GRADE tables for review question: B.1a What physical rehabilitation interventions are effective and acceptable for adults with complex rehabilitation needs after traumatic injury?

Early weight-bearing to mobilise

Table 11: Clinical evidence profile for early weight-bearing: Early weight-bearing versus late weight-bearing in unstable ankle fracture rehabilitation (outcomes reported as counts (%) and analysed accordingly)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early weight-bearing	Late weight-bearing	Relative (95% CI)	Absolute		
Return to work (measured using number of participants returned to work at each time point) - 6 weeks post-operation (intervention completion)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	23/49 (46.9%)	22/46 (47.8%)	RR 0.98 (0.64 to 1.5)	10 fewer per 1000 (from 172 fewer to 239 more)	VERY LOW	CRITICAL
Return to work (measured using number of participants returned to work at each time point) - 3 month post-operation (6 week follow-up)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	38/49 (77.6%)	36/44 (81.8%)	RR 0.95 (0.77 to 1.16)	41 fewer per 1000 (from 188 fewer to 131 more)	VERY LOW	CRITICAL
Return to work (measured using number of participants returned to work at each time point) - 6 months post-operation												
1 (Dehgha	randomised trials	very serious[1]	no serious	no serious	no serious	none	44/46 (95.7%)	40/43 (93%)	RR 1.03 (0.93 to	28 more per 1000	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early weight-bearing	Late weight-bearing	Relative (95% CI)	Absolute		
n 2016)			inconsistency	indirectness	imprecision				1.14)	(from 65 fewer to 130 more)		
Return to work (measured using number of participants returned to work at each time point) - 12 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	49/50 (98%)	40/43 (93%)	RR 1.05 (0.96 to 1.15)	47 more per 1000 (from 37 fewer to 140 more)	LOW	CRITICAL

CI: Confidence interval; RR: Risk ratio
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDSs (for all RR 0.8 and 1.25)
3 95% CI crosses 1 MID (for all RR 0.8 and 1.25)

Table 12: Clinical evidence profile for early weight-bearing: Early weight-bearing versus late weight-bearing in unstable ankle fracture rehabilitation (outcomes reported as means only and analysed accordingly)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early weight-bearing	Late weight-bearing	Early weight-bearing mean	Late weight-bearing mean		
Return to work (measured using total days off work [mean]; better indicated by lower values) – Time point not reported												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early weight-bearing	Late weight-bearing	Early weight-bearing mean	Late weight-bearing mean		
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	40	37	51.2[3]	47.8[3]	VERY LOW	CRITICAL
Changes in mobility (measured using total ankle dorsiflexion/plantar flexion range of motion in degrees; better indicated by higher values) – 6 weeks post-operation (intervention completion)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	53	54	41[4]	29[4]	VERY LOW	CRITICAL
Changes in mobility (measured using total ankle dorsiflexion/plantar flexion range of motion in degrees; better indicated by higher values) – 3 months post-operation (6 week follow-up)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	49	51	49[5]	49[5]	VERY LOW	CRITICAL
Changes in mobility (measured using total ankle dorsiflexion/plantar flexion range of motion in degrees; better indicated by higher values) – 6 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	46	46	56[5]	53[5]	VERY LOW	CRITICAL
Changes in mobility (measured using total ankle dorsiflexion/plantar flexion range of motion in degrees; better indicated by higher values) – 12 months post-operation (6 week follow-up)												
1 (Dehghan	randomised trials	very serious[1]	no serious	no serious	very serious[2]	none	50	52	60[5]	61[5]	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early weight-bearing	Late weight-bearing	Early weight-bearing mean	Late weight-bearing mean		
2016)			inconsistency	indirectness								
Changes in mobility (measured using Olerud/Molander ankle functions scores; range 0-100; better indicated by higher values) – 6 weeks post-operation (intervention completion)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	53	54	45[6]	32[6]	VERY LOW	CRITICAL
Changes in mobility (measured using Olerud/Molander ankle functions scores; range 0-100; better indicated by higher values) – 3 months post-operation (6 week follow-up)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	49	51	62[5]	56[5]	VERY LOW	CRITICAL
Changes in mobility (measured using Olerud/Molander ankle functions scores; range 0-100; better indicated by higher values) – 6 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	46	46	77[5]	73[5]	VERY LOW	CRITICAL
Changes in mobility (measured using Olerud/Molander ankle functions scores; range 0-100; better indicated by higher values) – 12 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	50	52	89[5]	85[5]	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early weight-bearing	Late weight-bearing	Early weight-bearing mean	Late weight-bearing mean		
Overall quality of life (measured using SF-36 Physical component score; range 0-100; better indicated by higher values) – 6 weeks post-operation (intervention completion)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	53	54	51[7]	42[7]	VERY LOW	CRITICAL
Overall quality of life (measured using SF-36 Physical component score; range 0-100; better indicated by higher values) – 3 months post-operation (6 weeks follow-up)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	49	51	66[5]	64[5]	VERY LOW	CRITICAL
Overall quality of life (measured using SF-36 Physical component score; range 0-100; better indicated by higher values) – 6 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	46	46	79[8]	72[8]	VERY LOW	CRITICAL
Overall quality of life (measured using SF-36 Physical component score; range 0-100; better indicated by higher values) – 12 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	50	52	85[9]	79[9]	VERY LOW	CRITICAL
Overall quality of life (measured using SF-36 mental component score; range 0-100; better indicated by higher values) – 6 weeks post-operation (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early weight-bearing	Late weight-bearing	Early weight-bearing mean	Late weight-bearing mean		
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	53	54	66[10]	54[10]	VERY LOW	CRITICAL
Overall quality of life (measured using SF-36 mental component score range 0-100; better indicated by higher values) – 3 months post-operation (6 weeks follow-up)												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	49	51	74[5]	73[5]	VERY LOW	CRITICAL
Overall quality of life (measured using SF-36 mental component score; range 0-100; better indicated by higher values) – 6 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	46	46	84[11]	79[11]	VERY LOW	CRITICAL
Overall quality of life (measured using SF-36 mental component score; range 0-100; better indicated by higher values) – 12 months post-operation												
1 (Dehghan 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	50	52	87[12]	83[12]	VERY LOW	CRITICAL

SF-36: 36-item Short Form Survey
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to lack of SD reporting and no published MIDs, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analysis performed by the authors, there is no significant difference between the means of each group (p=0.72, unclear which statistical test the authors used)

4 According to the statistical test performed by the authors, the mean is significantly higher (better) in the intervention group (p<0.0001, unclear which statistical test the authors used)
5 According to the statistical test performed by the authors, there is no significant difference between the means of each group (p value not reported, unclear which statistical test the authors used)
6 According to the statistical test performed by the authors, the mean is significantly higher (better) in the intervention group (p=0.0007, unclear which statistical test the authors used)
7 According to the statistical test performed by the authors, the mean is significantly higher (better) in the intervention group (p=0.0008, unclear which statistical test the authors used)
8 According to the statistical analysis performed by the authors, there is no significant difference between the means of each group (p=0.07, unclear which statistical test the authors used)
9 According to the statistical test performed by the authors, the mean is significantly higher (better) in the intervention group (p=0.04, unclear which statistical test the authors used)
10 According to the statistical test performed by the authors, the mean is significantly higher (better) in the intervention group (p=0.0008, unclear which statistical test the authors used)
11 According to the statistical analysis performed by the authors, there is no significant difference between the means of each group (p=0.08, unclear which statistical test the authors used)
12 According to the statistical analysis performed by the authors, there is no significant difference between the means of each group (p=0.09, unclear which statistical test the authors used)

Table 13: Clinical evidence profile for early weight-bearing: Early ambulation versus late ambulation in hip fracture rehabilitation (outcomes reported as means (range) and analysed accordingly)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early ambulation	Delayed ambulation	Early ambulation mean (range)	Delayed ambulation mean (range)		
Changes in mobility (measured using distance walked in m; better indicated by higher values) - Day 7 post-operation (intervention completion)												
1 (Oldmeadow 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	29	31	66 (not reported)[3]	29.71 (0 to 150)[3]	VERY LOW	CRITICAL

m: metre
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to lack of reported SD and published MIDs, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.

3 According to the statistical test performed by the authors, the mean is significantly higher (better) in the intervention group (p=0.03, Wilcoxon rank sum test)

Table 14: Clinical evidence profile for early weight-bearing: Early ambulation versus late ambulation in hip fracture rehabilitation (outcomes reported as counts (%) and analysed accordingly)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early ambulation	Delayed ambulation	Relative (95% CI)	Absolute		
Changes in ADL (measured as number of participants able to independently negotiate one step) - Day 7 post-operation (intervention completion)												
1 (Oldmeadow 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	10/23 (43.5%)	23/24 (95.8%)	RR 0.45 (0.28 to 0.73)	527 fewer per 1000 (from 259 fewer to 690 fewer)	LOW	CRITICAL
Changes in ADL (measured as number of participants able to independently transfer one step) - Day 7 post-operation (intervention completion)												
1 (Oldmeadow 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	16/26 (61.5%)	4/25 (16%)	RR 3.85 (1.49 to 9.93)	456 more per 1000 (from 78 more to 1000 more)	LOW	CRITICAL

ADL: Activities of daily living: CI: confidence interval; RR: Risk ratio
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2

