Randomised controlled trials

Study (subsidiary papers)	**Arthur 2002[13] (Smith 2011[229], Smith 2004[228])**
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=275)
Countries and setting	Conducted in Canada; setting: Cardiac Health and Rehabilitation Centre at a university hospital group
Line of therapy	Not applicable
Duration of study	Follow up (post intervention): 6 years
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Post coronary artery bypass grafting patients
Stratum	Early discharge
Subgroup analysis within study	Not applicable
Inclusion criteria	Between 35 and 49 days post-CABG surgery, achieved between 40 and 80% of age and sex-predicted minimum MET level on a progressive cycle ergometry exercise test, able to read and write English
Exclusion criteria	Recurrent angina, positive graded exercise test, unable to attend rehabilitation 3 times per week, unable to participate due to physical limitations, previously participated in an out-patient cardiac rehabilitation program
Recruitment/selection of patients	All referrals to the centre
Age, gender and ethnicity	Age - Mean (SD): Group 1: 64.2 (9.4); Group 2: 62.5 (8.8). Gender (M:F): 197:45. Ethnicity: NR
Further population details	1. Frail elderly: Not applicable/Not stated/Unclear
Indirectness of population	No indirectness
Interventions	(n=120) Intervention 1: Community-based rehabilitation services. Home based exercise training. Patients attended individual, 1-h exercise consultations with an exercise specialist at baseline and after 3 months of exercise training.

Study (subsidiary papers)	Arthur 2002[13] (Smith 2011[229], Smith 2004[228])
	Patients were advised to train a total of 5 times per week. Each exercise included a 10-15 min warm up/down and 40 mins of aerobic training. Home patients were telephoned every 2 weeks for 6 months by the exercise specialist to monitor progress, assess and document adherence, revise the exercise prescription if necessary, and provide support and education. Duration: 6 months. Concurrent medication/care: none stated. (n=122) Intervention 2: Hospital-based rehabilitation services. Hospital based exercise training. Patients were expected to attend supervise exercise sessions 3 times per week for 6 months. Classes were led by exercise specialists. Each exercise included a 10-15 min warm up/down and 40 minutes of aerobic training. Exercise logs were reviewed with the patient on a monthly basis. Duration: 6 months. Concurrent medication/care: none stated.
Funding	Academic or government funding (Heart and Stroke Foundation)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Quality of life during the study period - Actual outcome: SF-36 mental component at 12 months; Group 1: mean 53 (SD 10.9); n=102, Group 2: mean 50.2 (SD 10.9); n=96; Risk of bias: All domain - high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome: SF-36 physical component at 12 months; Group 1: mean 48.3 (SD 11.7); n=102, Group 2: mean 47.6 (SD 11.7); n=96; Risk of bias: High; Indirectness of outcome: No indirectness Protocol outcome 2: Mortality during the study period - Actual outcome: Mortality at 6 years; Group 1: 10/96, Group 2: 7/100; Risk of bias: All domain - high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Number of admissions to hospital at After 28 days of first admission - Actual outcome: Hospitalisations at 6 years; Group 1: 35/70, Group 2: 46/74; Risk of bias: All domain - high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Cowie 2012[56]
Study type	RCT (Patient randomised; Parallel)

Study	Cowie 2012[56]
Number of studies (number of participants)	1 (n=60 (n=20 hospital; n=20 home based; n=20 in control group not included in analysis))
Countries and setting	Conducted in United Kingdom; setting: Hospital and Home
Line of therapy	1st line
Duration of study	Intervention + follow up: follow-up 8 weeks
Method of assessment of guideline condition	Adequate method of assessment/diagnosis
Stratum	Overall
Subgroup analysis within study	Not applicable
Inclusion criteria	Left ventricular systolic dysfunction on echocardiography, clinically stable for at least one month, optimised medication dosages.
Exclusion criteria	Significant ischaemic symptoms at low workloads, uncontrolled diabetes, acute systemic illness or fever, recent embolism, active pericarditis or myocarditis, moderate to severe aortic stenosis, regurgitant valvular heart disease requiring surgery, myocardial infraction within past 3 weeks, new onset atrial fibrillation, signs and symptoms of decompensation, other co-morbidities(life threatening, uncontrolled, infectious or exacerbated by exercise)
Recruitment/selection of patients	Participants were recruited from the Heart Failure Nursing service, Scotland from May 2007 and August 2008.
Age, gender and ethnicity	Age - Mean (range): Home based: 65.5 (35-82); 71.2 (59-85). Gender (M:F): Home based: 18/2; hospital: 16/4. Ethnicity: not stated
Further population details	-
Extra comments	Patients with heart failure (NYHA class II/III)
Indirectness of population	No indirectness
Interventions	(n=20) Intervention 1: Community-based rehabilitation services. 1 hour aerobic based exercise session- DVD and booklet The session started with a 15 min warm-up and ended with a 15 min cool-down. Participants in both home and hospital groups were educated on symptoms of unstable heart failure, and avoided exercise where instability was suspected. A physiotherapist telephoned the home group every 2 weeks to modify their exercise prescription where appropriate. For monitoring of adherence and exercise intensity, the home group completed a diary detailing every session completed. Duration: 8 weeks. Concurrent medication/care: Number of patients on Beta-blockade (17); ACE inhibitor (17); lipid lowering (12); diuretic (18); aldosterone antagonist (9); anti-platelet (10). (n=20) Intervention 2: Hospital-based rehabilitation services. 1 hour aerobic based exercise session. Exercise session

Study	Cowie 2012[56]
	was a physiotherapist led class. Duration: 8 weeks. Concurrent medication/care: number of patients on Beta-blockade (18); ACE inhibitor (18); lipid lowering (13); diuretic (15); aldosterone antagonist (7); anti-platelet (14);anti-arrhythmic (2).
Funding	Academic or government funding
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Quality of life at during study period - Actual outcome: Quality of life -SF 36 (Physical component summary) at 8 weeks; Group 1: mean 34.01 (SD 11.04); n=20, Group 2: mean 33.83 (SD 10); n=20; Risk of bias: All domain - Low, Selection - High, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome: Quality of life -SF 36 (mental component summary) at 8 weeks; Group 1: mean 44.44 (SD 12.23); n=20, Group 2: mean 48.25 (SD 11.21); n=20; Risk of bias: All domain - Low, Selection - High, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality at during study period; Avoidable adverse events at during study period; Patient and/or carer satisfaction at during study period; Number of presentations to Emergency Department at during study period; Number of admissions to hospital at After 28 days of first admission; Number of GP presentations at during study period; Readmission at 7 and 28 days; Length of hospital stay at during study period

Study	Dalal 2007[65]
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=104)
Countries and setting	Conducted in United Kingdom; setting: Hospital and home
Line of therapy	1st line
Duration of study	Intervention + follow up: follow-up- 9 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis
Stratum	Early discharge
Subgroup analysis within study	Not applicable
Inclusion criteria	Confirmed acute myocardial infraction (WHO criteria), ability to read English, registered with GP in one of 2 primary

Study	Dalal 2007[65]
	care trusts. Acute myocardial infraction (WHO criteria), ability to read English, registered with GP in one of 2 primary care trusts.
Exclusion criteria	Severe heart failure, unstable angina, uncontrolled arrhythmia, history of major psychiatric illness, other significant comorbidity precluding the ability to exercise on the treadmill, patients readmitted with acute myocardial infarction who had already received an intervention earlier in the study.
Recruitment/selection of patients	All patients admitted to the Royal Cornwall Hospital during December 2000-September 2003with acute myocardial infarctions from the areas served by 2 primary care trusts were assessed for eligibility. Cardiac rehabilitation nurses in the hospital identified suitable patients.
Age, gender and ethnicity	Age - Mean (SD): hospital based- 64.3 (11.2); home-based- 60.6 (10.1). Gender (M:F): Define. Ethnicity:
Further population details	-
Indirectness of population	No indirectness
Interventions	(n=60) Intervention 1: Community-based rehabilitation services. Home-based rehabilitation Patients were seen by a cardiac rehabilitation nurse and received a self-help package (the Heart Manual) to use over 6 consecutive weeks'. This step-by step guide was a comprehensive cardiac rehabilitation programme using a structured programme of exercise, stress management and education. The cardiac rehab nurse made a home visit in the first week after discharge followed up by telephone calls over 6 weeks. Patients were advised to start using their manual during the first week after discharge. Duration: 9 months. Concurrent medication/care: not stated. (n=44) Intervention 2: Hospital-based rehabilitation services. Hospital-based rehabilitation classes over 8-10 weeks. Classes lasted 2 hours each and were conducted in groups of 8-10 people in the local hospital or for a small number of patients in one of the 2 community centres. Three different multidisciplinary teams delivered the programme. Patients were also encouraged to exercise at home. Each team included a cardiac rehabilitation nurse, physiotherapist, or exercise therapist, with input from a psychologist or occupational therapist, pharmacist and dietician. Patients typically attended their first session 4-6 weeks after discharge. Duration: 9 months. Concurrent medication/care: not stated.
Funding	Funding not stated
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Quality of life at during study period - Actual outcome: Quality of life - MacNew-Global at 9 months; Group 1: mean 5.6 (SD 1.12); n=60, Group 2: mean 5.67 (SD 1.12); n=60; Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of	

Study	Dalal 2007[65]
outcome: No indirectness Protocol outcome 2: Mortality at during study period - Actual outcome: Mortality at 9 months; Group 1: 4/60, Group 2: 1/44; Risk of bias: All domain - Low, Selection - Low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events at during study period; Patient and/or carer satisfaction at during study period; Number of presentations to Emergency Department at during study period; Number of admissions to hospital at After 28 days of first admission; Number of GP presentations at during study period; Readmission at 7 and 28 days; Length of hospital stay at during study period

Study (subsidiary papers)	ESD Stroke Bergen trial: Hofstad 2013[122] (Gjelsvik 2014[95])
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=306)
Countries and setting	Conducted in Norway
Line of therapy	Not applicable
Duration of study	Follow up (post intervention): 6 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis: Stroke patients
Stratum	Early discharge
Subgroup analysis within study	Not applicable
Inclusion criteria	Home-dwelling and live in the Municipality, Inclusion within 1-7 days after symptom onset, inclusion within 6-hours to 120 hours after admission to the Department of Neurology, NIHSS score at inclusion 2–26, or a two-point increase in mRS score if 0 or 1 previously, able to agree to the participation in the study
Exclusion criteria	Serious psychiatric disorders, Alcohol or substance abuse, Other serious conditions of importance to the cerebral disorder and subsequent rehabilitation process, Poor knowledge of the Norwegian language before the stroke
Recruitment/selection of patients	All stroke patients admitted to the Department of Neurology
Age, gender and ethnicity	Age - Mean (range): 72.24 (27-98). Gender (M:F): 169:137. Ethnicity: NR
Further population details	1. Frail elderly: Not applicable/Not stated/Unclear
Indirectness of population	No indirectness
Interventions	(n=103) Intervention 1: Community-based rehabilitation services. Early supported discharge from an outpatient ambulatory coordinating team during hospitalisation and for 5 weeks post-discharge at a community-based day unit.

