42, 54, 63, 73]	N	N	N	Y[23]	N	N	N	N	N	N
Home	Y*[33]	N	N	N	N	Y[96]	N	N	N	Y[96]	N	N	N	N	N	N	N	N	N	N
Enriched/adapted environment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Accessible therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Supervision	N	N	N	N	N	N	N	N	N	Y[15, 63]	N	N	N	Y[23]	N	N	N	N	N	N
Service factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Time spent in information exchange	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Time spent in other non-patient contact activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Staffing levels and deployment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Seven day working	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Influence of external audit	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of therapy timetabling	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Dedicated stroke care, staff training and expertise	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
An emphasis on discharge planning versus treatment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Transition from hospital care to community-based stroke rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

* = At least one of the studies included in this comparison compare to usual care, and so therapy may have been provided for additional time beyond that stated

M.4 Speech and Language Therapy

Table 53: Summary matrix comparing the effectiveness evidence for speech and language therapy interventions to the themes identified in the qualitative evidence

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Key principles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
More therapy is better	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual	N	N	N	N	N	Y[4]	N	N	N	N	N	N	N	Y[129]	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual (splitting therapy time during the day)	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Duration of therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical status	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Fatigue	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Physical factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Psychological factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Motivation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Social factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Education	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People requiring specific consideration	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
People with communication difficulties	N	N	N	N	N	Y[4, 26, 36]	N	N	Y[52]	Y[77, 94]	N	N	Y[112]	Y[129]	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
People with cognitive difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Carer/family member factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Support of family and friends	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Continuity of care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Healthcare professional factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Beliefs about intensity of rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Communication	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Feedback	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Confidence	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Safety	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Prioritisation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Consistency in care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Intervention factors - Methods of achieving more intense rehabilitation	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Individual therapy	N	N	N	Y[11]	N	Y[4, 26, 36]	N	N	Y[52]	Y[77, 94]	N	N	Y[112]	N	N	N	N	N	N	N
Group-based therapy	N	N	N	N	N	N	N	N	N	N	N	N	Y[112]	Y[129]	N	N	N	N	N	N
‘Homework’/ self management interventions	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Telerehabilitation, assistive technology and computer-based tools	N	N	N	N	N	N	N	N	Y[52]	Y[94]	N	N	N	N	N	N	N	N	N	N
Seven-day working	N	N	N	Y[11]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Longer term rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	**≤45 minutes <5 d/wk**	**≤45 minutes 5 d/wk**	**≤45 minutes 6 d/wk**	**≤45 minutes 7 d/wk**	**>45 minutes to 1 hour <5 d/wk**	**>45 minutes to 1 hour 5 d/wk**	**>45 minutes to 1 hour 6 d/wk**	**>45 minutes to 1 hour 7 d/wk**	**>1 hour to 2 hours <5 d/wk**	**>1 hour to 2 hours 5 d/wk**	**>1 hour to 2 hours 6 d/wk**	**>1 hour to 2 hours 7 d/wk**	**>2 hours to 4 hours <5 d/wk**	**>2 hours to 4 hours 5 d/wk**	**>2 hours to 4 hours 6 d/wk**	**>2 hours to 4 hours 7 d/wk**	**>4 hours <5 d/wk**	**>4 hours 5 d/wk**	**>4 hours 6 d/wk**	**>4 hours 7 d/wk**
Intervention factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Increased opportunity for social stimulation	N	N	N	N	N	Y[26]	N	N	N	N	N	N	Y[112]	Y[129]	N	N	N	N	N	N
Variety in activities and choice	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Level of person centred care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Provision of feedback	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Travel time	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Need for technical support and training	N	N	N	N	N	N	N	N	N	Y[94]	N	N	N	N	N	N	N	N	N	N
Physical environment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Goal setting	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of expensive/additional equipment	N	N	N	N	N	N	N	N	Y[52]	Y[94]	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Meaningful activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Environmental factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hospital care	N	N	N	Y[11]	N	Y[4, 26, 36]	N	N	Y[52]	Y[77]	N	N	Y[112]	N	N	N	N	N	N	N
Home	N	N	N	N	N	Y[4]	N	N	N	Y[94]	N	N	N	N	N	N	N	N	N	N
Enriched/adapted environment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Accessible therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Supervision	N	N	N	N	N	N	N	N	N	Y[94]	N	N	N	N	N	N	N	N	N	N
Service factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Time spent in information exchange	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Time spent in other non-patient contact activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Staffing levels and deployment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Seven day working	N	N	N	Y[11]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Influence of external audit	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of therapy timetabling	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Dedicated stroke care, staff training and expertise	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
An emphasis on discharge planning versus treatment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Transition from hospital care to community-based stroke rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

M.5 Psychology/neuropsychology

Table 54: Summary matrix comparing the effectiveness evidence for psychology/neuropsychology interventions to the themes identified in the qualitative evidence