Table 15: Clinical evidence profile for early weight-bearing: Weight-bearing versus non weight-bearing in hip fracture rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Weight-bearing	Non weight-bearing	Relative (95% CI)	Absolute		
Changes in mobility (measured using step test repetitions in affected leg range; better indicated by higher values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	37	-	MD 0.8 higher (0.26 lower to 1.86 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using step test repetitions in non-affected leg; better indicated by higher values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	37	-	MD 1.6 higher (0.01 lower to 3.21 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using velocity in m/sec; better indicated by higher values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	37	-	MD 0.06 higher (0.03 lower to 0.15 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using cadence in steps/sec; better indicated by higher values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	37	-	MD 0.2 higher (0.02 lower to 0.42 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using step length in affected leg in cm; better indicated by higher values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	22	-	MD 2.7 higher (6.81 lower to 12.21 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using step length in non-affected leg in cm; better indicated by higher values) - 2 weeks (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Weight-bearing	Non weight-bearing	Relative (95% CI)	Absolute		
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	19	22	-	MD 0.6 lower (8.01 lower to 6.81 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using time to stand in sec; better indicated by lower values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	37	-	MD 0.05 higher (0 to 0.1 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using time to sit up in sec; better indicated by lower values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	37	-	MD 0.03 higher (0.02 lower to 0.08 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using Physical Performance and Mobility Examination score; range 0-12; better indicated by higher values) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	37	-	MD 0.7 higher (0.53 lower to 1.93 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using lateral step up in affected leg) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	22/40 (55%)	7/37 (18.9%)	RR 2.91 (1.41 to 5.99)	361 more per 1000 (from 78 more to 944 more)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Weight-bearing	Non weight-bearing	Relative (95% CI)	Absolute		
Changes in mobility (measured using participants who became able to do lateral step up with affected leg) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	16/40 (40%)	6/37 (16.2%)	RR 2.47 (1.08 to 5.63)	238 more per 1000 (from 13 more to 751 more)	VERY LOW	CRITICAL
Changes in mobility (measured using lateral step up in non-affected leg) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	26/40 (65%)	21/37 (56.8%)	RR 1.15 (0.8 to 1.64)	85 more per 1000 (from 114 fewer to 363 more)	VERY LOW	CRITICAL
Changes in mobility (measured using participants who became able to do lateral step up with non-affected leg) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	15/40 (37.5%)	13/37 (35.1%)	RR 1.07 (0.59 to 1.93)	25 more per 1000 (from 144 fewer to 327 more)	VERY LOW	CRITICAL
Changes in mobility (measured using number of participants unable to walk 6 m) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	7/41 (17.1%)	4/39 (10.3%)	RR 1.66 (0.53 to 5.24)	68 more per 1000 (from 48 fewer to 435 more)	VERY LOW	CRITICAL
Changes in mobility (measured using number of participants able to walk 6 m with a frame) - 2 weeks (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Weight-bearing	Non weight-bearing	Relative (95% CI)	Absolute		
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20/41 (48.8%)	23/39 (59%)	RR 0.83 (0.55 to 1.24)	100 fewer per 1000 (from 265 fewer to 142 more)	VERY LOW	CRITICAL
Changes in mobility (measured using number of participants able to walk 6 m with 2 sticks) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	22/41 (53.7%)	7/39 (17.9%)	RR 2.99 (1.44 to 6.2)	357 more per 1000 (from 79 more to 933 more)	LOW	CRITICAL
Changes in mobility (measured using number of participants able to walk 6 m with 1 stick or no aid) - 2 weeks (intervention completion)												
1 (Sherrington 2003)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	8/41 (19.5%)	2/39 (5.1%)	RR 3.8 (0.86 to 16.82)	144 more per 1000 (from 7 fewer to 811 more)	VERY LOW	CRITICAL

CI: confidence interval; cm: centimetre; m: metre; MD: mean difference; RR: Risk ratio; sec: second
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for step test, affected leg +/-0.3; for step test, non-affected leg +/-0.65; for velocity +/-0.045; for cadence +/-0.165; for step length, affected leg +/-7.6; for time to stand +/-0.035; for time to sit up +/-0.035; for Physical Performance and Mobility Examination +/-1.25; for all RR 0.8 and 1.25)
3 95% CI crosses 2 MIDs (for step length, non-affected leg +/-4.65; for all RR 0.8 and 1.25)

Table 16: Clinical evidence profile for early weight-bearing: Comprehensive geriatric care versus orthopaedic care in hip fracture rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Comprehensive geriatric care	Orthopaedic care	Relative (95% CI)	Absolute		
Changes in mobility (measured using upright time in min; better indicated by higher values) - Day 4 (post-operation)												
1 (Taraldsen 2014)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	no serious imprecision	none	175	142	-	MD 12.5 higher (1.33 lower to 26.33 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using number of upright events range; better indicated by higher values) - Day 4 post-operation												
1 (Taraldsen 2014)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	175	142	-	MD 5.1 higher (0.85 to 9.35 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using Cumulative Ambulation Score; range 0-18; better indicated by higher values) - Day 1-3 post-operation												
1 (Taraldsen 2014)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	no serious imprecision	none	175	142	-	MD 0.5 higher (0.35 lower to 1.35 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using Short Physical Performance Battery score; range 0-12; better indicated by higher values) - Day 5 post-operation												
1 (Taraldsen 2014)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[3]	none	175	142	-	MD 0.6 higher (0.2 to 1 higher)	VERY LOW	CRITICAL
Changes in mobility (using upright time during a 24 hour period in min; better indicated by higher values) - Day 4 post-operation (during night, 00:00-06:00)												
1 (Taraldse	randomised trials	very serious[1]	no serious inconsiste	serious[2]	no serious imprecisio	none	175	142	-	MD 0.5 lower (2.14	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Comprehensive geriatric care	Orthopaedic care	Relative (95% CI)	Absolute		
n 2014)			ncy		n					lower to 1.14 higher)		
Changes in mobility (using upright time during a 24 hour period in min; better indicated by higher values) - Day 4 post-operation (during day, 06:00-12:00)												
1 (Taraldsen 2014)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[4]	none	175	142	-	MD 4.6 higher (33.24 lower to 42.44 higher)	VERY LOW	CRITICAL
Changes in mobility (using upright time during a 24 hour period in min; better indicated by higher values) - Day 4 post-operation (during afternoon, 12:00-18:00)												
1 (Taraldsen 2014)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	no serious imprecision	none	175	142	-	MD 4.9 higher (0.19 lower to 9.99 higher)	VERY LOW	CRITICAL
Changes in mobility (using upright time during a 24 hour period in min; better indicated by higher values) - Day 4 post-operation (during evening, 18:00-00:00)												
1 (Taraldsen 2014)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	no serious imprecision	none	175	142	-	MD 3.2 higher (0.59 lower to 6.99 higher)	VERY LOW	CRITICAL

CI: confidence interval; cm: centimetre; m: metre; MD: mean difference; min: minute
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB

2 Intervention is indirect: multi-disciplinary intervention that has an early mobilisation component
3 95% CI crosses 1 MID (for number of upright events +/-8.25; for Short Physical Performance Battery +/-0.8)
4 95% CI crosses 2 MIDs (for upright time between 06:00-12:00 +/-11.45)

Exercise class, reconditioning, cardiovascular and fitness training

Table 17: Clinical evidence profile for exercise class/reconditioning/cardiovascular/fitness training: Aerobic exercise + standard rehabilitation versus standard rehabilitation only in SCI rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aerobic exercise + standard rehabilitation	Standard rehabilitation only	Aerobic exercise + standard rehabilitation	Standard rehabilitation only		
Quality of Life (measured using WHOQOL-Bref-Tr physical domain score; scale not reported; better indicated by higher values) - 6 weeks from baseline (during intervention)												
1 (Akkurt 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	17	16	Median (range): 11.4 (6.9-14.3)[3]	Median (range): 10.86 (8.6-13.7)[3]	VERY LOW	IMPORTANT
Quality of Life (measured using WHOQOL-Bref-Tr physical domain score; scale not reported; better indicated by higher values) - 12 weeks from baseline (intervention completion)												
1 (Akkurt 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	17	16	Median (range): 10.9 (7.4-13.1)[3]	Median (range): 10.9 (6.3-14.3)[3]	VERY LOW	IMPORTANT
Quality of Life (measured using WHOQOL-Bref-Tr psychological domain score; scale not reported; better indicated by higher values) - 6 weeks from baseline (during intervention)												
1 (Akkurt	randomis	very	no	no	very	none	17	16	Median	Median	VERY	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aerobic exercise + standard rehabilitation	Standard rehabilitation only	Aerobic exercise + standard rehabilitation	Standard rehabilitation only		
2017)	ed trials	serious[1]	serious inconsistency	serious indirectness	serious[2]				(range): 13.3 (10.0-7.3)[3]	(range): 12.0 (7.3-14.7)[3]	LOW	
Quality of Life (measured using WHOQOL-Bref-Tr psychological domain score; scale not reported; better indicated by higher values) - 12 weeks from baseline (intervention completion)												
1 (Akkurt 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	17	16	Median (range): 13.7 (5.0-17.0)[3]	Median (range): 12.7 (9.0-17.0)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using FIM score; range 18-126; better indicated by higher values) - 6 weeks from baseline (during intervention)												
1 (Akkurt 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	17	16	Median (range): 63 (50-118)[3]	Median (range): 72 (56-94)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using FIM score; range 18-126; better indicated by higher values) - 12 weeks from baseline (intervention completion)												
1 (Akkurt 2017)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	17	16	Median (range): 62.5 (50-118)[3]	Median (range): 74 (56-119)[3]	VERY LOW	IMPORTANT

ADL: Activities of daily living; FIM: Functional independence measure; IQR: Interquartile range; WHOQOL-Bref-Tr: World Health Organization abbreviated Quality of Life Questionnaire [Turkish language]

1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels
3 According to the statistical analyses performed by the author, the median difference was not statistically significant between groups (p>0.05, Mann-Whitney U test)

