National Institute for Health and Care Excellence

Final

Stroke rehabilitation in adults (update)

[E1] 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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1 Intensity of rehabilitation

1.1 Review question

In people after stroke, what is the clinical and cost effectiveness of more intensive rehabilitation compared with standard rehabilitation?

This question includes two subquestions:

- In people after stroke, what is the clinical and cost effectiveness of more intensive rehabilitation compared with standard rehabilitation?
- In people after stroke what factors are associated with effective delivery of more intensive rehabilitation?

This review is split into five documents:

- 3.1 intensity of rehabilitation A introduction and quantitative
- 3.1 intensity of rehabilitation B qualitative, mixed methods and committee discussion
- 3.1 intensity of rehabilitation C appendix A to E (protocol, study selection diagrams, quantitative and qualitative evidence tables)
- 3.1 intensity of rehabilitation D appendix F to M (results, forest plots, GRADE and GRADE CerQUAL tables, excluded studies, research recommendations)
- 3.1 intensity of rehabilitation E quantitative evidence – economic sections only (included and excluded studies, unit costs, evidence statements)

1.1.1 Introduction

The primary goal of rehabilitation is to improve quality of life and maximise recovery post stroke. There is growing evidence demonstrating improved outcomes with greater intensity of therapy. It is recognised motor, cognitive and communication therapy is key to optimise recovery but there is a lack of consensus regarding the specific quantity and dose of individual therapies and how long they should be provided for. There is also lack of clarity regarding the type of therapy which has the greatest effect.

The current recommendations for physiotherapy, occupational and speech and language therapy is a minimum of 45 minutes a day, 5 days a week for those people who have the ability to participate, and where functional goals can be achieved. However national audit data and research shows this is rarely achieved in practice. This review aims to determine the clinical and cost effectiveness of more intensive rehabilitation compared with standard rehabilitation and to understand the elements and factors associated with effective delivery of more intensive rehabilitation.

1.1.2 Summary of the protocol

Table 1: PICO characteristics of review question

Population	Inclusion:
	• Adults (age ≥16 years) who have had a first or recurrent stroke (including people with communication difficulties)
	  ○ Without communication difficulties
	  ○ With communication difficulties
	• Family members of adults who have had a first or recurrent stroke
	• Carers supporting adults after a first or recurrent stroke

	• Healthcare professionals supporting adults after a first or recurrent stroke • Voluntary sector professionals supporting adults after a first or recurrent stroke Exclusion: • Children (age <16 years) • People who have had a transient ischaemic attack

Interventions	Quantitative data
	• Rehabilitation (inpatient and outpatient) therapy/therapies delivered by any members of a multidisciplinary team at different intensities
	  ○ Stratified by two categories:
	  ○ Minutes/Hours of rehabilitation per day (24 hour period)*
	  – ≤45 minutes
	  – >45 minutes to 1 hour
	  – >1-2 hours
	  – >2-4 hours
	  – >4 hours
	  ○ Number of days of treatment per week
	  – <5 days a week
	  – 5 days a week
	  – 6 days a week
	  – 7 days a week
	*Where an intervention does not compare the number of minutes/hours or rehabilitation per day directly, an average number of minutes/hours per day will be calculated from the available information and included in the relevant category as indirect evidence.
	
	Qualitative data
	Views, opinions and experiences relating to how intensively rehabilitation should be delivered (including the potential barriers and facilitators)
	Themes will be gathered from the evidence identified for this review and not stated prior to this. Topics may include (but will not be limited to):
	• When, how often and for how long intensive rehabilitation should be available for
	• Barriers to completing more intensive rehabilitation
	• Facilitators to completing more intensive rehabilitation

Comparisons	Quantitative data • Different numbers of minutes/hours of rehabilitation per day • Different numbers of days of treatment per week • Different numbers of minutes/hours of rehabilitation per day and different numbers of days of treatment per week (only used where both the number of minutes/hours per day and days of treatment per week changes) • Usual care** Usual care is only to be used when a) usual care is offered to both study arms (therefore, investigating the effect of an additional intervention that will require additional time), b) a study does not define the number of hours/days per week of the control intervention but defines the intervention offered as usual care.

	Confounding factors (for non-randomised studies only): • Presence of comorbidities • Stroke severity • Age • Time period since stroke Qualitative data N/A

Outcomes	All outcomes are considered equally important for decision making and therefore have all been rated as critical:
	At time period:
	• <6 months
	• ≥6 months
	
	If multiple outcomes are reported before or after these time period then the latest time period that is ≤6 months or >6 months will be extracted and used in the analysis.
	
	• Person/participant health-related quality of life (continuous outcomes will be prioritised [validated measures])
	• Carer generic health-related quality of life (continuous outcomes will be prioritised [validated measures])
	• Stroke outcome - modified Rankin scale (continuous outcome)
	• Activities of daily living (continuous outcomes will be prioritised)
	• Physical function (continuous outcomes will be prioritised)
	  ○ Physical function – upper limb
	  ○ Physical function – lower limb
	• Communication (continuous outcomes will be prioritised)
	  ○ Overall language ability
	  ○ Impairment specific measures
	  – Naming
	  – Auditory comprehension
	  – Reading
	  – Expressive language
	  – Dysarthria speech impairment
	  ○ Functional communication
	• Psychological distress (continuous outcomes will be prioritised)
	  ○ Depression (if people have communication difficulties, measures specific to this difficulty will be prioritised)
	• Stroke-related scale of cognition (continuous outcomes will be prioritised)
	  ○ Non-spatial attention and working memory
	  ○ Spatial attention
	  ○ Memory
	  ○ Executive functions
	• Swallow function and ability (continuous outcome)
	• Discontinuation from study (dichotomous outcomes)
	
	If not mentioned above, other validated scores will be considered and discussed with the committee to deliberate on their inclusion.

	Themes will be gathered from the evidence identified for this review and not stated prior to this. Topics may include (but will not be limited to): • When, how often and for how long intensive rehabilitation should be available for • Barriers to completing more intensive rehabilitation • Facilitators to completing more intensive rehabilitation

Study design	Quantitative data
	• Systematic reviews of RCTs
	• Parallel RCTs
	• Cluster randomised trials
	• Cluster randomised crossover trials (unit of randomisation = stroke unit)
	• Crossover trials (for people after chronic stroke only)
	• Non-randomised studies (if insufficient RCT evidence is available)
	  ○ Prospective cohort studies
	  ○ Retrospective cohort studies
	Published NMAs and IPDs will be considered for inclusion.
	
	Non-randomised studies will only be included if all of the key confounders have been accounted for in a multivariate analysis. In the absence of multivariate analysis, studies that account for key confounders with univariate analysis or matched groups will be considered.
	
	Qualitative data
	
	Qualitative interview and focus group studies (including studies using grounded theory, phenomenology or other appropriate qualitative approaches).
	Survey data or other types of questionnaires will only be included if they provide analysis from open-ended questions, but not if they reported descriptive quantitative data only.

For full details see the review protocol in Appendix A.

1.1.3 Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in Appendix A and the methods document.

Declarations of interest were recorded according to NICE's conflicts of interest policy.

2 Efficacy of intense rehabilitation (quantitative evidence)

2.1 Review question

In people after stroke, what is the clinical and cost effectiveness of more intensive rehabilitation compared with standard rehabilitation?

2.1.1 Effectiveness evidence

2.1.1.1 Included studies

1 individual patient data network meta-analysis[7] and 106 randomised controlled trial studies (114 papers) were included in the review;[1-6, 8-16, 18-20, 22-79, 81-96, 98-100, 102-121] these are summarised in **Table 2**. Evidence from these studies is summarised in the clinical evidence summaries (section 2.1.2 Summary of studies included in the quantitative evidence

Evidence from randomised controlled trial studies investigated the follow stratifications and comparisons:

- No communication difficulties
    - Physiotherapy
        - ≤45 minutes
            - <5 days a week compared to:
                - Usual care[27, 112, 119]
            - 5 days a week compared to:
                - Usual care[14, 25, 60, 111, 121]
                - ≤45 minutes, <5 days a week[79]
            - 6 days a week compared to:
                - Usual care[63]
                - >45 minutes to 1 hour, <5 days a week[72]
            - 7 days a week compared to:
                - ≤45 minutes, 5 days a week[22]
        - >45 minutes to 1 hour
            - <5 days a week compared to:
                - ≤45 minutes, <5 days a week[20]
            - 5 days a week compared to:
                - ≤45 minutes, <5 days a week[79]
                - ≤45 minutes, 5 days a week[37, 49, 66, 75, 76, 79, 86, 89, 90, 93]
                - >45 minutes to 1 hour, <5 days a week[24]
            - 7 days a week compared to:
                - ≤45 minutes, <5 days a week[2]
        - >1 hour to 2 hours
            - <5 days a week compared to:
                - ≤45 minutes, <5 days a week[36, 51, 105]
                - >45 minutes to 1 hour, <5 days a week[12, 54, 109]
            - 5 days a week compared to:
                - Usual care[114]
                - ≤45 minutes, <5 days a week[44]
                - ≤45 minutes, 5 days a week[1, 22, 28, 37, 98, 99, 118]
                - ≤45 minutes, 7 days a week[22]
                - >45 minutes to 1 hour, 5 days a week[9, 13, 33, 37, 39, 43, 50, 52, 53, 56-58, 64, 65, 68, 87, 88, 92, 94, 96, 106, 108, 113]

- 6 days a week compared to:
  - >45 minutes to 1 hour, 5 days a week[3]
  - >45 minutes to 1 hour, 6 days a week[110]
- >2 hours to 4 hours
  - 5 days a week compared to:
    - ≤45 minutes, 5 days a week[37]
    - >45 minutes to 1 hour, 5 days a week[33, 37, 38]
    - >1 hour to 2 hours, 5 days a week[33, 37, 40, 120]
  - 6 days a week compared to:
    - >1 hour to 2 hours, 5 days a week[34]
- >4 hours
  - 5 days a week compared to:
    - Usual care[116]
    - >2 hours to 4 hours, 5 days a week[91, 117]

- Occupational therapy
  - ≤45 minutes
    - <5 days a week compared to:
      - Usual care[26]
  - >45 minutes to 1 hour
    - <5 days a week compared to:
      - ≤45 minutes, <5 days a week[67, 101]
    - 5 days a week compared to:
      - ≤45 minutes, <5 days a week[74]
      - ≤45 minutes, 5 days a week[32, 77, 85]
  - >1 hour to 2 hours
    - 5 days a week compared to:
      - ≤45 minutes, <5 days a week[16]
      - ≤45 minutes, 5 days a week[45, 70, 85]
      - >45 minutes to 1 hour, 5 days a week[11, 35, 48, 61, 85]
  - >2 hours to 4 hours
    - 5 days a week compared to:
      - >1 hour to 2 hours, 5 days a week[15]
- Speech and Language Therapy
  - ≤45 minutes
    - 7 days a week compared to:
      - ≤45 minutes, <5 days a week[10]
  - >1 hour to 2 hours
    - 5 days a week compared to:
      - >45 minutes to 1 hour, 5 days a week[41]
- Psychology/neuropsychology
  - >1 hour to 2 hours
    - <5 days a week compared to:
      - Usual care[71]
    - 5 days a week compared to:
      - >1 hour to 2 hours, 5 days a week[62]
      -
- Multidisciplinary care
  - ≤45 minutes
    - <5 days a week compared to:
      - Usual care[81]
    - 5 days a week compared to:
      - Usual care[78]
  - >1 hour to 2 hours

        - 5 days a week compared to:
            - ≤45 minutes, 5 days a week[103]
            - >45 minutes to 1 hour, 5 days a week[8, 69, 102]
    - >2 hours to 4 hours
        - <5 days a week compared to:
            - Usual care[84]
    - >4 hours
        - 5 days a week compared to:
            - >2 hours to 4 hours, 5 days a week[47]
- Communication difficulties
    - Physiotherapy
        - >1 hour to 2 hours
            - <5 days a week compared to:
                - >45 minutes to 1 hour, <5 days a week[5]
    - Occupational therapy
        - >45 minutes to 1 hour
            - 5 days a week compared to:
                - ≤45 minutes, <5 days a week[55]
    - Speech and Language therapy
        - ≤45 minutes
            - 5 days a week compared to:
                - Usual care[4]
        - >45 minutes to 1 hour
            - 5 days a week compared to:
                - ≤45 minutes, <5 days a week[29]
                - >45 minutes to 1 hour, <5 days a week[18]
        - >1 hour to 2 hours
            - <5 days a week compared to:
                - ≤45 minutes, <5 days a week[17]
                - >45 minutes to 1 hour, <5 days a week[46]
            - 5 days a week compared to:
                - >45 minutes to 1 hour, 5 days a week[73, 82]
        - >2 hours to 4 hours
            - <5 days a week compared to:
                - >1 hour to 2 hours, <5 days a week[104]
            - 5 days a week compared to:
                - Usual care[95]
                - >1 hour to 2 hours, 5 days a week[115]
    - Psychology/neuropsychology
        - >45 minutes to 1 hour
            - <5 days a week compared to:
                - Usual care[107]

Individual patient data network meta-analysis

One individual patient data network meta-analysis[7ref] reporting the effect of different intensities of Speech and Language Therapy using results from 25 randomised controlled trials and including 928 individual patient data. This analysis included the results for the pilot trial for another study that was included in the review[29]. Otherwise, all other studies included in this review for the speech and language therapy stratification were not included in the individual patient data network meta-analysis mainly as the results were reported after the cut-off date for inclusion from the review (September 2015).

This study reports outcomes relating to intensity different from those specified in the protocol for this review, reporting intensity as the total number of hours of speech and language

therapy, number of hours per week, number of days per week and duration of therapy. The study includes studies that would not have been included in the protocol otherwise (such as those with no treatment comparisons) using network meta-analysis to provide data that is important for this review. The study reports outcomes using all of the data rather than separating the studies into different time points as agreed in the protocol for this review. Given these factors and the strength of the evidence provided, this review was included in the analysis. However, outcomes were downgraded for indirectness as required for the use of different measurements of intensity and combining time points together. In addition, the measures of intensity most related to those specified in the protocol for this review were used, namely the number of hours per week and the number of days per week.

Evidence for different stratifications

The evidence for the different therapy domains showed a disparity in studies. In those analysed in this review, the majority of the research was conducted in by physiotherapists of multidisciplinary teams. Where multidisciplinary teams were involved in the care, these teams were mostly made up of physiotherapists and occupational therapists, though in some cases also included specialist nurses, speech and language therapists, psychologists, stroke physicians and other allied professionals.

The evidence for other types of therapy were sporadic. This is particularly the case for psychology/neuropsychology, where the studies included compared to usual care (which meant that there was no information about the intensity of care received by both arms beyond that of the additional intervention). The interventions included in the psychology/neuropsychology stratification focussed on psychological support, and so may only represent a small part of what could be involved in the interventions provided by this group.

On examination of the evidence, the majority was reported as not including people with communication difficulties. In these cases either the studies reported that they excluded people with communication difficulties, or they did not report any information that indicated that people with communication difficulties were included or that speech and language therapy was involved in their management strategy.

Determining the intensity of therapy

In this review, intensity was considered to be the amount of therapy provided to a person, measured in the number of hours per day and the number of days per week. These values were extracted from studies to determine the stratification that therapy would be classified as. This would include the time for any interventions offered to all study arms in addition to the intervention of interest. In some cases, the information provided by the study would be unclear, where studies provided a range of therapy time that participants may use. In these cases, the most therapy possible was used to calculate the intensity for the study.

Where a study reported a total amount of therapy where the therapy provided to all study participants was provided for a different number of days than the additional intervention, an average number of hours was calculated (for example: where a study reported an additional intervention for one hour, three times a week and the care provided to everyone was 45 minutes, five days a week – an average of one hour across the five days was calculated to determine the number of hours of rehabilitation per day).

Where the study did not report the total number of hours/days of therapy provided to everyone but did provide information about the number of hours/days of additional therapy provided, the comparison was labelled usual care.

Inconsistency

Due to the number of stratifications involved in the review, there were few outcomes that involved more than one study and so most of the evidence was not downgraded for inconsistency. However, in cases where more than one study was included some studies were downgraded for inconsistency. Subgroup analyses did not resolve the heterogeneity in these cases.

Sensitivity analyses were conducted for the mixed methods synthesis. Please see report B, section 4 for additional information.

Indirectness

The majority of the evidence was direct to the specifications stated in the protocol. In one case (Multidisciplinary team [no communication difficulties] - ≤45 minutes, 7 days a week compared to ≤45 minutes, <5 days a week) and outcome was downgraded for outcome indirectness, as the outcome reported used a dichotomous for an outcome where the protocol specified that continuous outcomes would be preferred.

See also the study selection flow chart in Appendix C, study evidence tables in Appendix D, forest plots in Appendix G and GRADE tables in Appendix I.

2.1.1.2 Excluded studies

See the excluded studies list in Appendix N.

2.1.2 Summary of studies included in the quantitative evidence

Table 2: Summary of systematic reviews included in the evidence review

Study	Intervention and comparison	Population	Outcomes	Comments
Brady 2021[7]	**Speech and Language Therapy** (n=928) Including individual patient data from 25 randomised controlled trial studies comparing a range of different intensities (split into number of hours per week and number of days per week).	**Adults with communication difficulties who have had a first or recurrent stroke**	Communication – Overall language ability Communication – Impairment specific measures (naming) Communication – Impairment specific measures (auditory comprehension) Communication – Functional communication Reported time point includes times at <6 months and ≥6 months.	See section 2.1.1.1 for further information.

Table 3: Summary of quantitative studies included in the evidence review

Study	Intervention and comparison	Population	Outcomes	Comments
Allison 2007[1]	**Physiotherapy – >1 hour to 2 hours, 5 days per week** (n=17) Additional 45 minutes standing practice on each working day involving the use of either standing frames, tilt tables or standing at tables to provide support while enabling standing to occur. After discharge from hospital this was continued as outpatient or community-based physiotherapy, but at a reduced intensity (one or two sessions per week). For 12 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 74.5 (15.2) years N = 27 Time after stroke: Subacute (7 days – 6 months) Severity: not state/unclear Focus of care: Lower limb	Discontinuation from study at <6 months	Setting: A stroke rehabilitation unit in the United Kingdom. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	Physiotherapy – ≤45 minutes, 5 days per week (n=10) Conventional physiotherapy only. **Concomitant therapy:** Conventional physiotherapy from one or three physiotherapists working on the ward. Typically, a session of 45 minutes treatment on each working day, including work on strengthening, improving movement, mobility and upper limb function.			
Askim 2010[3]	**Physiotherapy – >1 hour to 2 hours, 6 days a week** (n=30) Intense motor training. 3 additional session of motor training each week for the first 4 weeks after discharge from the stroke unit, and 1 additional session every week for the next 8 weeks. Each session was intended to last from 30 to 50 minutes. The patients were also encouraged to perform home exercises during this period. The home exercises consisted of 4 tasks, with 10 repetitions of each task twice a day, 6 days per week. For 26 weeks. **Multidisciplinary team – >45 minutes to 1 hour,**	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age: 76.5 (8.9) years N = 62 Time after stroke: Hyperacute (24 – 72 hours) Severity: not stated/unclear Focus of care: Mixed (Upper limb and lower limb, general physical function, functional independence)	Person/participant health-related quality of life at ≥6 months Activities of daily living at ≥6 months Physical function – lower limb at ≥6 months Discontinuation from study at ≥6 months	Setting: A stroke unit at St. Olavs Hospital, Trondheim, Norway transition to early supported discharge with care in a person's home, outpatient clinic or rehabilitation service dependent on the discharge destination. Funding: Torunn Askim was supported through The Norwegian Fund for Postgraduate Training in Physiotherapy and from Clinical Service, St. Olavs Hospital, Trondheim University Hospital.

Study	Intervention and comparison	Population	Outcomes	Comments
	5 days a week (n=32) Physical therapy according to a task-oriented approach, focusing on independence in activities of daily living. The therapy was administered as 2 daily sessions of 30 minutes, 5 days per week. **Concomitant therapy**: Standard care. All people received early supported discharge, coordinated by a hospital-based multidisciplinary team.			
Askim 2018[2]	**Physiotherapy – >45 minutes to 1 hour, 7 days a week** (n=186) Based on patient preferences and goals, a schedule for physical activities and exercise was set for the next month. the exercise needed to last 45 to 60 minutes and include 2 to 3 periods of vigorous activity once a week while the physical activity needed to last 30 minutes 7 days a week. Follow up over 18 months. **Physiotherapy – ≤45 minutes, <5 days a week** (n=194) Standard therapy only. **Concomitant therapy:** Rehabilitation after discharge from	**Adults without communication difficulties who have had a first or recurrent stroke** Age: Unclear. >18 years N = 380 Time after stroke: Subacute (7 days-6 months) Severity: Mixed Majority <8, with a small number 8-16. Focus of care: Mixed (Physical function/activities of daily living)	Person/participant health-related quality of life at ≥6 months Stroke outcome – modified Rankin scale at ≥6 months Activities of daily living at ≥6 months Physical function – lower limb at ≥6 months Discontinuation from study at ≥6 months	Setting: Performed at 2 centres in Norway. Funding: Funded by Norwegian Research Council, Liaison Committee between Central Norway Regional Health Authority and Norwegian University of Science and Technology, Joint Research Committee between St. Olavs Hospital and NTNU, Norwegian Fund for Postgraduate Training in Physiotherapy, and Stroke Unity Research Fund at St. Olavs Hospital.

Study	Intervention and comparison	Population	Outcomes	Comments
	hospital usually consists of 45 minutes of physiotherapy at moderate intensity per week performed in the patient's home, at an outpatient clinic or during inpatient rehabilitation.			
Bakheit 2007[4]	**Speech and Language Therapy – >45 mins to 1 hour, 5 days per week** (n=51) 5 hours of speech and language therapy per week for 12 consecutive weeks**.** Follow up at 24 weeks. **Speech and Language Therapy – >45 mins to 1 hour, <5 days per week** (n=65) 2 hours of speech and language therapy per week for 12 consecutive weeks - this was split between the standard therapy intervention group (n=46) and the NHS group (n=19), who were supposed to receive the same amount of time but generally received less than the amount of the standard therapy intervention group. **Concomitant therapy:** This intervention was a part of a multidisciplinary, goal-directed rehabilitation program.	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 70.9 (15.0) years N = 116 Time after stroke: Subacute (7 days – 6 months) Severity: not stated/unclear Focus of care: Communication	Communication - Overall language ability at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: A hospital stroke unit and community in the United Kingdom. Funding: Supported by a research grant from the Tavistock Trust for Aphasia.

Study	Intervention and comparison	Population	Outcomes	Comments
Barcala 2013[5]	**Physiotherapy – >1 hour to 2 hours, <5 days a week** (n=10) Conventional physical therapy and 30 minutes of balance training with visual biofeedback using Wii Fit®. Follow up at 7 weeks. **Physiotherapy – >45 minutes to 1 hour, <5 days a week** (n=10) Conventional physical therapy only. **Concomitant therapy:** Conventional physical therapy, 60 minutes, 2 sessions per week for 5 weeks.	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 64.4 (13.6) years N = 20 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: A physical therapy clinic of the Universidade Nove De Julho in Brazil. Funding: Financial support from Conselho Nacional de Desenvolvimento Cientifico e Technologico (CNPq) and Coordenacao de Aperfeicoamento de pessoal de Nivel Superior (CAPES).
Burgar 2011[8]	**Multidisciplinary team – >1 hour to 2 hours, 5 days a week** (n=17) Robot assisted upper limb therapy, 30 hours in total. All therapy was delivered by physiotherapists and occupational therapists. Delivered over 3 weeks. Additional follow up at 6 months. **Multidisciplinary team – >45 minutes to 1 hour, 5 days a week** (n=37) Two groups: 1) robot assisted upper limb therapy for 15 hours in total. 2) 15 hours of other therapy over the same time period - therapy to improve the	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 63.1 (4.6) years N = 54 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Activities of daily living at <6 months and ≥6 months Physical function – upper limb at <6 months and ≥6 months	Setting: Inpatients in three centres in the United States of America. Funding: The material was based on work supported by the Veterans Affairs Rehabilitation Research and Development Service (grant B2695I).

Study	Intervention and comparison	Population	Outcomes	Comments
	function of the paretic upper limb through a variety of treatment modalities. **Concomitant therapy:** No additional information.			
Cabanas-Valdes 2016[9]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=40) In addition to usual care, people in the experimental group performed core stability exercises for 15 minutes daily, totalling 6.15 hours. Delivered over 5 weeks. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=40) Conventional programme only. **Concomitant therapy:** All people followed the conventional therapy programme for stroke patients provided by their respective rehabilitation centre for a 5-week period, consisting of 1 hour of treatment a day, 5 times a week for 5 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 75.3 (10.1) years N = 80 Time after stroke: Subacute (7 days – 6 months) Severity: Moderate (or NIHSS 5-14) Focus of care: Functional independency	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient rehabilitation hospital in two centres in Spain. Funding: The author(s) received no financial support for the research, authorship, and/or publication of this article.
Carnaby 2006[10]	**Speech and Language Therapy – ≤45 minutes, 7 days a week** (n=102) Standard high-intensity swallowing therapy consisting of direct swallowing exercises (for example: effortful swallowing, supraglottic	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 70.9 (12.5) years N = 306 Time after stroke: Acute (72 hours – 7 days)	Swallow function and ability at ≥6 months Discontinuation from study at ≥6 months	Setting: University teaching hospital (the Royal Perth Hospital), providing medical services to the eastern suburban region of Perth, Western Australia. Funding: This study was supported by an educational grant from the Royal Perth

Study	Intervention and comparison	Population	Outcomes	Comments
	swallow technique) and appropriate dietary modification every working day for a month or daily for the duration of the hospital stay (if less than a month). **Speech and Language Therapy – ≤45 minutes, <5 days a week** (n=102) Standard low-intensity swallowing therapy composed of swallowing compensations strategies, mainly environmental modification; safe swallowing advice and appropriate dietary modification, three times per week for a month or for the duration of the hospital stay (if less than a month). **Concomitant therapy:** Usual care, consisting of patient management by the attending physicians as per usual practice.	Severity: Not stated/unclear Focus of care: Swallow		Hospital Medical Research Foundation.
Cho 2012[11]	**Multidisciplinary team – >1 hour to 2 hours, 5 days a week** (n=11) Virtual reality balance training in addition to standard rehabilitation for 30 minutes a day, 3 times a week for 6 weeks. This used a conventional 42-inch LCD screen television and a balance board game system (Wii Fit balance board).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 64.2 (7.7) years N = 22 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Mixed (Balance, but also general	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Stroke unit in the Republic of Korea. Funding: The present study was supported by Sahmyook University Research Grant.