Study (subsidiary papers)	ESD Stroke Bergen trial: Hofstad 2013[122] (Gjelsvik 2014[95])
	Multi-disciplinary outpatient visits at 3 and 6 months. Duration: 5 weeks. Concurrent medication/care: none stated. (n=104) Intervention 2: Community-based rehabilitation services. Early supported discharge from an outpatient ambulatory coordinating team during hospitalisation and for 5 weeks post-discharge at the patient's home. Multi-disciplinary outpatient visits at 3 and 6 months. Duration: 5 weeks. Concurrent medication/care: none stated. (n=99) Intervention 3: Hospital-based rehabilitation services. Usual care, which consists of treatment in a stroke unit, followed by transfer to the Department of Physical Medicine and Rehabilitation if needed based on a professional judgment. Other alternatives are discharge directly to home or discharge to inpatient treatment in a municipal health care institution. Duration: not stated. Concurrent medication/care: none stated.
Funding	Academic or government funding (Norwegian Research Council, the Western Norway Regional Health Trust, Ministry of Health, and Sophies Minde Foundation)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Length of hospital stay during the study period - Actual outcome: Length of stay in institution from stroke to first discharge home at 6 months; Group 1: mean 37.7 days (SD 51.8); n=103, Group 2: mean 42.2 days (SD 55.7); n=99; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Patient and/or carer satisfaction during the study period - Actual outcome: Patient satisfaction at 6 months; Group 1: mean 1.62 (SD 1.22); n=73, Group 2: mean 1.68 (SD 1.01); n=53; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Length of hospital stay during the study period - Actual outcome: Length of stay in institution from stroke to first discharge home at 6 months; Group 1: mean 35.6 days (SD 46.91); n=104, Group 2: mean 42.2 days (SD 55.7); n=99; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Patient and/or carer satisfaction during the study period - Actual outcome: Patient satisfaction at 6 months; Group 1: mean 1.51 (SD 0.98); n=71, Group 2: mean 1.68 (SD 1.01); n=53; Risk of bias: All domain - high, Selection -	

Study (subsidiary papers)	ESD Stroke Bergen trial: Hofstad 2013[122] (Gjelsvik 2014[95])
high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Quality of life during the study period; Avoidable adverse events during the study period; Number of presentations to Emergency Department during the study period; Number of admissions to hospital at After 28 days of first admission; Number of GP presentations during the study period; Readmission at 7 and 28 days; Mortality during the study period

Study	Jolly 2007[131]
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=525)
Countries and setting	Conducted in United Kingdom; setting: Hospital and Home
Line of therapy	1st line
Duration of study	Intervention + follow up: Follow-up-2 years
Method of assessment of guideline condition	Adequate method of assessment/diagnosis
Stratum	Early discharge
Subgroup analysis within study	Not applicable
Inclusion criteria	Any adult patient was eligible if they had one of the following events within the previous 12 weeks: an acute MI and had been informed of their diagnosis; a coronary angioplasty with or without stenting; a CABG operation.
Exclusion criteria	Exclusion criteria were defined by a cardiologist: 1. inability to speak either English or Punjabi 2. Case-note reported dementia 3. Severe hearing impairment 4. Sight defects of sufficient severity to prevent them from reading the Heart Manual 5. serious persisting complications which had not been stabilised at the time of proposed randomisation, including: (a) unstable angina (angina at rest or minimal exertion, with ECG changes and requiring medical/non-medical intervention) (b) clinically significant heart failure

Study	Jolly 2007[131]
	(c) important cardiac arrhythmias (d) any other condition which, in the consultant's opinion, would preclude safe home exercise 6. complications during the angioplasty/CABG procedure or significant lesions remaining
Recruitment/selection of patients	Patients who had an MI,PTCA or CABG were recruited between 1 February 2002 and 31 January 2004.Patients were identified by CR nurses following hospital admission for MI or PTCA. Patients following CABG were followed up and referred for rehabilitation at their hospital of origin.
Age, gender and ethnicity	Age - Other: Age <65 years- 322; Age >65 years-203. Gender (M:F): Males- 402; Females-123. Ethnicity: White- 45.1%; South Asian-44.4%
Further population details	1. Frail elderly:
Extra comments	.
Indirectness of population	No indirectness
Interventions	(n=263) Intervention 1: Community-based rehabilitation services. This consisted of a manual, home visits and telephone contact. Patients who had an MI were discharged home with The Heart Manual (second edition). Those who had had a revascularisation had an adapted version of the Heart Manual designed for this patient group in conjunction with the Heart Manual Team. The Heart Manual is a facilitated home-based programme for the first 6 weeks following MI, based on the Health Belief Model and using cognitive behavioural techniques. It includes education, a home-based exercise programme and a tape-based relaxation and stress management programme. It also has accompanying tapes in ethnic minority languages for patients who are unable to read English. The Heart Manual was introduced to patients on an individual basis, either in hospital or on a home visit. The facilitators adhered to the format with which they had been familiarised at the Heart Manual training course. At this time the facilitator provided information about how they could be contacted and arranged a home visit for 7–10 days ahead. At the first visit the facilitator discussed the progress with the patient and agreed action or exercise goals with the patient. Patients were then telephoned at about 3 weeks post-recruitment and a further visit took place 6 weeks post-recruitment. A final visit took place at 12 weeks, when patients were encouraged to maintain their lifestyle changes and to continue with their exercise programme. Additional visits were made as deemed necessary by the rehabilitation nurse. Patients with no telephone had home visits instead of telephone contacts. Duration: 12 weeks. Concurrent medication/care: not stated. (n=262) Intervention 2: Hospital-based rehabilitation services. At Hospital 1, all patients were offered an individualised rehabilitation programme consisting of risk factor counselling, relaxation and twice-weekly supervised exercise sessions for 12 weeks. The exercise was mainly walking, fixed cycling and rowing. The relaxation session and

Study	Jolly 2007[131]
	information sessions occurred once during each rehabilitation session and participants could opt to attend. Patients completed the programme after attending 24sessions. Hospital 2 offered a more traditional 9-week course consisting of patient education and counselling and relaxation. Exercise sessions only took place once each week during the period of the trial. Each session lasted 1.5 hours with the exercise consisting of circuit training with 6 stations. Patients did 1–2 minutes of each exercise with additional walking. In addition, the patients received further follow-up and support in cardiology outpatients. The rehabilitation programme at Hospital 3 lasted for 8weeks and consisted of 8 sessions of education and exercise twice weekly over 4 weeks lasting 2.5 hours followed by a once per week hour-long exercise session for a further 4 weeks. Relaxation took place once per week. The exercise consisted of 45 minutes of circuit training. The CR programme at Hospital 4 consisted of 12 sessions held twice weekly over a 6-week period. The first 8 sessions consisted of 30minutes of education followed by a warm-up, 40 minutes of exercise on bicycles and treadmills and relaxation. This was followed by 4 further hour-long exercise sessions. The same cardiac rehabilitation team covered Hospitals 3 and4, with some staff working in only one hospital and others covering rehabilitation sessions in both. Duration: 12 weeks. Concurrent medication/care: not stated. Comments: During the first 6 weeks of the home-based CR programme, 11patients crossed over from the home- to the hospital-based programme. In 8 cases this was due to the development of additional cardiac or medical complications, requiring closer monitoring, and in 3 cases a lack of motivation to exercise at home was the predominant factor. These participants were analysed on an ITT basis as part of the home-based group.
Funding	Academic or government funding
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Quality of life at during study period - Actual outcome: Quality of life (SF-12) -physical component score at 6 months; Group 1: mean 42.8 (SD 10.9); n=263, Group 2: mean 42.6 (SD 10.8); n=262; Risk of bias: All domain - High, Selection - High, Blinding - High, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness: - Actual outcome: Quality of life (SF-12) -mental component score at 6 months; Group 1: mean 49.19 (SD 10.1); n=263, Group 2: mean 50.33 (SD 9.6); n=262; Risk of bias: All domain - High, Selection - High, Blinding - High, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Mortality at during study period		

Study	Jolly 2007[131]
- Actual outcome: Mortality at 2 years; Group 1: 6/263, Group 2: 3/262; Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events at during study period; Patient and/or carer satisfaction at during study period; Number of presentations to Emergency Department at during study period; Number of admissions to hospital at After 28 days of first admission; Number of GP presentations at during study period; Readmission at 7 and 28 days; Length of hospital stay at during study period

Study	Kalra 2000[134]
Study type	RCT (Patient randomised; Parallel)
Number of participants	457
Countries and setting	UK
Duration of study	Follow up at 3, 6 and 12 months
Stratum	Admission avoidance
Subgroup analysis within study	None
Inclusion criteria	Patients recovering from a moderately severe stroke. Stroke diagnosed clinically according to WHO criteria; patients included at time of presentation but no later than 72 hours after stroke onset; moderately severe stroke (persistent neurological deficit affecting continence, mobility and ability to look after themselves, requiring multidisciplinary treatment; could be supported at home with nursing, therapy and social services.
Exclusion criteria	Patients with mild stroke, severe strokes (unconscious, swallowing problems not amenable to dietary modification, heavy nursing needs); admitted to other hospitals; those with atypical neurological features who needed specialised assessments or investigation to establish diagnosis; institutionalised or severe disability before stroke.
Recruitment/selection of patients	Recruited from a population-based stroke register
Age, gender and ethnicity	Median (IQR) age (years) Stroke team in hospital=75 (72-84) Home care=77.7 (67-83) Home care: 68/149 (46%) female; stroke team 76/150 (51%)
Further population details	Living alone

Study	Kalra 2000[134]
	Home care=50/149 (34%) Stroke team=55/150 (37%)
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=149) Hospital outreach admission avoidance; multi-disciplinary with joint care from community services (domiciliary stroke care). Patients managed in their own home by specialist team consisting of a doctor, nurse, physiotherapist, occupational therapist and speech and language therapists, with support from district nursing and social services for nursing and personal care needs. Patients under joint care of stroke physician and general practitioner. Each patient had individualised care plan outlining activities and the objective of treatment, reviewed at weekly multidisciplinary meetings. Concurrent medication/care: not stated. Duration: up to 3 months. (n=150) Hospital admission to general wards with stroke care team support. Remained under the care of admitting physicians; seen by specialist team (doctor, nurse, physiotherapist, occupational therapist) with expertise in stroke management; team undertook stroke assessments and collaborated with ward-based nursing and therapy staff in goal setting, planning of treatment, discharge arrangement and liaison with patients and relatives; day-to-day treatment provided by staff on the ward. Concurrent medication/care: not stated. Duration: up to 3 months. (n=148) Third group had treatment in stroke unit; this group not included in Cochrane review. Stroke physician + multidisciplinary team with specialist experience in stroke management; clear guidelines for acute care, prevention of complications, rehabilitation and secondary prevention. Routine management involved joint assessments and goal setting, coordinated treatment and planned discharges. Concurrent medication/care: not stated. Duration: up to 3 months.
Funding	NHS R&D Executive's Health Technology Assessment Programme; Stroke Association; Bromley Health Authority
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community versus Hospital (general ward with stroke team) Protocol outcome 1: Protocol outcome 2: Mortality at 12 months: Community: 21/144; hospital: 34/149; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; admissions to hospital; Number of GP presentations during the study period;

Study	Kalra 2000[134]
	Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Maltais 2008[155]
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=252)
Countries and setting	Conducted in Canada; setting: pulmonary clinics of 8 university-based and 2 community-based centres
Line of therapy	Not applicable
Duration of study	Intervention + follow up: 1 year
Method of assessment of guideline condition	Partially adequate method of assessment/diagnosis: Stable COPD
Stratum	Early discharge
Subgroup analysis within study	Not applicable
Inclusion criteria	Stable COPD, 40 years or older, were current or former smokers of at least 10 pack-years, had an FEV1 less than 70% of the predicted value and FEV1-FVC ratio less than 0.70; had MRC dyspnoea score of at least 2
Exclusion criteria	Diagnosis of asthma, congestive left heart failure as the primary disease, terminal disease, dementia, or an uncontrolled psychiatric illness
Recruitment/selection of patients	All COPD patients
Age, gender and ethnicity	Age - Mean (SD): 66 (9). Gender (M:F): 140/112. Ethnicity: NR
Further population details	1. Frail elderly: Not applicable/Not stated/Unclear
Indirectness of population	No indirectness
Interventions	(n=126) Intervention 1: Community-based rehabilitation services. Home-based rehabilitation. A qualified exercise specialist initiated the program in the patient's home and subsequently made weekly telephone calls for 8 weeks to reinforce and detect problems. Patients were loaned portable ergocycles. Duration: 8 weeks. Concurrent medication/care: none stated. (n=126) Intervention 2: Hospital-based rehabilitation services. Hospital-based outpatient rehabilitation. Training program combined aerobic and strength exercises at a rate of 3 sessions per week for 8 weeks. Training was monitored by a qualified exercise specialist, who could modify training, in a ratio of 4 to 5 participants for 1 trainer. Duration: 8 weeks. Concurrent medication/care: none stated.