Table 18: Clinical evidence profile for exercise class/reconditioning/cardiovascular/fitness training: Upper-body exercise training + standard rehabilitation versus standard rehabilitation only in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upper body exercise training + standard rehabilitation	Standard rehabilitation only	Relative	Absolute (95% CI)		
Changes in mobility (measured using Timed Up and Go test in sec; better indicated by lower values) - 4 weeks from baseline (intervention completion)												
1 (Mendelsohn 2008)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	9	9	-	MD 14.8 lower (24.64 to 4.96 lower)	VERY LOW	CRITICAL
Changes in mobility (measured using 2MWT in meters; better indicated by higher values) - 4 weeks from baseline (intervention completion)												
1 (Mendelsohn 2008)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	10	10	-	MD 154.5 higher (105.49 to 203.51 higher)	LOW	CRITICAL
Changes in mobility (measured using 10MWT in meters; better indicated by higher values) - 4 weeks from baseline (intervention completion)												
1 (Mendelsohn 2008)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	10	10	-	MD 146 higher (27.82 to 264.18 higher)	VERY LOW	CRITICAL
Changes in ADL (measured using FIM score; range 18-126; better indicated by higher values) - 4 weeks from baseline (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Upper body exercise training + standard rehabilitation	Standard rehabilitation only	Relative	Absolute (95% CI)		
1 (Mendelsohn 2008)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	10	10	-	MD 3.4 higher (2.61 lower to 9.41 higher)	VERY LOW	IMPORTANT

2MWT: 2 minute walk test; 10MWT: 10 minute walk test; CI: confidence interval; FIM: Functional independence measure; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for TUG +/-6.15; for 10MWT +/-37.85; for FIM +/-4.15)

Table 19: Clinical evidence profile for exercise class/reconditioning/cardiovascular/fitness training: Aerobic exercise versus standard rehabilitation in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aerobic exercise	Standard rehabilitation	Relative	Absolute (95% CI)		
Changes in mobility (measured using SAM; better indicated by higher values) - 12 months from baseline (intervention completion)												
1 (Resnick 2007)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	35	40	-	MD 2399 higher (363.63 lower to	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Aerobic exercise	Standard rehabilitation	Relative	Absolute (95% CI)		
										5161.63 higher)[3]		
Changes in mobility (measured using YPAS-E in hours; better indicated by higher values) - 2 months follow-up (during intervention)												
1 (Resnick 2007)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious imprecision[4]	none	40	42	-	MD 0.07 higher (0.93 lower to 1.07 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using YPAS-E in hours; better indicated by higher values) - 6 months from baseline (during intervention)												
1 (Resnick 2007)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	43	-	MD 1.25 higher (0.5 to 2 higher)	LOW	IMPORTANT
Changes in mobility (measured using YPAS-E in hours; better indicated by higher values) - 12 months from baseline (intervention completion)												
1 (Resnick 2007)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	35	40	-	MD 2.42 higher (1.05 to 3.79 higher)	MODERATE	IMPORTANT

CI: confidence interval; SAM: Step Activity Measure; YPAS-E; Yale Physical Activity Survey Exercise sub-score
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for SAM +/-3239.98; for YPAS-E +/-0.714)
3 It should be noted that, in contrast to our findings, the analysis performed by the study authors concluded that this result was significantly higher (better) in the intervention group (p=0.03, Wald statistics)
4 95% CI crosses 2 MIDs (for YPAS-E +/-0.714)

Table 20: Clinical evidence profile for exercise class/reconditioning/cardiovascular/fitness training: Step exercises versus control (no details reported) in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Step exercises	Control	Relative	Absolute (95% CI)		
Changes in mobility (measured using velocity in m/sec; better indicated by higher values) - At intervention completion (time of measurement not clearly reported)												
1 (Sherrington 1997)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20	20	-	MD 0.01 higher (0.2 lower to 0.22 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using cadence in step/min; better indicated by higher values) - At intervention completion (time of measurement not clearly reported)												
1 (Sherrington 1997)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20	20	-	MD 1.8 lower (21.96 lower to 18.36 higher)	VERY LOW	CRITICAL

1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (for velociy +/-0.165; for cadence +/-16.05)

Gait re-education

Table 21: Clinical evidence profile for gait re-education: Body weight supported gait training (BWSGT) on a fixed track versus standard care

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWSGT on a fixed track	Standard care	Relative (95% CI)	Absolute		
Patient acceptability: Satisfaction with Abilities and Well-Being Scale (SAWS; scale not reported; better indicated by lower values) - at week 13 from baseline (after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	14	12	-	MD 3.4 higher (2.59 lower to 9.39 higher)	VERY LOW	CRITICAL
Patient acceptability: Satisfaction with Abilities and Well-Being Scale (SAWS; scale not reported; better indicated by lower values) - at week 17 from baseline (4 weeks after intervention completion) (Better indicated by lower values)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[4]	none	14	12	-	MD 1 higher (3.57 lower to 5.57 higher)	VERY LOW	CRITICAL
Overall quality of life: SF-36 General health perception score[1] (scale not reported; better indicated by lower values) - at week 13 from baseline (after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	14	12	-	MD 0.3 lower (0.88 lower to 0.28 higher)	VERY LOW	IMPORTANT
Overall quality of life: SF-36 General health perception score[1] (scale not reported; better indicated by lower values) - at week 17 from baseline (4 weeks after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	14	12	-	MD 0.3 lower (0.96 lower to 0.36 higher)	VERY LOW	IMPORTANT
Overall quality of life: SF-36 Energy score[1] (scale not reported; better indicated by lower values) - at week 13 from baseline (after intervention completion)												
1 (Alexeev	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	14	12	-	MD 1 lower (3.27 lower	VERY LOW	IMPORTANT

a 2011)										to 1.27 higher)		
Overall quality of life: SF-36 Energy score[1] (scale not reported; better indicated by lower values) - at week 17 from baseline (4 weeks after intervention completion) (Better indicated by lower values)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	14	12	-	MD 3.3 higher (1.22 to 5.38 higher)	VERY LOW	IMPORTANT
Overall quality of life: SF-36 Mental health perception Score[1] (scale not reported; better indicated by higher values) - at week 13 from baseline (after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	14	12	-	MD 0.5 higher (0.85 lower to 1.85 higher)	VERY LOW	IMPORTANT
Overall quality of life: SF-36 Mental health perception Score[1] (scale not reported; better indicated by higher values) - at week 17 from baseline (4 weeks after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[3]	none	14	12	-	MD 0.4 higher (1.02 lower to 1.82 higher)	VERY LOW	IMPORTANT
Overall quality of life: SF-36 Fatigue score[1] (scale not reported; better indicated by higher values) - at week 13 from baseline (after intervention completion) (Better indicated by higher values)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[4]	none	14	12	-	MD 0 higher (2.06 lower to 2.06 higher)	VERY LOW	IMPORTANT
Overall quality of life: SF-36 Fatigue score[1] (scale not reported; better indicated by higher values) - at week 17 from baseline (4 weeks after intervention completion) (Better indicated by higher values)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[4]	none	14	12	-	MD 0.4 lower (3.21 lower to 2.41 higher)	VERY LOW	IMPORTANT

CI: Confidence interval; MD: Mean difference; SF-36: the Short Form (36) Health Survey
1 Study authors report using measurements derived from corresponding SF-36 domains, but not all questions.

2 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
3 Confidence intervals crosses 1 MID (for SF-36 General health perception score +/- 0.40; SF-36 Energy score +/- 2.15; SAWS +/- 4.45; SF-36 Mental health perception Score +/- 1.00)
4 Confidence intervals crosses 2 MIDs (for SF-36 Mental health perception Score +/- 1.00; SF-36 Fatigue score +/- 1.35)

Table 22: Clinical evidence profile for gait re-education: Body weight supported gait training (BWSGT) on a treadmill versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	BWSGT on a treadmill	Standard care	Relative (95% CI)	Absolute		
Patient acceptability: Satisfaction with Abilities and Well-Being Scale (SAWS; scale not reported; better indicated by lower values) - at week 13 from baseline (after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	9	12	-	MD 6.2 higher (1.03 lower to 13.43 higher)	VERY LOW	CRITICAL
Patient acceptability: Satisfaction with Abilities and Well-Being Scale (SAWS; scale not reported; better indicated by lower values) - at week 17 from baseline (4 weeks after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[2]	none	9	12	-	MD 0.2 lower (6.17 lower to 5.77 higher)	VERY LOW	CRITICAL
Overall quality of life: SF-36 General health perception score[4] (scale not reported; better indicated by lower values) - at week 13 from baseline (after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9	12	-	MD 0.2 lower (1.05 lower to 0.65 higher)	VERY LOW	CRITICAL

Overall quality of life: SF-36 General health perception score[4] (scale not reported; better indicated by lower values) - at week 17 from baseline (4 weeks after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	9	12	-	MD 0.7 lower (1.64 lower to 0.24 higher)	VERY LOW	CRITICAL
Overall quality of life: SF-36 Energy score[4] (scale not reported; better indicated by lower values) - at week 13 from baseline (after intervention completion)												
11 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	9	12	-	MD 0.9 lower (3.56 lower to 1.76 higher)	VERY LOW	CRITICAL
Overall quality of life: SF-36 Energy score[4] (scale not reported; better indicated by lower values) - at week 17 from baseline (4 weeks after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	9	12	-	MD 1.6 lower (4.91 lower to 1.71 higher)	VERY LOW	CRITICAL
Overall quality of life: SF-36 Mental health perception Score[4] (scale not reported; better indicated by higher values) - at week 13 from baseline (after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	Serious[3]	none	9	12	-	MD 1.2 higher (0.23 lower to 2.63 higher)	VERY LOW	CRITICAL
Overall quality of life: SF-36 Mental health perception Score[4] (scale not reported; better indicated by higher values) - at week 17 from baseline (4 weeks after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9	12	-	MD 0.3 lower (1.87 lower to 1.27 higher)	VERY LOW	CRITICAL
Overall quality of life: SF-36 Fatigue score[4] (scale not reported; better indicated by higher values) - at week 13 from baseline (after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9	12	-	MD 0.2 lower (2.82 lower to	VERY LOW	CRITICAL

										2.42 higher)		
Overall quality of life: SF-36 Fatigue score[4] (scale not reported; better indicated by higher values) - at week 17 from baseline (4 weeks after intervention completion)												
1 (Alexeeva 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9	12	-	MD 1.4 higher (1.69 lower to 4.49 higher)	VERY LOW	CRITICAL

CI: Confidence interval; MD: Mean difference; SF-36: Short Form Health Survey – 36 item
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (for SF-36 General health perception score +/- 0.40; SF-36 Fatigue score +/- 1.35; SF-36 Mental health perception Score +/- 1.00; SAWS +/- 4.45)
3 95% CI crosses 1 MID (for SF-36 General health perception score +/- 0.40; SF-36 Energy score +/- 2.15; SF-36 Mental health perception Score +/- 1.00; SAWS +/- 4.45)
4 Study authors report using measurements derived from corresponding SF-36 domains, but not all questions.