Study	Intervention and comparison	Population	Outcomes	Comments
	Multidisciplinary team – 45 minutes to 1 hour, 5 days a week (n=11) Standard rehabilitation only. **Concomitant therapy**: Both groups participation in a standard rehabilitation program (physical and occupational therapy) for 60 minutes a day, 5 times a week for 6 weeks and speech and language therapy (if appropriate).	physiotherapy, occupational therapy and possibly speech and language therapy)		
Cooke 2010[12]	**Physiotherapy – >1 hour to 2 hours, <5 days a week** (n=71) Functional strength training and conventional physiotherapy (n=36) or conventional physiotherapy in addition to conventional physiotherapy (n=35). All additional therapy was provided for up to 1 hour, 4 days a week for 6 weeks by research physiotherapists who were independent of the clinical team. **Physiotherapy – 45 minutes to 1 hour, <5 days a week** (n=38) Conventional physiotherapy only. **Concomitant therapy:** Conventional physical therapy. People were allocated to therapy	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 68.3 (12.2) years N = 109 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Person/participant health-related quality of life at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Multiple clinical centres in the United Kingdom. Funding: Funding was provided by the Healthcare Foundation and the Dowager Countess Eleanor Peel Trust.

Study	Intervention and comparison	Population	Outcomes	Comments
	but did not receive any additional therapy. This therapy was provided for up to 1 hour, 4 days a week for 6 weeks.			
Coskunsu 2022[13]	**Physiotherapy – >1-2 hours, 5 days a week** (n=11) Robot-assisted rehabilitation for approximately 1 hour, 5 days a week for 3 weeks in addition to usual care. **Physiotherapy – >45 minutes-1 hour, 5 days a week** (n=9) Usual care only. **Concomitant therapy:** Combination of physiotherapy with electrical stimulation for 1 hour, 5 days a week for 3 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 64.5 (15.0) years N = 20 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Inpatients in Turkey. Funding: This study was supported, in part, by the Rehab Robotic Company.
Cui 2022 [14]	**Physiotherapy - ≤45 minutes, 5 days a week** (n=16) Mirror therapy for 30 minutes, 5 times a week for 3 weeks in addition to usual care. **Physiotherapy - usual care** (n=16) Usual care only. **Concomitant therapy:** Medication and routine rehabilitation therapy. Routine rehabilitation therapy included good limb positioning, joint mobility, control of muscle tension, promotion of active	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 60.0 (10.7) years N = 32 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Outpatient follow up in China. Funding: Supported by Sichuan Province Pharmaceutical Administration (Grant No. 2014B064), the Key R&D Program of Sichuan Province (No.2020YFS0415).

Study	Intervention and comparison	Population	Outcomes	Comments
	movement, transfer training, balance training, gait training, occupational therapy and traditional Chinese medicine rehabilitation such as acupuncture.			
Dai 2013[15]	**Occupational therapy – >2 hours to 4 hours, 5 days a week** (n=27) Vestibular rehabilitation. Trained by a registered nurse once a day for 30 minutes for a total of 10 sessions over 2 weeks. Then during the third and fourth weeks, was supervised and guided to use vestibular rehabilitation by their primary caregivers (who were also trained during the first week). The entire process took approximately 30 minutes. Follow up at 28 days. **Occupational therapy – >1 hour to 2 hours, 5 days a week** (n=28) Conventional rehabilitation only. **Concomitant therapy:** Conventional rehabilitation. All people received 2 hours of convention rehabilitation, specifically 1 hour for physical therapy and 1 hour for occupational therapy (for a total of 5 days a week).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 60.9 (14.0) years N = 55 Time after stroke: Acute (72 hours – 7 days) Severity: Not stated/unclear Focus of care: Mixed (Physical function, activities of daily living)	Activities of daily living at <6 months Physical function – lower limb at <6 months Stroke-related scale of cognition - Spatial attention at <6 months Discontinuation from study at <6 months	Setting: Rehabilitation wards of two medical centres located in central Taiwan. Funding: They disclose no conflicts of interest - 'no commercial party having a direct financial interest in the results of the research supporting this article has or will confer a benefit upon the authors or upon any organization with which the authors are associated).

Study	Intervention and comparison	Population	Outcomes	Comments
de Diego 2013[16]	**Occupational therapy – >1 hour to 2 hours, 5 days a week** (n=12) Exercise group who received 16 sessions of a protocol of 1 hour at the center during 8 weeks, 2 sessions per week and 1 daily session of 30 minutes of functional activity training at home (5 days a week). **Occupational therapy – ≤45 minutes, <5 days a week** (n=9) Usual treatment according to the Bobath concept (1 hour per session), without prioritizing therapy of the upper limb, with 2 sessions per week. **Concomitant therapy:** No additional information	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 61.3 (12.6) years N = 21 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Functional independency	Patient/participant health-related quality of life at <6 months Physical function – upper limb at <6 months	Setting: A rehabilitation centre in Spain. Funding: No additional information.
Di Lauro 2003[19]	**Physiotherapy – >1 hour to 2 hours, 5 days a week (n=29)** 2 hours a day with an interval of 6 hours between the morning and the afternoon treatment. Morning treatment – exercises of mobilisation for about 45 minutes; – exercises of proprioceptive recognition; – rehabilitative nursing (correct positioning in bed, bedsores prevention, intermittent bladder catheterisation) for 15	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD) intervention, control: 69.3 (8.0), 67.6 (9.3)years N = 60 Time after stroke: acute Severity: NIHSS = 10 (moderate) Focus of care: mixed	Activities of daily living at <6 and > 6 months Discontinuation from study at <6 and > 6 months	Setting: Hospital inpatient in Italy. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	minutes.Afternoon treatment – exercises of mobilization for about 15 minutes; – tactile, kinesthetic and proprioceptive stimulation; – exercises of visual stimulation (light sources that vary in intensity, such as television screen and stroboscopic light); – cognitive skill exercises; – exercises of acoustic stimulation (using a tape-recorder for 45 minutes). **Physiotherapy – ≤45 minutes, <5 days a week (n=31)** 45 minutes, once a day of passive and active mobilisation, bedsores prevention, correct positioning in bed. **Concomitant therapy:** No additional information			
De Luca 2018[17]	**Speech and Language Therapy – >1 hour to 2 hours, <5 days a week** (n=17) Power-Afa training 24 sessions of 45 minutes each, 3 times a week for 8 week. Commercially available PC program to optimize language recovery and other cognitive functions. **Speech and Language Therapy – ≤45**	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 51.7 (14.8) years N = 32 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Communication	Psychological distress – depression at ≤6 months	Setting: Outpatient follow up in Italy. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	minutes, <5 days a week (n=15) Traditional therapy only. **Concomitant therapy:** Traditional training available to all (standard cognitive rehabilitation for language disorders). 3 training sessions per week for 8 weeks (24 sessions of 45 minutes each).			
Denes 1996[18]	**Speech and Language Therapy – >45 minutes to 1 hour, 5 days a week** (n=8) Intensive speech treatment consisting of an average of 130 individual speech (range 94-160) therapy sessions. Each session lasted between 45 and 60 minutes and sessions were done mostly on an outpatient basis. Completed over 6 months. **Speech and Language Therapy – >45 minutes to 1 hour, <5 days a week** (n=9) Regular speech treatment consisting of an average of 60 individual speech (range 56-70) therapy sessions over a six month period (averaging at 3 sessions weekly). Each session lasted between 45 and 60	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 60.2 (10.5) years N = 17 Time after stroke: Subacute (7 days – 6 months) Severity: not stated/unclear Focus of care: Communication	Communication – naming at ≥6 months Communication – auditory comprehension at ≥6 months	Setting: Mainly outpatient basis in Italy. Funding: Partially supported by a grant of Regione Veneto to G.D.

Study	Intervention and comparison	Population	Outcomes	Comments
	minutes and sessions were done mostly on an outpatient basis. **Concomitant therapy:** No additional information.			
Donaldson 2009[20]	**Physiotherapy – >45 minutes to 1 hour, <5 days a week** (n=20) A combination of conventional therapy with either additional conventional therapy (n=10) or functional strength training (n=10). The intervention was provided for up to 1 hour, 4 days a week for 6 weeks. **Physiotherapy – ≤45 minutes, <5 days a week** (n=10) Conventional therapy only for an uncertain time (2.81 hours in total, so assumed as 30 minutes once a week). **Concomitant therapy:** All received conventional physical therapy delivered by clinical physiotherapists.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (range): 72.8 (43-90) years N = 30 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Functional independency	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Delivered in clinical centres in the United Kingdom. Funding: Funding provided by the Welcome Trust.
English 2015[21]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=93) Circuit class therapy for up to 3 hours per day, usually in two 90 minute sessions morning and afternoon. 5 days a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 70.1 (12.9) years N = 283 Time after stroke: Subacute (7 days – 6 months)	Discontinuation from study at <6 months	Setting: People recruited from one of five stroke rehabilitation centres in three states within Australia. Funding: This project was supported by a National Health and Medical Research Project Council Grant #631904.

Study	Intervention and comparison	Population	Outcomes	Comments
	Physiotherapy – ≤45 minutes, 7 days a week (n=96) Usual care provided 7 days a week on both Saturday and Sunday for the duration of their inpatient stay, in addition to their usual 5 days therapy. **Physiotherapy – ≤45 minutes, 5 days a week** (n=94) Usual care dependent on the site provided for 5 days a week. This was done with daily individual therapy and augmented for some people by group physiotherapy 1-4 times a week. **Concomitant therapy**: No additional information.	Severity: Not stated/unclear Focus of care: Lower limb Mobility		
Fasoli 2004[24]	**Physiotherapy - >45 minutes to 1 hour, 5 days a week** (n=30) Robot therapy for five 1-hour sessions per week, participating in at least 25 sessions of sensorimotor robotic training for the paretic arm. Follow up at 3.5 weeks. **Physiotherapy - >45 minutes to 1 hour, <5 days a week** (n=26) Robot exposure for one 1-hour session per week.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 64.3 (3.4) years N = 56 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Activities of daily living at <6 months Physical function – upper limb at <6 months	Setting: Inpatient rehabilitation stroke unit in the United States of America. Funding: This work was supported by grants from the National Institute of Child Health and Human Development of the National Institute of Health (NIH), #R01-HD-36827, #R01 HD37397; the Burke Medical Research Institute, and the Langeloth Foundation. S. E. Fasoli was supported, in part, by a National Research Service Award from

Study	Intervention and comparison	Population	Outcomes	Comments
	Concomitant therapy: All people also received conventional, interdisciplinary rehabilitation services.			the National Institute of Child Health and Human Development of NIH, grant F32 HD41795.
Galvin 2011[25]	**Physiotherapy – ≤45 minutes, 5 days a week** (n=20) Family-mediated exercise intervention conducted for 35 minutes daily at the bedside with the assistance of their nominated family member. Delivered in hospital or at home. Follow up at 8 weeks. **Usual care** (n=20) Usual rehabilitation (no information about how much time this equated to). **Concomitant therapy:** Routine physiotherapy was provided to all participants.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 66.6 (13.0) years N = 40 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient or outpatient setting in Ireland. Funding: Supported by a grant from the Irish Heart Foundation in association with the Medical Research Charities Group. The project also received funding from the Friends of the Royal Hospital Donnybrook, the O'Driscoll/O'Neil bursary in conjunction with the Irish Society of Chartered Physiotherapists (2006) and the Seed Funding Scheme in University College Dublin.
Gilbertson 2000[26]	**Occupational therapy – ≤45 minutes, <5 days a week** (n=67) A six week domiciliary programme comprising around 10 visits lasting 30-45 minutes tailored to recovery goals identified by the patient such as regaining self care or domestic or leisure activities. **Usual care** (n=71) Routine services only. **Concomitant therapy:** Routine	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (range): 71 (28-89) years N = 138 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Mixed	Discontinuation from study at <6 months and ≥6 months	Setting: Home based with people admitted to two hospital sites within a United Kingdom teaching hospital. Funding: Chest Heart and Stroke Scotland provided the funding for this study. Additional support came from Glasgow Royal Infirmary NHS Trust and the chief scientists office, Scottish Office, which funded a research training fellowship for LG.

Study	Intervention and comparison	Population	Outcomes	Comments
	services included inpatient multidisciplinary rehabilitation, a predischarge home visit for selected patients, the provision of support services and equipment, regular multidisciplinary review at a stroke clinic, and selected patients referred to a medical day hospital.			
Gjellesvik 2020[27]	**Physiotherapy – ≤45 minutes, <5 days a week** (n=36) High intensity interval training in addition to standard care provided 3 days a week. Total exercise time was 38 minutes each session for 8 weeks (3 sessions per week). Follow up at 8 weeks and 12 months. **Usual care** (n=34) Standard care. **Conventional therapy:** Activities with moderate to high intensity 3-5 days per week.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 58.1 (9.2) years N = 70 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Discontinuation from study at <6 months and ≥6 months	Setting: Specialised rehabilitation units at three hospitals in Norway. Funding: No additional information.
Glasgow Augmented Physiotherapy Study 2004[28]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=35) Conventional stroke services plus additional physiotherapy input (aiming to approximately double the total daily physiotherapy time to 60-80 minutes per day, five days a week). Follow up at 3 months and 6 months.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 67.5 (10.5) years N = 70 Time after stroke: Subacute (7 days-6 months) Severity: Not stated/unclear Focus of care: Mixed	Person/participant health-related quality of life at <6 months and ≥6 months Activities of daily living at <6 months and ≥6 months Physical function - lower limb at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: At stroke rehabilitation facilities at Stobhill, Drumchapel and Lighturn Hospitals, in Glasgow, Scotland. Funding: The UK Stroke Association funded the study.

Study	Intervention and comparison	Population	Outcomes	Comments
	Physiotherapy - ≤45 minutes, 5 days a week (n=35) Conventional stroke services only. **Concomitant therapy:** All people received conventional stroke services, including conventional physiotherapy (30-40 minutes, five days per week)			
Godecke 2020[29] Subsidiary studies: Godecke 2012[31] Godecke 2016[30]	**Speech and Language therapy – >45 minutes to 1 hour, 5 days a week** (n=164) VERSE/UC-Plus intervention - usual care therapy plus additional aphasia therapy. People were prescribed 20 sessions of 45-60 minutes (15-20 hours, or 4-5 hours per week) of aphasia therapy, commencing before day 15 and completed within four weeks. Follow up at 12 weeks and 26 weeks. **Speech and Language therapy – ≤45 minutes, <5 days a week** (n=81) Usual care was not controlled for amount, frequency of sessions, therapy type or therapist. On average they had 3.1 sessions per week, with each session being on average 37.2 hours.	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 75.3 (17.7) years N = 246 Time after stroke: Subacute (7 days – 6 months) Severity: Mixed (mild, moderate and severe in about equal amounts) Focus of care: Communication	Person/participant generic-health related quality of life at <6 months and ≥6 months Communication – overall language ability at <6 months and ≥6 months Communication - Impairment specific measures, naming at <6 months and ≥6 months Psychological distress – depression at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: 17 acute hospitals with later follow up at 45 subacute and community healthcare centers in Australia and New Zealand. Funding: Government or academic funding from multiple sources.

Study	Intervention and comparison	Population	Outcomes	Comments
	Concomitant therapy: No additional information			
Guo 2019[32]	**Occupational therapy - >45 minutes-1 hour, 5 days a week** (n=60) Mirror therapy with or without extracorporeal shockwave therapy for 30 minutes, 5 days a week for 4 weeks in addition to usual care. **Occupational therapy - ≤45 minutes, 5 days a week** (n=30) Usual care only. **Concomitant therapy:** Exercise therapy, occupational therapy and neurodevelopmental facilitation techniques for 30 minutes per day, 5 times a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 68.53 (11.03) years N = 90 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 and ≥6 months Discontinuation from study at <6 and ≥6 months	Setting: Inpatients in China. Funding: Zhejiang Province, medical and health science and technology projects (no. 2018PY033).
Han 2013[33]	**Physiotherapy – >2 hours to 4 hours, 5 days a week** (n=11) Arm motor relearning programme adapted on the person's impairments. Delivered for 3 hours, 5 days a week for 6 weeks. **Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=10) Arm motor relearning programme. Delivered for 2 hours, 5 days a week for 6 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 50.1 (12.9) years N = 32 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Activities of daily living at <6 months Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: People admitted to the Affiliated Hospital of Qingdao University Medical College in China. Funding: This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Study	Intervention and comparison	Population	Outcomes	Comments
	Physiotherapy – >45 minutes to 1 hour, 5 days a week (n=11) Arm motor relearning. Delivered for 1 hour, 5 days a week for 6 weeks. **Concomitant therapy:** All patients received regular rehabilitation therapy and medical treatment.			
Harris 2009[34]	**Physiotherapy – >2 hours to 4 hours, 6 days a week** (n=53) GRASP protocol. Self-administered homework-based exercise program to improve paretic upper performance and encourage the use of the paretic upper limb in activities of daily living. Each participant was asked to complete the exercises 6 days per week for 60 minutes each day. Follow up at 3 months. **Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=50) Received an education book with 4 modules, discussing information on stroke recovery and general health with a homework assignment related to the topic. **Concomitant therapy:** People received	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 69.4 (13.6) years N = 103 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Four inpatient sites in Canada. Funding: This work was supported from an operating grant from the Heart and Stroke Foundation of British Columbia and Yukon, Canada. Further support from other government or academic funding sources.

Study	Intervention and comparison	Population	Outcomes	Comments
	rehabilitation by the unit multidisciplinary team. This was the equivalent of around 90 minutes of therapy, 5 days a week.			
Horsley 2019[35]	**Occupational therapy – >1 hour to 2 hours, 5 days a week** (n=25) Repetitive active reaching training using the SMART Arm device for up to 1 hour per day, 5 days a week for 5 weeks (a goal of 25 sessions, 1500 minutes) in addition to usual care. Follow up at 7 weeks. **Occupational therapy – >45 minutes to 1 hour, 5 days a week** (n=25) Usual upper limb therapy only. **Concomitant therapy:** Usual upper limb therapy provided by treating occupational therapists and physiotherapists. This usually involved both group and individual sessions conducted 5 days a week. This averaged out to 53 minutes per session.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 67.2 (12.9) years N = 50 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – Upper limb at <6 months Discontinuation from study at <6 months	Setting: Three inpatient rehabilitation units in Australia. Funding: KS Hayward is supported by the National Health and Medical Research Council of Australia (GNT1088449). RD Herbert is supported by the National Health and Medical Research Council of Australia (RG153190).
Howe 2005[36]	**Physiotherapy – >1 hour to 2 hours, <5 days a week** (n=17) 12 additional therapy sessions (6 hour over four weeks) comprising exercises aimed at improving lateral weight transference	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 71.1 (9.4) years N = 35	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: The Stroke Unit at The James Cook University Hospital, Middlesbrough, United Kingdom. Funding: Funding from the Physiotherapy

Study	Intervention and comparison	Population	Outcomes	Comments
	in sitting delivered by trained physiotherapy assistants. Follow up at 8 weeks. **Physiotherapy – ≤45 minutes to 1 hour, <5 days a week** (n=18) Usual care only. **Concomitant therapy:** Usual care, including physiotherapy (14 sessions, 480 minutes in total, 34 minutes each session) over 4 weeks.	Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb		Research Foundation.
Hunter 2011[37]	**Physiotherapy – >2 hours to 4 hours, 5 days a week** (n=20) Up to 120 minutes per day of mobilisation and tactile stimulation (including joint and soft-tissue mobilisation and passive or active-assisted movement) every working day for 14 consecutive working days. **Physiotherapy - >1 hour to 2 hours, 5 days a week** (n=19) Up to 60 minutes per day of mobilisation and tactile stimulation every working day for 14 consecutive working days. **Physiotherapy - 45 minutes to 1 hour, 5 days a week** (n=18) Up to 30 minutes per day of mobilisation and tactile stimulation	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 72.6 (11.9) years N = 76 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient setting in London and Staffordshire, United Kingdom. Funding: The Stroke Association provided funding for this study.

Study	Intervention and comparison	Population	Outcomes	Comments
	every working day for 14 consecutive working days. **Physiotherapy - ≤45 minutes, 5 days a week** (n=19) No mobilisation and tactile stimulation intervention. Usual therapy only. **Concomitant therapy:** Everyone received usual therapy, which was physiotherapy delivered clinically for 30 minutes.			
Huseyinsinoglu 2012[38]	**Physiotherapy - >2 hours to 4 hours, 5 days a week** (n=13) Constraint-induced movement therapy group who received training 3 hours per day during 10 consecutive weekdays. Follow up at 2 weeks. **Physiotherapy - >45 minutes to 1 hour, 5 days a week** (n=11) The Bobath Concept group who received individualised therapy sessions, 1 hour daily for 10 consecutive week days. **Concomitant therapy:** No additional information	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 48.7 (14.5) years N = 24 Time after stroke: Chronic (≥ 6 months) Severity: Not stated/unclear Focus of care: Functional independency	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: The outpatient clinic of the Stroke Unit of the Florence Nightingale Hospital in Turkey. Funding: No specific grant from any funding agency in the public, commercial or not-for-profit sectors.
Ikbali Afsar 2018[39]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=19) Additional Xbox Kinect game system 30 minutes per day. The programs required	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 66.7 (12.7) years N = 35	Activities of daily living at <6 months Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: People admitted to an inpatient rehabilitation facility in Turkey. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	active movements of the upper extremity. Programs continued for a total of 30 minutes per session. Follow up at 4 weeks. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=16) Conventional therapy only. **Concomitant therapy:** All people received 60 minutes of conventional therapy for upper extremity, 5 times per week for 4 weeks.	Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: mixed		
Ikizler May 2020[40]	**Physiotherapy – >2 hours to 4 hours, 5 days a week** (n=21) Mirror therapy for 30 minutes in each session in addition to the conventional rehabilitation program. Follow up at 12 weeks. **Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=21) Conventional rehabilitation program only. **Concomitant therapy:** A conventional rehabilitation program for 4 weeks (60-120 minutes/day for 5 days a week).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 58.0 (8.8) years N = 42 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Unclear setting in Turkey. Funding: The authors received no financial support for the research and/or authorship of this article.
Jang 2019[41]	**Speech and language therapy - >1-2 hours, 5 days a week** (n=21)	**Adults without communication difficulties who have had a first or recurrent stroke**	Swallow function and ability at <6 months Discontinuation from study at <6 months	Setting: Inpatients in the Republic of Korea.

Study	Intervention and comparison	Population	Outcomes	Comments
	Mechanical inspiration and expiration exercises for 30 minutes once daily, five days a week for 2 weeks in addition to usual care. **Speech and language therapy - >45 minutes-1 hour, 5 days a week** (n=20) Usual care only. **Concomitant therapy:** Conventional swallowing therapy with oral motor and sensory stimulation, neuromuscular electrical stimulation and oral and lingual exercises for 30 minutes twice a day, 5 days a week for 2 weeks.	Mean age (SD): 69.2 (9.3) years N = 41 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Swallowing		Funding: No additional information.
Jiang 2020[43]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=23) Robot-assisted arm therapy (30 minutes twice a day, 5 days/week for 2 weeks) in addition to conventional therapy. Follow up at 1 month. **Physiotherapy – >45 minutes-1 hour, 5 days a week** (n=22) Conventional rehabilitation therapy only. **Concomitant therapy:** Conventional rehabilitation therapy 30 minutes	**Adults without communication difficulties who have had a first or recurrent stroke** Age range: 35 to 85 years N = 45 Time after stroke: Subacute (7 days – 6 months) Severity: Moderate (or NIHSS 5-14) Focus of care: upper limb	Activities of daily living at <6 months Physical function – upper limb at <6 months	Setting: Inpatient rehabilitation ward in a hospital in China. Funding: This work was supported by a fund from the Lanzhou Science and Technology Bureau (document number: 2016-2-59).