Study	Maltais 2008[155]
Funding	Academic or government funding (Canadian Institutes of Health Research, respiratory Health Network)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Quality of life during the study period - Actual outcome: St. George's Respiratory Questionnaire at 12 months; Group 1: mean -4.5 (SD 10.92); n=89, Group 2: mean -3.5 (SD 10.8); n=95; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Mortality during the study period - Actual outcome: Mortality at 12 months; Group 1: 1/126, Group 2: 1/126; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Avoidable adverse events during the study period - Actual outcome: Serious adverse events at 12 months; Group 1: 51/126, Group 2: 52/126; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: Number of admissions to hospital at After 28 days of first admission - Actual outcome: Hospitalisations at 12 months; Group 1: 50/126, Group 2: 51/126; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Rasmussen 2016[191]
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=41)
Countries and setting	Conducted in Denmark; setting: Home or hospital
Line of therapy	1st line
Duration of study	Intervention + follow up: Follow-up-90 days

Study	Rasmussen 2016[191]
Method of assessment of guideline condition	Adequate method of assessment/diagnosis
Stratum	Early discharge
Subgroup analysis within study	Not applicable
Inclusion criteria	Acute Stroke patients >18 years of age; premorbid Modified Rankin score of 0 to 3; premorbid ability to live in own home; patients with focal neurological deficits hospitalised in a stroke unit for more than 3days and in need of rehabilitation.
Exclusion criteria	Patients were excluded if they were terminal; unable to understand or speak the Danish language; living in or discharged to nursing homes; unable to take care of themselves in their own home; relocated to other hospital departments after being admitted to the stroke unit; unable to participate in home based rehabilitation; severe memory impairments or baseline modifiedBarthel-100 ADL Index score of 91 or better
Recruitment/selection of patients	Patients were recruited by neurologists at the Stroke Unit, Copenhagen University Hospital from 1 July 2007 to 4 August 2008
Age, gender and ethnicity	Age - Mean (SD): intervention- 78 (72-84); control- 79 (71-85). Gender (M:F): 58/42. Ethnicity:
Further population details	-
Indirectness of population	No indirectness
Interventions	(n=31) Intervention 1: Community-based rehabilitation services. Home based rehabilitation for 4 weeks after discharge Patients were treated by a multi-disciplinary, intersectoral and interventional team for providing coordinated and home based rehabilitation. This MDT included a nurse, physiotherapists, occupational therapists and physicians experienced in stroke treatment. Prior to home based training a physician evaluated each intervention inpatient to secure that the inpatient was able and fit to participate. The nurse participated in the home training if nursing intervention was needed. At home inpatients were tested and trained in difficult activities with or without assistive devices. Duration: 3 months. Concurrent medication/care: not stated. (n=30) Intervention 2: Hospital-based rehabilitation services. Control patients were treated following standard care procedures in the stroke unit. Duration: 3 months. Concurrent medication/care: not stated.
Funding	Academic or government funding
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION	

Study	Rasmussen 2016[191]
SERVICES Protocol outcome 1: Quality of life at during study period - Actual outcome: QOL - EuroQol-5D at 3 months; Other: Median (IQR)- Intervention -0.77 (0.66-0.79); control-0.66 (0.56-0.72); Risk of bias: All domain - High, Selection - Low, Blinding - High, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Length of hospital stay at during study period - Actual outcome: Length of stay at 3 months; Other: Median (IQR)- Intervention 18 (16-21); control 16 (12-21); Risk of bias: All domain - High, Selection - Low, Blinding - High, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events at during study period; Patient and/or carer satisfaction at during study period; Number of presentations to Emergency Department at during study period; Number of admissions to hospital at After 28 days of first admission; Number of GP presentations at during study period; Readmission at 7 and 28 days; Mortality at during study period

Study	Ricauda 2004[192]
Study type	RCT (Patient randomised; Parallel)
Number of participants	120
Countries and setting	San Giovanni Battista Hospital, Turin, Italy. A teaching & tertiary care hospital
Duration of study	6 months
Stratum	Admission avoidance
Subgroup analysis within study	None
Inclusion criteria	Patients recovering from a stroke. Patients admitted to the ED within 24 hours of onset of symptoms and evaluated for at least 24 hours since onset of symptoms; availability of carer
Exclusion criteria	Patients living outside the hospital catchment area; history of dementia before acute stroke; history or evidence of prior stroke; absence of family or social support; CNS mental status <0.5; symptoms or signs of cardiorespiratory instability
Recruitment/selection of patients	Patients admitted to the ED within 24 hours of onset of symptoms and evaluated for at least 24 hours since onset of symptoms were assessed

Study	Ricauda 2004[192]
Age, gender and ethnicity	Median (IQR) age 82 (76-88) years; 54/120 male
Further population details	None
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=60) Hospital outreach admission avoidance: home treatment from a geriatric home hospitalisation service (GHHS) 24 hour care available including diagnostic, therapeutic and rehabilitative interventions; multi-disciplinary team: physiotherapist, occupational therapist, nursing, hospital geriatrician, social worker, speech therapist, psychologist, dietician. Home rehabilitation emphasised a task-orientated approach; patients perform guided, supervised and self-directed activities in a functional and familiar context. Caregiver encouraged to be an active participant; individual counselling for caregivers if needed. Standard daily intervention consisted of 1 visit by a physician, a nurse and a physical therapist. Concurrent medication/care: not stated. Duration: not stated. (n=60) Hospital admission (general medical ward [GMW]) and routine hospital rehabilitation service Concurrent medication/care: not stated. Duration: not stated.
Funding	Not stated
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community versus Hospital Protocol outcome 1: Mortality - Actual outcome- Mortality at 6 months; community: 21/60; hospital: 24/60; Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; admissions to hospital; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Anderson 2000[7]
Study type	RCT (Patient randomised; Parallel)

Study	Anderson 2000[7]
Number of participants	86
Countries and setting	Location: Australia; 2 teaching hospitals, Adelaide
Duration of study	Follow up of patients: 1, 3, 6, 12 months
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Patients recovering from a stroke (first or recurrent); residual disability and requiring rehabilitation; medically stable and suitable for early discharge; sufficient physical and cognitive function for active participation in rehabilitation scheme; home environment suitable for simple modifications; community rehabilitation team available to provide care; GP willing to provide any necessary medical care; caregiver (if one identified) gave consent for participation
Exclusion criteria	Subarachnoid haemorrhage
Recruitment/selection of patients	All patients with clinical diagnosis of stroke admitted to 2 affiliated acute-care public teaching hospitals Feb 1997-June 1998 assessed for eligibility
Age, gender and ethnicity	Mean age: 72 years
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=42) Intervention 1: Hospital at home early discharge Type of service: specialist rehabilitation nurses; therapy sessions in patient's home and individually tailored to achieve mutually agreed goals over several weeks. Emphasis on self-learning, adjustment to disability and structured practice sessions were encouraged between sessions Occupational therapy, physiotherapy, speech therapist Concurrent medication/care: not stated. Duration: not stated. (n=44) Intervention 2: in-patient hospital care Concurrent medication/care: not stated. Duration: not stated.
Funding	Federal Government
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community rehabilitation versus hospital rehabilitation	

Study	Anderson 2000[7]
	Protocol outcome 1: Mortality at 12 months - Actual outcome for Adults: Mortality at 12 months; Community: 2/42; hospital: 0/44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Adverse events at 12 months - Actual outcome for Adults: Adverse events at 12 months; Community: 5/42; hospital: 7/44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Quality of life at 12 months - Actual outcome for Adults: SF-36 Physical component summary score: Community: 37.4 (10.3) 42; hospital: 39.6 (9) 44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness – Actual outcome for Adults: SF-36 Mental component summary score: Community: 54.4 (9.2) 42; hospital: 55.7 (8.4) 44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: Patient satisfaction at 12 months - Actual outcome for Adults: Patient satisfaction: Community: 33/42; hospital: 29/44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 5: Admission to hospital at 12 months - Actual outcome for Adults: Admission to hospital: Community: 15/42; hospital: 11/44 Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 6: Caregiver burden at 12 months - Actual outcome for Adults: Caregiver Strain Index: Community: 0.2 (0.4) 24; hospital: 0.2 (0.4) 21; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Askim 2004[15]
Study type	RCT (Patient randomised; Parallel)
Number of participants	62
Countries and setting	Stroke Unit at University Hospital, Trondheim, Norway
Duration of study	Follow up at 6, 26 and 52 weeks
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Diagnosis of acute stroke according to WHO definition, Scandinavian Stroke Scale score >2 points and <58 points, living at home before stroke, inclusion within 72 hours after admission to stroke unit and within 7 days after onset of symptoms; informed consent.
Exclusion criteria	Not stated
Recruitment/selection of patients	Patients from the municipality of Malvik, Melhus and Klaebu, admitted to the Stroke Unit at the University Hospital, Trondheim, Norway; lived within 30-90 minutes driving distance from the hospital; screened <7 days after stroke onset and within 72 hours of admission.
Age, gender and ethnicity	Mean age: ESUS group: 76.9; OSUS group: 76.3 years; ESUS group: 16/31 (51.6%) men; OSUS group: 17/31 (54.8%) men. Ethnicity not stated.
Further population details	Living alone: 11/31 (35.5%) ESUS and 15/31 (48.4%) OSUS
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=31) Intervention 1: Ordinary stroke unit service (OSUS): treatment in a combined acute and rehabilitation stroke unit and further follow up organised by rehabilitation clinics and/or the primary health care system. Concurrent medication/care: Not stated Duration: 4 weeks (n=31) Intervention 2: Extended stroke unit service (ESUS): stroke unit treatment combined with home-based programme of follow up care coordinated by a mobile stroke team that offers early supported discharge and works in close cooperation with the primary healthcare system during the first 4 weeks after discharge. Mobile team based in stroke unit and consisted of a nurse, a physiotherapist, an occupational therapist and the consulting service of a physician. For patients living within 30-45 minutes radius from the hospital, where direct discharge home was likely to occur, a home visit was performed as soon as the patient's medical condition allowed, to assess the home environment, define the goals of further rehabilitation, and make a plan for follow up with the family and primary healthcare providers; for those >45 minutes from the hospital, primary healthcare providers were asked to make this visit. The need for further rehabilitation was subsequently defined in a telephone conversation. The mobile team then established a service and support