Table 23: Clinical evidence profile for gait re-education: Body-weight supported gait training versus over ground training in SCI rehabilitation (outcomes reported as medians (IQR) and analysed accordingly)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Body-weight supported gait training	Over ground training		
Changes in mobility (measured using FIM-L score in ASIA B + C patients; range 1-7; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	52	57	Median (IQR): 6 (1-6)[3]	Median (IQR): 6 (2-6)[3]	VERY LOW	CRITICAL
Changes in mobility (in UMN ASIA C + D who were able to walk at 6 months measured using FIM-L; range 1-7; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin	randomised trials	very serious[1]	no serious	no serious	very serious[2]	none	27	18	Median (IQR): 6	Median (IQR): 6 (	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Body-weight supported gait training	Over ground training		
2006)			inconsistency	indirectness					(6-7)[4]	6-7)[4]		
Changes in mobility (measured using velocity in ASIA C + D (UMN and LMN) patients in m/sec; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	35	33	Median (IQR): 1.1 (0.8-1.4)[5]	Median (IQR): 1.0 (0.7-1.5)[5]	VERY LOW	CRITICAL
Changes in mobility (in UMN ASIA C + D patients measured using velocity in m/sec; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	30	25	Median (IQR): 1.0 (0.6-1.5)[6]	Median (IQR): 1.2 (0.9-1.7)[6]	VERY LOW	CRITICAL
Changes in mobility (in UMN ASIA C + D who were able to walk at 6 months, measured using velocity in m/sec; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	27	18	Median (IQR): 1.1 (0.6-1.5)[7]	Median (IQR): 1.1 (0.4-1.7)[7]	VERY LOW	CRITICAL
Changes in mobility (in UMN ASIA C + D who were able to walk at 6 months, measured using distance in m; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin 2006)	randomised trials	very serious[1]	no serious inconsist	indirectn	very serious[2]	none	27	18	Median (IQR): 312	Median (IQR): 401 (366-	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Body-weight supported gait training	Over ground training		
			ency	ess					(165-477)[8]	483)[8]		
Changes in mobility (in UMN ASIA C + D who were able to walk at 6 months, measured using LEMS score; range 0-50; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	27	18	Median (IQR): 45 (43-49)[9]	Median (IQR): 45 (36-49)[9]	VERY LOW	CRITICAL
Changes in mobility (in UMN ASIA C + D who were able to walk at 6 months, measured using Walking Index for Spinal Cord Injury score; range 0-20; better indicated by higher values) - 6 months (3 months after intervention completion)												
1 (Dobkin 2006)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	27	18	Median (IQR): 18 (13-19)[10]	Median (IQR): 18 (13-19)[10]	VERY LOW	CRITICAL

ASIA: American Spinal Injury Association; FIM-L: Functional independence measure locomotion sub-scale; IQR: Interquartile range; LEMS: Lower extremity motor score; m: metre; UMN: upper motor neurone; SCI: Spinal cord injury; sec: second
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.39, regression analysis)
4 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.69, regression analysis)
5 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.65, regression analysis)
6 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.58, regression analysis)
7 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.98, regression analysis)
8 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.27, regression analysis)
9 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.45, regression analysis)
10 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.69, regression analysis)

Table 24: Clinical evidence profile for gait re-education: Body-weight supported gait training versus over ground training in SCI rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
Changes in mobility (in participants with SCI level of ASIA B measured using FIM-L; range 1-7; better indicated by higher values) - 6 weeks (during intervention)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	17	-	MD 0.01 higher (0.17 lower to 0.19 higher)	LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA B measured using FIM-L; range 1-7; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	13	16	-	MD 0.63 lower (1.67 lower to 0.41 higher)	VERY LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA B measured using LEMS; range 0-50; better indicated by higher values) - 6 weeks (during intervention)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	16	-	MD 0.5 lower (4.79 lower to 3.79 higher)	LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA B measured using LEMS; range 0-50; better indicated by higher values) - 12 weeks (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	13	16	-	MD 1.2 lower (8.08 lower to 5.68 higher)	VERY LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA B measured using walking distance in m; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	9	12	-	MD 5.7 lower (35.01 lower to 23.61 higher)	VERY LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA C + D measured using FIM-L; range 1-7; better indicated by higher values) - 6 weeks (during intervention)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	39	-	MD 0.9 lower (1.83 lower to 0.03 higher)	VERY LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA C + D measured using FIM-L; range 1-7; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	43	40	-	MD 0.8 lower (1.56 to 0.04 lower)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
Changes in mobility (in participants with SCI level of ASIA C + D measured using velocity in m/sec; better indicated by higher values) - 6 weeks (during intervention)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	29	-	MD 0.18 higher (0.05 lower to 0.41 higher)	VERY LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA C + D measured using velocity in m/sec; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	34	37	-	MD 0.01 higher (0.24 lower to 0.26 higher)	LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA C + D measured using LEMS; range 0-50; better indicated by higher values) - 6 weeks (during intervention)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	40	39	-	MD 0.4 lower (6.09 lower to 5.29 higher)	LOW	CRITICAL
Changes in mobility (in participants with SCI level of ASIA C + D measured using LEMS; range 0-50; better indicated by higher values) - 12 weeks (intervention completion) (Better indicated by higher values)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsist	no serious indirectne	no serious imprecisi	none	43	40	-	MD 1 lower (6.3 lower to 4.3	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
			ency	ss	on					higher)		
Changes in mobility (in participants with SCI level of ASIA C + D measured using walking distance in m; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Dobkin 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	34	36	-	MD 3.6 lower (95.27 lower to 88.07 higher)	LOW	CRITICAL

ASIA: American Spinal Injury Association; CI: Confidence interval; FIM-L: Functional independence measure locomotion sub-scale; LEMS: Lower extremity motor score; m: metre; MD: Mean difference; UMN: upper motor neurone; SCI: Spinal cord injury; sec: second
1 Very serious risk of bias in the evidence contributing to the evidence as per RoB2
2 95% CI crosses 1 MID (for FIM-L in participants with SCI ASIA B +/-0.865; for FIM-L in SCI ASIA C+D +/-0.7; for velocity in SCI ASIA C+D +/-0.27)
3 95% CI crosses 2 MIDs (for LEMS score in ASIA B +/-5.15; for distance walked in ASIA B +/-18.15)

Table 25: Clinical evidence profile for gait re-education: Body-weight supported gait training versus over ground training in SCI rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
Changes in mobility (measured using velocity in m/sec; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	12	12	-	MD 0.27 higher (0.16 lower to 0.7 higher)	LOW	CRITICAL
Changes in mobility (measured using duration of gait cycle in sec; better indicated by lower values) - 12 weeks (intervention completion)												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 1.25 higher (0.57 to 1.93 higher)	MODERATE	CRITICAL
Changes in mobility (measured using percentage stance of whole gait cycle; better indicated by lower values) - 12 weeks (intervention completion)												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 5.99 lower (7.57 to 4.41 lower)	MODERATE	CRITICAL
Changes in mobility (measured using percentage swing of whole gait cycle; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 7.26 higher (5.56 to 8.96 higher)	MODERATE	CRITICAL
Changes in mobility (measured using step length in cm; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecisio	none	12	12	-	MD 13.31 higher (11.2 to	MODERATE	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
					n					15.42 higher)		
Changes in mobility (measured using distance walked in m; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 12.25 higher (5.71 to 18.79 higher)	MODERATE	CRITICAL
Changes in mobility (measured using cadence in steps/min; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 14.72 higher (7.83 to 21.62 higher)	MODERATE	CRITICAL
Changes in mobility (measured using maximum dorsiflexion during stance, right leg; better indicated by higher values) - Gain during intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 0.9 lower (1.4 to 0.4 lower)	MODERATE	CRITICAL
Changes in mobility (measured using maximum dorsiflexion during stance, left leg; better indicated by higher values) - Gain during intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 0.7 lower (1.2 to 0.2 lower)	MODERATE	CRITICAL
Changes in mobility (measured using maximum hip extension during stance, right leg; better indicated by higher values) - Gain during												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 7.6 higher (6.04 to 9.16 higher)	MODERATE	CRITICAL
Changes in mobility (measured using maximum hip extension during stance, left leg; better indicated by higher values) - Gain during intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 7.6 higher (6.03 to 9.17 higher)	MODERATE	CRITICAL
Changes in mobility (measured using maximum hip flexion during gait cycle, right leg; better indicated by higher values) - Gain during intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 0.3 lower (4.58 lower to 3.98 higher)	MODERATE	CRITICAL
Changes in mobility (measured using maximum hip flexion during gait cycle, left leg; better indicated by higher values) - Gain during intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 0.4 lower (4.68 lower to 3.88	MODERATE	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Body-weight supported gait training	Over ground training	Relative (95% CI)	Absolute		
										higher)		
Changes in mobility (measured using maximum knee extension during stance, right leg; better indicated by higher values) - Gain during intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 0.3 lower (4.77 lower to 4.17 higher)	MODERATE	CRITICAL
Changes in mobility (measured using maximum knee extension during stance, left leg; better indicated by higher values) - Gain during intervention												
1 (Lucareli 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	12	12	-	MD 0.3 lower (4.71 lower to 4.11 higher)	MODERATE	CRITICAL