Study	Intervention and comparison	Population	Outcomes	Comments
	twice a day, 5 days/week for 2 weeks.			
Jo 2012[44]	**Physiotherapy – >1 hour to 2 hours, 5 days** (n=15) Virtual reality training for 60-minute sessions, 5 times a week for 4 weeks using The Interactive Rehabilitation and Exercise System. **Physiotherapy - ≤45 minutes, <5 days a week** (n=14) Traditional rehabilitation therapy only. **Concomitant therapy:** Traditional rehabilitation therapy, 30 minutes, 3 times a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 63.9 (8.0) years N = 29 Time after stroke: Not stated/unclear Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Stroke-related scale of cognition – spatial attention at <6 months Discontinuation from study at <6 months	Setting: The B Hospital in the Republic of Korea. Funding: No additional information.
Kang 2012[45]	**Occupational therapy - >1-2 hours, 5 days a week** (n=25) Additional bedside exercise training, which consisted of oral, pharyngeal, laryngeal and respiratory exercises, 1 hour per day, 5 days a week for 2 months in addition to usual care. **Occupational therapy - <45 minutes, 5 days a week** (n=25) Usual care only. **Concomitant care:** Both groups received occupational therapy for 30 minutes a day, 5	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 67.5 (6.4) years N = 50 Time after stroke: Subacute (7 days - 6 months) Severity: Not stated/unclear Focus of care: Multidisciplinary team	Person/participant health-related quality of life at <6 months Activities of daily living at <6 months Psychological distress – depression at <6 months Swallow function and ability at <6 months	Setting: Inpatients in the Republic of Korea. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	days a week for 3 months through tactile-thermal stimulation.			
Kesav 2017[46]	**Speech and Language Therapy - >1 hour to 2 hours, <5 days a week** (n=12) Computer based language therapy along with conventional speech and language therapy delivered by a qualified speech/language pathologist. All the recruited subjects received a total of 12 therapy sessions of 1 hour each over a period of 4 weeks on a thrice weekly basis. Follow up at 12 weeks. **Speech and Language Therapy - >45 minutes to 1 hour, <5 days a week** (n=12) Conventional speech and language therapy only **Concomitant therapy:** Conventional speech and language therapy was available for all (12 therapy sessions of 1 hour each over a period of 4 weeks).	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 52.5 (12.3) years N = 24 Time after stroke: Subacute (7 days – 6 months) Severity: Moderate (or NIHSS 5-14) Focus of care: Mixed (Communication)	Communication – overall language ability at <6 months Discontinuation from study at <6 months	Setting: The Comprehensive Stroke Care Center of a tertiary health care institute situated in South India. Funding: Centre for Disability Studies, Government of India (CeDS/FA/2011-2012) [Clinical Trials Registry India 2016/08/012021].
Khan 2011[47]	**Multidisciplinary team - >4 hours, 5 days a week** (n=14) Constraint induced therapy (2.5 hours of physiotherapy and occupational	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 61.0 (14.8) years	Physical function - upper limb at <6 months and ≥6 months Discontinuation at <6 months and ≥6 months	Setting: People at the Neurorehabilitation Center Valens, Switzerland. Funding: This research received no

Study	Intervention and comparison	Population	Outcomes	Comments
	therapy, and 5 hours of group therapy) in addition to 5 hours of self-training (30 minutes after each physiotherapy and occupational therapy session) per week and usual care. Follow up at 4 weeks and 6 months. **Multidisciplinary team - >2 hours to 4 hours, 5 days a week** (n=30) Two groups, the convention therapy (n=15) group (receiving just usual care), and therapeutic climbing (n=15) group (receiving the same amount of care as usual care but including climbing-specific exercises). **Concomitant therapy:** Conventional neurological therapy included individual physiotherapy (5 hours) and occupational therapy (2.5 hours) per week.	N = 44 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb		specific grant from any funding agency in the public, commercial, or not-for-profit sectors.
Kim 2012[48]	**Occupational therapy – >1 hour to 2 hours, 5 days a week** (n=10) Task-oriented training for 1 hour per day, 3 days a week, for 4 weeks. **Occupational therapy – >45 minutes to 1 hour, 5 days a week** (n=10)	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 53.0 (11.9) years N = 20 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear	Physical function – lower limb at <6 months	Setting: Inpatient in the Republic of Korea. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	Conventional physical therapy only. **Concomitant therapy:** Consecutive physical therapy for 1 hour per day, 5 days a week for 4 weeks.	Focus of care: Lower limb		
Kim 2014[52]	**Physiotherapy – >1 hour to 2 hours, <5 days a week** (n=10) Additional individualised respiratory muscle training regimen using a respiratory exercise device for 20 minutes. Follow up at 4 weeks. **Physiotherapy – >45 minutes to 1 hour, <5 days a week** (n=10) Conventional therapy only. **Concomitant therapy:** Exercise training intervention 3 times per week consisting of 30 minutes of basic exercise treatments, followed by an automated full-body workout for 20 minutes.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 54.0 (9.2) years N = 20 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Mixed (general exercise and respiratory muscle exercise)	Physical function – lower limb at <6 months	Setting: Inpatient in the Republic of Korea. Funding: No additional information. This study is reported in forest plots as Kim 2014A.
Kim 2009[51]	**Physiotherapy – >1 hour to 2 hours, <5 days a week** (n=12) Additional 30 minutes of virtual reality therapy every session of conventional physical therapy. The intervention was delivered for 4 weeks. **Physiotherapy – ≤45 minutes, <5**	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 52.1 (8.7) years N = 24 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear	Physical function – lower limb at <6 months	Setting: A medical inpatient facility in the Republic of Korea. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	days a week (n=12) Conventional physical therapy only. **Concomitant therapy:** Conventional physical therapy, 40 minutes a day, 4 days a week for 4 weeks.	Focus of care: Mixed		
Kim 2019[55]	**Occupational therapy – ≤45 minutes, 5 days a week** (n=19) Robotic-assisted shoulder rehabilitation therapy for 30 minutes per day, 5 times per week for a total of 20 sessions for 4 weeks. Follow up at 8 weeks. **Usual care** (n=19) Conventional therapy only (time not provided, but available to both study arms). **Concomitant therapy:** Conventional physical therapy provided twice per day for both groups.	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 65.3 (8.9) years N = 38 Time after stroke: Subacute (7 days – 6 months) Severity: Moderate (or NIHSS 5-14) Focus of care: Upper limb	Activities of daily living at <6 months Discontinuation from study at <6 months	Setting: People at a single tertiary university hospital in the Republic of Korea. Funding: Supported by Wonkwang Institute of Clinical Medicine (2016-0669), Republic of Korea.
Kim 2014[54]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=11) Additional community walking training program 30 minutes per day, five times a week for four weeks. **Physiotherapy - >45 minutes to 1 hour, 5 days a week** (n=11)	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 50.5 (8.9) years N = 22 Time after stroke: Chronic (≥6 months) Severity: not stated/unclear	Person/participant health-related quality of life at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient rehabilitation hospital in the Republic of Korea. Funding: No additional information. This study is reported in forest plots as Kim 2014B.

Study	Intervention and comparison	Population	Outcomes	Comments
	Standard rehabilitation program only. **Concomitant therapy:** Standard rehabilitation program consisting of physical and occupational therapy for 60 minutes per day, five times a week for four weeks.	Focus of care: Lower limb		
Kim 2015[56]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=16) Additional daily session of stationary cycling exercise, 30 minutes, 5 times a week for 4 weeks. **Physiotherapy – ≤45 minutes, 5 days a week** (n=16) Standard rehabilitation program only. **Concomitant therapy:** Standard rehabilitation program for 30 minutes, 5 times a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 63.5 (6.5) years N = 32 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – lower limb at <6 months	Setting: Hospital setting in the Republic of Korea. Funding: No additional information. This study is reported in forest plots as Kim 2015B.
Kim 2016[57]	**Physiotherapy - >1-2 hours, 5 days a week** (n=10) 90-minutes of circuit training classes, 5 times a week for 4 weeks. **Physiotherapy - >45 minutes-1 hour, 5 days a week** (n=10) Conventional individual physiotherapy for 30 minutes twice a day, 5 days a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 65.6 (9.5) years N = 20 Time after stroke: Subacute (7 days - 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Activities of daily living at <6 months Physical function - lower limb at <6 months	Setting: Inpatients in the Republic of Korea. Funding: Supported by the research grant of the Jeju National University in 2012.

Study	Intervention and comparison	Population	Outcomes	Comments
	Concomitant therapy: No additional information.			
Kim 2017[53]	**Physiotherapy - >1-2 hours, 5 days a week** (n=15) Task-oriented circuit training for 50 minutes, five times a week for 4 weeks in addition to usual care. **Physiotherapy - >45 minutes-1 hour, 5 days a week** (n=15) Usual care only. **Concomitant therapy:** Neurodevelopment treatment (postural control exercise, resistance exercise and functional activity exercise) for approximately 1 hour per day.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 55.7 (12.2) years N = 30 Time after stroke: Subacute (7 days - 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limb at <6 months	Setting: Inpatients in South Korea. Funding: No additional information.
Kim 2022[50]	**Physiotherapy - >1-2 hours, 5 days a week** (n=28) Mirror therapy delivered conventionally or through a video augmented wearable reflection device for 30 minutes a day, five days a week for 4 weeks in addition to usual care. **Physiotherapy - >45 minutes-1 hour, 5 days a week** (n=14) Usual care only. **Concomitant therapy:** Physical and occupational therapies for 60 minutes a day, 5 times a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 59.8 (5.1) years N = 30 Time after stroke: Chronic (>6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Outpatient follow up in the Republic of Korea. Funding: This research was supported by a grant of the Korea Health Technology R&D Project through the Korea Health Industry Development Institute (KHIDI), funded by the Ministry of Health & Welfare, Republic of Korea (grant number: HI21C0572).

Study	Intervention and comparison	Population	Outcomes	Comments
Klassen 2020[58]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=25) DOSE2: 2 hours, 5 days/week weight-bearing walking related activities. Follow up at 12 weeks. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=50) Two groups, DOSE1 (N=25) and usual care (N=25). Usual care included physical therapy was inpatient physical therapy that progressed upper and lower limb functional exercises as tolerated. DOSE1 included 20 exercise sessions of weight-bearing walking related activities. **Concomitant therapy:** No additional information.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 57.3 (11.4) years N = 75 Time after stroke: Subacute (7 days – 6 months) Severity: Moderate (or NIHSS 5-14) Focus of care: Mixed	Person/participant health-related quality of life at <6 months Physical function – lower limb at <6 months Psychological distress – Depression at <6 months Discontinuation from study at <6 months	Setting: 6 study inpatient rehabilitation units over 3 provinces in the United States of America. Funding: This work was supported by the: Canadian Institutes of Health Research (Doctoral award to Dr Klassen; Operating Grant FDN 143340 to Dr Eng); Heart and Stroke Foundation Canadian Partnership for Stroke Recovery Operating Grant (Dr Eng); Canadian Stroke Network infrastructure (Dr Hill); Brenda Strafford Foundation Chair in Alzheimer Research (Dr Poulin).
Ko 2015[59]	**Physiotherapy – ≤45 minutes, 5 days a week** (n=26) Additional balance training with a Space Balance 3D exercise program for 30 minutes, 15 sessions over 3 weeks. **Usual care** (n=26) Usual care only. **Concomitant therapy:** Usual care (5 days a week, time not specified).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 46.7 (4.5) years N = 52 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limb at <6 months	Setting: Inpatient in the Republic of Korea. Funding: This study was supported by Sahmyook University.
Kong 2016[61]	**Occupational therapy - >1 hour**	**Adults without communication**	Person/participant health-related	Setting: An inpatient stroke rehabilitation

Study	Intervention and comparison	Population	Outcomes	Comments
	to 2 hours, 5 days a week (n=70) Two groups: Nintendo Wii gaming (N=35) and conventional therapy (N=35). Different games were designed to test the skills of the user in executing different movements and acceleration of the upper limbs. Follow up at 15 weeks. **Occupational therapy - >45 minutes to 1 hour, 5 days a week** (n=35) No additional treatment. **Concomitant therapy:** Usual upper limb exercises for 1 hour daily in occupational therapy.	**difficulties who have had a first or recurrent stroke** Mean age (SD): 57.7 (11.6) years N = 105 Time after stroke: Subacute (7 days – 6 months) Severity: Severe (or NIHSS 15-24) Focus of care: Upper limb	quality of life at <6 months Activities of daily living at <6 months Physical function – upper limb at <6 months Discontinuation from study at <6 months	program held in a rehabilitation centre in Singapore. Funding: This study was funded by a Health Services Research Outcome grant, Ministry of Health, Singapore.
Kongkasuwan 2016[62]	**Psychology/neuropsychology – >2 hours to 4 hours, 5 days a week** (n=59) Additional creative art therapy, twice a week for four weeks (8 sessions) in the rehabilitation ward. Each session of creative art therapy, twice a week for four weeks (8 sessions) in the rehabilitation ward. Each session lasted 1.5-2 hours and involved groups of 5-10 patients. Follow up at 4 weeks. **Psychology/neuropsychology – >1 hour to 2 hours, 5**	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 66.3 (9.6) years N = 118 Time after stroke: Not stated/unclear Severity: Not stated/unclear Focus of care: Mixed	Person/participant specific health-related quality of life at <6 months Activities of daily living at <6 months Psychological distress – Depression at <6 months Discontinuation from study at <6 months	Setting: Inpatient in Thailand. Funding: This study was supported by the National Research Council of Thailand.

Study	Intervention and comparison	Population	Outcomes	Comments
	days a week (n=59) Conventional therapy only. **Concomitant therapy:** All people received a conventional physical therapy program five days per week (20 sessions) conducted by a physical therapist for 1-2 hours per day.			
Kumar 2011[62]	**Physiotherapy – ≤45 minutes, 6 days a week** (n=10) 10 hours of additional trunk exercises over a period of 3 weeks. 10 hours in total, 45 minute sessions, 6 times a week for 3 weeks. **Usual care** (n=10) Conventional program only. **Concomitant therapy:** Conventional multidisciplinary rehabilitation program (no information about amount of time).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 58.7 (12.8) years N = 20 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limb at <6 months	Setting: Inpatient in Karnataka, India. Funding: No additional information.
Kuys 2011[64]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=15) Treadmill for 30 minutes (excluding rests), three times a week for six weeks. Follow up at 18 weeks. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=15)	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 67.5 (16.2) years N = 30 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Two rehabilitation units in Brisbane, Australia. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	Usual physiotherapy intervention only. **Concomitant therapy:** Usual physiotherapy intervention, comprising approximately one hour per day of comprehensive therapy using a task-oriented approach targeting impairments and activity limitations specific to each participant.	Focus of care: Lower limb		
Kwakkel 2016[65]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=29) Modified constraint induced movement therapy group daily with 60 minutes of supervised intensive graded practice. People were instructed to wear padded safety mitts for 3 hours per working day, during 3 consecutive weeks and lasting up until 5 weeks poststroke. Follow up at 12 weeks. **Physiotherapy – ≤45 minutes to 1 hour, 5 days a week** (n=29) Usual care only. **Concomitant therapy:** Face-to-face by a physical therapist or occupational therapist for 30 minutes per working day executed for 3 consecutive weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 62.2 (13.2) years N = 58 (favourable prognosis, 101 were included in the unfavourable prognosis group making 159 in total) Time after stroke: Subacute (7 days – 6 months) Severity: Mild (or NIHSS 1-5) Focus of care: Upper limb	Person/participant health-related quality of life at <6 months Physical function - upper limb at <6 months Discontinuation from study at <6 months	Setting: Multicentre inpatient treatment in the Netherlands. Funding: The research leading to these results received funding from the Netherlands Organisation for Health Research and Development (ZonMw Grant No. 89000001) and was supported by the European Research Council (ERC) under the European Union's Seventh Framework Programme (FP/2007-2013)/ERC Grant Agreement no. 291339-4D-EEG and grants awarded to EW and CM from the Dutch Brain Foundation (de Hersenstichting).

Study	Intervention and comparison	Population	Outcomes	Comments
Lee 2014[66]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=10) Additional augmented reality-based postural control training for 30 minutes per day, 3 days per week for a period of 4 weeks in addition to conventional therapy. **Physiotherapy - ≤45 minutes, 5 days a week** (n=11) General physical therapy only. **Concomitant therapy:** General physical therapy program for a duration of 30 minutes per session, 5 days per week, for a period of 4 weeks.	**Adults without communication difficulty who have had a first or recurrent stroke** Mean age (SD): 51.1 (12.3) years N = 21 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Unclear, in the Republic of Korea. Funding: All authors declare that they have no conflicts of interest.
Lee 2013[67]	**Occupational therapy - >45 minutes to 1 hour, <5 days a week** (n=7) Video games played on the Xbox Kinect together with conventional occupational therapy for 6 weeks (1 hour/day, 3 days/week). Two games were played for 15 minutes each, for a total of 30 minutes. **Occupational therapy - ≤45 minutes, <5 days a week** (n=7) Conventional occupational therapy only. **Concomitant therapy:**	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 74.1 (8.0) years N = 14 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Mixed	Activities of daily living at <6 months	Setting: Inpatient in the Republic of Korea. Funding: This work was supported by Kyungnam University Foundation Grant, 2012.

Study	Intervention and comparison	Population	Outcomes	Comments
	Conventional occupational therapy focused on upper extremity function and activities of daily living. That was performed for 30 minutes.			
Lee 2012[68]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=20) Training with a balance control trainer for 20 minutes a day, 5 days a week for 4 weeks in addition to concurrent conventional therapy. **Physiotherapy - >45 minutes to 1 hour, 5 days a week** (n=20) Conventional physical therapy only. **Concomitant therapy:** Conventional physical therapy, 1 hour a day, 5 days a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 53.9 (11.2) years N = 40 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Unclear setting in South Korea. Funding: No additional information.
Lin 2020[69]	**Multidisciplinary team – >1 hour to 2 hours, 5 days a week** (n=38) Extra 5 days of supervised virtual reality training (15 minutes of time, 2 times per day). Follow up at 14 days. **Multidisciplinary team – >45 minutes to 1 hour, 5 days a week** (n=114) Conventional therapy only. >45 minutes to 1 hour, 5 days a week until	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 66.3 (13.4) years N = 152 Time after stroke: Acute (72 hours – 7 days) Severity: Not stated/unclear Focus of care: Mixed	Activities of daily living at <6 months Physical function – lower limb at <6 months Psychological distress – Depression at <6 months Discontinuation from study at <6 months	Setting: Neurological care ward of a medical center in Taiwan. Funding: Funded by the Tri-Service General Hospital (TSGH-C106-128), Taipei, Taiwan.

Study	Intervention and comparison	Population	Outcomes	Comments
	discharge (between 7 and 21 days). **Concomitant therapy: E**arly rehabilitation (five 60-minute sessions per week), prescribed by a rehabilitation physician, was performed at 3 to 6 days after admission by the physical, occupational and speech therapists at the rehabilitation department.			
Long 2020[70]	**Occupational therapy – >1 hour to 2 hours, 5 days a week** (n=30) Virtual reality - additional 45 minutes virtual reality training, 5 times per week over 3 weeks. **Occupational therapy – ≤45 minutes, 5 days a week** (n=30) Conventional rehabilitation only. **Concomitant therapy:** Both groups received dose-matched conventional rehabilitation (i.e., 45 minutes, 5 times per week, over 3 weeks).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 53.7 (15.1) years N = 60 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Discontinuation from study at <6 months	Setting: Outpatient and inpatient care at a large acute hospital in Changsha, China. Funding: This study was supported by Clinical Medical Technology Innovation Guidance Project of Hunan Province Technology Innovation Guidance Program (No. 2017SK50113). Funding agencies could provide appropriate financial support for data collection and manuscript polishing.
Majumdar 2019[71]	**Psychology/neuropsychology – >1 hour to 2 hours, <5 days a week** (n=26) 'ACTivate Your Life after Stroke' intervention, consisting of 2 hour weekly didactic PowerPoint group sessions for four consecutive	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age: 62.6 years N = 53 Time after stroke: Chronic (≥6 months)	Person/participant health-related quality of life at <6 months Psychological distress – Depression at <6 months	Setting: Libraries (community setting) in the United Kingdom. Funding: This research did not receive any specific grant from funding agencies in the public, commercial or not-for-profit sectors.

Study	Intervention and comparison	Population	Outcomes	Comments
	weekly. Follow up at 2 months. **Usual care N=27** Usual care only (no information about amount of time of therapy received). **Concomitant therapy:** All people had access to usual treatments should they choose, including community services such as GP, charity support or online resources.	Severity: Not stated/unclear Focus of care: Cognition		
Malagoni 2016[72]	**Physiotherapy - ≤45 minutes, 6 days a week** (n=6) The Ti-To program consisting of a hospital-based phase and a structured home-based phase. The intervention was based on 2 10-minute sessions/day (6 days/week) of intermittent walking. Follow up at 10 weeks. **Physiotherapy - >45 minutes to 1 hour, <5 days a week** (n=6) The standard rehabilitation program was conducted in a group setting for 1 hour, 3 times/week. **Concomitant therapy:** No additional information.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 66.6 (12.4) years N = 12 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Person/participant health-related quality of life at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: The Department of Rehabilitation in the Hospital-University of Ferrara, Italy. Funding: No additional information.
Martins 2013[73]	**Speech and Language Therapy - >1 hour to 2 hours, 5 days a week** (n=15) Intensive speech and language	**Adults without communication difficulties who have had a first or recurrent stroke**	Communication – Overall language ability at <6 months and ≥6 months Communication – Functional	Setting: Two medical centres: an academic hospital with a speech and language rehabilitation outpatient unit, acute

Study	Intervention and comparison	Population	Outcomes	Comments
	therapy, 2 hours per day, 5 days per week for 10 weeks. Follow up at 10 weeksand 62 weeks. **Speech and Language Therapy - >1 hour to 2 hours, <5 days a week** (n=15) Speech and language therapy - 2 hours per week for 50 weeks. **Concomitant therapy:** All people were evaluated by staff neurologists or clinicians and received antidepressant medication with sertraline (50mg daily).	Mean age (SD): 61.3 (11.8) years N = 30 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Communication	communication at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	stroke unit and a rehabilitation centre with inpatient and outpatient departments in Portugal. Funding: No additional information.
Masiero 2007[74]	**Occupational therapy – >45 minutes to 1 hour, 5 days a week** (n=17) Additional early sensorimotor robotic training, 4 hours a week for 5 weeks using the NeReBot device. Follow up at 3 months and 8 months. **Occupational therapy – ≤45 minutes, <5 days a week** (n=18) Exposed to the robotic device 30 minutes a week, twice a week but the exercises were performed with the unimpaired limb. **Concomitant therapy:** All people received the same dose and length	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 66.2 (11.5) years N = 35 Time after stroke: Acute (72 hours – 7 days) Severity: Not stated/unclear Focus of care: Upper limb	Activities of daily living at <6 months and ≥6 months Physical function - upper limb at <6 months and ≥6 months	Setting: Inpatient at the Stroke Unit of Padova Hospital in Italy. Funding: Supported by the Italian University Ministry (grant no. grant RBAU019C3C_001).

Study	Intervention and comparison	Population	Outcomes	Comments
	per day of standard rehabilitation treatment (based on the Bobath concept) and poststroke occupational therapy by the same interdisciplinary clinical team (amount of therapy not provided).			
Min 2020[75]	**Physiotherapy - >45 minutes to 1 hour, 5 days a week** (n=19) 30 minutes of trunk stability robot training in addition to conventional physical therapy. Using the Trunk Stability Rehabilitation Robot Trainer (3DBT-33). Follow up at 8 weeks. **Physiotherapy - ≤45 minutes, 5 days a week** (n=19) Conventional physical therapy only. **Concomitant therapy:** Conventional physical therapy for 30 minutes a day, 5 days a week for 4 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 58.9 (10.5) years N = 38 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Outpatient clinics in two national university hospitals in the Republic of Korea. Funding: This research was supported by a grant of the Korea Health Technology R&D Project through the Korea Health Industry Development Institute, funded by the Ministry of Health and Welfare, Republic of Korea (grant number: HI15C1529).
Mirela Cristina 2015[76]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=7) Mirror therapy for 30 minutes every day, five times a week for 6 weeks in addition to conventional therapy. **Physiotherapy – ≤45 minutes, 5 days a week** (n=8)	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 57.5 (7.8) years N = 15 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient setting in Romania. Funding: The research is not financed.

Study	Intervention and comparison	Population	Outcomes	Comments
	Conventional therapy only. **Concomitant therapy:** Comprehensive rehabilitative treatment - five half an hour sessions per week with therapy consisting of neurorehabilitative techniques, electrical stimulation and occupational therapy.	Focus of care: Upper limb		
Moon 2017[77]	**Occupational therapy – >45 minutes to 1 hour, 5 days a week** (n=9) Expiratory Muscle training using the EMST 150. Each person received seven trainings per session (lasting 30 minutes), 5 times a week for 4 weeks. **Occupational therapy - ≤45 minutes, 5 days a week** (n=9) Traditional swallowing rehabilitation therapy only. **Concomitant therapy:** Traditional swallowing rehabilitation therapy in 30 minute sessions, five times a week for four weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 63.1 (5.5) years N = 18 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Swallow	Swallow function and ability at <6 months Discontinuation from study at <6 months	Setting: The I Hospital in the Republic of Korea. Funding: No additional information.
Mudie 2002[78]	**Occupational therapy – ≤45 minutes, 5 days a week** (n=30) Three groups: 1) portable computer-linked Balance Performance Monitor feedback	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 72.4 (9.01) N = 40	Discontinuation from study at <6 months	Setting: The Kingston Centre for rehabilitation in Australia. Funding: The project was funded by a La Trobe University Health Services

Study	Intervention and comparison	Population	Outcomes	Comments
	console. 2) Task-related reach training. 3) Training based on Bobath practices. All training was provided for 30 minutes (appears to be five days a week) for 2 weeks. Follow up at 16 weeks. **Usual care** (n=10) No additional training **Concomitant therapy:** All people had standard physiotherapy and occupational therapy programmes.	Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb		Faculty Grant No.A33.
Mustafaoglu 2018[79]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=15) Combination of body weight-supported treadmill training 45 minutes, twice per week and conventional therapy, 45 minutes, 5 times a week. Follow up at 6 weeks. **Physiotherapy – ≤45 minutes, 5 days a week** (n=15) Conventional therapy, 45 minutes, 5 times a week. **Physiotherapy – ≤45 minutes, <5 days a week** (n=15) Body weight-supported treadmill training 45 minutes, twice per week. **Concomitant therapy:** No	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 53.0 (13.4) years N = 45 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Unclear, likely outpatient in Turkey. Funding: The authors received no financial support for the research and/or authorship of this article.

Study	Intervention and comparison	Population	Outcomes	Comments
	additional information			
Norouzi-Gheidari 2019[81]	**Occupational therapy – ≤45 minutes, <5 days a week** (n=9) The Jintronix system, a rehabilitation exergaming system is an interactive exergame. Each person received training with the device two to three times per week, 30 minutes per session (excluding preparation and other interactions with the system) for 4 weeks in addition to usual care. Follow up at 8 weeks. **Usual care** (n=9) Conventional therapy only. **Concomitant therapy:** Occupational and/or physical therapy services provided two to three times a week.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 49.9 (12.6) years N = 18 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Person/participant health-related quality of life at <6 months Physical function - upper limb at <6 months	Setting: Outpatient rehabilitation services in Canada. Funding: This study was partially funded by the Lindsay Rehabilitation Hospital Foundation and Jintronix Inc.
Øra 2020[82]	**Speech and Language Therapists - >1 hour to 2 hours, 5 days a week** (n=32) Telerehabilitation intervention. At least 5 hours a week should be delivered in addition to usual care (on average totalling >1 hour to 2 hours, 5 days a week). Follow up at 4 months. **Speech and Language Therapists - >45 minutes to 1 hour,**	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 64.9 (12.0) years N = 62 Time after stroke: Not stated/unclear Severity: Not stated/unclear Focus of care: Communication	Communication – Impairment specific measures (Naming) at <6 months Communication – Impairment specific measures (Auditory Comprehension) at <6 months Communication – Functional communication at <6 months Discontinuation from study at <6 months	Setting: Telerehabilitation delivered from tertiary rehabilitation center to participants at their home or admitted to secondary rehabilitation centers in Norway. Funding: The trial is funded by the South-Eastern Norway Regional Health Authority (project number 2015037) and has also received financial support from the University of Oslo and Sunnaas

Study	Intervention and comparison	Population	Outcomes	Comments
	5 days a week (n=30) Usual care only. **Concomitant therapy:** All participants received usual care during the study period provided by local speech language pathologists. Hours of usual care: 25 (13.8), delivered approximately as 1 hour sessions, 5 days a week.			Rehabilitation Hospital. The NMAHP RU and MB is supported by the Chief Scientist Office, part of the Scottish Government Health and Social Care Directorates.
Page 2012[85]	**Occupational Therapy - >1 hour to 2 hours, 5 days a week** (n=8) 2 hour group where they practice valued activities identified from the Canadian Occupational Performance Measure at home for 120 minutes for 5 days a week over an 8 week period. **Occupational therapy - >45 minutes to 1 hour, 5 days a week** (n=8) 1 hour group where they practice valued activities identified from the Canadian Occupational Performance Measure at home for 60 minutes for 5 days a week over an 8 week period. **Occupational therapy - ≤45 minutes, 5 days a week N=16** Two groups: 1) 30 minute group where they practice valued activities	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 57.6 (10.1) years N = 32 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months	Setting: Outpatient rehabilitation hospital in the United States of America. Funding: Supported by an award from the American Heart Association.