Study	Askim 2004[15]
	system for the patient allowing him or her to return home as soon as possible and to continue the necessary training and rehabilitation at home, in a day clinic, or both. On the day of discharge, a meeting was organised with the patient and their family, the physician and the mobile stroke team member, to jointly define the plans for further follow up and care (date of discharge decided in collaboration with the mobile team, the patient and the family. For patients with extensive deficits after a stroke who needed help and support 24 hours a day, plans for further inpatient rehabilitation in a rehabilitation clinic were made following a protocol. For the first 4 weeks after discharge, the mobile team acted as a safety net for the patient, and kept in contact by telephone and at least 1 more home visit to ensure the functioning of follow-up care, terminated with an outpatient consultation for patients within a 30-45 minute radius from the hospital; a consultation in the patient's home was conducted for patients living further away. This included the physician responsible for the patient's treatment during the acute hospital stay, the mobile team member, the patient and if possible the family. When a group of patients was identified in the same community, the mobile team invited them and their families to a local meeting, to give general information about acute and chronic issues of stroke care and give patients the opportunity to share experiences. Concurrent medication/care: Not stated Duration: 4 weeks
Funding	Not stated
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community versus hospital Protocol outcome 1: Mortality at 1 year - Actual outcome for Adults: Mortality at 52 weeks; ESUS: 8/31, OSUS: 5/31; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Caregiver burden at 1 year - Actual outcome for Adults: Caregiver strain index at 52 weeks; ESUS: 24.3 (2.7) n=23, OSUS: 24.8 (1.9) n=22; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Askim 2010A[14]
Study type	RCT (Patient randomised; Parallel)
Number of participants	62
Countries and setting	Stroke Unit at St Olavs Hospital, Trondheim, Norway

Study	Askim 2010A[14]
Duration of study	26 weeks
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Diagnosis of acute stroke according to WHO definition, modified Rankin Scale score <3 before admission, Berg Balance Scale score <45 points, Scandinavian Stroke Scale score >14 points, Scandinavian Stroke Scale leg item <6 points or Scandinavian Stroke Scale transfer item <12 points, Mini-Mental State Examination score >20 points; informed consent.
Exclusion criteria	Could not tolerate the increased amount of motor training because of serious cardiovascular diseases (uncompensated heart failure with dyspnoea or angina pectoris with chest pain during rest) or other functional impairments (for example, severe rheumatoid arthritis or Parkinson's disease.
Recruitment/selection of patients	Patients admitted to the Stroke Unit at St Olavs Hospital, Trondheim, Norway between April 2004 and September 2007; screened 4-14 days after stroke.
Age, gender and ethnicity	Mean age: IMT group: 75.4 (7.9); ST group: 77.6 (9.6) years; IMT group: 19/30 (59.4%) women; ST group: 14/32 (44.8%) women. Ethnicity not stated.
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=30) Intervention 1: Intensive Motor training (IMT) group: 3 additional sessions of motor training each week for the first 4 weeks after discharge and 1 additional session per week for the next 8 weeks; each session 30-50 minutes. Patients also encouraged to perform home exercises during this period. Additional training comprised reaching tasks in sitting and standing positions, sit-to-stand, step tasks and walking tasks. Tasks were individually adapted and varied according to base of support, speed, weight and complexity; as many repetitions as tolerated. Patients were instructed to exert themselves between "somewhat hard" and "hard". Patients also partly wore an orthosis on the less affected leg to force the use of the more affected leg. Programme provided by physical therapists in the primary health care system, who also provided the standard care. Treatment administered in patient's home, rehabilitation clinic or outpatient clinic, depending on where patient discharged after hospital stay. Home exercises consisted of 4 tasks that were individually chosen according to patient's functional level; 10 repetitions of each task, twice a day, 6 days a week. Concurrent medication/care: not stated. Duration: 12 weeks. (n=32) Intervention 2: Standard treatment (ST) group: All patients were treated in a comprehensive stroke unit emphasising mobilisation to standing or sitting position out of bed within first 24 hours after onset of symptoms and physical therapy according to a task-

Study	Askim 2010A[14]
	orientated approach, focusing on independence in activities of daily living. 2 daily sessions of 30 minutes, 5 days per week. In addition, specially trained nurses in the stroke unit offered training in activities of daily living when appropriate during 24 hours. Stroke unit treatment based on team approach combining acute medical treatment and rehabilitation. All patients received early supported discharge, coordinated by a hospital-based multidisciplinary team who worked in close collaboration with the primary health care system during the first 4 weeks after discharge. Further rehabilitation was administered as inpatient, outpatient in home rehabilitation according to patients' needs. Concurrent medication/care: not stated. Duration: 4 weeks.
Funding	Academic or government funding (The Norwegian Fund for Postgraduate Training in Physiotherapy and Clinical Service, St Olavs Hospital, Trondheim University Hospital, Norway)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Intensive Motor training versus Standard treatment Protocol outcome 1: Adverse events at End of follow-up - Actual outcome for Adults: Adverse events at 26 weeks; IMT Group: 2/30, ST Group: 0/32; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Bautz-Holter 2002[19]
Study type	RCT (Patient randomised; Parallel)
Number of participants	82
Countries and setting	Location: Norway; university hospital
Duration of study	Follow-up of patients: 1 week, 3, 6 months
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Recovering from a stroke; home dwelling and not severely disabled prior to the stroke (Oxford Handicap Scale score 0-3); no other medical condition likely to preclude rehabilitation; medically stable with Barthel ADL Index score between 5 and 19 at 72 hours after stroke.

Study	Bautz-Holter 2002[19]
Exclusion criteria	Admitted to medical departments other than stroke unit; subarachnoid haemorrhage; unable to consent due to mental or communication problems.
Recruitment/selection of patients	Recruited from June 1997 to January 1999; all patients with acute stroke (onset <6 days prior to hospitalisation) admitted to acute stroke unit of Ullevaal university hospital assessed
Age, gender and ethnicity	Median age (IQR): treatment = 79.5 (69 to 84); control = 78 (74 to 82); ESD 21/42 (50%) female; CRS 24/40 (60%) female
Further population details	Living alone: ESD: 24/42 (57%); CRS 25/40 (63%)
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=42) Intervention 1: Early supported discharge (ESD), hospital outreach community based rehabilitation Type of service: multidisciplinary hospital based team (1 nurse, 1 occupational therapist, 1 physiotherapist) plus community nurses. Patients assessed by team; 1 member of team served as primary contact for patients and relatives throughout study period; in cooperation with ordinary hospital staff, the primary contact started immediate preparations for discharge and coordination of continued rehabilitation, provided by general community services in local areas. 4 weeks after discharge, patients seen in outpatient's clinic. Also offered the opportunity to make new contact with outpatient clinic if they wished, or to be readmitted to hospital whenever needed. Concurrent medication/care: not stated. Duration: as long as considered necessary. (n=40) Intervention 2: in-patient hospital care: conventional rehabilitation service (CRS). Conventional procedures for discharge and continued rehabilitation (anticipated to be less well organised) Concurrent medication/care: not stated. Duration: as long as considered necessary.
Funding	Not stated
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community versus hospital Protocol outcome 1: Mortality at 6 months - Actual outcome for Adults: Mortality at 6 months; Community: 2/40; hospital: 4/37; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Admission to hospital at 6 months - Actual outcome for Adults: Admission to hospital at 6 months; Community: 3/34; hospital: 4/31; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	

Study	Bautz-Holter 2002[19]
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Caplan 2006A[38]
Study type	RCT (Patient randomised; Parallel)
Number of participants	n=104
Countries and setting	Location: Australia; Prince of Wales Hospital, a tertiary referral hospital attached to the University of New South Wales, Sydney
Duration of study	Follow-up of patients: 1 and 6 months
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Elderly patients whose length of hospital stay exceeded 6 days, who required and were suitable for geriatric rehabilitation and expected to return home and live reasonably independently; lived in the local area of the hospital; patients and carers gave consent
Exclusion criteria	Lived in a nursing home
Recruitment/selection of patients	Between April 2000 and October 2002, all inpatients with a length of stay >6 days, referred for geriatric rehabilitation were assessed.
Age, gender and ethnicity	Mean age: treatment = 83.86 (7.8); control = 84.0 (7.02); male: female: home rehabilitation group: 43:20; hospital rehabilitation group: 22:11
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=70) Intervention 1: Early discharge hospital based outreach. Type of service: nurses, physiotherapy, occupational therapy, physician. Patients kept in hospital until they could transfer independently and mobilise sufficiently to toilet themselves. Home rehabilitation by hospital outreach team. Concurrent medication/care: Not stated Duration: Not stated, but patients visited a mean of 20 times and any equipment supplied free for up to 3 months

Study	Caplan 2006A[38]
	(n=34) Intervention 2: in-patient hospital care. Patients transferred to geriatric rehabilitation ward when a bed became available and acute illness settling. Concurrent medication/care: Not stated Duration: Not stated
Funding	National Demonstration Hospitals Program 3, Commonwealth Department of Health and Ageing
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community rehabilitation versus hospital rehabilitation Protocol outcome 1: Mortality at 6 months - Actual outcome for Adults: Mortality at 6 months; Community: 15/70; hospital: 7/34; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Patient satisfaction at 6 months - Actual outcome for Adults: Patient satisfaction at 6 months; Community: 4.66 (0.64) 70; hospital: 4.06 (0.94) 34; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Carer satisfaction at 6 months - Actual outcome for Adults: Carer satisfaction at 6 months; Community: 4.47 (0.86) 70; hospital: 4.08 (1.04) 34; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: Length of stay at 6 months - Actual outcome for Adults: Length of stay at 6 months; Community: 34.91 (15.37) 70; hospital: 40.09 (23.22) 34; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 5: Admission to hospital at 6 months - Actual outcome for Adults: Admission to hospital at 6 months; Community: 13/70; hospital: 8/34; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Quality of life

Study	Cunliffe 2004[64]
Study type	RCT (Patient randomised; Parallel)
Number of participants	370
Countries and setting	Location: UK (Nottingham)
Duration of study	Follow up: 1, 3 and 12 months

Study	Cunliffe 2004[64]
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Aged 65 or above; residing in Nottingham Health Authority boundary; medically fit for discharge; rehabilitation needs that could be met at home with a home-based package of care and rehabilitation. 3 most common conditions were fractures (105/370, 28%), neurological conditions, mainly stroke (97/370, 26%), cardio-respiratory illnesses (50/370, 14%).
Exclusion criteria	People in need of constant or overnight care; admitted from or discharged to institutional care
Recruitment/selection of patients	Participants identified from medical and surgical hospital wards
Age, gender and ethnicity	Median age: 80 years (IQR 73-85); 246/370 (67%) female
Further population details	247/370 (66%) lived alone
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=185) Early discharge and rehabilitation service (EDRS). Aimed to assess the patient and arrange discharge as soon as possible. Up to 4 visits per day could be provided, up to 7 days a week, between 8am and 10pm. Type of service: provided by community services, GP had clinical responsibility, physiotherapy, occupational therapy, 3 dedicated nurses plus 7 rehabilitation assistants. Community care officer liaised with social services Concurrent medication/care: Not stated Duration: up to 4 weeks (n=185) Control group: in-patient hospital care. Patients managed in hospital until fit for home using existing after-care services (hospital out-patient department rehabilitation, geriatric day hospitals, all usual social services) as required Concurrent medication/care: Not stated Duration: Not stated
Funding	Nottingham Health Authority
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community rehabilitation versus hospital rehabilitation Protocol outcome 1: Mortality at 12 months - Actual outcome for Adults: Mortality at 12 months; Community: 6/43; hospital: 1/44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Length of stay at 12 months	