CI: confidence interval; cm: centimetre; m: metre; MD: mean difference; min: minute; sec: second
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses1 MID (for velocity +/-0.305)

Table 26: Clinical evidence profile for gait re-education: High intensity gait re-education versus standard care in hip fracture rehabilitation (outcomes reported at means (SD) or counts (%) and analysed accordingly)

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High intensity gait re-training	Standard care	Relative (95% CI)	Absolute		
Changes in mobility (measured as participants able to walk unaided or with sticks or crutches) - 4 weeks (during intervention)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	26/78 (33.3%)	23/80 (28.8%)	RR 1.16 (0.73 to 1.85)	46 more per 1000 (from 78 fewer to 244 more)	VERY LOW	CRITICAL
Changes in mobility (measured as participants able to walk unaided or with sticks or crutches) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	44/73 (60.3%)	46/77 (59.7%)	RR 1.01 (0.78 to 1.31)	6 more per 1000 (from 131 fewer to 185 more)	VERY LOW	CRITICAL
Changes in mobility (measured as participants reporting good mobility compared to those reported poor or fair mobility) - 4 weeks (during intervention)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	28/78 (35.9%)	29/80 (36.3%)	RR 0.99 (0.65 to 1.5)	4 fewer per 1000 (from 127 fewer to 181 more)	VERY LOW	CRITICAL
Changes in mobility (measured as participants reporting good mobility compared to those reported poor or fair mobility) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious[3]	none	41/73 (56.2%)	34/77 (44.2%)	RR 1.27 (0.92 to 1.76)	119 more per 1000 (from 35 fewer to 336 more)	LOW	CRITICAL
Changes in mobility (measured as participants that fell during study period) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	19/73 (26%)	22/77 (28.6%)	RR 0.91 (0.54 to 1.54)	26 fewer per 1000 (from 131 fewer to 154 more)	VERY LOW	CRITICAL
Changes in mobility (measured using Modified Falls Efficacy Scale; range 0-140; better indicated by higher values) - 4 weeks (during intervention)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High intensity gait re-training	Standard care	Relative (95% CI)	Absolute		
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	78	79	-	MD 4 higher (5.56 lower to 13.56 higher)	MODERATE	CRITICAL
Changes in mobility (measured using Modified Falls Efficacy Scale; range 0-140; better indicated by higher values) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	72	76	-	MD 3 higher (8 lower to 14 higher)	MODERATE	CRITICAL
Changes in mobility (measured using velocity in m/sec; better indicated by higher values) - 4 weeks (during intervention)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	78	80	-	MD 0.05 higher (0.02 lower to 0.12 higher)	LOW	CRITICAL
Changes in mobility (measured using velocity in m/sec; better indicated by higher values) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	73	77	-	MD 0.03 higher (0.07 lower to 0.13 higher)	LOW	CRITICAL
Changes in mobility (measured PPME score; range 0-12; better indicated by higher values) - 4 weeks (during intervention)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious inconsistency	none	78	80	-	MD 0.2 higher (0.39 lower to 0.79 higher)	MODERATE	CRITICAL
Changes in mobility (measured PPME score; range 0-12; better indicated by higher values) - 16 weeks (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High intensity gait re-training	Standard care	Relative (95% CI)	Absolute		
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	73	77	-	MD 0.2 higher (0.57 lower to 0.97 higher)	LOW	CRITICAL
Changes in mobility (measured using Sit-to-stand test in sec; better indicated by higher values) - 4 weeks (during intervention)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	78	80	-	MD 0.05 higher (0.01 to 0.09 higher)	LOW	CRITICAL
Changes in mobility (measured using Sit-to-stand test in sec; better indicated by higher values) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	73	77	-	MD 0.04 higher (0 to 0.08 higher)	LOW	CRITICAL
Changes in mobility (measured using step test standing on affected leg; better indicated by higher values) - 4 weeks (during intervention)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	78	80	-	MD 1.90 higher (0.34 lower to 3.46 higher)	LOW	CRITICAL
Changes in mobility (measured using step test standing on affected leg; better indicated by higher values) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	73	77	-	MD 1.4 higher (0.23 lower to 3.03 higher)	LOW	CRITICAL
Pain (measured as participants reporting no or slight pain compared to those reporting some, moderate or severe pain) - 4 weeks (during intervention)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High intensity gait re-training	Standard care	Relative (95% CI)	Absolute		
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	34/78 (43.6%)	39/80 (48.8%)	RR 0.89 (0.64 to 1.25)	54 fewer per 1000 (from 176 fewer to 122 more)	VERY LOW	IMPORTANT
Pain (measured as participants reporting no or slight pain compared to those reporting some, moderate or severe pain) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43/73 (58.9%)	48/77 (62.3%)	RR 0.94 (0.73 to 1.22)	37 fewer per 1000 (from 168 fewer to 137 more)	LOW	IMPORTANT
Overall quality of life (measured using EQ-5D score; scale not reported; better indicated by higher values) - 4 weeks (during intervention)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	78	80	-	MD 0.01 higher (0.07 lower to 0.09 higher)	MODERATE	IMPORTANT
Overall quality of life (measured using EQ-5D score; scale not reported; better indicated by higher values) - 16 weeks (intervention completion)												
1 (Mosely 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	73	77		MD 0 higher (0.09 lower to 0.09 higher)	MODERATE	IMPORTANT

CI: confidence interval; EQ-5D: EuroQol 5 dimensions; PPME: Physical Performance and Mobility Examination; RR: risk ratio; SD: standard deviation
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (for all RR 0.8 and 1.25)
3 95% CI crosses 1 MID (for all RR 0.8 and 1.25; for velocity +/-0.08; for PPME +/-0.8; for Sit-to-stand +/-0.04; for step test +/-1.05)

Table 27: Clinical evidence profile for gait re-education: High intensity gait re-education versus standard care in hip fracture (outcomes reported at means (IQR) and analysed accordingly)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High intensity gait re-education	Standard care	High intensity gait re-education	Standard care		
Changes in ADL (measured using Barthel Index score; range 0-100; better indicated by higher values) - 4 weeks (during intervention)												
1 (Moseley 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	78	80	Mean (IQR): 93 (85-100)[3]	Mean (IQR): 90 (85-95)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using Barthel Index score; range 0-100; better indicated by higher values) - 16 weeks (intervention completion)												
1 (Moseley 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	73	77	Mean (IQR): 95 (90-100)[4]	Mean (IQR): 95 (85-100)[4]	VERY LOW	IMPORTANT

ADL: Activities of daily living; ANOVA: Analysis of variance; IQR: Interquartile range
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analysis performed by the authors, the mean difference was not significantly different between groups (p=0.196, ANOVA)
4 According to the statistical analysis performed by the authors, the mean difference was not significantly different between groups (p=0.771, ANOVA)

Table 28: Clinical evidence profile for gait re-education: Gait training versus no gait training in SCI rehabilitation (outcomes reported at counts (%) and analysed accordingly)

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Gait training	No gait training	Relative (95% CI)	Absolute		
Changes in mobility (measured using number of participants walking at discharge)												
1 (Rigot 2018)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	109/430 (25.3%)	1/317 (0.32%)	RR 80.36 (11.28 to 572.52)	250 more per 1000 (from 32 more to 1000 more)	LOW	CRITICAL

CI: confidence interval; RR: risk ratio
1 Very serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I

Table 29: Clinical evidence profile for gait re-education: Gait training versus no gait training in SCI rehabilitation (outcomes reported at medians (IQR) and analysed accordingly)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Gait training	No gait training	Gait training	No gait training		
Changes in mobility (measured using CHART-Physical independence sub-score among those primarily using wheelchair; range 0-100; better indicated by higher values) - 1 year after discharge												
1 (Rigot 2018)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	144	299	Median (IQR): 88.0 (48-100)[3]	Median (IQR): 96 (76-100)[3]	LOW	CRITICAL
Changes in mobility (measured using CHART-Mobility sub-score among those primarily using wheelchair; better indicated by												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Gait training	No gait training	Gait training	No gait training		
higher values) - 1 year after discharge												
1 (Rigot 2018)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	140	297	Median (IQR): 77 (57-100)[4]	Median (IQR): 89 (63-100)[4]	LOW	CRITICAL
Pain (measured using numerical scale reporting usual pain over last 4 weeks among those primarily using wheelchair; range 1-10; better indicated by lower values) - 1 year after discharge												
1 (Rigot 2018)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	152	296	Median (IQR): 5 (3-7)[5]	Median (IQR): 4 (1-6)	LOW	CRITICAL
Overall quality of life (measured using Diener Satisfaction With Life scale among those primarily using wheelchair; range 5-35; better indicated by higher values) - 1 year after discharge												
1 (Rigot 2018)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	serious imprecision	none	124	261	Median (IQR): 19 (12-25)[6]	Median (IQR): 22 (14-26)[6]	VERY LOW	CRITICAL