Study	Intervention and comparison	Population	Outcomes	Comments
	identified from the Canadian Occupational Performance Measure at home for 30 minutes for 5 days a week over an 8 week period. 2) Conventional home exercise program for 30 minutes for 5 days a week over 8 weeks. **Concomitant therapy:** All people had an education session (the content being relevant to their intervention aims).			
Pálsdóttir 2020[84]	**Multidisciplinary team - >2 hours to 4 hours, <5 days a week** (n=51) Nature based rehabilitation program, 10 weeks completed in groups of up to 8 patients, at Alnarp Rehabilitation Garden. Follow up at 14 months. **Usual care** (n=50) Standard care. **Concomitant therapy:** Standard care was available.	**Adults without communication difficulties who have had a first or recurrent stroke** Age range: 47 to 80 N = 101 Time after stroke: Chronic (≥6 months) Severity: Mild (or NIHSS 1-5) Focus of care: Mixed	Person/participant health-related quality of life at ≥6 months Stroke outcome – modified Rankin scale at ≥6 months Psychological distress – Depression at ≥6 months Discontinuation from study at ≥6 months	Setting: Skane University Hospital at the acute stroke stage in Sweden. Funding: The study was funded by Region Skane county council; the Crafoord Research Fund and the Swedish Stroke Association.
Park 2017[86]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=12) Received virtual reality training using Xbox Kinect-based game and conventional physical therapy (30 minute VR training session, followed by 30 minute session of physical therapy). Conducted for 6 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 63.7 (14.3) years N = 24 Time after stroke: Chronic (≥6 months) Severity: Mot stated/unclear	Physical function - lower limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient at the rehabilitation centre in the Republic of Korea. Funding: No financial or nonfinancial competing interest exists for either of this paper's authors.

Study	Intervention and comparison	Population	Outcomes	Comments
	Physiotherapy – ≤45 minutes, 5 days a week (n=12) Conventional physical therapy only for 6 weeks. **Concomitant therapy:** Conventional physical therapy. The program was performed for 30 minutes.	Focus of care: Mixed		
Park 2011[87]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=14) Community-based ambulation training, which was performed for an hour, once a day, three times a week for four weeks. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=13) Routine physical therapy only. **Concomitant therapy**: Routine physical therapy based on the Bobath concept daily for an hour.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 58.2 (8.2) years N = 27 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function - lower limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient rehabilitation hospital in the Republic of Korea. Funding: This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.
Park 2014[88]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=11) The underwater gait program. Beginning with a warm up in the water for 5 minutes to establish psychological stability and prevent accidents. The main exercise was carried out for 30 minutes. At the end of the main exercise, cool-	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 61.2 (11.9) years N = 22 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: People admitted to the rehabilitation hospital in Incheon, Republic of Korea. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	down exercises were carried out for 5 minutes. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=11) General rehabilitation program only. **Concomitant therapy:** General rehabilitation program. The motor exercises were performed five times a week, once per day, for 30 minutes. Functional electrical stimulation was applied to the upper and lower extremities for 15 minutes each. Occupational therapy was performed five times per week, once a day for 30 minutes each time.			
Park 2021[89]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=22) A game-based virtual reality rehabilitation program of 30 minutes per session, 5 sessions per week for 4 weeks. **Physiotherapy – ≤45 minutes, 5 days a week** (n=22) Conventional physical therapy only. **Concomitant therapy:** Conventional physical therapy,	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 61.4 (16.2) years N = 44 Time after stroke: Not stated/unclear Severity: Not stated/unclear Focus of care: Upper limb	Activities of daily living at <6 months Physical function – Upper limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient in the Republic of Korea. Funding: This research received no external funding.

Study	Intervention and comparison	Population	Outcomes	Comments
	30 minutes per session, 5 days a week during the 4 week training period.			
Partridge 2000[90]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=60) Standard plus therapy (60 minutes/day). Follow up at 6 weeks and 6 months. **Physiotherapy - ≤45 minutes, 5 days a week** (n=54) Standard therapy (30 minutes/day). **Concomitant therapy:** No additional information.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age: 76.5 years N = 114 Time after stroke: Not stated/ unclear Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limbs at <6 months and ≥6 months Psychological distress – depression at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: Outpatient care in the United Kingdom. Funding: This project was funded jointly by South East Thames R&D Directorate and East Kent Health Authority.
Pervane Vural 2016[91]	**Physiotherapy – >4 hours, 5 days a week** (n=15) An additional mirror therapy program for 30 minutes/day. Follow up at 4 weeks. **Physiotherapy – >2 hours to 4 hours, 5 days a week** (n=15) Conventional stroke rehabilitation program only. **Concomitant therapy:** Patient-specific conventional stroke rehabilitation program for 4 weeks, 5 days a week for 2-4 hours/day.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 65.2 (11.8) years N = 30 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Discontinuation from study at <6 months	Setting: Inpatient rehabilitation centre in Turkey. Funding: No additional information.
Peurala 2009[92]	**Physiotherapy - >1 hour to 2 hours, 5 days a week** (n=43) Two groups: 1) gait trainer exercise, 2)	**Adults without communication difficulties who have had a first or recurrent stroke**	Physical function – lower limb at <6 months and ≥6 months	Setting: Inpatient rehabilitation in the acute care hospital in Finland.

Study	Intervention and comparison	Population	Outcomes	Comments
	walking training over ground. 15 sessions of either intervention over 3 weeks in addition to usual physiotherapy. A maximum of 1 hour/day therapy in order to obtain 20 minutes of actual walking either in the electromechanical gait trainer or over ground. Follow up at 3 weeks and 6 months. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=13) Conventional therapy only. **Concomitant therapy**: Gait-oriented physiotherapy for 55 minutes daily.	Mean age (SD): 66.4 (10.1) years N = 56 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Lower limb	Discontinuation at <6 months and ≥6 months	Funding: This study was supported by the Brain Research and Rehabilitation Center Neuron, Kuopio, Finland, the Department of Neurology, University of Kuopio, and Kuopio University Hospital, Kuopio, Finland (grant # EVO477338, 57/2003, 36/2004) and Academy of Finland (grant #114291).
Platz 2005[93]	**Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=40) Patients receiving augmented exercise therapy time with conventional arm rehabilitation (augmented exercise therapy time Bobath), or patients receiving augmented exercise therapy time with impairment-oriented arm rehabilitation (augmented exercise therapy time BASIS). Both groups of patients received augmented exercise therapy time with 20	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 61.3 (12.6) years N = 60 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Inpatients and outpatients stroke rehabilitation centre in Germany. Funding: The study sponsor had no role in study design; in the collection, analysis, and interpretation of data; in the writing of the report; and in the decision to submit the paper for publication.

Study	Intervention and comparison	Population	Outcomes	Comments
	additional arm training sessions (each lasting 45 min) over the course of four weeks. **Physiotherapy – ≤45 minutes, 5 days a week** (n=20) Standard rehabilitation therapy. **Concomitant therapy:** The treatment made use of different therapeutic concepts and addressed various issues such as activities of daily living, arm activities, stance and gait, speech and cognition. no details on dose or intensity provided.			
Rodgers 2019[94]	**Physiotherapy – >1 hour to 2 hours, 5 days per week** (n=516) Two groups combined: Robot-assisted training and enhanced upper limb therapy (EULT) programmes that were delivered at the same frequency and duration: 45 min of face-to-face therapy, three times per week for 12 weeks. Follow up at 3 and 6 months. **Physiotherapy – >45 minutes to 1 hour, 5 days per week** (n=254) Participants received usual NHS care, which was provided by	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 60.6 (13.5) years N = 770 Time after stroke: Chronic (≥6 months) Severity: Moderate (or NIHSS 5-14) Focus of care: Upper limb	Person/participant health-related quality of life at <6 months and ≥6 months Activities of daily living at <6 months and ≥6 months Physical function – general at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: 4 NHS stroke rehabilitation units in the United Kingdom. Funding: The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

Study	Intervention and comparison	Population	Outcomes	Comments
	their local clinical service. **Concomitant therapy:** Participants in all groups received usual NHS care, which was provided by their local clinical service. The English national quality standard is that patients with stroke should be offered a minimum of 45 min of each appropriate therapy that is required, for a minimum of 5 days per week.			
Rose 2022[95]	**Speech and language therapy - >2-4 hours, 5 days a week** (n=146) 3 hours of either constraint-induced group speech and language therapy or multi-modality group speech and language therapy, 5 days a week for 2 weeks. **Usual care** (n=70) Usual care only. **Concomitant therapy:** All people could receive anything from no intervention to non-intense, computerised or social/support group sessions.	**Adults with communication difficulties who have had a first or recurrent stroke** Median age (IQR): Constraint group: 63.93 (19.79) years Multi-modality group: 63.77 (21.02) years Usual care: 63.16 (14.10) years N = 216 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Communication	Person/participant health-related quality of life at <6 months Communication – overall language ability at <6 months Communication – impairment specific measures (naming) at <6 months Communication – functional communication at <6 months Discontinuation from study at <6 months	Setting: Community based in Australia. Funding: Funded by the Australian National Health and Medical Research Council (#1083010). Additional funded by La Trobe University.
Ross 2009[96]	**Physiotherapy – >1 hour to 2 hours, 5 days per week** (n=20) The experimental group received an additional one-hour session of task-specific motor training for the hand five times a	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 59.5 (20.0) years N = 39	Activities of daily living at <6 months Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Stroke rehabilitation hospital - inpatients and outpatients in Australia. Funding: This research was conducted with financial support from a Queensland

Study	Intervention and comparison	Population	Outcomes	Comments
	week over a six-week period. **Physiotherapy – >45 minutes to 1 hour, 5 days per week** (n=20) Usual care only. **Concomitant therapy:** Both groups continued to receive usual arm care. It consisted of half an hour of motor training for the shoulder and elbow five times a week. In addition, participants in the control group had similar hand therapy as participants in the experimental group but for only 10 minutes, three times a week for 6 weeks.	Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb		Health Allied Health Research Scheme award. No commercial party having a direct financial interest in the results of the research supporting this article has or will confer a benefit upon the author(s) or upon any organization with which the author(s) is/are associated.
Seo 2012[98]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=6) The experimental group performed trunk stabilisation exercises using sonographic visual feedback for 30 minutes. The intervention was conducted 5 times a week, for 5 weeks for a total of 25 times. **Physiotherapy – ≤45 minutes, 5 days a week** (n=6) Patients received routine physical therapy for 30 min, 5 times a week for 5 weeks. **Concomitant therapy:** Patients received routine physical therapy for	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 58.8 (11.8) years N = 12 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Functional independency	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Outpatient rehabilitation in the Republic of Korea. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	30 min, 5 times a week for 5 weeks.			
Shaukat 2022[99]	**Physiotherapy - >1 hour to 2 hours, 5 days a week** (n=11) Constraint induced movement therapy two hours a day, five days a week for eight weeks. **Physiotherapy - ≤45 minutes, 5 days a week** (n=11) Standard therapy with mental rehearsal of upper limb movements during 45 minute supervised sessions three times a week and structured independent sessions twice a week. **Concomitant therapy:** No additional information.	**People without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 54.0 (6.3) years N = 22 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Outpatient follow up in Pakistan. Funding: None stated.
Sin 2013[101]	**Occupational therapy – >45 minutes to 1 hour, <5 days a week** (n=20) VR Training Using Xbox Kinect for a total of 30 minutes per session (three times a week for 6 weeks). **Occupational therapy – ≤45 minutes, <5 days a week** (n=20) Conventional occupational therapy only. **Concomitant therapy:** All people underwent conventional occupational therapy for 30	**People without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 73.7 (8.0) years N = 40 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Inpatient in the Republic of Korea. Funding: Supported by Kyungnam University Research Fund, 2013.

Study	Intervention and comparison	Population	Outcomes	Comments
	minutes three times a week for 6 weeks.			
Sivenius 1985[102]	**Multidisciplinary team – >1 hour to 2 hours, 5 days a week** (n=50) Intensive treatment (IT). Usually one physiotherapy session lasted half an hour. When a patient in IT was in the medical ward of University Hospital, they were treated by a physiotherapist twice a day. Follow up at 3 and 12 months. **Multidisciplinary >45 minutes to 1 hour, 5 days per week** (n=45) The patients in normal treatment received the normal physical therapy in the conventional medical wards, the duration and amount of which was determined by the therapists. **Concomitant therapy:** No additional information.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age: not reported N = 95 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Functional independency	Activities of daily living at <6 months and ≥6 months Physical function – lower limb at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: Inpatient rehabilitation in Finland. Funding: No additional information.
Smith 1981[103]	**Multidisciplinary team – >45 minutes to 1 hour, 5 days a week** (n=46) Intensive attendance in the rehabilitation department with treatment by occupational therapists and physiotherapists four whole days a week. Total therapy = 124.1 hours delivered for approximately 6	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age: 64.5 years N = 89 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear	Discontinuation from study at <6 months	Setting: Outpatient rehabilitation in the United Kingdom. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	months. Follow up at 3 and 6 months. **Multidisciplinary team – ≤45 minutes, 5 days a week** (n=43) Conventional attendance three half days a week for approximately 6 months. Total therapy = 66 hours delivered over approximately 6 months. **Concomitant therapy:** No additional information.	Focus of care: Functional independency		
Stahl 2018[104]	**Speech and Language Therapy – >2 hours to 4 hours, <5 days per week** (n=15) Intensive Language-Action Therapy (ILAT, an expanded version of Constrained-Induced Aphasia Therapy requiring request and planning communication) 3 x weekly sessions for a total of 4 hours totalling 12 hours per week for 4 weeks. **Speech and Language Therapy – >1 hour to 2 hours, <5 days per week** (n=15) Intensive Language-Action Therapy (ILAT, an expanded version of Constrained-Induced Aphasia Therapy requiring request and planning communication) 3 x	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 60.2 (15.5) years N = 30 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Communication (aphasia)	Communication – Overall language ability at <6 months Discontinuation from study at <6 months	Setting: Outpatient centre in Germany. Funding: The current trial was supported by the Deutsche Forschungsgemeinschaft (Pu 97/15-1 to FP) and the Deutsche Akademische Austauschdienst (fellowship to GL).

Study	Intervention and comparison	Population	Outcomes	Comments
	weekly sessions for a total of 2 hours totalling 6 hours per week for 4 weeks. **Concomitant therapy:** No additional information.			
Takatori 2012[105]	**Physiotherapy – 1 hour to 2 hours, <5 days per week** (n=22) The experimental group received primarily intensive strengthening exercise for 2 hours per session, 2 days per week for 12 weeks. **Physiotherapy – ≤45 mins, <5 days per week** (n=22) The control group received standard physical therapy. **Concomitant therapy:** Standard therapy consisting mainly of stretching of the muscle of upper and lower extremity and gait training for 40 minutes per sessions 2 days per week. Both groups underwent the rehabilitation program for 12 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 68.6 (9.0) years N = 44 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Functional Independency	Physical function – upper limb at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Community based outpatient rehabilitation programme in Japan. Funding: No commercial party having a direct financial interest in the results of the research supporting this article has or will confer a benefit on the authors or on any organisation with which the authors are associated.
Taravati 2022[106]	**Physiotherapy - >1 hour to 2 hours, 5 days a week** (n=22) Robot arm therapy for 30-45 minutes, 5 days a week in addition to usual care. **Physiotherapy - >45 minutes-1 hour, 5 days a week** (n=23) Usual care only.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 53.4 (14.8) years N = 45 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear	Person/participant health-related quality of life at <6 months Activities of daily living at <6 months Physical function – upper limb at <6 months Psychological distress – depression at <6 months	Setting: Outpatient follow up in Turkey. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	Concomitant therapy: Physiotherapy, occupoational therapy and cognitive rehabilitation. This totals to at least 60+ minutes of rehabilitation per day.	Focus of care: Multidisciplinary team	Discontinuation from study at <6 months	
Thomas 2013[107]	**Psychology/neuro psychology – >45 minutes to 1 hour, <5 days a week** (n=51) Participants allocated to receive behavioural therapy received up to 20 sessions of treatment over three months, with each session lasting approximately 1 hour in addition to usual care. No patients required the maximum 20 sessions allowed, indicating that the intervention did not need to be delivered as intensively as expected. On average patients received around 10 sessions. Follow up at 3 and 6 months. **Usual care** (n=54) Usual care (all other services available in usual practice). No further details provided. **Concomitant therapy:** Usual care (all other services available in usual practice).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 67.0 (13.6) years N = 105 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Mood	Carer generic health-related quality of life at <6 months and ≥6 months Psychological distress – depression at <6 months and ≥6 months Activities of daily living at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: Community stroke rehabilitation in the United Kingdom. Funding: This work was supported by The Stroke Association, UK (TSA 2007/03).
Tollar 2021[108]	**Physiotherapy – >1 hour to 2**	**Adults without communication difficulties who**	Person/participant health-related	Setting: Outpatient physiotherapy clinics in Hungary.

Study	Intervention and comparison	Population	Outcomes	Comments
	hours, 5 days a week (n=290) The exergaming group exercised twice daily for 1 hour per session. This consisted of 5 sessions per week for 5 weeks in the hospital outpatient physiotherapy gym. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=390) The exergaming group exercised once daily for 1 hour per session. This consisted of 5 sessions per week for 5 weeks in the hospital outpatient physiotherapy gym. **Concomitant therapy:** After the exercise sessions participants in each group received 20 minutes of medical massage of the lower extremities.	**have had a first or recurrent stroke** Mean age (SD): 66.5 (5.87) years N = 680 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Functional independency	quality of life at <6 months Stroke outcome – Modified Rankin scale at <6 months Activities of daily living at <6 months Physical function – lower limb at <6 months Discontinuation from study at <6 months	Funding: No additional information.
Unal 2020[109]	**Physiotherapy – >1 hour to 2 hours, <5 days per week** (n=15) Matrix Rhythm therapy was applied to the study group in addition to Bobath therapy and was applied to the affected side of the body and lower extremity for 60 mins each session, 3 x per week. Follow up at 4 weeks. **Physiotherapy – >45 minutes to 1 hour, <5 days a week** (n=15) Bobath therapy as usual care.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 49.6 (14.3) years N = 30 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Lower limb	Physical function – lower limb at <6 months Discontinuation from study at <6 months	Setting: Neurorehabilitation unit in Turkey. Funding: Supported by the Pamukkale university scientific research commission grant.

Study	Intervention and comparison	Population	Outcomes	Comments
	Concomitant therapy: Both groups were treated with Bobath therapy as a neurodevelopmental therapy. Each session was performed for 60 minutes, 3 days per week for 12 weeks.			
Valkenborghs 2019[110]	**Physiotherapy – >1 hour to 2 hours, 6 days a week** (n=9) Aerobic exercise - a high intensity interval approach. The aerobic exercise + TST group performed 30 minutes of aerobic exercise immediately prior to the 1 hr of TST with the therapist, motor function and adherence. Follow up at 6 months. **Physiotherapy – >45 minutes to 1 hour, 6 days a week** (n=11) Task specific training (TST) as below. **Concomitant therapy:** Participants performed 30 hours of supervised task specific training and were prescribed an additional 30 hours of home-based practice. Both groups were prescribed 60 hr of task specific training over 10 weeks. (3 x 1-hr sessions with a therapist per week and 3 x 1 hr of home-base self-practice per week).	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 55.4 (16) years N = 20 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Person/participant health-related quality of life at ≥6 months Physical function – upper limb at ≥6 months Discontinuation from study at ≥6 months	Setting: Rehabilitation centre and home based in Australia. Funding: Funding was provided by a national stroke foundation of Australia seed grant and a faculty of health and medicine, university of Newcastle Australia research equipment grant. the main author is funded by a Jennie Thomas medical research grant.

Study	Intervention and comparison	Population	Outcomes	Comments
Verheyden 2009[111]	**Physiotherapy – ≤45 minutes, <5 days a week** (n=17) In addition to the conventional treatment, patients from the experimental group received 30 minutes of extra training, 4 times a week, for 5 weeks. **Usual care** (n=16) Conventional rehabilitation only. **Concomitant therapy:** Patients in both groups received the conventional multidisciplinary stroke rehabilitation program provided by the rehabilitation centre.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 58.4 (13.0) years N = 33 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Functional independency	Discontinuation from study at <6 months	Setting: In-patient rehabilitation in Belgium. Funding: No additional information.
Vloothuis 2019[112]	**Physiotherapy – ≤45 minutes, 5 days a week** (n=32) The program consisted of 8 weeks of exercise therapy, executed with a caregiver, in addition to usual care following the current guidelines in the Netherlands. The patients and their caregivers were instructed to perform the selected set of exercises at least five times a week for 30 minutes. Follow up at 12 weeks. **Usual care** (n=34) Usual care only. **Concomitant therapy**: all participants received usual care	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 59.9 (14.9) years N = 66 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Functional independency	Person/participant health-related quality of life at <6 months Carer generic health-related quality of life at <6 months Stroke Outcome – Modified Rankin Scale at <6 months Activities of daily living at <6 months Physical function – lower limb at <6 months	Setting: Any rehabilitation setting, whether it is in a rehabilitation centre, hospital, nursing home, or the home environment. When patients are discharged during the intervention period, training can continue at home in the Netherlands. Funding: This study was funded by the Netherlands Organization of Health Research and Development (ZonMW - www.zonmw.nl) grant number 837001408 (2013) and grant number 606300098012 (2015) Both grants were awarded to GK and EvW.

Study	Intervention and comparison	Population	Outcomes	Comments
	according to the guidelines for physical therapy for patients with stroke of the Royal Dutch Society for Physical Therapy (KNGF).			
Wall 2020[113]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=17) Hybrid assistive limb gait training (HAL). training was performed using the single-leg version of HAL 4 days per week for 4 weeks (16 sessions in total). Patients were encouraged to continue walking as far as possible, but at most for 60 minute's effective gait training time. Each session could at most proceed for 90 minutes, including time for putting on and taking off the suit, the gait training, and pauses at patients' request. Follow up at 6 months. **Physiotherapy – >45 minutes to 1 hour, 5 days a week** (n=16) Conventional rehabilitation only. **Concomitant therapy:** Conventional team-based training most often daily for 30–60 minutes, 5 days a week.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (range): 56.2 (48.25-62.5) years N= 33 Time after stroke: Subacute (7 days – 6 months) Severity: Moderate (or NIHSS 5-14) Focus of care: Lower limb	Discontinuation from study at ≥6 months	Setting: Inpatient rehabilitation unit in Sweden. Funding: Funding: This work was supported with grants from the Promobilia Foundation (16096, 17097, 17066) (AW), STROKE-Riksforbundet (na)(AW), NEURO Sweden (na) (AW), the Norrbacka-Eugenia Foundation (865/16) (AW), and a donation by Lars Hedlund (Karolinska Institutet Dnr 2-1582/2016) (JB). HAL suits were provided by Cyberdyne Inc., Japan.
Winstein 2004[114]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=43) Combined the 2 treatment arms of task specific	**Adults who have had a or recurrent first stroke** Age: Not stated/unclear N = 45	Physical function – upper limb at <6 months and ≥6 months Discontinuation from study at <6	Setting: Inpatient and outpatient rehabilitation setting in the United States of America.

Study	Intervention and comparison	Population	Outcomes	Comments
	functional training plus standard care and strengthening and motor control training plus standard care. 1 hour of either therapy plus standard care for 5 days per week lasting 4 weeks. 20 hours full dose of therapy. **Usual care** (n=21) Standard care only. **Concomitant therapy:** Standard care was provided to all groups.	Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	months and ≥6 months	Funding: Supported in part by the national institute of child health and human development, national institutes of health, and the foundation for physical therapy. No commercial party had a direct financial interest in the results of the research supporting this article, had or will confer a benefit upon the authors or upon any organisation with which the authors are associated.
Woldag 2017[115]	**Speech and Language Therapy - >2 hours to 4 hours, 5 days a week** (n= 42) Both intervention groups have been combined for the purposes of this review as both received the same intensity of therapy. Constraint induced aphasia therapy (CIAT) - Patients in the CIAT arm of the study received 3 hours of CIAT therapy per day over a span of 10 workdays (30 training hours total) as group therapy. The second arm of the study included patients who were in a conventional communication treatment group (CTG), a therapeutic approach vastly different from that of CIAT. Although the intensity of the therapy remained the same (3 h/d	**Adults with communication difficulties who have had a first or recurrent stroke** Mean age (SD): 68.2 (11.6) years N = 62 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Communication	Communication - Impairment specific measures (Naming) at <6 months Discontinuation from study at <6 months	Setting: Inpatient in Germany. Funding: The authors received no financial support for the research, authorship, and/or publication of this article.

Study	Intervention and comparison	Population	Outcomes	Comments
	over a span of 10 workdays, totalling 30 training hours). Follow up at 2 weeks. **Speech and Language Therapy >1 hour to 2 hours, 5 days a week** (n=20) The control group (CG) received a clinic-typical therapeutic approach, which includes evidence-based SLT and is commonly used and widely accepted in neurological rehabilitation centres. Therapy in consisted of 30 minutes of individual therapy twice a day over a span of 10 workdays (10 hours) and 1 hour of group therapy 4 times within a time span of 2 weeks (a total of 14 training hours). **Concomitant therapy:** No additional information.			
Wolf 2006[116]	**Physiotherapy – >4 hours, 5 days a week** (n=106) Participants in the intervention group were taught to apply an instrumented protective safety mitt and encouraged to wear it on their less-impaired upper extremity for a goal of 90% of their waking hours for a total of 14 days. On each weekday,	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 62.2 (13.1) years N = 222 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Person/participant health-related quality of life at <6 months and ≥6 months Physical function – lower limb at <6 months and ≥6 months Discontinuation from study at <6 months and ≥6 months	Setting: Outpatient follow up in the United States of America. Funding: This research was supported by National Institutes of Health grant HD 37606 from the National Center for Medical Rehabilitation Research (National Institute of Child Health and Human Development) and

Study	Intervention and comparison	Population	Outcomes	Comments
	participants received shaping (adaptive task practice) and standard task training of the paretic limb for up to 6 hours per day. After completing each treatment, participants were encouraged to practice 2 to 3 tasks daily at home. Participants were encouraged to perform about 30 minutes of task practice daily following completion of the intervention period. Follow up at 2 weeks and 12 months. **Usual care** (n=116) Usual care only. **Concomitant therapy**: Usual and customary care ranged from no treatment to the application of mechanical interventions (orthotics) or various occupational and physical therapy approaches in the home, day treatment programs, or outpatient hospital visits.			the National Institute of Neurological Diseases and Stroke.
Yadav 2016[117]	**Physiotherapy – >4 hours, 5 days a week** (n=32) The study group participated in a modified constraint induced movement therapy (CIMT) programme in addition to the conventional	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 46.7 (13.7) years N = 65	Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Outpatient Department of Physical Medicine and Rehabilitation at VMMC and Safdarjung Hospital in India. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	rehabilitation programme. This was done for three hours in a day alternatively for three days a week. A constraint session of the unaffected limb was also used for five hours per day for five days a week. The total duration of intervention was four weeks. Follow up at 3 months. **Physiotherapy >2 hours to 4 hours, 5 days a week** (n= 33) Conventional rehabilitation only. **Concomitant therapy:** Both groups received 3 hours daily of conventional rehabilitation programme.	Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb		
Yoo 2013[118]	**Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=11) The experimental group received three-dimensional robot assisted therapy (RAT) and conventional rehabilitation therapy (CRT) for a total of 90 minutes. The experimental group received training 3 days a week for 6 weeks. **Physiotherapy – ≤45 minutes, 5 days a week** (n=11) The control group received conventional rehabilitation for 60 mins per day. They	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 50.3 (10.0) years N = 22 Time after stroke: Chronic (≥6 months) Severity: Not stated/unclear Focus of care: Upper limb	Activities of Daily Living at <6 months Physical function – upper limb at <6 months Discontinuation from study at <6 months	Setting: Unclear setting in South Korea. Funding: No additional information.