Study	Cunliffe 2004[64]
- Actual outcome for Adults: Length of stay at 12 months; Community: 39.56 (47.7) 52; hospital: 41.08 (30.7) 50; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Admission to hospital at 12 months - Actual outcome for Adults: Admission to hospital at 12 months; Community: 49/185; hospital: 40/185; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days;

Study	Donnelly 2004[76]
Study type	RCT (Patient randomised; Parallel)
Number of participants	113
Countries and setting	Location: UK (Belfast): Belfast City Hospital and Ulster Hospital
Duration of study	Follow-up of patients: 12 months
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Recovering from a stroke; stroke in 4 weeks prior to admission; potential to benefit from rehabilitation
Exclusion criteria	Resident in nursing or residential home; pre-existing physical or mental disability judged to make further rehabilitation inappropriate
Recruitment/selection of patients	Research nurses in collaboration with hospital staff identified patients in Belfast City Hospital and Ulster Hospital
Age, gender and ethnicity	Mean age: 75 (8.2) years; median age: treatment = 68; control = 71; 57% female
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=54) Intervention 1: Early discharge community based (community stroke team CST) Type of service: average of 2.5 home visits a week for 3 months, each visit lasting 45 minutes. Multidisciplinary meetings held to discuss the assessment of patients and progress towards rehabilitation goals, which were set by relatives, patient and therapist. Patients discharged to home following home assessment and placement of aids and equipment. Physiotherapist, occupational therapist, nurses, speech therapist. Discharged as soon as the liaison therapist had assessed their home and ensured any necessary aids and equipment

Study	Donnelly 2004[76]
	were in place Concurrent medication/care: Not stated Duration: 3 months (n=59) Intervention 2: in-patient hospital care. Discharge arranged in the usual way by hospital-based rehabilitation team, that is, in-patient rehabilitation in stroke unit and follow up rehabilitation in day hospital Concurrent medication/care: Not stated Duration: Not stated
Funding	South and East Belfast Health and Social Services Trust and Northern Ireland Chest Heart and Stroke Association
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community rehabilitation versus hospital rehabilitation Protocol outcome 1: Quality of life at 12 months - Actual outcome for Adults: SF-36 Physical component summary score at 1 year: Community: 35.59 (31.32) 51; hospital: 34.67 (32.01) 46 ; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: SF-36 Mental component summary score at 1 year: Community: 69.49 (18.26) 51; hospital: 67.3 (20.07) 46 ; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Patient satisfaction at 12 months - Actual outcome for Adults: Patient satisfaction at 1 year; Community: 10.72 (1.44) 54; hospital: 9.7 (2.1) 59; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Admissions to hospital at 12 months - Actual outcome for Adults: Admissions to hospital at 1 year; Community: 6/59; hospital: 7/54; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: Caregiver burden at 12 months - Actual outcome for Adults: Caregiver strain index at 1 year; Community: 5.92 (2.86) 27; hospital: 6 (4.23) 25; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Evans 1997B[88]
Study type	RCT (Patient randomised; Parallel)

Study	Evans 1997B[88]
Number of participants	85
Countries and setting	VA Puget Sound Health Care System, Seattle, USA
Duration of study	1 year
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Presence of a physical limitation based on psychiatry exam; medically stable as indicated by an illness severity index of 1 (lowest mortality); first time hospitalisation for a disabling condition in any of 4 Major Diagnostic Categories (MDC 1 – nervous, 5 – circulatory, 8 – musculoskeletal and 21 – injury).
Exclusion criteria	Not stated
Recruitment/selection of patients	Hospital admissions were screened on the 3rd day of admission
Age, gender and ethnicity	Age not stated; gender: in-patient rehabilitation: 41/43 (95%) male; out-patient follow up: 42/42 (100%) male; ethnicity: Black 4/43 (9%) versus 4/42 (9%); White: 39/43 (91%) versus 37/42 (89%); Other: 0/43 (0%) versus 1/42 (2%)
Further population details	Nervous: 16% versus 17%, circulatory: 16% versus 14%, musculoskeletal: 52% versus 60%, injury: 13% versus 9%
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=42) Intervention 1: Out-patient follow-up: Usual medical services but no scheduled rehabilitation therapies; patients received a mean of 0.6 (1.3) rehabilitation services during acute rehabilitation and 0.1 (0.2) during out-patient follow up. Concurrent medication/care: Not stated Duration: Not stated (n=43) Intervention 2: In-patient comprehensive rehabilitation: patients received a mean of 18.0 (8.1) rehabilitation services during acute rehabilitation and 8.3 (10.9) during out-patient rehabilitation Concurrent medication/care: Not stated Duration: Not stated
Funding	Academic or government funding (VA Health Services Research and Development Program)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: In-patient comprehensive rehabilitation versus Out-patient follow-up	

Study	Evans 1997B[88]
Protocol outcome 1: Mortality at End of follow-up - Actual outcome for Adults: Mortality at 1 year: In-patient comprehensive rehabilitation: 7/43 (16%); Out-patient follow-up: 4/42 (10%) Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Quality of life at End of follow up - Actual outcome for Adults: Life satisfaction (LSIA; items scored from 1 very dissatisfying to 6 very satisfying) at 1 year; In-patient comprehensive rehabilitation: 19.9 (9.9) (n=43), Out-patient follow-up: 20.2 (10.6) (n=42); Risk of bias: All domain - high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Length of stay at End of follow up - Actual outcome for Adults: Length of stay (days) at 1 year; In-patient comprehensive rehabilitation: 21.0 (16.8) (n=43), Out-patient follow-up: 16.7 (10.2) (n=42); Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: Admissions to hospital at End of follow-up - Actual outcome for Adults: admissions to hospital at 1 year; In-patient comprehensive rehabilitation: 16/43 (37%), Out-patient follow-up: 13/42 (31%); Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days

Study	Fleming 2004[93]
Study type	RCT (Patient randomised; Parallel)
Number of participants	165
Countries and setting	Social Services Care Home Rehabilitation Services in Nottingham, UK
Duration of study	1 year
Stratum	Early discharge
Subgroup analysis within	None

Study	Fleming 2004[93]
study	
Inclusion criteria	Hospitalised patients who were aged over 65 years; lived in the Social Services districts served by the CHRS scheme; wished to return to their own homes; no longer needed in-patient medical care; were unable to return home due to activity limitation that might be improved by a period of short-term rehabilitation in a care home setting; agreed to a period of rehabilitation in a care home setting; met Social Services criteria for eligibility for residential home care.
Exclusion criteria	Dementia, depression or distress that interfered with rehabilitation; required 2 or more people to mobilise or perform personal activities of daily living, or with severe incontinence.
Recruitment/selection of patients	Referrals were discussed to confirm eligibility; trial co-ordinator obtained consent, completed baseline data and allocated patient; CHRS OT assessed participants and arranged transfer to nearest unit to their home
Age, gender and ethnicity	Median 81 (77-88) years; 113/165 (69%) female; ethnicity not stated
Further population details	Principal diagnostic condition: cardio-respiratory disorder: 26/165 (16%), gastroenterology disorder 11/165 (7%), infection 3/165 (2%), neurological disorder: 23/165 (14%), orthopaedic disorder: 29/165 (18%), peripheral vascular disease: 5/165 (3%), non-specific condition: 64/165 (40%)
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=81) Intervention 1: Care Home Rehabilitation Services (CHRS): Occupational therapists assessed patients in the units and devised their treatment plans. Community Care Officers (Social Services employed staff with experience in the delivery of community care services for people with a disability). Day to day staffing was by rehabilitation assistants: these were care assistants in the local authority homes who had been trained by the OTs. Physiotherapy was provided by existing community physiotherapy service; medical cover provided by GP; referrals made to District nurses. Patients had single rooms and had access to a dedicated rehabilitation kitchen; encouraged to practice the activities of daily living under the supervision of, or with the assistance of, the rehabilitation assistants. Home visits were encouraged to increase the patients' confidence to return home. Treatment programmes were tailored to individual needs. Concurrent medication/care: Not stated Duration: Up to 6 weeks (n=84) Intervention 2: Usual care Concurrent medication/care: Not stated Duration: Not stated
Funding	Academic or government funding (Trent NHS Executive)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Care Home Rehabilitation Services (CHRS) versus usual care Protocol outcome 1: Mortality at End of follow-up	

Study	Fleming 2004[93]
- Actual outcome for Adults: Mortality at 12 months; CHRS: 22/81 (27%), usual care: 23/84 (27%); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Length of stay - Actual outcome for Adults: Median (IQR) length of stay at discharge from index admission; CHRS: 8 (7-15), usual care: 18 (8-34); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: Median (IQR) hospital bed days from randomisation to 12 months; CHRS: 16 (8-35), usual care: 34.5 (18-60); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: Median (IQR) days either in hospital or in CHRS facility from randomisation to 12 months; CHRS: 60 (34-87), usual care: 34.5 (18-63) Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Admissions to hospital at 12 months - Actual outcome for Adults: Number of patients re-admitted to hospital at 12 months; CHRS: 41/81 (51%), usual care: 46/84 (55%); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: Number of GP presentations at End of follow-up - Actual outcome for Adults: Median (IQR) GP visits at 12 months; CHRS: 3 (1-6), usual care: 4 (0-6); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Readmission at 7 and 28 days; Quality of life

Study	Gladman 1993[96]
Study type	RCT (Patient randomised; Parallel)
Number of participants	327
Countries and setting	Patients discharged from 2 acute and 3 rehabilitation hospitals in Nottingham, UK

Study	Gladman 1993[96]
Duration of study	6 months
Stratum	Early discharge
Subgroup analysis within study	Health Care of the Elderly (HCE), General medical (GM) and Stroke Unit (SU)
Inclusion criteria	Acute stroke (first or recurrent)
Exclusion criteria	Discharged to residential or nursing homes those requiring respite or terminal care; those who had been receiving outpatient rehabilitation before the stroke; those who had no significant disability from their stroke; those who stayed in hospital <7 days
Recruitment/selection of patients	Identified from a register of all those admitted to the City and University hospitals, Nottingham with acute stroke
Age, gender and ethnicity	Mean 70 years in both groups; 77/162 (48%) female in DRS group and 77/165 (47%) in HRS group; ethnicity not stated
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=162) Intervention 1: Domiciliary rehabilitation service (DRS): provided by 2 half-time physiotherapists and 1 OT who assessed all patients referred to DRS at home and then organised or provided appropriate therapy and arranged other relevant help. Concurrent medication/care: Not stated Duration: Up to 6 months, then referred back to routine services (n=165) Intervention 2: Hospital-based rehabilitation service (HRS): eligible for out-patient rehabilitation according to usual practices, that is, for those discharged from Health Care of the Elderly wards, the main option was a day hospital, while for those discharged from General Medical wards, outpatient physiotherapy or occupational therapy could be arranged. Concurrent medication/care: Not stated Duration: Not stated
Funding	Academic or government funding (Chest, Heart and Stroke Association, Nottingham Fights Stroke Association, Medical Research Council and the Rehabilitation and Medical Research Trust)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Domiciliary rehabilitation service (DRS) versus Hospital-based rehabilitation service (HRS) Protocol outcome 1: Mortality at End of follow-up - Actual outcome for Adults: Mortality at 6 months; Domiciliary rehabilitation service (DRS): 16/162 (10%), Hospital-based rehabilitation service (HRS): 7/165 (4%); Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups -	