1 Very serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I
2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analysis performed by the authors, the median difference was significantly lower (worse) in the intervention group (p=0.002, unclear which statistical test the authors used)
4 According to the statistical analysis performed by the authors, the median difference was significantly lower (worse) in the intervention group (p=0.024, unclear which statistical test the authors used)
5 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.70, unclear which statistical test the authors used)
6 According to the statistical analysis performed by the authors, the median difference was not significantly different between groups (p=0.89, unclear which statistical test the authors used)

Table 30: Clinical evidence profile for manual therapy interventions: Massage + standard care versus standard care only in burn rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Massage + standard care	Standard care only	Relative	Absolute (95% CI)		
Pain (measured using VAS score; range 0-10; better indicated by lower values) - At discharge (specific time frame not reported)												
1 (Cho 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	76	70	-	MD 1.45 lower (1.81 to 1.09 lower)	MODERATE	IMPORTANT

CI: Confidence interval; MD: Mean difference; VAS: Visual analogue scale
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2

Table 31: Clinical evidence profile for manual therapy interventions: Early muscle energy technique versus delayed muscle energy technique in elbow fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early muscle energy technique	Delayed muscle energy technique	Relative	Absolute (95% CI)		
Upper limb function (measured using DASH score; range 0-100; better indicated by lower values) - 3 weeks (intervention completion)												
1 (Faqih 2019)	randomised trials	very serious[1]	no serious	no serious	no serious	none	13	14	-	MD 18.2 higher	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Early muscle energy technique	Delayed muscle energy technique	Relative	Absolute (95% CI)		
			inconsistency	indirectness	imprecision					(13.8 to 22.6 higher)[2]		
Changes in mobility (measured using elbow flexion; better indicated by higher values) - 3 weeks (intervention completion)												
1 (Faqih 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	13	14	-	MD 11.7 higher (6.32 to 17.08 higher)	LOW	CRITICAL
Changes in mobility (measured using elbow extension; better indicated by lower values) - 3 weeks (intervention completion)												
1 (Faqih 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	13	14	-	MD 8.6 lower (12.53 to 4.67 lower)	LOW	CRITICAL
Pain (measured using VAS; range 0-10; better indicated by lower values) - 3 weeks (intervention completion)												
1 (Faqih 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	13	14	-	MD 1.3 higher (0.77 to 1.83 higher)[2]	LOW	IMPORTANT

CI: Confidence interval; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 The authors of this paper have interpreted higher DASH and VAS scores as better function and better pain respectively. However, when used as validated, both measurement tools report that lower values are better. The paper makes no mention of inversion of data scales or transformation.

Table 32: Clinical evidence profile for manual therapy interventions: Ankle stretching versus no ankle stretching in SCI rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Ankle stretching	No ankle stretching	Relative	Absolute (95% CI)		
Changes in mobility (measured using mobility around ankle with no torque and knee extended in degrees; better indicated by higher values) - 2 weeks from baseline (halfway through intervention)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	14	14	-	MD 1 lower (5.4 lower to 3.4 higher)	LOW	CRITICAL
Changes in mobility (measured using mobility around ankle with no torque and knee extended in degrees; better indicated by higher values) - 4 weeks from baseline (at intervention completion)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	14	14	-	MD 2 higher (2.7 lower to 6.7 higher)	LOW	CRITICAL
Changes in mobility (measured using mobility around ankle with no torque and knee extended in degrees; better indicated by higher values) - 5 weeks from baseline (1 week follow-up)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 1 lower (4.7 lower to 2.7 higher)	MODERATE	CRITICAL
Changes in mobility (measured using mobility around ankle with no torque and knee flexed in degrees; better indicated by higher values) - 2 weeks from baseline (halfway through intervention)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 2 higher (1.2 lower to 5.2 higher)	MODERATE	CRITICAL
Changes in mobility (measured using mobility around ankle with no torque and knee flexed in degrees; better indicated by higher values) - 4												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Ankle stretching	No ankle stretching	Relative	Absolute (95% CI)		
weeks from baseline (at intervention completion)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 2 higher (0 to 4 higher)	MODERATE	CRITICAL
Changes in mobility (measured using mobility around ankle with no torque and knee flexed in degrees; better indicated by higher values) - 5 weeks from baseline (1 week follow-up)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 1 higher (2.3 lower to 4.3 higher)	MODERATE	CRITICAL
Changes in mobility (measured using mobility around ankle with 10nm torque and knee extended in degrees; better indicated by higher values) - 2 weeks from baseline (halfway through intervention)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 1 higher (2.5 lower to 4.5 higher)	MODERATE	CRITICAL
Changes in mobility (measured using mobility around ankle with 10nm torque and knee extended in degrees; better indicated by higher values) - 4 weeks from baseline (at intervention completion)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 0 higher (3.3 lower to 3.3 higher)	MODERATE	CRITICAL
Changes in mobility (measured using mobility around ankle with 10nm torque and knee extended in degrees; better indicated by higher values) - 5 weeks from baseline (1 week follow-up)												
1 (Harvey	randomis	serious[1]	no	no	no	none	14	14	-	MD 0	MODER	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Ankle stretching	No ankle stretching	Relative	Absolute (95% CI)		
2000)	ed trials		serious inconsistency	serious indirectness	serious imprecision					higher (3 lower to 3 higher)	ATE	
Changes in mobility (measured using mobility around ankle with 10nm torque and knee flexed in degrees; better indicated by higher values) - 2 weeks from baseline (halfway through intervention)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	14	14	-	MD 2 higher (2.7 lower to 6.7 higher)	LOW	CRITICAL
Changes in mobility (measured using mobility around ankle with 10nm torque and knee flexed in degrees; better indicated by higher values) - 4 weeks from baseline (at intervention completion)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 0 higher (2.7 lower to 2.7 higher)	MODERATE	CRITICAL
Changes in mobility (measured using mobility around ankle with 10nm torque and knee flexed in degrees; better indicated by higher values) - 5 weeks from baseline (1 week follow-up)												
1 (Harvey 2000)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	14	-	MD 0 higher (3.2 lower to 3.2 higher)	MODERATE	CRITICAL

CI: Confidence interval; MD: Mean difference; nm: Newton metre
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for ankle mobility with no torque, knee extended +/-5.15; for ankle mobility with 10nm torque, knee flexed +/-5.1)

Table 33: Clinical evidence profile for manual therapy interventions: Hamstring stretching versus no hamstring stretching in SCI rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hamstring stretching	No hamstring stretching	Relative	Absolute (95% CI)		
Changes in mobility (measured using mobility differences between stretched and unstretched ankle with 48nm torque and knee flexed in degrees; better indicated by higher values) - 4 weeks from baseline (intervention completion)												
1 (Harvey 2003)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	14	14	-	MD 1 higher (2 lower to 4 higher)	VERY LOW	CRITICAL

CI: Confidence interval; MD: Mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.

Table 34: Clinical evidence profile for manual therapy interventions: Ankle passive movement versus no ankle passive movement in SCI rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Ankle passive movement	No ankle passive movement	Relative	Absolute (95% CI)		
Changes in mobility (measured using passive ankle dorsiflexion range of motion with 2nm torque applied in degrees; better indicated by higher												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Ankle passive movement	No ankle passive movement	Relative	Absolute (95% CI)		
values) - 6 months + 1 day (intervention completion)												
1 (Harvey 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	20	-	MD 3 higher (2.9 lower to 8.9 higher)	LOW	CRITICAL
Changes in mobility (measured using passive ankle dorsiflexion range of motion with 3nm torque applied in degrees; better indicated by higher values) - 6 months + 1 day (intervention completion)												
1 (Harvey 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	20	-	MD 3 higher (2.58 lower to 8.58 higher)	LOW	CRITICAL
Changes in mobility (measured using passive ankle dorsiflexion range of motion with 5nm torque applied in degrees; better indicated by higher values) - 6 months + 1 day (intervention completion)												
1 (Harvey 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	20	-	MD 3 higher (2.58 lower to 8.58 higher)	LOW	CRITICAL
Changes in mobility (measured using passive ankle dorsiflexion range of motion with 7nm torque applied in degrees; better indicated by higher values) - 6 months + 1 day (intervention completion)												
1 (Harvey 2009)	randomised trials	serious[1]	no serious	no serious	serious[2]	none	20	20	-	MD 3 higher	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Ankle passive movement	No ankle passive movement	Relative	Absolute (95% CI)		
			inconsistency	indirectness						(2.9 lower to 8.9 higher)		
Changes in mobility (measured using passive ankle dorsiflexion range of motion with 8nm torque applied in degrees; better indicated by higher values) - 6 months + 1 day (intervention completion)												
1 (Harvey 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	20	-	MD 4 higher (1.9 lower to 9.9 higher)	LOW	CRITICAL
Changes in mobility (measured using passive ankle dorsiflexion range of motion with 10nm torque applied in degrees; better indicated by higher values) - 6 months + 1 day (intervention completion)												
1 (Harvey 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	20	20	-	MD higher (5 lower to 5 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using passive ankle dorsiflexion range of motion with 12nm torque applied in degrees; better indicated by higher values) - 6 months + 1 day (intervention completion)												
1 (Harvey 2009)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	20	-	MD 4 higher (1.9 lower to 9.9 higher)[4]	LOW	CRITICAL

CI: Confidence interval; MD: Mean difference; nm: Newton metre
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for ankle dorsiflexion with 2nm torque +/-3.5; for ankle dorsiflexion with 3nm torque +/-3.5; for ankle dorsiflexion with 5nm torque +/-5; for ankle dorsiflexion with 7nm torque +/-3.5; for ankle dorsiflexion with 8nm torque +/-3.5; for ankle dorsiflexion with 10nm torque +/-3.5; for ankle dorsiflexion with 12nm torque +/-4.5)

3 95% CI crosses 2 MIDs (for ankle dorsiflexion with 10nm torque +/-3.5)
4 This 95% CI has been calculated but using the data reported in the article and calculated in Revman. However, it should be noted that it differs from the confidence interval reported in the article (2-6 degrees).