Study	Intervention and comparison	Population	Outcomes	Comments
	received training 3 days a week for 6 weeks. **Concomitant therapy:** All patients received conventional rehabilitation for 60 mins per day, 3 days a week for 6 weeks			
Yoo 2010[119]	**Physiotherapy – ≤45 minutes, <5 days a week** (n=28) Both groups underwent physiotherapy for 4 weeks. Core stability strengthening was performed for 30 mins 3 x per week for 4 weeks. **Usual care** (n=31) Usual care only. **Concomitant therapy:** All patients tried a neuro-developmental technique, walking and occupational therapy 3 x per week.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 60.8 (15.5) years N = 59 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Functional independency	Physical function – lower limb at <6 months	Setting: In-patient rehabilitation in the Republic of Korea. Funding: Supported from a grant from Kyung Hee University.
Yoon 2014[120]	**Physiotherapy – >2 hours to 4 hours, 5 days a week** (n=17) Constraint induced movement therapy (CIMT) combined with mirror therapy and CIMT for 2 hours 3 days per week + self exercise programme for 30 mins 5 days per week + conventional rehabilitation 40 mins for 5 days per week were combined for the purposed of this	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 57.8 (15.4) years N = 26 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Activities of daily living at <6 months Physical function – upper limb at <6 months	Setting: In-patients at the Department of Rehabilitation Medicine at Pusan National University Yangsan Hospital in the Republic of Korea. Funding: This work was supported by a 2-year research grant of Pusan National University.

Study	Intervention and comparison	Population	Outcomes	Comments
	review. Follow up at 2 weeks. **Physiotherapy – >1 hour to 2 hours, 5 days a week** (n=9) The patients of the control group were recommended to perform the self-exercise program as well as the palliative rehabilitation therapy that is routinely recommended for the hospitalized patients. **Concomitant therapy:** Both groups received conventional therapy for 40 minutes per day, 5 days per week for 2 weeks.			
Zengin-Metli 2018[121]	**Physiotherapy – ≤45 minutes, 5 days a week** (n=20) Armeo Spring HocomAg inc. was used for the robotic rehabilitation. The robotic rehabilitation was provided 5 times per week for 3 weeks of 30 minutes per session. **Usual care** (n=15) Conventional rehabilitation only. **Concomitant therapy:** All subjects received conventional rehabilitation 5 times per week for 3 weeks.	**Adults without communication difficulties who have had a first or recurrent stroke** Mean age (SD): 61.0 (6.9) years N = 35 Time after stroke: Subacute (7 days – 6 months) Severity: Not stated/unclear Focus of care: Upper limb	Person/participant health-related quality of life at <6 months Physical function – upper limb at <6 months	Setting: Rehabilitation centre in Turkey. Funding: No additional information.

2.1.4 Quality assessment of clinical studies included in the evidence review

2.1.4.1 Physiotherapy (no communication difficulties)

2.1.4.1.1 ≤45 minutes

Table 4: Clinical evidence summary: Physiotherapy (no communication difficulties) - ≤45 minutes, <5 days a week versus usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Physiotherapy (no communication difficulties) - ≤45 minutes, <5 days a week	
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months	59 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [a,b]	-	The mean physical function - lower limb at <6 months was 26.87	MD **4.63 higher** (3.99 lower to 13.25 higher)	MID = 7.8 (0.5 x median baseline SD)
Discontinuation from study at <6 months	103 (2 RCTs) follow up: 6.5 weeks	⨁◯◯◯ Very low [a,c,d]	RD 0.00 (-0.10 to 0.09)	60 per 1,000	**0 fewer per 1,000** (100 fewer to 90 more) [e]	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	70 (1 RCT) follow up: 12 months	⨁◯◯◯ Very low [a,b]	RR 1.26 (0.49 to 3.25)	176 per 1,000	**46 more per 1,000** (90 fewer to 397 more)	MID = RR 0.8-1.25.

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 5: Clinical evidence summary: Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	
Person/participant health-related quality of life (Stroke Impact Scale mobility subscale, 0-100, higher values are better, final value) at <6 months	59 (1 RCT) follow up: 12 weeks	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at <6 months was 69.35	MD **8.6 higher** (2.19 lower to 19.39 higher)	MID = 11.2 (0.5 x median baseline SD)
Person/participant health-related quality of life (SF-36 physical component, 0-100, higher values are better, final value) at <6 months	35 (1 RCT) follow up: 3 weeks	⊕◯◯◯ Very low [b,c]	-	The mean person/participant health-related quality of life at <6 months was 34.56	MD **0.01 higher** (6.85 lower to 6.87 higher)	MID = 2 (SF-36 Physical component established MID)
Person/participant health-related quality of life (SF-36 mental component, 0-100, higher values are better, final value) at <6 months	35 (1 RCT)	⊕◯◯◯ Very low [b,c]	-	The mean person/participant health-related quality of life at <6 months was 38.95	MD **13.6 higher** (4.87 higher to 22.33 higher)	MID = 3 (SF-36 Mental component established MID)
Carer health-related quality of life (Carer Quality of Life, 0-14, lower values are better, final value) at <6 months	59 (1 RCT) follow up: 12 weeks	⊕◯◯◯ Very low [a,b]	-	The mean carer health-related quality of life at <6 months was 10.96	MD **0.44 lower** (1.51 lower to 0.63 higher)	MID = 0.91 (0.5 x median baseline SD)
Stroke outcome - modified Rankin Scale (modified Rankin Scale, 0-5, lower values are better, final value) at <6 months	59 (1 RCT) follow up: 12 weeks	⊕◯◯◯ Very low [a,b]	-	The mean stroke outcome - modified Rankin Scale at <6 months was 2.44	MD **0.48 lower** (0.8 lower to 0.38 higher)	MID = 0.35 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	
Activities of daily living (Barthel index, 0-100, higher values are better, change score) at <6 months	32 (1 RCT) follow-up: 3 weeks	⊕⊕◯◯ Low[d]	-	The mean activities of daily living at <6 months was 20.25	MD **23.5 higher** (14.3 higher to 32.7 higher)	MID = Barthel Index 1.85 (established MID)
Activities of daily living (Barthel Index, [different scale ranges], higher values are better, final values) at <6 months	99 (2 RCTs) follow up: 10 weeks	⊕⊕◯◯ Low [b,e]	-	-	SMD **0.48 SD higher** (0.08 higher to 0.88 higher)	MID = 0.5 SD (SMD)
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at <6 months	35 (1 RCT) follow up: 3 weeks	⊕⊕◯◯ Low[f]	-	The mean physical function - upper limb at <6 months was 24.65	MD **0** (3.05 lower to 3.05 higher)	MID = 6.6 (Fugl-Meyer upper extremity = Difference by 10% of the total scale)
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, 0-34, higher values are better, change score) at <6 months	40 (1 RCT) follow up: 8 weeks	⊕⊕⊕◯ Moderate[b]	-	The mean physical function - lower limb at <6 months was 1.75	MD **7.75 higher** (2.61 higher to 12.89 higher)	MID = 3.4 (Fugl-Meyer lower extremity = Difference by 10% of the total scale)
Physical function - lower limb (Berg Balance Scale, Rivermead Mobility Index [different scale ranges], higher values are better, final values) at <6 months	143 (3 RCTs) follow up: mean 6 weeks	⊕◯◯◯ Very low [b,g,h]	-	-	SMD **0.64 SD higher** (0.14 higher to 1.14 higher)	MID = 0.5 SD (SMD)
Discontinuation from study at <6 months	145 (3 RCTs)	⊕◯◯◯ Very low [b,i,j]	RR 0.50 (0.19 to 1.29)	149 per 1,000	**74 fewer per 1,000** (120 fewer to 43 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	
	follow up: mean 8 weeks					

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 6: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - ≤45 minutes, 5 days a week	
Discontinuation from study at <6 months	30 (1 RCT) follow up: 6 weeks	⊕◯◯◯ Very low [a,b,c]	RD 0.00 (-0.12 to 0.12)	0 per 1,000	**0 fewer per 1,000** (120 fewer to 120 more)	MID = RR 0.8-1.25.

a. Downgraded by 1 increment as the majority of the evidence was at high risk of bias (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 7: Clinical evidence summary: Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week compared to usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk with Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week	
Physical function - lower limb (Trunk Impairment Scale, 0-23, higher values are better, final value) at <6 months	20 (1 RCT) follow up: 3 weeks	⊕⊕◯◯ Low [a]	-	The mean physical function - lower limb was 14.2	MD **4.23 higher** (3.08 higher to 5.38 higher)	MID = 1.1 (0.5 x median baseline SD)

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 8: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - ≤45 minutes, 6 days a week	
Person/participant health-related quality of life (SF-36 physical function subscale, 0-100, higher values are better, final value) at <6 months	12 (1 RCT) follow up: 10 weeks	⨁◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at <6 months was 47	MD **20 higher** (1.86 higher to 38.14 higher)	MID = 3 (SF-36 physical function established MID)
Physical function - lower limb (6-minute walk test, meters, higher values are better, final value) at <6 months	12 (1 RCT) follow up: 10 weeks	⨁◯◯◯ Very low [b,c]	-	The mean physical function - lower limb at <6 months was 47	MD **56.8 higher** (74.94 lower to 188.54 higher)	MID = 28 (6 minute walk test established MID)
Discontinuation from study at <6 months	12 (1 RCT) follow up: 10 weeks	⨁⨁◯◯ Low [d]	RD 0.00 (-0.27 to 0.27)	0 per 1,000	**0 fewer per 1,000** (270 fewer to 270 more) [e]	Sample size used to determine precision: 75-150 = serious imprecision, <75 = very serious imprecision

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 9: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - ≤45 minutes, 7 days a week	
Discontinuation from study at ≥6 months	190 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [a]	RR 1.47 (0.54 to 3.96)	64 per 1,000	**30 more per 1,000** (29 fewer to 189 more)	MID = RR 0.8-1.25.

[a] Downgraded by 1 increment if the confidence interval crossed one MID or by 2 increments if the confidence interval crossed both MIDs

2.1.4.1.2 >45 minutes to 1 hour

Table 10: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week	
Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at <6 months	28 (1 RCT) follow up: 6 weeks	⨁⨁◯◯ Low [a,b]	-	The mean physical function - upper limb at <6 months was 45	MD **2.3 lower** (14.88 lower to 10.28 higher)	MID = 12 points dominant side (17 points non-dominant side) (ARAT established MID)
Discontinuation from study at <6 months	30 (1 RCT) follow up: 6 weeks	⨁◯◯◯ Very low [a,b]	RR 0.60 (0.24 to 1.49)	500 per 1,000	**200 fewer per 1,000** (380 fewer to 245 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week	

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 11: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months	30 (1 RCT) follow up: 6 weeks	⨁⨁◯◯ Low [a,b]	-	The mean physical function - lower limb at <6 months was 42.9	MD **4.8 higher** (0.93 higher to 8.67 higher)	MID = 2.6 (0.5 x median baseline SD)
Discontinuation from study at <6 months	30 (1 RCT) follow up: 6 weeks	⨁◯◯◯ Very low [a,c]	RD 0.00 (-0.12 to 0.12)	0 per 1,000	**0 fewer per 1,000** (120 fewer to 120 more)	Sample size used to determine precision: 75-150 = serious imprecision, <75 = very serious imprecision

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 12: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Person/participant generic health-related quality of life (Stroke Impact Scale - hand, 5-25, higher values are better, final value) at <6 months	58 (1 RCT) follow up: 12 weeks	⊕⊕◯◯ Low [a,b]	-	The mean person/participant generic health-related quality of life at <6 months was 18.71	MD **2.94 higher** (0.18 higher to 5.7 higher)	MID = 2.3 (0.5 x median baseline SD)
Person/participant generic health-related quality of life (Stroke Impact Scale - hand, 5-25, higher values are better, final value) at ≥6 months	58 (1 RCT) follow up: 24 weeks	⊕⊕◯◯ Low [a,b]	-	The mean person/participant generic health-related quality of life at ≥6 months was 20.04	MD **2.41 higher** (0.16 higher to 4.98 higher)	MID = 2.3 (0.5 x median baseline SD)
Activities of daily living (Modified Barthel Index, 0-100, higher values are better, final values) at <6 months	82 (2 RCTs) follow up: mean 6 weeks	⊕◯◯◯ Very low [b,c]	-	The mean activities of daily living at <6 months was 65.4	MD **7.39 higher** (0.56 lower to 15.34 higher)	MID = Barthel Index 1.85 (established MID)
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	121 (3 RCTs) follow up: mean 3 weeks	⊕⊕⊕◯ Moderate [d]	-	-	SMD **0.08 SD higher** (0.28 lower to 0.43 higher)	MID = 0.5 SD (SMD)
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at ≥6 months	58 (1 RCT) follow up: 24 weeks	⊕⊕◯◯ Low [b,e]	-	The mean physical function – upper limb at ≥6 months was 65.4	MD **3.21 higher** (1.83 lower to 8.25 higher)	MID = 6.6 (Fugl-Meyer upper extremity = Difference by 10% of the total scale)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, Berg Balance Scale [different scale ranges], higher values are better, change scores) at <6 months	52 (2 RCTs) follow up: mean 5 weeks	⨁⨁◯◯ Low [b,e]	-	-	SMD **0.91 SD higher** (0.33 higher to 1.48 higher)	MID = 0.5 SD (SMD)
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, Berg Balance Scale [different scale ranges], higher values are better, final values) at <6 months	89 (3 RCTs) follow up: 6 weeks	⨁⨁◯◯ Low [c]	-	-	SMD **1.14 SD higher** (0.69 higher to 1.6 higher)	MID = 0.5 SD (SMD)
Physical function - lower limb (Timed walk, units unclear, lower values are better, final values) at <6 months	55 (1 RCT) follow up: 6 weeks	⨁⨁◯◯ Low [b,e]	-	The mean physical function - lower limb at <6 months was 39.9	MD **9.3 higher** (7.29 lower to 25.89 higher)	MID = 15.0 (0.5 x median control SD)
Physical function - lower limb (Timed walk, units unclear, lower values are better, final values) at ≥6 months	60 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [b,e]	-	The mean physical function - lower limb at ≥6 months was 49.4	MD **13.6 lower** (26.2 lower to 1 lower)	MID = 16.1 (0.5 x median control SD)
Psychological distress - depression (HADS depression, 0-42, lower values are better, final values) at <6 months	92 (1 RCT) follow up: 6 weeks	⨁⨁⨁◯ Moderate [e]	-	The mean psychological distress - depression at <6 months was 12.9	MD **0.3 lower** (3.31 lower to 2.71 higher)	MID = 3.8 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Psychological distress - depression (HADS depression, 0-42, lower values are better, final values) at ≥6 months	86 (1 RCT) follow up: 6 months	⨁⨁⨁◯ Moderate [e]	-	The mean psychological distress - depression at ≥6 months was 12.9	MD **0** (3.15 lower to 3.15 higher)	MID = 3.8 (0.5 x median baseline SD)
Discontinuation from study at <6 months	348 (8 RCTs) follow up: 5 weeks	⨁◯◯◯ Very low [f,g,h]	**RD 0.02** (-0.03 to 0.06)	35 per 1,000	**20 more per 1,000** (30 fewer to 60 more) [i]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.37 (0.8-0.9 = serious, <0.8 = very serious)
Discontinuation from study at ≥6 months	114 (1 RCT) follow up: 6 months	⨁◯◯◯ Very low [b,e,g]	**RR 0.99** (0.46 to 2.15)	185 per 1,000	**2 fewer per 1,000** (100 fewer to 213 more) [i]	MID = RR 0.8-1.25.

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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
i. Absolute effect calculated by risk difference due to zero events in at least one study arm						

Table 13: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Activities of daily living (Functional Independence Measure - Upper and Lower Limbs, 0-77, higher values are better, final value) at <6 months	56 (1 RCT) follow up: 3.5 weeks	⨁⨁◯◯ Low [a,b]	-	The mean activities of daily living at <6 months was 44.6	MD **9.9 higher** (3.7 higher to 16.1 higher)	MID = 3.9 (0.5 x median baseline SD)
Activities of daily living (Functional Independence Measure - Upper limb Self-Care, 0-42, higher values are better, final value) at <6 months	56 (1 RCT) follow up: 3.5 weeks	⨁⨁◯◯ Low [a,b]	-	The mean activities of daily living at <6 months was 25	MD **4.9 higher** (1.14 higher to 8.66 higher)	MID = 2.5 (0.5 x median baseline SD)
Activities of daily living (Functional Independence Measure - cognitive, 0-35, higher values are better, final value) at <6 months	56 (1 RCT) follow up: 3.5 weeks	⨁⨁⨁◯ Moderate [a]	-	The mean activities of daily living at <6 months was 23.2	MD **7.2 higher** (4.37 higher to 10.03 higher)	MID = 3.4 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Physical function - upper limb (Fugl-Meyer Assessment, 0-66, higher values are better, final value) at <6 months	56 (1 RCT) follow up: 3.5 weeks	⨁◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at <6 months was 16.3	MD **0.6 lower** (7.83 lower to 6.63 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)

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 14: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 7 days a week	
Person/participant health-related quality of life (Stroke Impact Scale, 0-100, higher values are better, final value) at ≥6 months	380 (1 RCT) follow up: 18 months	⨁⨁⨁◯ Moderate [a]	-	The mean person/participant health-related quality of life at ≥6 months was 73.5	MD **0.7 lower** (7.98 lower to 6.58 higher)	MID = 18.0 (0.5 x median control SD)
Stroke outcome - modified Rankin scale (modified Rankin scale, 0-6, lower values are better, final value) at ≥6 months	380 (1 RCT) follow up: 18 months	⨁⨁⨁◯ Moderate [a]	-	The mean stroke outcome - modified Rankin scale at ≥6 months was 1.33	MD **0.05 lower** (0.37 lower to 0.27 higher)	MID = 0.47 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >45 minutes to 1 hour, 7 days a week	
Activities of daily living (Barthel Index, 0-100, higher values are better, final value) at ≥6 months	380 (1 RCT) follow up: 18 months	⨁⨁⨁◯ Moderate [a]	-	The mean activities of daily living at ≥6 months was 90.2	MD **0** (0.47 lower to 0.47 higher)	MID = Barthel Index 1.85 (established MID)
Physical function - lower limb (Berg Balance Scale item 14, 0-4, higher values are better, final value) at ≥6 months	380 (1 RCT) follow up: 18 months	⨁⨁⨁◯ Moderate [a]	-	The mean physical function - lower limb at ≥6 months was 2.71	MD **0.08 lower** (0.39 lower to 0.23 higher)	MID = 0.72 (0.5 x median baseline SD)
Discontinuation from study at ≥6 months	380 (1 RCT) follow up: 18 months	⨁⨁⨁◯ Moderate [a]	RR 4.87 (2.44 to 9.72)	46 per 1,000	**180 more per 1,000** (67 fewer to 405 more)	MID = RR 0.8-1.25.

[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)

2.1.4.1.3 >1 hour to 2 hours

Table 15: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	
Physical function - upper limb (grip strength, kg,	44 (1 RCT)	⨁◯◯◯ Very low [a,b]	-	The mean physical	MD **7.3 higher** (2.39 higher to 12.21 higher)	MID = 4.1 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	
higher values are better, final value) at <6 months	follow up: 12 weeks			function - upper limb at <6 months was 19.9		
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months	24 (1 RCT) follow up: 4 weeks	⨁◯◯◯ Very low [b,c]	-	The mean physical function - lower limb at <6 months was 48.25	MD **2.92 higher** (0.38 lower to 6.22 higher)	MID = 2.4 (0.5 x median baseline SD)
Physical function - lower limb (timed up and go, seconds, lower values are better, final value) at <6 months	44 (1 RCT) follow up: 12 weeks	⨁◯◯◯ Very low [a,b]	-	The mean physical function - lower limb at <6 months was 21.2	MD **5.8 lower** (13.4 lower to 1.8 higher)	MID = 10 seconds (established MID)
Physical function - lower limb (sit-to-stand test, seconds, lower values are better, final value) at <6 months	26 (1 RCT) follow up: 8 weeks	⨁◯◯◯ Moderate [d]	-	The mean physical function - lower limb at <6 months was 2.5	MD **0.6 higher** (1.18 lower to 2.38 higher)	MID = 2.8 (0.5 x median baseline SD)
Discontinuation from study at <6 months	79 (2 RCTs) follow up: mean 10 weeks	⨁◯◯◯ Very low [d,e,g]	RD 0.00 (-0.10 to 0.11)	50 per 1,000	**0 fewer per 1,000** (100 fewer to 110 more) [f]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.03 (0.8-0.9 = serious, <0.8 = very serious)

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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	

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 high risk of bias (due to bias arising from the randomisation process)

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 16: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	
Patient/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final value) at <6 months	109 (1 RCT) follow up: 12 weeks	⨁◯◯◯ Very low [a,b]	-	The mean patient/participant health-related quality of life at <6 months was 0.6	MD **0** (0.11 lower to 0.11 higher)	MID = EQ-5D 0.03 (established MID)
Physical function - lower limb (Modified Rivermead mobility index, 0-40, higher values are better, final value) at <6 months	109 (1 RCT) follow up: 12 weeks	⨁⨁⨁◯ Moderate [a]	-	The mean physical function - lower limb at <6 months was 39.7	MD **1.4 lower** (4.12 lower to 1.32 higher)	MID = 5.2 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, <5 days a week	
Physical function - lower limb (6-minute walk test, meters, higher values are better, change score) at <6 months	20 (1 RCT) follow up: 4 weeks	⨁◯◯◯ Very low [b,c]	-	The mean physical function - lower limb at <6 months was 8.7 meters	MD **46.3 meters higher** (10.83 higher to 81.77 higher)	MID = 28 meters (established MID)
Physical function - lower limb (Timed up and go, 0-3, higher values are better, final value) at <6 months	30 (1 RCT) follow up: 4 weeks	⨁⨁⨁◯ Moderate [b]	-	The mean physical function - lower limb at <6 months was 1.93	MD **0.4 higher** (0.14 lower to 0.94 higher)	MID = 0.51 (0.5 x median baseline SD)
Discontinuation from study at <6 months	30 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [d]	RD 0.00 (-0.12 to 0.12)	0 per 1,000	**0 fewer per 1,000** (120 fewer to 120 more) [e] **No clinically important difference**	Sample size used to determine precision: 75-150 = serious imprecision, <75 = very serious imprecision

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 17: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, motor function, 0-66, higher values are better, change score) at <6 months	60 (1 RCT) follow up: 6 weeks	⊕◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at <6 months was 9.05	MD **8.3 higher** (2.95 higher to 13.65 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, motor function, 0-66, higher values are better, change score) at ≥6 months	44 (1 RCT) follow up: 9 months	⊕◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at ≥6 months was 8.33	MD **2.83 lower** (9.12 lower to 3.46 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
Discontinuation from study at <6 months	60 (1 RCT) follow up: 6 weeks	⊕⊕◯◯ Low [b]	RR 0.17 (0.02 to 1.50)	150 per 1,000	**124 fewer per 1,000** (147 fewer to 75 more)	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	60 (1 RCT) follow up: 9 months	⊕⊕⊕◯ Moderate [c]	RR 0.21 (0.10 to 0.47)	700 per 1,000	**553 fewer per 1,000** (630 fewer to 371 more)	MID = RR 0.8-1.25.

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 18: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Physical function - upper limb (Wolf Motor Function Test Performance Time, 0-120 seconds, lower values are better, final value) at <6 months	29 (1 RCT) follow up: 4 weeks	⊕⊕◯◯ Low [a,b]	-	The mean physical function - upper limb at <6 months was 42.8	MD **6.4 seconds lower** (19.09 lower to 6.29 higher)	MID = MID = 19s (dominant side - 16% of 120s limit) (established MID)
Stroke-related scale of cognition - spatial attention (Motor-free visual perception test, 0-46, higher values are better, final value) at <6 months	29 (1 RCT) follow up: 4 weeks	⊕⊕◯◯ Low [a,b]	-	The mean stroke-related scale of cognition - spatial attention at <6 months was 23.9	MD **2.9 higher** (0.04 higher to 5.76 higher)	MID = 2.2 (0.5 x median baseline SD)
Discontinuation from study at <6 months	31 (1 RCT) follow up: 4 weeks	⊕◯◯◯ Very low [a,b]	RR 0.94 (0.06 to 13.68)	67 per 1,000	**4 fewer per 1,000** (63 fewer to 845 more)	MID = RR 0.8-1.25.