Study	Gladman 1993[96]
Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period; Quality of life

Study	Indredavik 2000[126] Fjaertoft 2005[91,92]
Study type	RCT (Patient randomised; Parallel)
Number of participants	320
Countries and setting	Stroke Unit, city of Trondheim, Norway
Duration of study	26 weeks (Indredavik 2000); follow up to 1 year (Fjaertoft 2005); follow up 5 years (Fjaertoft 2013)
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Signs and symptoms of an acute stroke according to the World Health Organization definition of stroke; Scandinavian Stroke Scale (SSS) score between 2 and 57 points; living at home before the stroke; included within 72 hours after admission to the stroke unit and within 7 days after the onset of symptoms; lack of participation in other trials; and provision of informed consent
Exclusion criteria	Not stated
Recruitment/selection of patients	Patients with signs and symptoms of acute stroke from the city of Trondheim, Norway, who were admitted to the stroke unit were screened for inclusion
Age, gender and ethnicity	Mean (median) age: ESUS: 74.0 (74.5); OSUS: 73.8 (74.0); males: ESUS: 86/160 (54%); OSUS: 70/160 (44%); ethnicity not stated
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=160) Intervention 1: Extended stroke unit service (ESUS): A mobile stroke team was developed and established as part of this trial to organize and coordinate the extended service. ESUS may therefore be defined as stroke unit treatment similar to OSUS combined with service from a mobile team that offers early supported discharge and coordinates further rehabilitation and follow-up in close cooperation with the primary healthcare system. The team consisted of a nurse, a physiotherapist, an occupational therapist, and the

Study	Indredavik 2000[126] Fjaertoft 2005[91,92]
	part-time services of a physician. As soon as a patient was randomised to ESUS, a member of the team collected basic information about the patient and his/her medical condition, comorbidity, the situation at home before the stroke, and existing support from family, friends, and eventually the healthcare system. Together with the staff in the stroke unit, a preliminary evaluation of the needs of the patient during the recovery phase was made. Simultaneously, the primary healthcare system was informed about the patient. In cases in which direct discharge to home was likely to occur, a visit at home was usually performed as soon as the medical condition of the patient was stable. The patient, the family if possible, and representatives from the primary healthcare system and the mobile stroke team participated. During the visit, a plan for further follow-up for necessary nursing, support, and rehabilitation was made. Furthermore, the different tasks necessary for the follow-up program were delegated to dedicated members of the service system. The mobile stroke team was responsible for coordination of the different agencies and activities. The team tried to establish a service and support system that allowed the patient to live at home as soon as possible after the stroke and to continue necessary training and rehabilitation at home, in a day clinic, or by a combination of those 2 alternatives. In most cases the primary role of the team was coordination, but for some patients with more extensive needs, the team also offered training and support at home in addition to service from other agencies. However, most of the service and support was offered by trained staff in the community healthcare system, which played an important role in the support system. On the day of discharge, a dedicated discharge meeting was organized in which all plans were again checked, and the patient and family were informed in detail about further plans for treatment, rehabilitation, support, help, and follow-up. For patients with very extensive deficits after the stroke who needed continuous help and support 24 hours a day, a plan for further inpatient rehabilitation in a rehabilitation clinic was made in close cooperation between the mobile team, the stroke unit, and the rehabilitation clinics. Similar to the case for patients who were discharged directly to home, early discharge and further treatment/rehabilitation while the patient stayed at home were emphasized. Hence, the stay in rehabilitation clinics was kept as short as possible. The close follow-up by the mobile team was present for the first month after discharge to home and was terminated with an outpatient consultation. The physician who had treated the patient during the acute stage in the hospital (that is, the stroke unit), a member of the mobile team, the patient, and eventually the family participated during this outpatient consultation. An evaluation and summary of the period from stroke onset through the acute stage to the establishment at home were made. During this evaluation the patient and the family were invited to present their view about plans that did not work, plans and goals that had to be changed, and needs, hopes, and worries they had for the future. An evaluation of the treatment program for secondary prophylaxis was also made, and improvements and changes were introduced if necessary. A final report was sent to the family physician with advice for further follow-up. The home nursing personnel and therapists or other members of the primary healthcare system, when indicated, were also informed about the present condition of the patient, the treatment and rehabilitation thus far, and further plans. After care by the outpatient clinic 1 month after discharge, the primary healthcare system was responsible for all further follow-up but could immediately contact members of the stroke team if problems occurred that were difficult to solve by the primary healthcare system alone. Three months after discharge, the patients and their families were invited to a meeting for a larger group of stroke patients. There they were generally informed about stroke and the problems and possibilities for stroke victims. Concurrent medication/care: Not stated Duration: 3 months

Study	Indredavik 2000[126] Fjaertoft 2005[91,92]
	(n=160) Intervention 2: Ordinary stroke unit service (OSUS): treatment in a combined acute and rehabilitation stroke unit and further follow-up organized by rehabilitation clinics and/or the primary healthcare system. The service includes systematic diagnostic evaluation, standardized observation of vital signs and neurological deficits, an acute medical treatment program, and very early mobilization and rehabilitation in a stroke unit. OSUS may be defined as stroke unit treatment according to evidence-based recommendations combined with further inpatient rehabilitation when more long-term rehabilitation is necessary and a follow-up program organized by the primary healthcare system after discharge. Concurrent medication/care: Not stated Duration: Not stated
Funding	Academic or government funding (Norwegian Department of Health and the Stroke Units Fund of Stroke Research, University of Trondheim)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Extended stroke unit service (ESUS) versus ordinary stroke unit service (OSUS) Protocol outcome 1: Mortality at End of follow-up - Actual outcome for Adults: Mortality at 6 months; ESUS: 13/160 (8.1%), OSUS: 15/160 (9.4%); Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Length of stay at End of follow up - Actual outcome for Adults: Length of stay in stroke unit at index admission; ESUS: 11 days, OSUS: 11 days; Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: Length of stay in hospital (stroke unit plus rehabilitation clinics) at index admission; ESUS: 18.6 days, OSUS: 31.1 days; Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: Mean (range) length of stay in stroke unit at 1 year; ESUS: 12.6 (1-48) days, OSUS: 12.5 (1-74) days; Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: Mean (range) length of stay in inpatient rehabilitation at 1 year; ESUS: 11.1 (0-182) days, OSUS: 23.4 (0-163) days; Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Hospital readmission at End of follow up - Actual outcome for Adults: Mean (range) hospital readmission days at 1 year; ESUS: 5.8 (0-120) days, OSUS: 7.3 (0-62) days; Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: GP presentations at End of follow up - Actual outcome for Adults: Mean (range) number of GP visits at 1 year; ESUS: 7.5 (0-58) days, OSUS: 6.4 (0-35); Risk of bias: All domain - high, Selection - high, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to

Study	Indredavik 2000[126] Fjaertoft 2005[91,92]
reported by the study	Emergency Department during the study period

Study	Mayo 2000[164]
Study type	RCT (Patient randomised; Parallel)
Number of participants	114
Countries and setting	Location: Canada; 5 acute care hospitals in Montreal
Duration of study	Follow-up of patients: 1, 3 months
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Patients recovering from an acute stroke; persistent motor deficits after stroke; caregivers willing and able to provide live-in care over 4 weeks after discharge
Exclusion criteria	Stroke patients who still required the assistance of >1 person to walk by 28 days after stroke; cognitive impairment (>5 errors on the Short Portable Mental Status Questionnaire; important co-existing conditions that affected ability to function independently (for example, dialysis requirement, paraplegia)
Recruitment/selection of patients	Patients admitted for acute stroke to 5 acute care hospitals in Montreal; project nurses consulted emergency room records and admission lists daily to identify potentially eligible patients
Age, gender and ethnicity	Mean age: treatment = 70.3 (12.7); control = 69.6 (12.7); home care group: 37/58 (63.8%) men; usual care group: 40/56 (71.4%) men
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=58) Intervention 1: Early discharge hospital outreach Type of service: multi-disciplinary team: physiotherapist, occupational therapist, dedicated nurses, speech therapist, dietary consultation. Home intervention consisted of prompt discharge from hospital with immediate provision of follow up services from multidisciplinary team. Medical follow up arranged at discharge. Intervention individualised, coordinated by a team member who had the most contact with the patient (usually nurse or physical therapist); rehabilitation provided at home; participants received at least 1 home visit form nurse; subsequent home visits arranged as needed and supplemented with telephone monitoring. Patients not scheduled to have >1 active treatment session per day, although nursing visit sometimes scheduled the same day as therapy. Concurrent medication/care: Not stated

Study	Mayo 2000[164]
	Duration: 4 weeks (n=56) Intervention 2: in-patient hospital care. Current practices for discharge planning and referral for follow up services, including physiotherapy, occupational therapy, speech therapy as requested by patient's care provider and offered through extended acute-care hospital stay; inpatient or outpatient rehabilitation or home care via local community health clinics; patients could also arrange for private care for which they themselves paid. Concurrent medication/care: Not stated Duration: Not stated
Funding	National Health Research Development Program
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Intensive multidisciplinary rehabilitation services as inpatients versus rehabilitation in the patients' homes Protocol outcome 1: Quality of life at 3 months - Actual outcome for Adults: SF-36 Physical component summary score at 3 months; Community: 42.9 (10.1) 51; hospital: 37.9 (10.6) 44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: SF-36 Mental component summary score at 3 months; Community: 46.5 (11.7) 51; hospital: 46.7 (10.8) 44; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectnessProtocol outcome 2: Length of stay at 3 months - Actual outcome for Adults: Length of stay at 3 months; Community: 9.8 (5.3) 58; hospital: 16.1 (14.6) 56; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality; Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days

Study	Ozdemir 2001[177]
Study type	RCT (Patient randomised; Parallel)
Number of participants	60
Countries and setting	Trakya University Hospital Physical Medicine and Rehabilitation Department Polyclinic, Turkey
Duration of study	60 days