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Key principles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
More therapy is better	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual	N	N	N	N	Y*[117]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual (splitting therapy time during the day)	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Duration of therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Person factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical status	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Fatigue	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Physical factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Psychological factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Motivation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Social factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Education	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People requiring specific consideration	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
People with communication difficulties	N	N	N	N	Y*[117]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People with cognitive difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Carer/family member factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Support of family and friends	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Continuity of care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Healthcare professional factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Beliefs about intensity of rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Communication	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Feedback	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Confidence	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Safety	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Prioritisation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Consistency in care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors - Methods of	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
achieving more intense rehabilitation																				
Individual therapy	N	N	N	N	Y*[117]	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Group-based therapy	N	N	N	N	N	N	N	N	Y*[74]	N	N	N	N	Y[64]	N	N	N	N	N	N
'Homework'/ self management interventions	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Telerehabilitation, assistive technology and computer-based tools	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Seven-day working	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Longer term rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Increased opportunity for social stimulation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Variety in activities and choice	N	N	N	N	N	N	N	N	N	N	N	N	N	Y[64]	N	N	N	N	N	N
Level of person centred care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Provision of feedback	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Travel time	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Need for technical support and training	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Physical environment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Goal setting	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of expensive/additional equipment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Meaningful activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Environmental factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hospital care	N	N	N	N	Y*[117]	N	N	N	N	N	N	N	N	Y[64]	N	N	N	N	N	N
Home	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Enriched/adapted environment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Accessible therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Supervision	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Service factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Time spent in information exchange	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Time spent in other non-patient contact activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Staffing levels and deployment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Seven day working	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Influence of external audit	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of therapy timetabling	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Dedicated stroke care, staff training and expertise	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
An emphasis on discharge planning versus treatment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Transition from hospital care to community-based stroke rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

** = At least one of the studies included in this comparison compare to usual care, and so therapy may have been provided for additional time beyond that stated*

M.6 Multidisciplinary team

Table 55: Summary matrix comparing the effectiveness evidence for multidisciplinary team interventions to the themes identified in the qualitative evidence

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Key principles	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
More therapy is better	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person centred care: Intensity tailored to the individual (splitting therapy time during the day)	N	N	N	N	N	N	N	N	N	Y[110]	N	N	N	N	N	N	N	N	N	N
Duration of therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Person factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Medical status	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Fatigue	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Physical factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Psychological factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Motivation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Social factors	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Education	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People requiring specific consideration	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
People with communication difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
People with cognitive difficulties	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Carer/family member factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Support of family and friends	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Continuity of care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Healthcare professional factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Beliefs about intensity of rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Communication	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Feedback	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Confidence	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Safety	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Prioritisation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Consistency in care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors - Methods of achieving more intense	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
rehabilitation																				
Individual therapy	N	N	N	N	N	N	N	N	N	Y*[8, 72, 110, 111]	N	N	N	N	N	N	N	Y[53]	N	N
Group-based therapy	N	N	N	N	N	N	N	N	N	Y[111]	N	N	Y*[95]	N	N	N	N	Y[53]	N	N
‘Homework’/self management interventions	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y[53]	N	N
Telerehabilitation, assistive technology and computer-based tools	N	N	N	N	N	N	N	N	N	Y[8, 72]	N	N	N	N	N	N	N	N	N	N
Seven-day working	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Longer term rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Intervention factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Increased opportunity	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
for social stimulation																				
Variety in activities and choice	N	N	N	N	N	N	N	N	N	N	N	N	Y*[95]	N	N	N	N	Y[53]	N	N
Level of person centred care	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Provision of feedback	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Travel time	N	N	N	N	N	N	N	N	N	Y[72]	N	N	N	N	N	N	N	N	N	N
Need for technical support and training	N	N	N	N	N	N	N	N	N	Y[72]	N	N	N	N	N	N	N	N	N	N
Physical environment	N	N	N	N	N	N	N	N	N	Y[72]	N	N	N	N	N	N	N	N	N	N
Goal setting	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of expensive/additional equipment	N	N	N	N	N	N	N	N	N	Y[72]	N	N	N	N	N	N	N	N	N	N
Meaningful activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Environmental factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Hospital care	N	N	N	N	N	N	N	N	N	Y*[8, 72, 110, 111]	N	N	N	N	N	N	N	N	N	N
Home	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Enriched/adapted environment	N	N	N	N	N	N	N	N	N	Y[15]	N	N	N	N	N	N	N	N	N	N
Accessible therapy	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Supervision	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Service factors	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Time spent in information exchange	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Time spent in other non-patient contact activities	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Staffing levels and deployment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Seven day working	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

Number minutes and hours per day and number of days per week of therapy	≤45 minutes <5 d/wk	≤45 minutes 5 d/wk	≤45 minutes 6 d/wk	≤45 minutes 7 d/wk	>45 minutes to 1 hour <5 d/wk	>45 minutes to 1 hour 5 d/wk	>45 minutes to 1 hour 6 d/wk	>45 minutes to 1 hour 7 d/wk	>1 hour to 2 hours <5 d/wk	>1 hour to 2 hours 5 d/wk	>1 hour to 2 hours 6 d/wk	>1 hour to 2 hours 7 d/wk	>2 hours to 4 hours <5 d/wk	>2 hours to 4 hours 5 d/wk	>2 hours to 4 hours 6 d/wk	>2 hours to 4 hours 7 d/wk	>4 hours <5 d/wk	>4 hours 5 d/wk	>4 hours 6 d/wk	>4 hours 7 d/wk
Influence of external audit	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Use of therapy timetabling	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Dedicated stroke care, staff training and expertise	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
An emphasis on discharge planning versus treatment	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
Transition from hospital care to community-based stroke rehabilitation	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

** = At least one of the studies included in this comparison compare to usual care, and so therapy may have been provided for additional time beyond that stat*

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