[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 19: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Person/participant health-related quality of life (EuroQol, 0-100, higher values are better, change score) at ≥6 months	64 (1 RCT) follow up: 6 months	⊕⊕◯◯ Low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was -2	MD **11.78 higher** (1.27 lower to 24.83 higher)	MID = 9.3 (0.5 x median baseline SD)
Activities of daily living (Barthel Index, 0-100, higher values are better, change score and final value) at <6 months	138 (3 RCTs) follow up: mean 9 weeks	⊕⊕◯◯ Low [a]	-	The mean activities of daily living at <6 months was 31.6	MD **0.27 higher** (0.69 lower to 1.23 higher)	MID = Barthel Index 1.85 (established MID)
Activities of daily living (Barthel Index, 0-100, higher values are better, change score) at ≥6 months	110 (2 RCT) follow up: 6 months	⊕⊕◯◯ Low [a]	-	The mean activities of daily living at ≥6 months was 6.8	MD **0.18 lower** (1.44 lower to 1.08 higher)	MID = Barthel Index 1.85 (established MID)
Physical function - upper limb (Action Research Arm Test, Wolf Motor Function [different scale ranges], higher values are better, final values) at <6 months	81 (3 RCTs) follow up: mean 5 weeks	⊕◯◯◯ Very low [b,c]	-	-	SMD **0.26 SD higher** (0.19 lower to 0.7 higher)	MID = 0.5 SD (SMD)
Physical function - upper limb (functional reach test, cm, higher values are better, final value) at <6 months	12 (1 RCT) follow up: 5 weeks	⊕⊕◯◯ Low [a,b]	-	The mean physical function - upper limb at <6 months was 10.44 cm	MD **4.9 cm higher** (1.66 lower to 11.46 higher)	MID = 2.4 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Physical function - lower limb (Rivermead Mobility Index, 0-15, higher values are better, change score) at <6 months	66 (1 RCT) follow up: 3 months	⨁⨁◯◯ Low [a,b]	-	The mean physical function - lower limb at <6 months was 3.5	MD **1.2 higher** (0.15 lower to 2.55 higher)	MID = 1.4 (0.5 x median control SD)
Physical function - lower limb (Postural Assessment Scale for Stroke patients, 0-36, higher values are better, final value) at <6 months	12 (1 RCT) follow up: 5 weeks	⨁◯◯◯ Very low [a,b]	-	The mean physical function - lower limb at <6 months was 32.5	MD **0.17 higher** (2.52 lower to 2.86 higher)	MID = 1.7 (0.5 x median baseline SD)
Physical function - lower limb (Rivermead Mobility Index, 0-15, higher values are better, change score) at ≥6 months	64 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [a,b]	-	The mean physical function - lower limb at ≥6 months was 4.4	MD **0.7 higher** (0.75 lower to 2.15 higher)	MID = 1.6 (0.5 x median control SD)
Discontinuation from study at <6 months	349 (6 RCTs) follow up: mean 6 weeks	⨁◯◯◯ Very low [b,c,d]	RD 0.05 (-0.01 to 0.10)	63 per 1,000	**50 more per 1,000** (10 fewer to 100 more) [e]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.65 (0.8-0.9 = serious, <0.8 = very serious)
Discontinuation from study at ≥6 months	130 (2 RCT) follow up: 6 months	⨁◯◯◯ Very low [a,b,f]	RR 1.70 (0.76 to 3.81)	121 per 1,000	**85 more per 1,000** (49 fewer to 571 more)	MID = RR 0.8-1.25.

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)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
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 or 2 increments because heterogeneity, unexplained by subgroup analysis 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 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						

Table 20: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 7 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Discontinuation from study at <6 months	189 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [a]	RR 1.03 (0.43 to 2.49)	94 per 1,000	**3 more per 1,000** (53 fewer to 140 more)	MID = RR 0.8-1.25.
a. Downgraded by 1 increment if the confidence interval crossed one MID or by 2 increments if the confidence interval crossed both MIDs						

Table 21: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final values) at <6 months	748 (2 RCTs) follow up: mean 8 weeks	⨁◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at <6 months was 0.59	MD **0.06 higher** (0.02 higher to 0.09 higher)	MID = EQ-5D 0.03 (established MID)
Person/participant health-related quality of life (EQ-VAS, 0-100, higher values are better, change score) at <6 months	641 (1 RCT) follow up: 5 weeks	⨁◯◯◯ Very low [b,c]	-	The mean person/participant health-related quality of life at <6 months was 4.85	MD **4.65 higher** (3.32 higher to 5.98 higher)	MID = 4.68 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale Social Participation, 0-100, higher values are better, change score) at <6 months	22 (1 RCT) follow up: 4 weeks	⨁◯◯◯ Very low [b,d]	-	The mean person/participant health-related quality of life at <6 months was 4.25	MD **8.24 higher** (1.83 higher to 14.65 higher)	MID = 9.7 (0.5 x median baseline SD)
Person/participant health-related quality of life (stroke specific quality of life, 49-245, higher values are better, final value) at <6 months	37 (1 RCT) follow-up: 4 weeks	⨁◯◯◯ Very low [b,e]	-	The mean person/participant health-related quality of life at <6 months was 140.8	MD **2.21 lower** (23.36 lower to 18.94 higher)	MID = 14.1 (0.5 x median baseline SD)
Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final values) at ≥6 months	693 (2 RCTs) follow up: mean 9 months	⨁◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 0.63	MD **0.03 higher** (0.01 lower to 0.06 higher)	MID = EQ-5D 0.03 (established MID)
Stroke outcome - modified Rankin scale (modified Rankin Scale, 0-6, lower values are better, change score) at <6	641 (1 RCT) follow up: 5 weeks	⨁◯◯◯ Very low [b,e]	-	The mean stroke outcome - modified Rankin scale at <6 months was **-1.24**	MD **0.56 lower** (0.7 lower to 0.42 lower)	MID = 0.32 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
months						
Activities of daily living (Barthel Index, Functional Independence Measure - self-care score [different scale ranges], higher values are better, change scores) at <6 months	776 (4 RCTs) follow up: mean 5 weeks	⨁◯◯◯ Very low [b,g,h]	-	-	SMD **0.49 SD higher** (0 to 0.99 higher)	MID = 0.5 SD (SMD)
Activities of daily living (Barthel Index, Canadian Occupational Performance Measure [different scale ranges], higher values are better, final values) at <6 months	852 (6 RCTs) follow up: mean 6 weeks	⨁⨁◯◯ Low [a]	-	-	SMD **0.15 SD higher** (0.01 higher to 0.29 higher)	MID = 0.5 SD (SMD)
Activities of daily living (Barthel Index, 0-100, higher values are better, final value) at ≥6 months	635 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [i]	-	The mean activities of daily living at ≥6 months was 15.3	MD **0.5 higher** (0.17 lower to 1.17 higher)	MID = Barthel Index 1.85 (established MID)
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	55 (2 RCTs) follow up: mean 4 weeks	⨁◯◯◯ Very low [b,h,j]	-	-	SMD **0.21 SD higher** (0.72 lower to 1.15 higher)	MID = 0.5 SD (SMD)
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, Action Research Arm	848 (6 RCTs)	⨁◯◯◯ Very low [b,k]	-	-	SMD **0.17 SD higher** (0.02 higher to 0. 31 higher)	MID = 0.5 SD (SMD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	Comments
Test [different scale ranges], higher values are better, final values) at <6 months	follow up: mean 7 weeks					
Physical function - upper limb (Fugl Meyer Upper Extremity - shoulder, elbow and forearm, 0-36, higher values are better, final value) at <6 months	36 (1 RCT) follow-up: 4 weeks	⨁◯◯◯ Very low[b,l]	-	The mean physical function - upper limb at <6 months was 29.42	MD **1.87 higher** (1.22 lower to 4.96 higher)	MID = 3.6 (Fugl Meyer established MID = 10% of scale)
Physical function - upper limb (Fugl Meyer Upper Extremity - wrist, 0-10, higher values are better, final value) at <6 months	36 (1 RCT) follow-up: 4 weeks	⨁◯◯◯ Very low[b,l]	-	The mean physical function - upper limb at <6 months was 6	MD **1.29 higher** (0.19 higher to 2.39 higher)	MID = 1.0 (Fugl Meyer established MID = 10% of scale)
Physical function - upper limb (Fugl Meyer Upper Extremity - hand, 0-14, higher values are better, final value) at <6 months	36 (1 RCT) follow-up: 4 weeks	⨁◯◯◯ Very low[b,l]	-	The mean physical function - upper limb at <6 months was 8	MD **1.25 higher** (0.16 higher to 2.34 higher)	MID = 1.4 (Fugl Meyer established MID = 10% of scale)
Physical function - upper limb (Fugl Meyer Upper Extremity - coordination, 0-6, higher values are better, final value) at <6 months	36 (1 RCT) follow-up: 4 weeks	⨁◯◯◯ Very low[b,l]	-	The mean physical function - upper limb at <6 months was **3.67**	MD **0.12 higher** (0.53 lower to 0.77 higher)	MID = 0.6 (Fugl Meyer established MID = 10% of scale)
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-120, higher values are better, final value) at ≥6 months	635 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low[i]	-	The mean physical function - upper limb at ≥6 months was 77.9	MD **0.9 higher** (3.06 lower to 4.86 higher)	MID = 12.0 (Fugl-Meyer Assessment = Difference by 10% of the total scale)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, change score and final values) at <6 months	833 (4 RCTs) follow up: mean 4 weeks	⊕⊕◯◯ Low[b]	-	The mean physical function - lower limb at <6 months was 31	MD **5.12 higher** (0.83 higher to 9.4 higher)	MID = 3.9 (0.5 x median baseline SD)
Physical function - lower limb (Fugl Meyer Assessment Lower Extremity, 0-36, higher values are better, change score) at <6 months	20 (1 RCT) follow-up: 4 weeks	⊕⊕◯◯ Low[b,m]	-	The mean physical function - lower limb at <6 months was 3	MD **1 lower** (4.33 lower to 2.33 higher)	MID = 3.6 (Fugl Meyer established MID = 10% of scale)
Physical function - lower limb (6-minute walk test, meters, higher values are better, change score) at <6 months	25 (1 RCT) follow up: 4 weeks	⊕⊕◯◯ Low[b.m]	-	The mean physical function - lower limb at <6 months was 23.75 meters	MD **43.25 meters higher** (0.48 lower to 86.98 higher)	MID = 28 meters (established MID)
Physical function - lower limb (10 meter walk test, m/s, higher values are better, change score) at <6 months	22 (1 RCT) follow up: 4 weeks	⊕⊕◯◯ Low[b,m]	-	The mean physical function - lower limb at <6 months was 0.07 m/s	MD **0.24 m/s higher** (0.08 higher to 0.4 higher)	MID = 0.085 (0.5 x median baseline SD)
Physical function - lower limb (fast walking speed, m/s, higher values are better, change score) at <6 months	24 (1 RCT) follow up: 18 weeks	⊕◯◯◯ Very low[b,i]	-	The mean physical function - lower limb at <6 months was 0.12 m/s	MD **0.24 m/s higher** (0.08 higher to 0.4 higher)	MID = 16cm/sec (acute stroke), 20cm/sec (chronic stroke) (established MID)
Physical function - lower limb (Dynamic Balance Ability, scale range unclear, higher values are	20 (1 RCT) follow up: 4 weeks	⊕◯◯◯ Very low[b,c]	-	The mean physical function - lower limb at <6 months was 0.9	MD **0.2 higher** (0.85 lower to 1.25 higher)	MID = 0.73 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
better, change score) at <6 months						
Physical function - lower limb (Rivermead Motor Assessment Gross motor function subscale, 0-13, higher values are better, final value) at <6 months	47 (1 RCT) follow up: 3 weeks	⊕⊕◯◯ Low[b,n]	-	The mean physical function - lower limb at <6 months was 6.3	MD **2.1 higher** (0.17 lower to 4.37 higher)	MID = 1.4 (0.5 x median baseline SD)
Physical function - lower limb (Rivermead Motor Assessment leg and trunk subscale, 0-13, higher values are better, final value) at <6 months	47 (1 RCT) follow up: 3 weeks	⊕⊕◯◯ Low[b,n]	-	The mean physical function - lower limb at <6 months was 4.5	MD **2.4 higher** (0.5 higher to 4.3 higher)	MID = 1.2 (0.5 x median baseline SD)
Physical function - lower limb (Rivermead Motor Assessment Gross motor function subscale, 0-13, higher values are better, final value) at ≥6 months	45 (1 RCT) follow up: 6 months	⊕⊕◯◯ Low[b,n]	-	The mean physical function - lower limb at ≥6 months was 8.8	MD **2 higher** (0.21 higher to 3.79 higher)	MID = 1.4 (0.5 x median baseline SD)
Physical function - lower limb (Rivermead Motor Assessment leg and trunk subscale, 0-13, higher values are better, final value) at ≥6 months	45 (1 RCT) follow up: 6 months	⊕⊕◯◯ Low[b,n]	-	The mean physical function - lower limb at ≥6 months was 5.8	MD **2 higher** (0.28 higher to 3.72 higher)	MID = 1.2 (0.5 x median baseline SD)
Physical function - lower limb (6-minute walk test, meters, higher values are better, final value) at	57 (1 RCT) follow up: 12 months	⊕◯◯◯ Very low[b,o]	-	The mean physical function - lower limb at ≥6 months was 376 meters	MD **1 meters lower** (83.98 lower to 81.98 higher)	MID = 28 meters (established MID)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
≥6 months						
Psychological distress - depression (PHQ-9, Center for Epidemiological Studies - Depression [different scale ranges], lower values are better, final values) at <6 months	72 (2 RCTs) follow up: mean 4 weeks	⨁⨁◯◯ Low[b,h]	-	-	SMD **0.41 SD lower** (1.08 lower to 0.27 higher)	MID = 2.4 (0.5 x median baseline SD)
Discontinuation from study at <6 months	1362 (16 RCTs) follow up: mean 6 weeks	⨁⨁◯◯ Low[p,q]	RD -0.03 (-0.06 to 0.00)	110 per 1,000	**30 fewer per 1,000** (60 fewer to 0 more) [r]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.96 (0.8-0.9 = serious, <0.8 = very serious)
Discontinuation from study at ≥6 months	923 (4 RCTs) follow up: mean 8 months	⨁⨁⨁◯ Moderate [s]	RR 0.56 (0.40 to 0.80)	183 per 1,000	**80 fewer per 1,000** (110 fewer to 37 more)	MID = RR 0.8-1.25.

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)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
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 22: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	
Person/participant health-related quality of life (Stroke Impact Scale - Mobility subscale, 0-100, higher values are better, final value) at ≥6 months	62 (1 RCT) follow up: 26 weeks	⨁⨁⨁◯ Moderate [a]	-	The mean person/participant health-related quality of life at ≥6 months was 79.5	MD **1.5 higher** (8.27 lower to 11.27 higher)	MID = 12.4 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale - Recovery subscale, 0-100, higher values are better, final value) at ≥6 months	62 (1 RCT) follow up: 26 weeks	⨁⨁◯◯ Low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 63.1	MD **2.9 higher** (6.63 lower to 12.43 higher)	MID = 12.4 (0.5 x median baseline SD)
Activities of daily living (Barthel index, 0-100, higher values are better, final value) at ≥6 months	62 (1 RCT) follow up: 26 weeks	⨁⨁◯◯ Low [b]	-	The mean activities of daily living at ≥6 months was 91.4	MD **1.1 higher** (5.71 lower to 7.91 higher)	MID = Barthel Index 1.85 (established MID)
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at ≥6 months	62 (1 RCT) follow up: 26 weeks	⨁⨁⨁◯ Moderate [b]	-	The mean physical function - lower limb at ≥6 months was 45.1	MD **1.8 higher** (3.73 lower to 7.33 higher)	MID = 5.9 (0.5 x median baseline SD)
Discontinuation from study at ≥6 months	62 (1 RCT) follow up: 26 weeks	⨁⨁◯◯ Low [b]	Peto OR 8.18 (0.50 to 133.94)	0 per 1,000	**70 more per 1,000** 40 fewer to 170 more) [c]	MID = Peto OR 0.8-1.25.

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 23: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 6 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	
Person/participant health-related quality of life (Stroke Impact Scale - Strength subscale, 0-80, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 45	MD **12.2 lower** (27.37 lower to 2.97 higher)	MID = 7.6 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale - Memory subscale, 0-80, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 61.8	MD **3.9 higher** (9.24 lower to 17.04 higher)	MID = 9.5 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale - Mood subscale, 0-80, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 58.4	MD **4.8 lower** (19.01 lower to 9.41 higher)	MID = 9.0 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale - Communication subscale, 0-80, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 58.7	MD **0.7 higher** (17.77 lower to 19.17 higher)	MID = 12.9 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 6 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	
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	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 58.6	MD **9 lower** (22.76 lower to 4.76 higher)	MID = 7.2 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale - Mobility subscale, 0-80, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 63.8	MD **4.8 lower** (17.36 lower to 7.76 higher)	MID = 7.1 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale - Hand use subscale, 0-80, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 24	MD **5.3 lower** (28.53 lower to 17.93 higher)	MID = 12.3 (0.5 x median baseline SD)
Person/participant health-related quality of life (Stroke Impact Scale - Activities subscale, 0-80, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 55	MD **17.5 lower** (33.26 lower to 1.74 lower)	MID = 9.3 (0.5 x median baseline SD)
Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at ≥6 months	18 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [b,c]	-	The mean physical function - upper limb at ≥6 months was 14.8	MD **3 lower** (18.9 lower to 12.9 higher)	MID = 12 points dominant side (17 points non-dominant side) (ARAT established MID)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 6 days a week	Risk difference with Physiotherapy (no communication difficulties) - >1 hour to 2 hours, 6 days a week	
Discontinuation from study at ≥6 months	20 (1 RCT) follow up: 6 months	⨁◯◯◯ Very low [b,c]	RR 0.61 (0.07 to 5.70)	182 per 1,000	**71 fewer per 1,000** (169 fewer to 855 more)	MID = RR 0.8-1.25.

[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)

2.1.4.1.4 >2 hours to 4 hours

Table 24: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
Physical function - upper limb (Action Research Arm Test, 0-57, higher values are better, final value) at <6 months	39 (1 RCT) follow up: 14 days	⨁⨁⨁◯ Moderate [a]	-	The mean physical function - upper limb at <6 months was **6.5**	MD **3.3 higher** (4.36 lower to 10.96 higher)	MID = 12 points dominant side (17 points non-dominant side) (ARAT established MID)
Discontinuation from study at <6 months	39 (1 RCT) follow up: 14 days	⨁◯◯◯ Very low [a,b]	RD 0.00 (-0.09 to 0.09)	0 per 1,000	**0 fewer per 1,000** (90 fewer to 90 more) [c]	Sample size used to determine precision: 75-150 = serious imprecision,

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
						<75 = very serious imprecision

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 25: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at <6 months	42 (2 RCTs) follow up: mean 4 weeks	⨁◯◯◯ Very low a,b	-	-	SMD **0.24 SD higher** (0.37 lower to 0.85 higher)	MID = 0.5 SD (SMD)
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	58 (2 RCTs) follow up: mean 4 weeks	⨁◯◯◯ Very low b,c,d	-	-	SMD **0.83 SD higher** (0.4 lower to 2.06 higher)	MID = 0.5 SD (SMD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
Physical function - lower limb (Wolf Motor Function Test Performance Time, 0-120 seconds, lower values are better, final values) at <6 months	22 (1 RCT) follow up: 2 weeks	⨁◯◯◯ Very low [a,b]	-	The mean physical function - lower limb at <6 months was 20.5 seconds	MD **5.3 seconds lower** (18.67 lower to 8.07 higher)	MID = 10.7 (0.5 x median baseline SD)
Discontinuation from study at <6 months	86 (3 RCTs) follow up: mean 3 weeks	⨁◯◯◯ Very low [c,e,g]	RD 0.04 (-0.06 to 0.14)	25 per 1,000	**40 more per 1,000** (60 fewer to 140 more) [f]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.24 (0.8-0.9 = serious, <0.8 = very serious)

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 26: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >1 hour to 2 hours, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
Activities of daily living (Barthel Index, Functional Independence Measure [different scale ranges], higher values are better, final values) at <6 months	88 (3 RCTs) follow up: 7 weeks	⨁◯◯◯ Very low [a,b,c]	-	-	SMD **0.75 SD higher** (0.3 lower to 1.81 higher)	MID = 0.5 SD (SMD)
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	84 (3 RCTs) follow up: 3 weeks	⨁⨁◯◯ Low [c,d]	-	-	SMD **0.45 SD higher** (0.01 higher to 0.89 higher)	MID = 0.5 SD (SMD)
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final values) at <6 months	42 (1 RCT) follow up: 12 weeks	⨁⨁◯◯ Low [e]	-	The mean physical function - lower limb at <6 months was 15.9	MD **23.6 higher** (15.83 higher to 31.37 higher)	MID = 5.4 (0.5 x median baseline SD)
Discontinuation from study at <6 months	102 (3 RCTs) follow up: 7 weeks	⨁◯◯◯ Very low [d,f]	RD 0.00 (-0.08 to 0.08)	20 per 1,000	**0 fewer per 1,000** (80 fewer to 80 more) [h]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.22 (0.8-0.9 = serious, <0.8 = very serious)

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)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >1 hour to 2 hours, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
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 27: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >1 hour to 2 hours, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >2 hours to 4 hours, 6 days a week	
Physical Function - upper limb (Action Research Arm Test, 0-57, higher values are better, change score) at <6 months	103 (1 RCT) follow up: 3 months	⊕⊕⊕⊕ High	-	The mean physical Function - upper limb at <6 months was 7	MD **4.7 higher** (0.63 higher to 8.77 higher)	MID = 12 points dominant side (17 points non-dominant side) (ARAT established MID)
Discontinuation from study at <6 months	103 (1 RCT) follow up: 3 months	⊕⊕◯◯ Low [a]	RR 0.47 (0.12 to 1.79)	120 per 1,000	**64 fewer per 1,000** (106 fewer to 95 more)	MID = RR 0.8-1.25.
a. Downgraded by 1 increment if the confidence interval crossed one MID or by 2 increments if the confidence interval crossed both MIDs						

2.1.4.1.5 >4 hours

Table 28: Clinical evidence summary: Physiotherapy (no communication difficulties) - >4 hours, 5 days a week compared to usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Physiotherapy (no communication difficulties) - >4 hours, 5 days a week	
Person/participant health-related quality of life (Stroke impact scale hand function, scale range unclear, higher values are better, change score) at ≥6 months	222 (1 RCT) follow up: 12 months	⨁◯◯◯ Very low [a,b]	-	-	MD **0.3 higher** (0.04 higher to 0.56 higher)	MID = 0.45 (0.5 x mean difference SD)
Person/participant health-related quality of life (Stroke impact scale physical function, scale range unclear, higher values are better, change score) at ≥6 months	222 (1 RCT) follow up: 12 months	⨁◯◯◯ Very low [a,b]	-	-	MD **7.04 higher** (0.6 lower to 14.68 higher)	MID = 14.5 (0.5 x mean difference SD)
Physical function - lower limb (Wolf Motor Function Test Log Performance Time, higher values are better, change score) at ≥6 months	222 (1 RCT) follow up: 12 months	⨁⨁◯◯ Low [a]	-	-	MD **1.14 higher** (4.86 lower to 7.14 higher)	MID = 11.4 (0.5 x mean difference SD)
Discontinuation from study at <6 months	222 (1 RCT) follow up: 2 weeks	⨁⨁◯◯ Low [b]	RR 0.80 (0.33 to 1.90)	95 per 1,000	**19 fewer per 1,000** (64 fewer to 85 more)	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	222 (1 RCT) follow up: 12 months	⨁◯◯◯ Very low [b,c]	RR 0.84 (0.52 to 1.35)	259 per 1,000	**41 fewer per 1,000** (124 fewer to 91 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Physiotherapy (no communication difficulties) - >4 hours, 5 days a week	
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 29: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >2 hours to 4 hours, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >4 hours, 5 days a week	
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-66, higher values are better, final value) at <6 months	60 (1 RCT) follow up: 3 months	⨁◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at <6 months was 46.93	MD **3.64 higher** (1.48 higher to 5.8 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
Discontinuation from study at <6 months	90 (2 RCTs) follow up: mean 8 weeks	⨁◯◯◯ Very low [c,d,f]	RD -0.02 (-0.12 to 0.08)	67 per 1,000	**20 fewer per 1,000** (120 fewer to 80 fewer) [e]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.12 (0.8-0.9 = serious, <0.8 = very serious)
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						

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >2 hours to 4 hours, 5 days a week	Risk difference with Physiotherapy (no communication difficulties) - >4 hours, 5 days a week	
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						

2.1.4.2 Physiotherapy (communication difficulties)

2.1.4.2.1 >1 hour to 2 hours

Table 30: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Physiotherapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	
Activities of daily living (Functional Independence Measure, 1-7, higher values are better, final value) at <6 months	20 (1 RCT) follow up: 7 weeks	⨁⨁⨁◯ Moderate [a]	-	The mean activities of daily living at <6 months was 5.72	MD **0.4 higher** (0.19 lower to 0.99 higher)	MID = 0.40 (0.5 x median baseline SD)
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better, final value) at <6 months	20 (1 RCT) follow up: 7 weeks	⨁⨁◯◯ Low [a]	-	The mean physical function - lower limb at <6 months was 42.2	MD **0.3 lower** (5.51 lower to 4.91 higher)	MID = 2.9 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Physiotherapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	
Discontinuation from study at <6 months	20 (1 RCT) follow up: 7 weeks	⨁⨁◯◯ Low [b]	RD 0.00 (-0.17 to 0.17)	0 per 1,000	**0 fewer per 1,000** (170 fewer to 170 more) [c]	Sample size used to determine precision: 75-150 = serious imprecision, <75 = very serious imprecision

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

2.1.4.3 Occupational Therapy (no communication difficulties)

2.1.4.2.1 ≤45 minutes

Table 31: Clinical evidence summary: Occupational therapy (no communication difficulties) - ≤45 minutes, <5 days a week compared to usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Occupational therapy (no communication difficulties) - ≤45 minutes, <5 days a week	
Person/participant health-related quality of life (Stroke Impact Scale total, 0-100, higher values are better, final value) at <6 months	18 (1 RCT) follow up: 8 weeks	⨁◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality at <6 months was 73.5	**MD 2.3 higher** (10.96 lower to 15.56 higher)	MID = 6.3 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Occupational therapy (no communication difficulties) - ≤45 minutes, <5 days a week	
Physical function - upper limb (Fugl Meyer Assessment - Upper Extremity, 0-66, higher values are better, final value) at <6 months	18 (1 RCT) follow up: 8 weeks	⊕◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at <6 months was 47.6	**MD 0.4 lower** (13.35 lower to 12.55 higher)	MID = 6.6 (Fugl-Meyer upper extremity = Difference by 10% of the total scale established MID)
Discontinuation from study at <6 months	138 (1 RCT) follow up: 8 weeks	⊕⊕◯◯ Low [b]	RR 1.59 (0.27 to 9.22)	28 per 1,000	**17 more per 1,000** (21 fewer to 232 more)	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	138 (1 RCT) follow up: 6 months	⊕⊕◯◯ Low [b]	RR 0.93 (0.36 to 2.42)	113 per 1,000	**8 fewer per 1,000** (72 fewer to 160 more)	MID = RR 0.8-1.25.