Study	Ozdemir 2001[177]
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Aged under 80 years, diagnosed with stroke (first or recurrent) between 1996 and 1999
Exclusion criteria	Age > 80 years; unconscious; medically unstable; significant complications (for example, pressure ulcers, severe contractures) that would inhibit rehabilitation recovery; history of transient ischaemic attacks.
Recruitment/selection of patients	Referred after medical stabilisation to the Trakya University Hospital Physical Medicine and Rehabilitation Department Polyclinic from the neurology and neurosurgery departments of the various hospitals in Turkey.
Age, gender and ethnicity	Mean (SD) (range) age: hospital: 59.1 (5.9) (49-79) years; community: 61.8 (9.2) (43-84) years; hospital: 21 male, 9 female (30% female); community: 19 male, 11 female (37% female); ethnicity not stated
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=30) Group 1: intensive multidisciplinary rehabilitation services as inpatients in the rehabilitation clinic. Therapeutic exercises (range of motion, passive stretching, muscle strengthening, mobilisation) and neuromuscular facilitation for 2 hours a day, 5 days a week. Physical agents such as ice, hot packs, TENS and ultrasound were used when necessary. Regular occupational therapy but no speech therapy. Hand and/or wrist splints, ankle-foot orthoses, tripods and canes were provided if needed. Patients evaluated daily by a physician. Stroke-related symptoms and complications were treated with multi-disciplinary approaches. Concurrent medication/care: Not stated Duration: Mean 64 days (range 25-147 days) (n=30) Group 2: rehabilitation in the patients' homes. Family members showed how convenient bed positioning and exercises should be performed by patient and family members. No neuromuscular facilitation. Family provided therapy at least 2 hours a day, 7 days a week. Splints, orthoses and devices were provided. A team consisting of a rehabilitation physician and a physiotherapist regularly visited the patients for 2 hours once a week and instructed family caregivers and provided medical support to the patients. Concurrent medication/care: Not stated Duration: Mean 64 days (range 29-150 days)
Funding	Not stated (no commercial funding)
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Intensive multidisciplinary rehabilitation services as inpatients versus rehabilitation in the patients' homes	

Study	Ozdemir 2001[177]
Protocol outcome 1: Adverse events at End of follow-up - Actual outcome for Adults: Adverse events at 9 weeks; Group 1: 11/30 (37%), Group 2: 22/30 (73%); Risk of bias: All domain - high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Mortality during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period; Quality of life

Study	Roderick 2001[198]
Study type	RCT (Patient randomised; Parallel)
Number of participants	140
Countries and setting	Poole area, East Dorset, England
Duration of study	6 months
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Confirmed diagnosis of stroke; aged 55 years or over; residents of East Dorset; needed further rehabilitation for disability caused by stroke; physically able to attend the day hospital; any previous disability was not too severe that it would prevent further rehabilitation; no signs of advanced dementia.
Exclusion criteria	Terminal illness, needing day hospital for social or medical reasons.
Recruitment/selection of patients	Patients with a newly-identified stroke admitted to Poole Hospital NHS Trust or 1 of its associated community hospitals and those with recent strokes directly referred from the community for day-hospital rehabilitation
Age, gender and ethnicity	Mean age (range): domiciliary: 78.3 (62-91); day hospital: 79.6 (60-95); female: 33 (52%) and 42 (57%); ethnicity not stated
Further population details	Not stated
Extra comments	-
Indirectness of population	No indirectness
Interventions	(n=66) Intervention 1: Domiciliary stroke team: physiotherapist and occupational therapist who met daily to plan activity and fortnightly with a consultant geriatrician to review patients, using a goal-setting approach. Outpatient speech and language therapy provided Concurrent medication/care: Not stated

Study	Roderick 2001[198]
	Duration: Until maximum potential for recovery was reached (n=74) Intervention 2: Five day hospitals were involved; care was coordinated by multi-disciplinary teams who gave therapy in both individual and group sessions Concurrent medication/care: Not stated Duration: Until maximum potential for recovery was reached
Funding	Academic or government funding (South and West Research and Development Directorate)

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Domiciliary stroke team versus day hospital

Protocol outcome 1: Mortality at End of follow-up
- Actual outcome for Adults: Mortality at 6 months; Domiciliary stroke team: 4/66 (7%), day hospital: 7/74 (9%); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

Protocol outcome 2: Quality of life at End of follow up
- Actual outcome for Adults: Median (IQR) SF-36 Physical health at 6 months; Domiciliary stroke team: 35.2 (26.5, 43.7) (n=49), day hospital: 32.7 (26.8, 39.2) (n=50); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: Median (IQR) SF-36 Mental health at 6 months; Domiciliary stroke team: 57.4 (49.9, 62.9) (n=49), day hospital: 57.1 (50.6, 63.0) (n=50); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

Protocol outcome 3: Length of stay at End of follow up
- Actual outcome for Adults: Median (IQR) length of stay at 6 months; Domiciliary stroke team: 7 (2, 30) (n=54), day hospital: 11 (4, 26) (n=58); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

Protocol outcome 4: Admissions to hospital at End of follow-up
- Actual outcome for Adults: Number of patients readmitted at 6 months; Domiciliary stroke team: 12/54 (22%), day hospital: 13/58 (22%); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

Protocol outcome 5: GP presentations at End of follow-up

Study	Roderick 2001[198]
- Actual outcome for Adults: Number of patients attending GP at 6 months; Domiciliary stroke team: 49/54 (91%), day hospital: 55/58 (95%); Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Readmission at 7 and 28 days

Study	Rodgers 1997[199]
Study type	RCT (Patient randomised; Parallel)
Number of participants	92
Countries and setting	Location: UK: 3 acute hospitals in Newcastle upon Tyne (Freeman Hospital, Royal Victoria Infirmary and Newcastle General Hospital)
Duration of study	Follow-up of patients: 7 to 10 days and 3 months
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Patients recovering from a stroke. Home address in Newcastle; not living in residential or nursing home care prior to incident stroke; not severely handicapped prior to incident stroke (Oxford Handicap Scale 0-3); no other condition likely to preclude rehabilitation; medically stable with a Barthel Activities of Daily Living Index between 5 and 19 at 72 hours post-stroke
Exclusion criteria	None apart from above
Recruitment/selection of patients	All patients admitted with acute stroke to the 3 Newcastle acute hospitals between 1 February 1995 and 31 January 1996 identified within 48 hours of admission
Age, gender and ethnicity	Median age: 73 (range 44-93) years; 42/92 (46%) female
Further population details	Living alone: 43/92 (47%)
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=46) Intervention 1: Hospital at home (early discharge) Type of service: community based stroke team that provided an in reach service to 3 local acute hospitals, visiting patients prior to discharge. Multi-disciplinary team of occupational therapist, physiotherapist, speech and language therapist, social worker. Nursing provided by the primary care team. GP had clinical responsibility, with support from a consultant working in stroke medicine. The stroke

Study	Rodgers 1997[199]
	team used a key worker approach and patients held a copy of their record which they or their carer could add to. Review meetings involved patients and carers in their homes. Care available 24 hours a day if required Concurrent medication/care: Not stated Duration: Not stated (no time limit) (n=46) Intervention 2: Conventional in-patient hospital and community care; 1 hospital had a dedicated inpatient stroke service; in the other 2 hospitals, stroke patients were cared for on general medical or care of the elderly wards; discharge planning and services post-discharge arranged and provided according to the usual practice of each participating ward or unit; community support by primary care team, community rehabilitation services, outpatient services and social services as appropriate. Concurrent medication/care: Not stated Duration: Not stated
Funding	National CVD & Stroke R & D Programme; Newcastle Health Authority Primary Care Development Fund.
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community versus hospital Protocol outcome 1: Mortality at 3 months - Actual outcome for Adults: Mortality at 3 months; Community: 1/46; hospital: 4/46; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Admission to hospital at 3 months - Actual outcome for Adults: Admission to hospital at 3 months; Community: 5/46; hospital: 5/46; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period; Quality of life

Study	Ronning 1998[202]
Study type	RCT (Patient randomised; Parallel)
Number of participants	251
Countries and setting	Rehabilitation unit in the Central Hospital of Ahershus in Norway (generalised unit physically separated from the stroke unit, which rehabilitates patients with a disabling illness not exclusively stroke patients)
Duration of study	7 months

Study	Ronning 1998[202]
Stratum	Early discharge
Subgroup analysis within study	-
Inclusion criteria	Acute (first or recurrent) stroke patients aged 60 or older, with a Scandinavian Stroke Scale (SSS) score between 12 and 52, who were conscious on admission, and who could cooperate in the rehabilitation programme (that is, scored at least 4 points on the subject orientation section of the SSS); patients with malignant diseases not in the terminal stages were included.
Exclusion criteria	Comatose or somnolent on admission (even if they showed improvement in the first few days); admitted from nursing homes
Recruitment/selection of patients	Assessed for eligibility within the first day after admission to hospital
Age, gender and ethnicity	Mean (SD) age: hospital: 75.5 (6.7); municipality: 76.5 (6.4) years; women: hospital: 60/127 (47.2%); municipality: 60/124 (48.4%); ethnicity not stated
Further population details	Not stated
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=127) Intervention 1: Hospital rehabilitation unit (after initial short length of stay in acute stroke unit or general medical ward): patients had access to a coordinated multidisciplinary rehabilitation team of nurses; physical, occupational and speech therapists; a social worker and a neurologist. The staff is specially trained to treat and rehabilitate stroke patients and they take part in education programmes to improve their knowledge of stroke. Patients assessed on arrival by members of the multidisciplinary team to identify problems affecting activities of daily living, speech problems and disturbances affecting their living at home. Spouses participated routinely in meetings. Long- and short-term goals were planned and each patient had 1 therapist coordinating the rehabilitation. The staff were instructed in the Bobath technique, which was the main approach for physical and functional rehabilitation. Concurrent medication/care: Not stated Duration: Mean 27.8 days (n=124) Intervention 2: Health services in the municipality (after initial short length of stay in acute stroke unit or general medical ward): most municipalities have a nursing home that provides rehabilitation through a multidisciplinary staff (in-patient or day patient) and further ambulatory rehabilitation by a visiting physical therapist, speech therapist and/or nurse. Municipalities offer access to primary health care including physical therapy, occupational therapy, speech therapy and nurse support. Concurrent medication/care: Not stated Duration: Not stated

Study	Ronning 1998[202]
Funding	Academic or government funding (National Association for Heart and Vascular Diseases)

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Hospital rehabilitation unit versus Health services in the municipality

Protocol outcome 1: Mortality at End of follow-up
- Actual outcome for Adults: Mortality at 7 months; Hospital rehabilitation unit: 12/127 (9.4%), Health services in the municipality: 20/124 (16.1%); Risk of bias: High; Indirectness of outcome: No indirectness

Protocol outcome 2: Quality of life at End of follow up
- Actual outcome for Adults: SF-36 Physical functioning at 7 months; Hospital rehabilitation unit: 49 (34) (n=82), Health services in the municipality: 48 (36) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: SF-36 Role Physical at 7 months; Hospital rehabilitation unit: 47 (40) (n=82), Health services in the municipality: 49 (41) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: SF-36 Bodily Pain at 7 months; Hospital rehabilitation unit: 42 (14) (n=82), Health services in the municipality: 42 (14) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: SF-36 General Health at 7 months; Hospital rehabilitation unit: 52 (21) (n=82), Health services in the municipality: 55 (22) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: SF-36 Vitality at 7 months; Hospital rehabilitation unit: 48 (20) (n=82), Health services in the municipality: 46 (18) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: SF-36 Social Functioning at 7 months; Hospital rehabilitation unit: 75 (30) (n=82), Health services in the municipality: 75 (26) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: SF-36 Role Emotional at 7 months; Hospital rehabilitation unit: 87 (31) (n=82), Health services in the municipality: 84 (35) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Adults: SF-36 Mental Health Domain at 7 months; Hospital rehabilitation unit: 71 (17) (n=82), Health services in the municipality: 69 (15) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness

Study	Ronning 1998[202]
- Actual outcome for Adults: SF-36 Mental Health Summary score at 7 months; Hospital rehabilitation unit: 70 (19) (n=82), Health services in the municipality: 70 (17) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: SF-36 Physical Health Summary score at 7 months; Hospital rehabilitation unit: 47 (20) (n=82), Health services in the municipality: 48 (19) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Adults: SF-36 Health Change at 7 months; Hospital rehabilitation unit: 4 (0.8) (n=82), Health services in the municipality: 4 (0.9) (n=65); Risk of bias: All domain – very high, Selection - high, Blinding - high, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - high, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period

Study	Rudd 1997[208]
Study type	RCT (Patient randomised; Parallel)
Number of participants	331
Countries and setting	Location: London, UK: 2 teaching hospitals
Duration of study	Follow- up of patients: 2, 4 and 6 months and 1 year
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Patients recovering from a stroke
Exclusion criteria	Patients were excluded if they lived too far away for the team to visit.
Recruitment/selection of patients	A hospital based stroke register was maintained at St Thomas' and King's College Hospitals, London between January 1993 and July 1995. Twice weekly checks of the wards were undertaken by 2 dedicated research associates with nursing training. If patients lived alone, they

Study	Rudd 1997[208]
	needed to be able to perform functional independent transfer, and if they lived with a willing carer they needed to be able to perform transfer with assistance. The point at which these criteria were met was decided after consultation with the hospital physiotherapist. All patients were assessed within 1 working day of notification by a consultant physician or medical registrar.
Age, gender and ethnicity	Mean age: treatment = 70 (SD 11); control = 72 (SD 12); 185/331 (56%) male
Further population details	113/331 (34%) lived alone
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=167) Intervention 1: Hospital at home (early discharge) Type of service: co-ordinated by hospital based consultant, community based nursing and therapy (physiotherapy, occupational therapy, speech and language therapy; therapy aide); 24 hour care not available. Remained in hospital until the required package of social service care could be organised and any home adaptations undertaken. A store of commodes, high chairs and toilet frames was kept by the team to expedite discharge. Patients were assessed for rehabilitation needs before discharge in conjunction with the hospital based therapists to set initial objectives and to ensure continuity of care. After discharge, patients were given a planned course of domiciliary physiotherapy, occupational therapy and speech therapy, with visits as frequently as considered appropriate (maximum 1 daily visit from each therapist). Each patient had an individual care plan which was reviewed at a weekly team meeting; on discharge (at maximum 3 months), patients were referred to conventional services when appropriate. All other services apart from therapy were as for control group (no augmentation of social services resources). Concurrent medication/care: Not stated Duration: Maximum 3 months (n=164) Intervention 2: hospital care and hospital organised rehabilitation. Treatment, discharge planning and outpatient care in the normal way; about half the patients treated in stroke unit, the rest in general medical or elderly care wards. Outpatient resources available included a hospital based stroke clinic, geriatric day hospital, generic domiciliary physiotherapy and speech and language therapy, hospital outpatient physiotherapy and usual community resources. Maximum level of home care available was 3 one-hour visits daily by a home help for personal care, meals on wheels and community nurse visits for specific tasks. Concurrent medication/care: Not stated Duration: Not stated
Funding	The Stroke Association, Lambeth, Southwark and Lewisham Health Authority, the Special Trustees of St Thomas's Hospital, the Nuffield Provincial Hospitals Trust, Wandsworth Health Gain Fund.
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Community versus hospital	

Study	Rudd 1997[208]
Protocol outcome 1: Mortality at 1 year - Actual outcome for Adults: Mortality at 1 year; Community: 26/167; hospital: 34/164; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Patient satisfaction at 1 year - Actual outcome for Adults: Patient satisfaction at 1 year; Community: 56/136; hospital: 46/126; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 3: Carer satisfaction at 1 year - Actual outcome for Adults: Carer satisfaction (overall) at 1 year; Community: 68/82; hospital: 52/63; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 4: Length of stay at 1 year - Actual outcome for Adults: Length of stay at 1 year; Community: 12 (19) 167; hospital: 18 (24) 164; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 5: Admissions to hospital at 1 year - Actual outcome for Adults: Admissions to hospital at 1 year; Community: 44/167; hospital: 42/164; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 6: Caregiver burden at 1 year - Actual outcome for Adults: Caregiver strain index at 1 year; Community: 5 (4) 75; hospital: 4 (3) 59; Risk of bias: All domain - low, Selection - low, Blinding - Low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Number of presentations to Emergency Department during the study period; Number of GP presentations during the study period; Readmission at 7 and 28 days; Length of hospital stay during the study period; Quality of life

Study	Santana 2016[211]
Study type	RCT (Patient randomised; Parallel)
Number of studies (number of participants)	1 (n=190)
Countries and setting	Denmark
Line of therapy	1st line
Duration of study	Intervention + follow up: follow-up- 6 months
Method of assessment of guideline condition	Adequate method of assessment/diagnosis

Study	**Santana 2016[211]**
Stratum	Early discharge
Subgroup analysis within study	Not applicable
Inclusion criteria	Stroke patients aged 25-85 years admitted to the stroke unit who had some residual disability in the form of an initial Functional Independence Measure of up to 100, no significant previous neurological disability
Exclusion criteria	Major speech and language problems preventing participation in the study, major psychological illness or dementia, other severe comorbidity, pregnancy or transfer to another acute care hospital for more than5 days.
Recruitment/selection of patients	Patients recruited with a clinical definition of stroke(confirmed on brain imaging) who were admitted to the stroke unit of the hospital.
Age, gender and ethnicity	Age - Mean (range): EHSD- 67.5 (40-84); control- 66.5 (35-84). Gender (M:F): female %- EHDS group 51%; control-43%. Ethnicity:
Further population details	-
Indirectness of population	No indirectness
Interventions	(n=95) Intervention 1: Community-based rehabilitation services. Early home supported discharge group (EHSD) – rehabilitation in the stroke unit and at home EHSD team of therapists included 2 physiotherapists, 2 occupational therapists and a psychologist. Patients and carers received education on healthy behaviours and information about stroke, its consequences, how to best participate in rehabilitation and how to find help within their communities. The team provided information and training tailored to the patient's needs; the mix of physiotherapy, occupational therapy and psychological sessions was also adapted to the specific condition of each patient. Rehabilitation was focused on daily activities valued by the patient in their usual context. EHSD team worked with the patients to provide approximately 8 home based training. Duration: 6 months. Concurrent medication/care: not stated. (n=95) Intervention 2: Hospital-based rehabilitation services. Usual care group Patients received rehabilitation as part of standard care in the stroke unit. Patients received information from the case manager about services available in the community, but no further specific input was provided. They began their rehabilitation as part of standard care in the stroke unit and then accessed the standard rehabilitation available in the region following discharge. The usual care rehabilitation frequently focused on components of training of impairments, such as ambulatory rehabilitation, with less emphasis on understanding how skills would be transferred in to normal living. Access to healthcare professionals was less easy for the usual care group and it was to address questions arising during rehabilitation. Duration: 6 months. Concurrent medication/care: Not stated.
Funding	Academic or government funding

Study	Santana 2016[211]
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: COMMUNITY-BASED REHABILITATION SERVICES versus HOSPITAL-BASED REHABILITATION SERVICES Protocol outcome 1: Length of hospital stay at during study period - Actual outcome: Length of stay in the stroke unit at 6 months; Group 1: mean 9.8 (SD 5.3); n=95, Group 2: mean 10 (SD 5.3); n=95; Risk of bias: All domain - High, Selection - Low, Blinding - High, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Quality of life at during study period; Avoidable adverse events at during study period; Patient and/or carer satisfaction at during study period; Number of presentations to Emergency Department at during study period; Number of admissions to hospital at After 28 days of first admission; Number of GP presentations at during study period; Readmission at 7 and 28 days; Mortality at during study period; Quality of life

Study	Thorsen 2005[243] Thorsen 2006[244] von Koch 2000[252] von Koch 2001[251]
Study type	RCT (Patient randomised; Parallel)
Number of participants	83
Countries and setting	Stroke unit of the Neurology Department of Huddinge University Hospital in Stockholm, Sweden
Duration of study	5 years
Stratum	Early discharge
Subgroup analysis within study	None
Inclusion criteria	Mild to moderate impairments after first or recurrent stroke according to clinical criteria of the WHO
Exclusion criteria	Not stated
Recruitment/selection of patients	Patients admitted to the stroke unit of the Neurology Department of Huddinge University Hospital in Stockholm, Sweden from September 1993 to April 1996, diagnosed with first or recurrent stroke according to clinical criteria of the WHO were screened for inclusion 5-7 days after stroke onset
Age, gender and ethnicity	Overall (83 patients): mean 72 years; of the 54 followed up at 5 years (excluding those who died, were lost to follow up or declined), mean 71 years; Home rehabilitation group: 15 men/15 women (50% women); Conventional rehabilitation group: 14 men/10 women (42% women); ethnicity not stated
Further population details	Living with spouse: 69%

Study	Thorsen 2005[243] Thorsen 2006[244] von Koch 2000[252] von Koch 2001[251]
Extra comments	
Indirectness of population	No indirectness
Interventions	(n=42) Intervention 1: Early supported hospital discharge (after initial medical care and rehabilitation in the stroke unit) to a home rehabilitation group (HRG). An outreach team of occupational therapists, physiotherapists and a speech-and-language pathologist provided services; the duration, frequency and content of the intervention were decided on together with the patient and his or her family. Mean number of home visits was 12; most common foci of home visits were speech and communication, ADL and ambulation. Concurrent medication/care: Not stated Duration: Mean 14 weeks (n=41) Intervention 2: Conventional rehabilitation group (CRG) (after initial medical care and rehabilitation in the stroke unit). If required, and after evaluation by specialists, patients in CRG received additional rehabilitation in the Geriatrics or Rehabilitation Department. The content and duration did not adhere to a standardised programme but rather reflected services available within the District Health Authority. Concurrent medication/care: Not stated Duration: Not stated
Funding	Academic or government funding (Swedish Association of Neurologically Disabled; Swedish Stroke Association; Swedish Association of Registered Physiotherapists; Centre for Health Care Sciences, Karolina Institute)

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: Home rehabilitation group versus Conventional rehabilitation group

Protocol outcome 1: Mortality at End of follow-up
- Actual outcome for Adults: Mortality at 5 years; Home rehabilitation group: 8/42 (19%), Conventional rehabilitation group: 12/41 (29%); Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

Protocol outcome 2: Adverse events at End of follow up
- Actual outcome for Adults: Falls at 5 years; Home rehabilitation group: 19/30 (63%), Conventional rehabilitation group: 14/23 (61%); Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

Protocol outcome 3: Length of stay at index admission
- Actual outcome for Adults: Length of stay at index admission; Home rehabilitation group: 14 days, Conventional rehabilitation group: 30 days; Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

Study	Thorsen 2005[243] Thorsen 2006[244] von Koch 2000[252] von Koch 2001[251]
Protocol outcome 4: GP presentations at End of follow up - Actual outcome for Adults: Number of patients presenting to GPs at 5 years; Home rehabilitation group: 25/30 (83%), Conventional rehabilitation group: 22/24 (92%); Risk of bias: All domain - high, Selection - high, Blinding - low, Incomplete outcome data - Low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Avoidable adverse events during the study period; Patient and/or carer satisfaction during the study period; Number of presentations to Emergency Department during the study period; Readmission at 7 and 28 days; Quality of life