Table 35: Clinical evidence profile for manual therapy interventions: Active controlled motion + physiotherapy versus physiotherapy only in unstable ankle fracture rehabilitation (outcomes reported as means (SD) and analysed appropriately)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active controlled motion + physiotherapy	Physiotherapy only	Relative	Absolute (95% CI)		
Changes in mobility (measured using range of motion of ankle joint; better indicated by higher values) - 6 weeks post-operation (intervention completion)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	MD 7.7 higher (2.2 to 13.2 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using range of motion of ankle joint; better indicated by higher values) - 12 weeks post-operation (6 weeks follow-up)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	22	-	MD 4.6 higher (0.94 lower to 10.14 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using range of motion of subtalar joint; better indicated by higher values) - 6 weeks post-operation (intervention completion)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsiste	no serious indirectne	serious[2]	none	24	24	-	MD 2.3 higher (1.1 lower	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active controlled motion + physiotherapy	Physiotherapy only	Relative	Absolute (95% CI)		
			ncy	ss						to 5.7 higher)		
Changes in mobility (measured using range of motion of subtalar joint; better indicated by higher values) - 12 weeks post-operation (6 weeks follow-up)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	22	22	-	MD 44.2 higher (38.5 to 49.9 higher)	LOW	CRITICAL
Changes in mobility (measured using VAS for foot and ankle; range 0-100; better indicated by higher values) - 6 weeks post-operation (intervention completion)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	24	24	-	MD 15.4 higher (8.49 to 22.31 higher)	LOW	CRITICAL
Changes in mobility (measured using VAS for foot and ankle; range 0-100; better indicated by higher values) - 12 weeks post-operation (6 weeks follow-up)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	22	22	-	MD 16.3 higher (7.38 to 25.22 higher)	LOW	CRITICAL
Changes in mobility (measured using Philip score; scale not reported; better indicated by higher values) - 6 weeks post-operation (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active controlled motion + physiotherapy	Physiotherapy only	Relative	Absolute (95% CI)		
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	MD 6.7 higher (1.33 lower to 14.73 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using Philip score; scale not reported; better indicated by higher values) - 12 weeks post-operation (6 weeks follow-up)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	22	22	-	MD 19 higher (8.85 to 29.15 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using Mazur score; scale not reported; ; better indicated by higher values) - 6 weeks post-operation (intervention completion)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	MD 7.7 higher (0.88 to 14.52 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using Mazur score; scale not reported; ; better indicated by higher values) - 12 weeks post-operation (6 weeks follow-up)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsiste	no serious indirectne	serious[2]	none	22	22	-	MD 10.8 higher (3.4 to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active controlled motion + physiotherapy	Physiotherapy only	Relative	Absolute (95% CI)		
			ncy	ss						18.2 higher)		
Changes in mobility (measured using American Orthopaedic Foot and Ankle score; range 0-100; better indicated by higher values) - 6 weeks post-operation (intervention completion)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	MD 7.6 higher (1.67 to 13.53 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using American Orthopaedic Foot and Ankle score; range 0-100; better indicated by higher values) - 12 weeks post-operation (6 weeks follow-up)												
1 (Jansen 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	22	-	MD 12.3 higher (6.4 to 18.2 higher)	VERY LOW	CRITICAL

AOFAS: American Orthopaedic Foot and Ankle score; CI: Confidence interval; MD: Mean difference; SD: standard deviation; VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1MID (for ankle range of motion +/-4.05; for subtalar range of motion +/-2.85; for Philip score +/-7.15; for Mazur score +/-5.9; for AOFAS +/-8.35)

Table 36: Clinical evidence profile for manual therapy interventions: Active controlled motion + physiotherapy versus physiotherapy only in unstable ankle fracture rehabilitation (outcomes reported as means (range) and analysed appropriately)

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active controlled motion + physiotherapy	Physiotherapy only	Active controlled motion + physiotherapy	Phzysiotherapy only		
Return to work (measured using mean weeks to return to work; better indicated by lower values) - No time point reported												
1 (Jansen 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	24	24	Mean 10.5 (range 3-17)[3]	Mean 14.7 (range 9-26)[3]	VERY LOW	IMPORTANT

CI: Confidence interval; MD: Mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analysis performed by the authors, the mean difference is significantly lower (better) in intervention group (p=0.02, unable to discern statistical test)

Nutrition support

Table 37: Clinical evidence profile for nutrition support interventions: rehabilitation + essential amino acids versus rehabilitation + placebo in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Essential amino acids + rehabilitation	Placebo + rehabilitation	Relative (95% CI)	Absolute		
Changes in mobility (measured using 6MWT in m; better indicated by higher values) - At discharge												
1 (Aquilani 2019)	randomised trials	very serious[1]	no serious inconsist	no serious indirectn	serious[2]	none	28	28	-	MD 18.8 higher (35.42 lower to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Essential amino acids + rehabilitation	Placebo + rehabilitation	Relative (95% CI)	Absolute		
			ency	ess						73.02 higher)		
Changes in mobility (measured using 6MWT in m; better indicated by higher values) – Gain during intervention (discharge score - admission score)												
1 (Aquilani 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	28	28	-	MD 44.6 higher (0.07 to 89.13 higher)	VERY LOW	CRITICAL
Patients achieving minimal Clinically important different in 6MWT												
1 (Aquilani 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21/28 (75%)	13/28 (46.4%)	RR 1.62 (1.06 to 1.95)	288 more per 1000 (from 28 more to 441 more)	VERY LOW	CRITICAL

6MWT: 6 minute walk test; CI: confidence interval; m: metre
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for 6MWT +/-35.95, for patients achieving minimal clinical significance 0.8 and 1.25)

Table 38: Clinical evidence profile for nutrition support interventions: vitamin D supplementation versus no treatment in hip fracture rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Vitamin D (all groups)	No treatment	Relative (95% CI)	Absolute		
Changes in mobility (measured as experience of falls) - At 12-months follow-up												
1 (Harwood 2004)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/31 (12.9%)	3/9 (33.3%)	RR 0.39 (0.07 to 1.37)	203 fewer per 1000 (from 310 fewer to 123 more)	VERY LOW	CRITICAL

CI: confidence interval
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (for experience of falls 0.8 and 1.25)

Table 39: Clinical evidence profile for nutrition support interventions: whey protein + standard rehabilitation versus standard rehabilitation in hip fracture rehabilitation (outcomes reported as medians (IQR) and analysed appropriately)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Whey protein + standard rehabilitation	Standard rehabilitation	Whey protein + standard rehabilitation	Standard rehabilitation		
Changes in mobility (measured using Barthel Index Walking score; range 0-15; better indicated by higher values) - Day 14 Post-operation (intervention completion)												
1 (Niitsu 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20	18	Median (IQR):15 (15-15)[3]	Median (IQR): 10 (10-15)[3]	VERY LOW	CRITICAL
Changes in mobility (measured using Barthel Index Stair score; range 0-10; better indicated by higher values) - Day 14 Post-operation												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Whey protein + standard rehabilitation	Standard rehabilitation	Whey protein + standard rehabilitation	Standard rehabilitation		
(intervention completion)												
1 (Niitsu 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20	18	Median (IQR): 5 (5-5)[4]	Median (IQR): 5 (5-5)[4]	VERY LOW	CRITICAL

IQR: Interquartile range
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analyses performed by the author, the median was significantly higher in the intervention group (p<0.05, Mann-Whitney U test)
4 According to the statistical analyses performed by the author, the median difference was not statistically significant between groups (p>0.05, Mann-Whitney U test)

Table 40: Clinical evidence profile for nutrition support interventions: whey protein + standard rehabilitation versus standard rehabilitation in hip fracture rehabilitation (outcomes reported as means (SD) and analysed appropriately)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Whey protein + standard rehabilitation	Standard rehabilitation	Relative	Absolute (95% CI)		
Pain at rest (measured using VAS; range 0-10; better indicated by lower values) - Day 7 Post-operation (during intervention)												
1 (Niitsu 2016)	randomised trials	very serious[1]	no serious	no serious	serious[2]	none	20	18	-	MD 0.4 lower (1.39	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Whey protein + standard rehabilitation	Standard rehabilitation	Relative	Absolute (95% CI)		
			inconsistency	indirectness						lower to 0.59 higher)		
Pain at rest (measured using VAS; range 0-10; better indicated by lower values) - Day 14 Post-operation (intervention completion)												
1 (Niitsu 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	18	-	MD 0.4 lower (1.04 lower to 0.24 higher)	VERY LOW	IMPORTANT
Pain in motion (measured using VAS; range 0-10; better indicated by lower values) - Day 7 Post-operation (during intervention												
1 (Niitsu 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	18	-	MD 1.5 lower (3.03 lower to 0.03 higher)	VERY LOW	IMPORTANT
Pain in motion (measured using VAS; range 0-10; better indicated by lower values) - Day 14 Post-operation (intervention completion)												
1 (Niitsu 2016)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	18	-	MD 2.2 lower (3.47 to 0.93 lower)	VERY LOW	IMPORTANT

CI: confidence intervals; VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for pain at rest +/-0.75; for pain in motion +/-1.2)