[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 32: Clinical evidence summary: Occupational therapy (no communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Occupational therapy (no communication difficulties) - ≤45 minutes, 5 days a week	
Discontinuation from study at <6 months	40 (1 RCT)	⊕◯◯◯ Very low [a,b,c]	RR 0.60 (0.26 to 1.37)	500 per 1,000	**200 fewer per 1,000** (370 fewer to 185 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Occupational therapy (no communication difficulties) - ≤45 minutes, 5 days a week	
	follow up: 16 weeks					

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

2.1.4.2.2 >45 minutes to 1 hour

Table 33: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week	
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months	14 (1 RCT) follow up: 6 weeks	⨁◯◯◯ Very low a,b,c	-	The mean activities of daily living at <6 months was 61.24	MD **10.18 higher** (4.02 lower to 24.38 higher)	MID = 22 points total score (Functional Independence Measure established MID)
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months	35 (1 RCT) follow-up: 6 weeks	⨁◯◯◯ Very low b,c	-	The mean physical function - upper limb at <6 months was 6.53	MD **4.36 higher** (1.19 higher to 7.53 higher)	MID = 6.6 (Fugl-Meyer upper extremity = Difference by 10% of the total scale established MID)
Discontinuation from study at <6 months	40 (1 RCT)	⨁◯◯◯ Very low b,d	RR 0.67 (0.12 to 3.57)	150 per 1,000	**49 fewer per 1,000** (132 fewer to 385 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, <5 days a week	
	follow-up: 6 weeks					

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 34: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months	35 (1 RCT) follow up: 3 months	⨁◯◯◯ Very low [a,b]	-	The mean activities of daily living at <6 months was 29.7	MD **14.5 higher** (5.67 higher to 23.33 higher)	MID = 22 total points (Functional Independence Measure established MID)
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value)	35 (1 RCT) follow up: 8 months	⨁◯◯◯ Very low [a,b]	-	The mean activities of daily living at ≥6 months was 31.8	MD **14.4 higher** (6.04 higher to 22.76 higher)	MID = 22 total points (Functional Independence

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
at ≥6 months						Measure established MID)
Physical function - upper limb (Fugl Meyer Assessment - Shoulder/elbow and coordination subsections, 0-42, higher values are better, final value) at <6 months	35 (1 RCT) follow up: 3 months	⊕◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at <6 months was 8.9	MD **9.9 higher** (5.01 higher to 14.79 higher)	MID = 4.2 (Fugl Meyer Assessment = 10% of total scale established MID)
Physical function - upper limb (Fugl Meyer Assessment - Shoulder/elbow and coordination subsections, 0-42, higher values are better, final value) at ≥6 months	35 (1 RCT) follow up: 8 months	⊕◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at ≥6 months was 10.5	MD **9.5 higher** (2.4 higher to 16.6 higher)	MID = 4.2 (Fugl Meyer Assessment = 10% of total scale established MID)
Physical function - upper limb (Fugl Meyer Assessment - Wrist/hand subsections, 0-24, higher values are better, final value) at <6 months	35 (1 RCT) follow up: 3 months	⊕⊕◯◯ Low [a]	-	The mean physical function - upper limb at <6 months was 6.1	MD **0.3 lower** (2.35 lower to 1.75 higher)	MID = 2.4 (Fugl Meyer Assessment = 10% of total scale established MID)
Physical function - upper limb (Fugl Meyer Assessment - Wrist/hand subsections, 0-24, higher values are better, final value) at ≥6 months	35 (1 RCT) follow up: 8 months	⊕◯◯◯ Very low [a,b]	-	The mean physical function - upper limb at ≥6 months was 5.8	MD **0.2 higher** (2.12 lower to 2.52 higher)	MID = 2.4 (Fugl Meyer Assessment = 10% of total scale established MID)

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 35: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, change scores) at <6 months	114 (2 RCTs) follow up: mean 10 weeks	⊕◯◯◯ Very low[a,b,c]	-	The mean physical function - upper limb at <6 months was 9.4	MD **1.46 lower** (1.92 lower to 4.84 higher)	MID = 6.6 (Fugl Meyer Assessment = 10% of total scale established MID)
Physical function - upper limb (Fugl Meyer Assessment Upper Extremity, 0-66, higher values are better, final value) at ≥6 months	90 (1 RCT) follow-up: 12 months	⊕◯◯◯ Very low[c,d,e]	-	The mean physical function - upper limb at ≥6 months was 19.46	MD **6.52 higher** (5.01 higher to 8.03 higher)	MID = 6.6 (Fugl-Meyer upper extremity = Difference by 10% of the total scale)
Swallow function and ability (Penetration Aspiration Scale, 1-8, lower values are better, change score) at <6 months	18 (1 RCT) follow up: 4 weeks	⊕◯◯◯ Very low [e,f]	-	The mean swallow function and ability at <6 months was **-** 1.11	MD **1.56 lower** (2.45 lower to 0.67 lower)	MID = 0.72 (0.5 x median baseline SD)
Discontinuation at <6 months	108 (2 RCTs) follow up: mean 10 weeks	⊕◯◯◯ Very low [c,g,h]	RD 0.00 (-0.06 to 0.06)	0 per 1,000	**0 fewer per 1,000** (60 fewer to 60 more) [i]	Sample size used to determine precision: 75-150 = serious imprecision, <75 = very serious imprecision
Discontinuation at <6 months	90 (1 RCT) follow up: 12 months	⊕◯◯◯ Very low [c,d,h]	RD 0.00 (-0.05 to 0.05)	0 per 1,000	**0 fewer per 1,000** (50 fewer to 50 more) [i]	Sample size used to determine precision: 75-150 = serious imprecision, <75 = very serious imprecision

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
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						

2.1.4.2.3 >1 hour to 2 hours

Table 36: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Person/participant health-related quality of life (Stroke Impact Scale-16, 0-100, higher values	21 (1 RCT)	⨁⨁◯◯ Low [a]	-	The mean person/participant health-	MD **9.58 higher** (7.27 higher to 11.89 higher)	MID = 3.1 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
are better, change score) at <6 months	follow up: 8 weeks			related quality of life at <6 months was 0.25		
Physical function - upper limb (Fugl-Meyer Assessment upper extremity, 0-66, higher values are better, change score) at <6 months	21 (1 RCT) follow up: 8 weeks	⨁⨁◯◯ Low [a]	-	The mean physical function - upper limb at <6 months was 3	MD **2.1 higher** (1.27 higher to 2.93 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
[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 37: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Person/participant health-related quality of life (stroke-specific quality of life, 49-245, higher values are better, final value) at <6 months	50 (1 RCT) follow-up: 8 weeks	⨁◯◯◯ Very low[a,b]	-	The mean person/participant health-related quality of life at <6 months was 144.5	MD **3.2 higher** (10 lower to 16.4 higher)	MID = 12.9 (0.5 x median baseline SD)
Activities of daily living (Functional Independence Measure, 18-126, higher values	50 (1 RCT)	⨁◯◯◯ Very low[a,b]	-	The mean activities of daily living at <6 months was 72.9	MD **1.3 higher** (3.57 lower to 6.17 higher)	MID = 5.1 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
are better, final value) at <6 months	follow-up: 8 weeks					
Physical function - upper limb (Fugl-Meyer Assessment Upper Extremity, 0-66, higher values are better, change score) at <6 months	24 (1 RCT) follow up: 8 weeks	⨁⨁◯◯ Low[c]	-	The mean physical function - upper limb at <6 months was **1.6**	MD **2.5 higher** (0.2 higher to 4.8 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
Psychological distress - depression (Beck Depression Inventory, 0-63, lower values are better, final value) at <6 months	50 (1 RCT) follow-up: 8 weeks	⨁◯◯◯ Very low[a,b]	-	The mean psychological distress - depression at <6 months was 29.2	MD **2.4 lower** (5.27 lower to 0.47 higher)	MID = 2.9 (0.5 x median baseline SD)
Swallow function and ability (Functional Oral Intake Scale, 1-7, higher values are better, final value) at <6 months	50 (1 RCT) follow-up: 8 weeks	⨁◯◯◯ Very low[a,b]	-	The mean swallow function and ability at <6 months was 3.6	MD **1 higher** (0.39 higher to 1.61 higher)	MID = 0.73 (0.5 x median baseline SD)
Discontinuation from study at <6 months	60 (1 RCT) follow up: 3 weeks	⨁◯◯◯ Very low [b,d]	**RR 1.67** (0.44 to 6.36)	100 per 1,000	**67 more per 1,000** (from 56 fewer to 536 more)	MID = RR 0.8-1.25.

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 38: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Person/participant health-related quality of life (Stroke Impact Scale - Upper Limb Items, 5-25, higher values are better, final value) at <6 months	105 (1 RCT) follow up: 15 weeks	⊕⊕◯◯ Low [a,b]	-	The mean person/participant health-related quality of life at <6 months was 13.5	MD **1.2 lower** (4.19 lower to 1.79 higher)	MID = 1.4 (0.5 x median baseline SD)
Activities of daily living (Functional Independence Measure, 18-126, higher values are better, final value) at <6 months	105 (1 RCT) follow up: 15 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean activities of daily living at <6 months was 113.4	MD **7.3 lower** (14.84 lower to 0.24 higher)	MID = 22 points total score (Functional Independence Measure established MID)
Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, change score and final value) at <6 months	121 (2 RCTs) follow up: mean 12 weeks	⊕◯◯◯ Very low [c,d]	-	The mean physical function - upper limb at <6 months was 21.5	MD **1.14 higher** (3.94 lower to 6.22 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
Physical function - upper limb (Motor Assessment Scale, 0-18, higher values are better, final value) at <6 months	45 (1 RCT) follow up: 7 weeks	⊕⊕◯◯ Low [b]	-	The mean physical function - upper limb at <6 months was 3.1	MD **1.3 higher** (1.71 lower to 4.31 higher)	MID = 1.3 (0.5 x median baseline SD)
Physical function - lower limb (Berg Balance Scale, 0-56, higher values are better,	42 (2 RCTs)	⊕⊕⊕⊕ High	-	The mean physical function - lower limb at <6 months was **23.7**	MD **1.24 higher** (0.5 higher to 1.97 higher)	MID = 2.7 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
change score and final value) at <6 months	follow up: mean 5 weeks					
Discontinuation from study at <6 months	177 (3 RCTs) follow up: mean 9 weeks	⨁◯◯◯ Very low [a,b,e]	RD 0.00 (-0.08 to 0.08)	70 per 1,000	**0 fewer per 1,000** (80 fewer to 80 more) [f]	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.04 (0.8-0.9 = serious, <0.8 = very serious)

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

2.1.4.2.4 >2 hours to 4 hours

Table 39: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >1 hour to 2 hours, 5 days a week	Risk difference with Occupational therapy (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
Activities of daily living (Functional Independence Measure, 13-91, higher values are better, final value) at <6 months	48 (1 RCT) follow up: 28 days	⨁⨁◯◯ Low [a,b]	-	The mean activities of daily living at <6 months was 65.17	MD **11.04 higher** (1.59 lower to 23.67 higher)	MID = 22 points total score (Functional Independence Measure established MID)
Physical function - lower limb (Postural outcome assessment scale, 0-36, higher values are better, final value) at <6 months	48 (1 RCT) follow up: 28 days	⨁⨁◯◯ Low [a,b]	-	The mean physical function - lower limb at <6 months was 18.04	MD **3.5 higher** (0.52 lower to 7.52 higher)	MID = 4.3 (0.5 x median baseline SD)
Stroke-related scale of cognition - spatial attention (Behavioural inattention test conventional, 0-146, higher values are better, final value) at <6 months	48 (1 RCT) follow up: 28 days	⨁⨁◯◯ Low [a,b]	-	The mean stroke-related scale of cognition - spatial attention at <6 months was 68.83	MD **19.88 higher** (5.38 lower to 45.14 higher)	MID = 21.1 (0.5 x median baseline SD)
Discontinuation of study at <6 months	173 (2 RCTs) follow up: mean 4 weeks	⨁◯◯◯ Very low [a,b]	RR 0.78 (0.19 to 3.16)	143 per 1,000	**31 fewer per 1,000** (116 fewer to 309 more)	MID = RR 0.8-1.25.

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

2.1.4.4 Occupational therapy (communication difficulties)

2.1.4.5.1 ≤45 minutes

Table 40: Clinical evidence summary: Occupational therapy (communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Occupational therapy (communication difficulties) - ≤45 minutes, 5 days a week	
Activities of daily living (Korean Shoulder Disability Questionnaire, 0-100, lower values are better, final value) at <6 months	36 (1 RCT) follow up: 8 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean activities of daily living at <6 months was 82	MD **17 lower** (22.39 lower to 11.61 lower)	MID = 1.8 (0.5 x median baseline SD)
Discontinuation from study at <6 months	38 (1 RCT) follow up: 8 weeks	⊕◯◯◯ Very low [a,b]	RR 1.00 (0.07 to 14.85)	53 per 1,000	**0 fewer per 1,000** (49 fewer to 729 more)	MID = RR 0.8-1.25.

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

Speech and Language Therapy (no communication difficulties)

2.1.4.3.3 ≤45 minutes

Table 41: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Speech and Language Therapy (no communication difficulties) - ≤45 minutes, 7 days a week	
Swallow function and ability (functional swallow) at ≥6 months	204 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [a,b]	RR 1.11 (0.82 to 1.50)	431 per 1,000	**47 more per 1,000** (78 fewer to 216 more)	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	204 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [b]	RR 0.90 (0.52 to 1.58)	206 per 1,000	**21 fewer per 1,000** (99 fewer to 119 more)	MID = RR 0.8-1.25.

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

2.1.4.5.1 >1 hour to 2 hours

Table 42: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Speech and Language Therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Swallow function and ability (Penetration Aspiration Scale, 1-8, lower values are better, change score) at <6 months	36 (1 RCT) follow-up: 2 weeks	⨁◯◯◯ Very low[a,b]	-	The mean swallow function and ability at <6 months was -0.76	MD **0.1 lower** (0.83 lower to 0.63 higher)	MID = 0.27 (0.5 x median baseline SD)
Discontinuation at <6 months	41 (1 RCT) follow-up: 2 weeks	⨁◯◯◯ Very low[a,b]	RR 1.43 (0.27 to 7.67)	100 per 1,000	**43 more per 1,000** (73 fewer to 667 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Speech and Language Therapy (no communication difficulties) - >1 hour to 2 hours, 5 days a week	

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

2.1.4.5 Speech and Language Therapy (communication difficulties)

2.1.4.3.1 Individual patient data meta-analysis results – Hours per week

Table 43: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 4-9 hours per week of speech and language therapy	Risk difference with 9+ hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	146 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Overall language ability was 12.22	MD **3.42 higher** (6.45 lower to 13.29 higher)	MID = 13.5 (0.5 x median control group SD)
Communication – Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	87 (1 individual patient data network meta analysis)	⊕⊕◯◯ Low[a,b]	-	The mean Communication - Impairment specific measures (Naming) was 5.71	MD **2.84 lower** (12.45 lower to 6.77 higher)	MID = 12.4 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are	244 (1 individual patient data	⊕⊕◯◯ Low[a,b]	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 2.47	MD **4.83 higher** (0.17 higher to 9.49 higher)	MID = 8.8 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 4-9 hours per week of speech and language therapy	Risk difference with 9+ hours per week	
better, change score) (study includes <6 months and ≥6 months time points)	network meta analysis)					
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	119 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Functional communication was 0.53	MD **0.16 higher** (0.37 lower to 0.69 higher)	MID = 0.77 (0.5 x median control group SD)

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 44: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 3-4 hours per week of speech and language therapy	Risk difference with 9+ hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	200 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Overall language ability was 15.8	MD **0.16 lower** (9.56 lower to 9.24 higher)	MID = 17.9 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	173 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean Communication - Impairment specific measures (Naming) was 9.7	MD **6.83 lower** (15.96 lower to 2.3 higher)	MID = 19.9 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 3-4 hours per week of speech and language therapy	Risk difference with 9+ hours per week	
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	253 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 6.01	MD **1.29 higher** (4.57 lower to 7.15 higher)	MID = 13.3 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	238 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Functional communication was 0.7	MD **0.01 lower** (0.51 lower to 0.49 higher)	MID = 1.2 (0.5 x median control group SD)

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 45: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 2-3 hours per week of speech and language therapy	Risk difference with 9+ hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	189 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Overall language ability was 10.18	MD **5.46 higher** (3.37 lower to 14.29 higher)	MID = 14.9 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study	147 (1 individual patient data	⊕⊕⊕◯ Moderate[a]	-	The mean Communication - Impairment specific	MD **3.18 lower** (11.65 lower to 5.29 higher)	MID = 15.5 (0.5 x median

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 2-3 hours per week of speech and language therapy	Risk difference with 9+ hours per week	
includes <6 months and ≥6 months time points)	network meta analysis)			measures (Naming) was 6.05		control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	261 (1 individual patient data network meta analysis)	⊕⊕◯◯ Low[a,b]	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 0.32	MD **6.98 higher** (2.33 higher to 11.63 higher)	MID = 9.5 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	133 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Functional communication was 0.76	MD **0.07 lower** (0.61 lower to 0.47 higher)	MID = 0.90 (0.5 x median control group SD)

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 46: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 hours of speech and language therapy	Risk difference with 9+ hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	168 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Overall language ability was 15.85	MD **0.21 lower** (10.2 lower to 9.78 higher)	MID = 16.6 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 hours of speech and language therapy	Risk difference with 9+ hours per week	
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	64 (1 individual patient data network meta analysis)	⨁⨁◯◯ Low[a,b]	-	The mean Communication - Impairment specific measures (Naming) was 13.83	MD **10.96 lower** (20.48 lower to 1.44 lower)	MID = 8.0 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	160 (1 individual patient data network meta analysis)	⨁⨁◯◯ Low[a,b]	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 6.5	MD **0.8 higher** (4.68 lower to 6.28 higher)	MID = 5.0 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	143 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderate[a]	-	The mean communication - Functional communication was 0.77	MD **0.08 lower** (0.62 lower to 0.46 higher)	MID = 0.94 (0.5 x median control group SD)

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 47: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 3-4 hours per week of speech and language therapy	Risk difference with 4-9 hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	154 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Overall language ability was 15.8	MD **3.58 lower** (13.75 lower to 6.59 higher)	MID = 17.9 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	168 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean Communication - Impairment specific measures (Naming) was 9.7	MD **3.99 lower** (14.24 lower to 6.26 higher)	MID = 19.9 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	215 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 6.01	MD **3.54 lower** (9.52 lower to 2.44 higher)	MID = 13.3 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	237 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Functional communication was 0.7	MD **0.17 lower** (0.69 lower to 0.35 higher)	MID = 1.2 (0.5 x median control group SD)

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 48: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 2-3 hours per week of speech and language therapy	Risk difference with 4-9 hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	143 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Overall language ability was 10.18	MD 2.04 higher (7.61 lower to 11.69 higher)	MID = 14.9 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	142 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean Communication - Impairment specific measures (Naming) was 6.05	MD 0.34 lower (10.01 lower to 9.33 higher)	MID = 15.5 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	223 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 0.32	MD 2.15 higher (2.65 lower to 6.95 higher)	MID = 9.5 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	132 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Functional communication was 0.76	MD 0.23 lower (0.8 lower to 0.34 higher)	MID = 0.90 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 2-3 hours per week of speech and language therapy	Risk difference with 4-9 hours per week	
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 49: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 hours of speech and language therapy	Risk difference with 4-9 hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	122 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Overall language ability was 15.85	MD 3.63 lower (14.35 lower to 7.09 higher)	MID = 16.6 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	59 (1 individual patient data network meta analysis)	⊕⊕◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Naming) was 13.83	MD 8.12 lower (18.72 lower to 2.48 higher)	MID = 8.0 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher	122 (1 individual patient data network meta analysis)	⊕⊕◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 6.5	MD 4.03 lower (9.64 lower to 1.58 higher)	MID = 5.0 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 hours of speech and language therapy	Risk difference with 4-9 hours per week	
values are better, change score) (study includes <6 months and ≥6 months time points)						
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	142 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Functional communication was 0.77	MD 0.24 lower (0.8 lower to 0.32 higher)	MID = 0.94 (0.5 x median control group SD)

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 50: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 2-3 hours per week of speech and language therapy	Risk difference with 3-4 hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	197 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Overall language ability was 10.18	MD 5.62 higher (3.55 lower to 14.79 higher)	MID = 14.9 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 2-3 hours per week of speech and language therapy	Risk difference with 3-4 hours per week	
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	228 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean Communication - Impairment specific measures (Naming) was 6.05	MD 3.65 higher (5.54 lower to 12.84 higher)	MID = 15.5 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	232 (1 individual patient data network meta analysis)	⊕⊕◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 0.32	MD 5.69 higher (0.28 lower to 11.66 higher)	MID = 9.5 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	251 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Functional communication was 0.76	MD 0.06 lower (0.6 lower to 0.48 higher)	MID = 0.90 (0.5 x median control group SD)

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 51: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 hours of speech and language therapy	Risk difference with 3-4 hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	176 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Overall language ability was 15.85	MD **0.05 lower** (10.34 lower to 10.24 higher)	MID = 16.6 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	145 (1 individual patient data network meta analysis)	⊕⊕◯◯ Low[a,b]	-	The mean Communication - Impairment specific measures (Naming) was 13.83	MD **4.13 lower** (14.29 lower to 6.03 higher)	MID = 8.0 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	131 (1 individual patient data network meta analysis)	⊕◯◯◯ Very low[a,b]	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 6.5	MD **0.49 lower** (7.13 lower to 6.15 higher)	MID = 5.0 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	261 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderate[a]	-	The mean communication - Functional communication was 0.77	MD **0.07 lower** (0.6 lower to 0.46 higher)	MID = 0.94 (0.5 x median control group SD)

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 52: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 hours of speech and language therapy	Risk difference with 2-3 hours per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	165 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Overall language ability was 15.85	MD 5.67 lower (15.44 lower to 4.1 higher)	MID = 16.6 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	119 (1 individual patient data network meta analysis)	⨁⨁◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Naming) was 13.83	MD 7.78 lower (17.35 lower to 1.79 higher)	MID = 8.0 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	139 (1 individual patient data network meta analysis)	⨁⨁◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 6.5	MD 6.18 lower (11.78 lower to 0.58 lower)	MID = 5.0 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	156 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Functional communication was 0.77	MD 0.01 lower (0.59 lower to 0.57 higher)	MID = 0.94 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 hours of speech and language therapy	Risk difference with 2-3 hours per week	
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						

2.1.4.3.2 Individual patient data meta-analysis results – Days per week

Table 53: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 5 days per week of speech and language therapy	Risk difference with 5+ days per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	226 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Overall language ability was 14.95	MD 0.81 lower (10.82 lower to 9.2 higher)	MID = 22.3 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	222 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 4.63	MD 2.25 lower (7.27 lower to 2.77 higher)	MID = 10.5 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 5 days per week of speech and language therapy	Risk difference with 5+ days per week	
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	164 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Functional communication was 0.78	MD 0.12 lower (0.76 lower to 0.52 higher)	MID = 0.95 (0.5 x median control group SD)
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 54: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 4 days per week of speech and language therapy	Risk difference with 5+ days per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	108 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Overall language ability was 13.08	MD 1.06 higher (9.82 lower to 11.94 higher)	MID = 16.8 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months	207 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean Communication - Impairment specific measures (Naming) was 7.8	MD 3.73 lower (11.9 lower to 4.44 higher)	MID = 16.8 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 4 days per week of speech and language therapy	Risk difference with 5+ days per week	
and ≥6 months time points)						
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	165 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 5.86	MD 3.48 lower (9.21 lower to 2.25 higher)	MID = 11.4 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	111 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Functional communication was 0.7	MD 0.04 lower (0.76 lower to 0.68 higher)	MID = 1.1 (0.5 x median control group SD)
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 55: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 3 days per week of speech and language therapy	Risk difference with 5+ days per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	53 (1 individual patient data network meta analysis)	⨁◯◯◯ Very lowa,b	-	The mean communication - Overall language ability was 13.35	MD 0.79 higher (10.78 lower to 12.36 higher)	MID = 10.0 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	188 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean Communication - Impairment specific measures (Naming) was 6.45	MD 2.38 lower (10.25 lower to 5.49 higher)	MID = 14.3 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	140 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 1.86	MD 0.52 higher (4.99 lower to 6.03 higher)	MID = 9.3 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	102 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Functional communication was 0.62	MD 0.04 higher (0.65 lower to 0.73 higher)	MID = 0.97 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 3 days per week of speech and language therapy	Risk difference with 5+ days per week	
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 56: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 days per week of speech and language therapy	Risk difference with 5+ days per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	122 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Overall language ability was 10.24	MD 3.9 higher (6.37 lower to 14.17 higher)	MID = 16.1 (0.5 x median control group SD)
Communication - Impairment specific measures (Naming) (BNT, 0-60, higher values are better, change score) (study includes <6 months and ≥6 months time points)	146 (1 individual patient data network meta analysis)	⊕⊕◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Naming) was 12.06	MD 7.99 lower (16.03 lower to 0.05 higher)	MID = 10.5 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT	115 (1 individual patient data network meta analysis)	⊕⊕◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Auditory comprehension) was -0.51	MD 2.89 higher (2.37 lower to 8.15 higher)	MID = 7.2 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 days per week of speech and language therapy	Risk difference with 5+ days per week	
Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)						
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	91 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Functional communication was 0.52	MD 0.14 higher (0.52 lower to 0.8 higher)	MID = 0.77 (0.5 x median control group SD)

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 57: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 4 days per week of speech and language therapy	Risk difference with 5 days per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	270 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Overall language ability was 13.08	MD 1.87 higher (7.93 lower to 11.67 higher)	MID = 16.8 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 4 days per week of speech and language therapy	Risk difference with 5 days per week	
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	285 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 5.86	MD 1.23 lower (6.45 lower to 3.99 higher)	MID = 11.4 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	257 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Functional communication was 0.7	MD 0.08 higher (0.46 lower to 0.62 higher)	MID = 1.1 (0.5 x median control group SD)

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 58: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 3 days per week of speech and language therapy	Risk difference with 5 days per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score)	215 (1 individual patient data network meta analysis)	⨁⨁◯◯ Lowa,b	-	The mean communication - Overall language ability was 13.35	MD 1.6 higher (8.96 lower to 12.16 higher)	MID = 10.0 (0.5 x median control group SD)

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with 3 days per week of speech and language therapy	Risk difference with 5 days per week	
(study includes <6 months and ≥6 months time points)						
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	260 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean Communication - Impairment specific measures (Auditory comprehension) was 1.86	MD 2.77 higher (2.2 lower to 7.74 higher)	MID = 9.3 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	248 (1 individual patient data network meta analysis)	⊕⊕⊕◯ Moderatea	-	The mean communication - Functional communication was 0.62	MD 0.16 higher (0.33 lower to 0.65 higher)	MID = 0.97 (0.5 x median control group SD)

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 59: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with up to 2 days per week of speech and language therapy	Risk difference with 5 days per week	
Communication - Overall language ability (WAB-AQ, 0-100, higher values are better, change score) (study includes <6 months and ≥6 months time points)	284 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Overall language ability was 10.24	MD 4.71 higher (4.4 lower to 13.82 higher)	MID = 16.1 (0.5 x median control group SD)
Communication - Impairment specific measures (Auditory comprehension) (AAT Token Test, 0-50, higher values are better, change score) (study includes <6 months and ≥6 months time points)	235 (1 individual patient data network meta analysis)	⨁⨁◯◯ Lowa,b	-	The mean Communication - Impairment specific measures (Auditory comprehension) was -0.51	MD 5.14 higher (0.44 higher to 9.84 higher)	MID = 7.2 (0.5 x median control group SD)
Communication - Functional communication (AAT-SSC, 0-5, higher values are better, change score) (study includes <6 months and ≥6 months time points)	237 (1 individual patient data network meta analysis)	⨁⨁⨁◯ Moderatea	-	The mean communication - Functional communication was 0.52	MD 0.26 higher (0.19 lower to 0.71 higher)	MID = 0.77 (0.5 x median control group SD)

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

2.1.4.3.4 >45 minutes to 1 hour

Table 60: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	
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	217 (1 RCT) follow up: 12 weeks	⊕⊕◯◯ Low [a,b]	-	The mean person/participant health-related quality of life at <6 months was 3.6	MD **0.3 lower** (0.53 lower to 0.07 lower)	MID = 0.38 (0.5 x median control SD)
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	217 (1 RCT) follow up: 26 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean person/participant health-related quality of life at ≥6 months was 3.65	MD **0.15 lower** (0.37 lower to 0.07 higher)	MID = 0.38 (0.5 x median control SD)
Communication - Overall language ability (Western Aphasia Battery-Revised Aphasia Quotient, 0-100, higher values are better, final values) at <6 months	217 (1 RCT) follow up: 12 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean communication - Overall language ability at <6 months was 70.02	MD **2.82 lower** (11.1 lower to 5.46 higher)	MID = 14.2 (0.5 x median baseline SD)
Communication - Overall language ability (Western Aphasia Battery-Revised Aphasia Quotient, 0-100, higher values are better, final values) at ≥6 months	217 (1 RCT) follow up: 26 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean communication - Overall language ability at ≥6 months was 75.7	MD **4 lower** (11.55 lower to 3.55 higher)	MID = 14.2 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Communication - Impairment specific measures (naming) (Boston Naming Test, number of incorrect names, lower values are better, final values) at <6 months	217 (1 RCT) follow up: 12 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean communication - Impairment specific measures (naming) at <6 months was 31.3	MD **1 lower** (6.54 lower to 4.54 higher)	MID = 8.4 (0.5 x median baseline SD)
Communication - Impairment specific measures (naming) (Boston Naming Test, number of incorrect names, lower values are better, final values) at >6 months	217 (1 RCT) follow up: 26 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean communication - Impairment specific measures (naming) at >6 months was 37.5	MD **2.9 lower** (8.21 lower to 2.41 higher)	MID = 8.4 (0.5 x median baseline SD)
Psychological distress - depression (Aphasia Depression Rating Scale, 0-32, lower values are better, final values) at <6 months	217 (1 RCT) follow up: 12 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean psychological distress - depression at <6 months was 5.6	MD **0** (1.08 lower to 1.08 higher)	MID = 1.9 (0.5 x median control SD)
Psychological distress - depression (Aphasia Depression Rating Scale, 0-32, lower values are better, final values) at ≥6 months	217 (1 RCT) follow up: 26 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean psychological distress - depression at ≥6 months was 4.76	MD **0.56 lower** (1.6 lower to 0.48 higher)	MID = 1.9 (0.5 x median control SD)
Discontinuation from study at <6 months	245 (1 RCT) follow up: 12 weeks	⊕⊕◯◯ Low [a,b]	RR 2.07 (1.13 to 3.77)	136 per 1,000	**145 more per 1,000** (18 more to 376 more)	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	245 (1 RCT)	⊕⊕◯◯ Low [a,b]	RR 1.48 (0.93 to 2.35)	222 per 1,000	**107 more per 1,000** (16 fewer to 300 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	
	follow up: 26 weeks					

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 61: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Communication - Overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at <6 months	116 (1 RCT) follow up: 12 weeks	⊕⊕◯◯ Low a	-	The mean Communication – Overall language ability was 23.1	MD **1.7 higher** (3.77 lower to 7.17 higher)	MID = 14.95 (0.5 x median baseline SD)
Communication - Overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at ≥6 months	116 (1 RCT) follow up: 24 weeks	⊕⊕◯◯ Low a	-	The mean Communication – Overall language ability was 26.0	MD **1.7 higher** (3.77 lower to 7.17 higher)	MID = 14.95 (0.5 x median baseline SD)
Communication - impairment specific measures (naming) (Aachen Aphasia Test Naming, scale range unclear, higher values are better, change score) at ≥6 months	17 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low a,b	-	The mean communication - impairment specific measures (naming) was 4.5	MD **5.7 higher** (1.69 lower to 13.09 higher)	MID = 2.2 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Communication - impairment specific measures (auditory comprehension) (Aachen Aphasia Test Token Test, scale range unclear, higher values are better, change score) at ≥6 months	17 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [a,b]	-	The mean communication - impairment specific measures (auditory comprehension) was 5.2	MD **6.2 higher** (3.32 lower to 15.72 higher)	MID = 5.0 (0.5 x median baseline SD)
Discontinuation from study at <6 months	116 (1 RCT) follow up: 12 weeks	⊕◯◯◯ Very low [a,b]	RR 2.07 (0.93 to 4.61)	123 per 1,000	**132 more per 1,000** (9 fewer to 444 more)	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	116 (1 RCT) follow up: 24 weeks	⊕◯◯◯ Very low [a,b]	RR 1.44 (0.80 to 2.60)	231 per 1,000	**102 more per 1,000** (46 fewer to 369 more)	MID = RR 0.8-1.25.

[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

2.1.4.3.5 >1 hour to 2 hours

Table 62: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow-up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	
Psychological distress - depression (Aphasic Depression Rating Scale, scale range unclear, higher values are better, change score) at <6 months	32 (1 RCT) follow-up: 20 weeks	⊕◯◯◯ Very lowa,b	-	The mean psychological distress - depression at <6 months was -0.1	MD 4.9 higher (2.95 higher to 6.85 higher)	MID = 3.2 (0.5 x median baseline SD)

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 63: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	
Communication - Overall language ability (Western Aphasia Battery-Aphasia Quotient, 0-100, higher values are better, final value) at <6 months	20 (1 RCT) follow up: 12 weeks	⊕◯◯◯ Very low a,b	-	The mean communication - Overall language ability at <6 months was 73.3	MD **5.7 lower** (31.82 lower to 20.42 higher)	MID = 13.6 (0.5 x median baseline SD)
Discontinuation from study at <6 months	24 (1 RCT)	⊕◯◯◯ Very low a,b	RR 0.33 (0.04 to 2.77)	250 per 1,000	**167 fewer per 1,000** (240 fewer to 443 more)	MID = RR 0.8-1.25.

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, <5 days a week	
	follow up: 12 weeks					

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 64: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, 5 days a week	
Communication - Impairment specific measures, naming (NGA subtest naming, 0-100, higher values are better, final value) at <6 months	62 (1 RCT) follow up: 4 months	⊕◯◯◯ Very low a,b	-	The mean communication - Impairment specific measures, naming at <6 months was 54.1	MD **3.7 lower** (15.52 lower to 8.12 higher)	MID = 7.8 (0.5 x median baseline SD)
Communication - Impairment specific measures, auditory comprehension (NGA subtest comprehension, 0-100, higher values are better, final value) at <6 months	62 (1 RCT) follow up: 4 months	⊕◯◯◯ Very low a,b	-	The mean communication - Impairment specific measures, auditory comprehension at <6 months was 61.5	MD **0.5 lower** (13.94 lower to 12.94 higher)	MID = 11.0 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >1 hour to 2 hours, 5 days a week	
Communication - functional communication (Communicative Effectiveness Index, 0-100, higher values are better, final value) at <6 months	62 (1 RCT) follow up: 4 months	⨁⨁◯◯ Low [a]	-	The mean communication - functional communication at <6 months was 61.3	MD **0** (10.23 lower to 10.23 higher)	MID = 11.0 (0.5 x median control SD)
Discontinuation from study at <6 months	62 (1 RCT) follow up: 4 months	⨁◯◯◯ Very low [b,c]	RR 0.94 (0.20 to 4.29)	100 per 1,000	**6 fewer per 1,000** (80 fewer to 329 more)	MID = RR 0.8-1.25.

[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)

2.1.4.3.6 >2 hours to 4 hours

Table 65: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week	
Person/participant health-related quality of life (SAQOL-39g, 1-5, higher values are better, change score) at <6 months	200 (1 RCT) follow-up: 14 weeks	⊕⊕⊕⊕ High	-	The mean person/participant health-related quality of life at <6 months was 0.01	MD **0.02 higher** (0.09 lower to 0.13 higher)	MID = 0.31 (0.5 x median baseline SD)
Communication - overall language ability (Western Aphasia Battery, 0-100, higher values are better, change score) at <6 months	200 (1 RCT) follow-up: 14 weeks	⊕⊕⊕⊕ High	-	The mean communication - overall language ability at <6 months was 3.07	MD **1.74 lower** (3.57 lower to 0.09 higher)	MID = 9.1 (0.5 x median baseline SD)
Communication - impairment specific measures, naming (COMPARE naming battery 100 untreated items, 0-100, higher values are better, change score) at <6 months	200 (1 RCT) follow-up: 14 weeks	⊕⊕⊕⊕ High	-	The mean communication - impairment specific measures, naming at <6 months was 2.97	MD **0.38 higher** (1.84 lower to 2.6 higher)	MID = 13.8 (0.5 x median baseline SD)
Communication - Functional communication (Communicative Effectiveness Index, 0-100, higher values are better, change score) at <6 months	200 (1 RCT) follow-up: 14 weeks	⊕⊕⊕⊕ High	-	The mean communication - Functional communication at <6 months was 0.2	MD **3.04 higher** (1.13 lower to 7.21 higher)	MID = 8.62 (0.5 x median baseline SD)
Discontinuation from study at <6 months	221 (1 RCT) follow-up: 14 weeks	⊕⊕◯◯ Low[a]	RR 0.79 (0.39 to 1.61)	147 per 1,000	**31 fewer per 1,000** (89 fewer to 89 more)	MID = RR 0.8-1.25.

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

Table 66: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >1 hour to 2 hours, <5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, <5 days a week	
Communication - Overall language ability (Action Communication Test, scale range unclear, higher values are better, final value) at <6 months	30 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [a]	-	The mean communication - Overall language ability at <6 months was 53.4	MD **0.7 lower** (4.1 lower to 2.7 higher)	MID = 2.1 (0.5 x median baseline SD)
Communication – Functional communication (Aachen Aphasia Test, scale range unclear, higher values are better, final value) at <6 months	30 (1 RCT) follow up: 4 weeks	⨁⨁⨁◯ Moderate [a]	-	The mean communication – Functional communication at <6 months was 54	MD **3.8 lower** (7.57 lower to 0.03 lower)	MID = 2.6 (0.5 x median baseline SD)
Discontinuation from study at <6 months	30 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [b]	RD 0.00 (-0.12 to 0.12)	0 per 1,000	**0 fewer per 1,000** [c] (120 fewer to 120 more)	Precision calculated through Optimal Information Size (OIS) due to zero events in some studies. OIS determined power for the sample size = 0.37 (0.8-0.9 = serious, <0.8 = very serious)

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 67: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >1 hour to 2 hours, 5 days a week	Risk difference with Speech and Language Therapy (communication difficulties) - >2 hours to 4 hours, 5 days a week	
Communication - Impairment specific measures, naming (Aachen Aphasia Test - Naming Test, scale range unclear, higher values are better, change score) at <6 months	60 (1 RCT) follow up: 2 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean communication - Impairment specific measures, naming at <6 months was 4	MD **0.5 lower** (3.04 lower to 2.04 higher)	MID = 4.2 (0.5 x median baseline SD)
Communication - Impairment specific measures, auditory comprehension (Aachen Aphasia Test - Token Test, scale range unclear, higher values are better, change score) at <6 months	60 (1 RCT) follow up: 2 weeks	⊕⊕⊕◯ Moderate [a]	-	The mean communication - Impairment specific measures, auditory comprehension at <6 months was 2.6	MD **1.15 higher** (1.27 lower to 3.57 higher)	MID = 4.1 (0.5 x median baseline SD)
Discontinuation from study at <6 months	60 (1 RCT) follow up: 2 weeks	⊕⊕◯◯ Low [a]	Peto OR 4.60 (0.24 to 89.21)	0 per 1,000	**50 more per 1,000** (50 fewer to 150 more) [b]	MID = Peto OR 0.8-1.25.

[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

2.1.4.4 Psychology/neuropsychology (no communication difficulties)

2.1.4.4.1 >1 hour to 2 hours

Table 68: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Psychology/neuropsychology (no communication difficulties) - >1 hour to 2 hours, <5 days a week	
Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, final value) at <6 months	53 (1 RCT) follow up: 2 months	⨁◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at <6 months was 0.7	MD **0.05 lower** (0.17 lower to 0.07 higher)	MID = EQ-5D 0.03 (established MID)
Psychological distress - depression (PHQ-9, 0-27, lower values are better, final value) at <6 months	53 (1 RCT) follow up: 2 months	⨁◯◯◯ Very low [a,b]	-	The mean psychological distress - depression at <6 months was 9.74	MD **1.47 lower** (5.22 lower to 2.28 higher)	MID = 3.5 (0.5 x median baseline SD)
Discontinuation from study at <6 months	53 (1 RCT) follow up: 2 months	⨁◯◯◯ Very low [b,c]	RR 2.08 (0.42 to 10.39)	74 per 1,000	**80 more per 1,000** (43 fewer to 696 more)	MID = RR 0.8-1.25.

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)

2.1.4.4.2 >2 hours to 4 hours

Table 69: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >1 hour to 2 hours, 5 days a week	Risk difference with Psychology/neuropsychology (no communication difficulties) - >2 hours to 4 hours, 5 days a week	
Person/participant health-related quality of life (Pictorial Thai Quality of Life Scale, 0-72, higher values are better, change score) at <6 months	113 (1 RCT) follow up: 4 weeks	⊕⊕◯◯ Low [a,b]	-	The mean person/participant health-related quality of life at <6 months was 8.6	MD **8.9 higher** (3.96 higher to 13.84 higher)	MID = 6.8 (0.5 x median baseline SD)
Activities of daily living (Barthel Index, 0-20, higher values are better, change score) at <6 months	113 (1 RCT) follow up: 4 weeks	⊕⊕◯◯ Low [a,b]	-	The mean activities of daily living at <6 months was 3.5	MD **1.2 higher** (0.07 higher to 2.33 higher)	MID = Barthel Index 1.85 (established MID)
Psychological distress - Depression (HADS depression, 0-21, lower values are better, change score) at <6 months	113 (1 RCT) follow up: 4 weeks	⊕⊕◯◯ Low [a,b]	-	The mean psychological distress - Depression at <6 months was -1.8	MD **4.5 lower** (6.5 lower to 2.5 higher)	MID = 2.7 (0.5 x median baseline SD)
Discontinuation of study at <6 months	118 (1 RCT) follow up: 4 weeks	⊕⊕⊕◯ Moderate [a]	Peto OR 7.93 (1.33 to 47.21)	46 per 1,000	**57 more per 1,000** (39 fewer to 1,519 more) [c]	MID = Peto OR 0.8-1.25.

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

2.1.4.4 Psychology/neuropsychology (communication difficulties)

2.1.4.4.1 >45 minutes to 1 hour

Table 70: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Psychology/neuropsychology (communication difficulties) - >45 minutes to 1 hour, <5 days a week	
Carer health-related quality of life (Carer Strain Index, 0-13, lower values are better, final value) at ≥6 months	83 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [a,b]	-	The mean carer health-related quality of life at ≥6 months was 6.3	MD **0.3 higher** (1.14 lower to 1.74 higher)	MID = 1.8 (0.5 x median control group SD)
Activities of daily living (Nottingham Leisure Questionnaire, 0-60, higher values are better, final value) at ≥6 months	83 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [a,b]	-	The mean activities of daily living at ≥6 months was 15.9	MD **1.1 higher** (2.02 lower to 4.22 higher)	MID = 3.4 (0.5 x median control group SD)
Psychological distress - depression (Stroke Aphasic Depression Questionnaire Hospital version 21, 0-30, lower values are better, final value) at ≥6 months	83 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [a,b]	-	The mean psychological distress - depression at ≥6 months was 21.9	MD **4.5 lower** (8.71 lower to 0.29 lower)	MID = 5.3 (0.5 x median baseline SD)
Discontinuation from study at ≥6 months	105 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [b]	RR 1.06 (0.43 to 2.61)	148 per 1,000	**9 more per 1,000** (84 fewer to 239 more)	MID = RR 0.8-1.25.

[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

2.1.4.5 Multidisciplinary Team (no communication difficulties)

2.1.4.5.2 >45 minutes to 1 hour

Table 71: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Multidisciplinary team (no communication difficulties) - >45 minutes to 1 hour, 5 days a week	
Discontinuation from study at <6 months	89 (1 RCT) follow up: 3 months	⨁⨁◯◯ Low [a]	RR 1.34 (0.56 to 3.19)	163 per 1,000	**55 more per 1,000** (72 fewer to 357 more)	MID = RR 0.8-1.25.
Discontinuation from study at ≥6 months	89 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [a]	RR 1.34 (0.56 to 3.19)	163 per 1,000	**55 more per 1,000** (72 fewer to 357 more)	MID = RR 0.8-1.25.

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

2.1.4.5.3 >1 hour to 2 hours

Table 72: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with ≤45 minutes, 5 days a week	Risk difference with Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Discontinuation from study at <6 months	60 (1 RCT) follow up: 3 weeks	⊕◯◯◯ Very low [a,b]	RR 1.67 (0.44 to 6.36)	100 per 1,000	**67 more per 1,000** (56 fewer to 536 more)	MID = RR 0.8-1.25.

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 73: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Activities of daily living (Barthel Index, Functional Independence Measure upper limb [different scale ranges], higher values are better, change scores) at <6 months	219 (2 RCTs) follow up: mean 7 weeks	⊕◯◯◯ Very low [a,b,c,]	-	-	SMD **0.28 SD higher** (0.14 lower to 0.7 higher)	MID = 0.5 SD (SMD)
Activities of daily living (Functional independence measure upper limb, 0-63, higher values are better, change score) at <6 months	43 (1 RCT) follow up: 3 weeks	⊕⊕◯◯ Low [c,d]	-	The mean activities of daily living at <6 months was 16.8	MD **4.7 higher** (0.34 lower to 9.74 higher)	MID = 4.3 (0.5 x median baseline SD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Activities of daily living (Functional independence measure upper limb, 0-63, higher values are better, change score) at ≥6 months	37 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [c,e]	-	The mean activities of daily living at ≥6 months was 25.4	MD **2.1 higher** (5.14 lower to 9.34 higher)	MID = 4.3 (0.5 x median baseline SD)
Activities of daily living (Activities of daily living and ambulation, 0-23, higher values are better, final value) at ≥6 months	77 (1 RCT) follow up: 12 months	⊕◯◯◯ Very low [c,e]	-	The mean activities of daily living at ≥6 months was 18.4	MD **2.7 higher** (1.34 lower to 6.74 higher)	MID = 5.4 (0.5 x median control SD)
Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, change score and final value) at <6 months	54 (1 RCT) follow up: 3 weeks	⊕◯◯◯ Very low [c,f]	-	The mean physical function - upper limb at <6 months was 10.3	MD **4.1 higher** (4.04 lower to 12.24 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
Physical function - upper limb (Fugl-Meyer assessment upper extremity, 0-66, higher values are better, final value) at ≥6 months)	26 (1 RCT) follow up: 6 months	⊕◯◯◯ Very low [c,e]	-	The mean physical function - upper limb at ≥6 months) was 15.6	MD **8 higher** (4.73 lower to 20.73 higher)	MID = 6.6 (Fugl-Meyer Assessment = Difference by 10% of the total scale)
Physical function - lower limb (Postural assessment scale for stroke, motor function test [different scale ranges], higher values are better, final values) at <6 months	215 (2 RCTs) follow up: mean 7 weeks	⊕◯◯◯ Very low [b,c,e]	-	-	SMD **0.19 SD higher** (0.23 lower to 0.61 higher)	MID = 0.5 SD (SMD)

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >45 minutes to 1 hour, 5 days a week	Risk difference with Multidisciplinary team (no communication difficulties) - >1 hour to 2 hours, 5 days a week	
Physical function - lower limb (Motor function test, scale range unclear, higher values are better, final value) at ≥6 months	75 (1 RCT) follow up: 12 months	⊕◯◯◯ Very low [c,e]	-	The mean physical function - lower limb at ≥6 months was 21.1	MD **4.9 higher** (2.35 lower to 12.15 higher)	MID = 7.7 (0.5 x median control SD)
Psychological distress - Depression (HADS depression, 0-21, lower values are better, final value) at <6 months	145 (1 RCT) follow up: 14 days	⊕⊕◯◯ Low [c,d]	-	The mean psychological distress - Depression at <6 months was 10	MD **0.7 lower** (2.03 lower to 0.63 higher)	MID = 1.8 (0.5 x median baseline SD)
Discontinuation from study at <6 months	240 (2 RCTs) follow up: mean 6 weeks	⊕⊕⊕◯ Very lowModerate [d]	**Peto OR 0.2**0 (0.05 to 0.77)	72 per 1,000	**70 fewer per 1,000** (110 fewer to 20 fewer) [g]	MID = Peto OR 0.8-1.25.
Discontinuation from study at ≥6 months	95 (1 RCT) follow up: 12 months	⊕◯◯◯ Very low [c,d]	RR 0.72 (0.31 to 1.66)	222 per 1,000	**62 fewer per 1,000** (153 fewer to 147 more)	MID = RR 0.8-1.25.

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 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

2.1.4.5.4 >2 hours to 4 hours

Table 74: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Multidisciplinary team (no communication difficulties) - >2 hours to 4 hours, <5 days a week	
Person/participant health-related quality of life (EQ-5D 5L, -0.11-1, higher values are better, change score) at ≥6 months	87 (1 RCT) follow up: 14 months	⊕◯◯◯ Very low [a,b]	-	The mean person/participant health-related quality of life at ≥6 months was 0.04	MD **0** (0.37 lower to 0.37 higher)	MID = EQ-5D 0.03 (established MID)
Stroke outcome - modified Rankin Scale (modified Rankin scale, 0-5, lower values are better, change score) at ≥6 months	86 (1 RCT) follow up: 14 months	⊕◯◯◯ Very low [a,b]	-	The mean stroke outcome - modified Rankin Scale at ≥6 months was -0.21	MD **0.25 lower** (0.65 lower to 0.15 higher)	MID = 0.47 (0.5 x median control SD)
Psychological distress - depression (HADS depression, 0-21, lower values are better, change score) at ≥6 months	88 (1 RCT) follow up: 14 months	⊕◯◯◯ Very low [a,b]	-	The mean psychological distress - depression at ≥6 months was -0.96	MD **0.33 higher** (1.94 lower to 2.6 higher)	MID = 1.4 (0.5 x median control SD)
Discontinuation from study at ≥6 months	101 (1 RCT) follow up: 14 months	⊕◯◯◯ Very low [a,b]	RR 0.33 (0.09 to 1.14)	180 per 1,000	**121 fewer per 1,000** (164 fewer to 25 more)	MID = RR 0.8-1.25.

[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

2.1.4.5.5 >4 hours

Table 75: Clinical evidence summary: 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

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with >2 hours to 4 hours, 5 days a week	Risk difference with Multidisciplinary team (no communication difficulties) - >4 hours, 5 days a week	
Physical function - upper limb (Wolf Motor Function Test, 0-120 seconds, lower values are better, final value) at <6 months	42 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [a]	-	The mean physical function - upper limb at <6 months was 34.4	MD **1.4 lower** (25.82 lower to 23.02 higher)	MID = 20.3 (0.5 x median baseline SD)
Physical function - upper limb (Wolf Motor Function Test, 0-120 seconds, lower values are better, final value) at ≥6 months	39 (1 RCT) follow up: 6 months	⨁⨁⨁◯ Moderate [a]	-	The mean physical function - upper limb at ≥6 months was 33	MD **5.1 lower** (28.29 lower to 18.09 higher)	MID = 20.3 (0.5 x median baseline SD)
Discontinuation of study at <6 months	44 (1 RCT) follow up: 4 weeks	⨁⨁◯◯ Low [a]	RR 2.14 (0.14 to 31.83)	33 per 1,000	**38 more per 1,000** (29 fewer to 1,028 more)	MID = RR 0.8-1.25.
Discontinuation of study at ≥6 months	44 (1 RCT) follow up: 6 months	⨁⨁◯◯ Low [a]	RR 0.54 (0.07 to 4.36)	133 per 1,000	**61 fewer per 1,000** (124 fewer to 448 more)	MID = RR 0.8-1.25.

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

2.1.4.5 Multidisciplinary Team (communication difficulties)

2.1.4.5.1 ≤45 minutes

Table 76: Clinical evidence summary: Multidisciplinary team (communication difficulties) - ≤45 minutes, 5 days a week compared to usual care for people after a first or recurrent stroke

Outcomes	№ of participants (studies) Follow up	Certainty of the evidence (GRADE)	Relative effect (95% CI)	Anticipated absolute effects		Comments
				Risk with usual care	Risk difference with Multidisciplinary team (communication difficulties) - ≤45 minutes, 5 days a week	
Discontinuation from study at <6 months	38 (1 RCT) follow up: 8 weeks	⨁◯◯◯ Very low a,b	RR 1.00 (0.07 to 14.85)	53 per 1,000	0 fewer per 1,000 (49 fewer to 729 more)	MID = 3.2 (0.5 x median baseline SD)

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

See Appendix I for full GRADE tables.

2.1.6 References

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