Table 41: Clinical evidence profile for nutrition support interventions: Omega-3 supplements versus placebo in SCI rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Omega-3 supplement**	**Placebo**	**Relative**	**Absolute (95% CI)**		
Changes in mobility (measured using FIM+FAM Motor sub-score; range 16-112; better indicated by higher values) - 14 months follow-up												
1 (Norouzi Javidan 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	54	50	-	MD 5.2 lower (13.36 lower to 2.96 higher)	LOW	CRITICAL
Changes in mobility (measured using FIM+FAM Locomotion sub-score; range 7-49; better indicated by higher values) - 14 months follow-up												
1 (Norouzi Javidan 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	54	50	-	MD 2.72 lower (7.21 lower to 1.77 higher)	LOW	CRITICAL
Changes in ADL (measured using FIM+FAM Total score; range 30-210; better indicated by higher values) - 14 months follow-up												
1 (Norouzi Javidan 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	54	50	-	MD 6.21 lower (16.82 lower to 4.4 higher)	LOW	IMPORTANT
Changes in ADL (measured using FIM+FAM Cognitive sub-score; range 14-98; better indicated by higher values) - 14 months follow-up												
1 (Norouzi Javidan 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	54	50	-	MD 0 higher (3.32 lower to 3.32 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Omega-3 supplement	Placebo	Relative	Absolute (95% CI)		
Changes in ADL (measured using FIM+FAM Psychosocial sub-score; range 9-63; better indicated by higher values) - 14 months follow-up												
1 (Norouzi Javidan 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	54	50	-	MD 0.88 lower (3.23 lower to 1.47 higher)	LOW	IMPORTANT
Changes in ADL (measured using FIM+FAM Communication sub-score; range 5-35; better indicated by higher values) - 14 months follow-up												
1 (Norouzi Javidan 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision[4]	none	54	50	-	MD 0.03 higher (1.69 lower to 1.75 higher)	MODERATE	IMPORTANT
Changes in ADL (measured using FIM+FAM Self-care sub-score; range 7-49; better indicated by higher values) - 14 months follow-up												
1 (Norouzi Javidan 2014)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	54	50	-	MD 1.89 lower (5.73 lower to 1.95 higher)	LOW	IMPORTANT

ADL: Activities of daily living; CI: confidence interval; FIM+FAM: Functional independence measure and functional assessment measure
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for FIM+FAM Motor sub-score +/-10.83; for FIM+FAM Locomotion sub-score +/-6.015; for FIM+FAM total score +/-13.21; for FIM+FAM Psychosocial sub-score +/-3.09; for FIM+FAM Self-care sub-score +/-4.91)
3 95% CI crosses 2 MIDs (for FIM+FAM Cognitive sub-score +/-3.125)
4 The article reported a standard deviation of 0 for the control group FIM+FAM Communication sub-score so we were unable to calculate the MID using this figure. Instead we chose to use the standard deviation of the control group at follow-up to calculate the MIDs for imprecision and clinical importance.

Table 42: Clinical evidence profile for nutrition support interventions: High vitamin D versus low vitamin D supplementation in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	High Vit D	Low Vit D	Relative	Absolute (95% CI)		
Quality of life (measured using changes in the EQ-5D-3L index value; scale not reported; better indicated by higher values) - Between baseline and 6 months												
1 (Renerts 2019)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[3]	none	60	60	-	MD 0.02 lower (0.16 lower to 0.12 higher)	VERY LOW	IMPORTANT
Quality of life (measured using changes in the EQ-5D-3L index value; scale not reported; better indicated by higher values) - Between 6 months and 12 months												
1 (Renerts 2019)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[4]	none	60	59	-	MD 0.07 lower (0.17 lower to 0.03 higher)	VERY LOW	IMPORTANT
Quality of life (measured using changes in the EQ-5D-3L index value; scale not reported; better indicated by higher values) - Between baseline and 12 months												
1 (Renerts 2019)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[3]	none	60	59	-	MD 0.05 higher (0.1 lower to 0.2 higher)	VERY LOW	IMPORTANT

1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Study marked down for indirectness because drop out is only reported for the whole RCT population (4 arms, baseline N = 173, at 6 months N = 120, at 12 months N = 119). For the purposes of analysis, we have assumed dropout was equal between the study arms but cannot be certain.
3 95% CI crosses 2 MIDs (for EQ-5D-3L Index value +/-0.074)
4 95% CI crosses 1 MID (for EQ-5D-3L Index value +/-0.074)

Scar, swelling and oedema management

Table 43: Clinical evidence profile for scar, swelling and oedema management interventions: active laser therapy versus placebo laser therapy in burn rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Active laser therapy	placebo laser therapy	Relative	Absolute(95% CI)		
Quality of life (measured using MDLQI; range 0-21; better indicated by lower values) - 6 weeks from baseline (intervention completion)												
1 (Ebid 2017)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	25	-	MD 3 lower (5.25 to 0.75 lower)	LOW	IMPORTANT
Quality of life (measured using MDLQI; range 0-21; better indicated by lower values) - 12 weeks from baseline (6 weeks after intervention completion)												
1 (Ebid 2017)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	24	25	-	MD 5.1 lower (7.24 to 2.96 lower)	MODERATE	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) - 6 weeks from baseline (intervention completion)												
1 (Ebid 2017)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	25	-	MD 3.85 lower (5.84 to 1.86 lower)	LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) - 12 weeks from baseline (6 weeks after intervention completion)												
1 (Ebid 2017)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	25	-	MD 3.23 lower (5.41 to 1.05 lower)	LOW	IMPORTANT

CI: confidence interval; MDLQI: modified Dermatology life quality index; VAS: Visual analogue scale
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for MDLQI +/-2.4; for VAS +/-2.25)

Table 44: Clinical evidence profile for scar, swelling and oedema management interventions: pressure garment therapy + massage versus massage only in burn rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Pressure garment + massage	Massage only	Relative	Absolute (95% CI)		
Pain (measured using VAS; range 0-10; better indicated by lower values) at 2 months from baseline (during intervention)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	21	-	MD 1.59 higher (0.55 to 2.63 higher)	VERY LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) at 4 months from baseline (during intervention)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	21	-	MD 0.84 higher (0.38 lower to 2.06 higher)	VERY LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) at 6 months from baseline (intervention completion)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	12	-	MD 1.16 higher (0.58 lower to 2.9 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Pressure garment + massage	Massage only	Relative	Absolute (95% CI)		
Pain (measured using VAS; range 0-10; better indicated by lower values) at 7 months from baseline (1 month follow-up)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	12	-	MD 0.64 higher (0.82 lower to 2.1 higher)	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference; VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for VAS +/-1.235)

Table 45: Clinical evidence profile for scar, swelling and oedema management interventions: silicone gel sheeting + massage versus massage only in burn rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Silicone gel sheeting + massage	Massage only	Relative	Absolute (95% CI)		
Pain (measured using VAS; range 0-10; better indicated by lower values) at 2 months from baseline (during intervention)												
1 (Li-Tsang	randomised trials	very serious[1]	no serious	no serious	serious[2]	none	24	21	-	MD 0.78 higher	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Silicone gel sheeting + massage	Massage only	Relative	Absolute (95% CI)		
2010)			inconsistency	indirectness						(0.13 lower to 1.69 higher)		
Pain (measured using VAS; range 0-10; better indicated by lower values) at 4 months from baseline (during intervention)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	21	-	MD 0.47 lower (1.36 lower to 0.42 higher)	VERY LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) at 6 months from baseline (intervention completion)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	12	-	MD 0.7 lower (2.12 lower to 0.72 higher)	VERY LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) at 7 months from baseline (1 month follow-up)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	12	-	MD 1.26 lower (2.26 to 0.26 lower)	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference; VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for VAS +/-1.235)

Table 46: Clinical evidence profile for scar, swelling and oedema management interventions: pressure garment therapy + silicone gel sheeting + massage versus massage only in burn rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Pressure garment + silicone gel sheeting + massage	Massage only	Relative	Absolute (95% CI)		
Pain (measured using VAS; range 0-10; better indicated by lower values) - 2 months from baseline (during intervention)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	21	-	MD 0.59 higher (0.14 lower to 1.32 higher)	VERY LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) at 4 months from baseline (during intervention)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	21	-	MD 0.61 lower (1.53 lower to 0.31 higher)	VERY LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) at 6 months from baseline (intervention completion)												
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	12	-	MD 1.08 lower (2.41 lower to 0.25 higher)	VERY LOW	IMPORTANT
Pain (measured using VAS; range 0-10; better indicated by lower values) at 7 months from baseline (1 month follow-up)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Pressure garment + silicone gel sheeting + massage	Massage only	Relative	Absolute (95% CI)		
1 (Li-Tsang 2010)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	12	-	MD 1.03 lower (2.1 lower to 0.04 higher)	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference; VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for VAS +/-1.235)

Table 47: Clinical evidence profile for scar, swelling and oedema management interventions: compression bandage versus ice and elevation in ankle fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compression bandage	Ice and elevation	Compression bandage	Ice and elevation		
Patient acceptability (measured using VAS; range 0-100; better indicated by higher values) at 12 weeks from baseline												
1 (Rohner-Spengler	randomised trials	very serious[1]	no serious inconsiste	no serious indirectne	very serious[2]	none	20	22	Median (IQR): 85 (74-93)3	Median (IQR): 80 (67-	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Compression bandage	Ice and elevation	Compression bandage	Ice and elevation		
2014)			ncy	ss						90)3		
Patient acceptability (measured using VAS; range 0-100; better indicated by higher values) at 1 year from baseline												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	19	22	Median (IQR): 83 (64-95)[3]	Median (IQR): 90 (80-96)[3]	VERY LOW	CRITICAL
Changes in mobility (measured using degrees of plantar flexion; better indicated by higher values) at 6 weeks from baseline (intervention completion)												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	22	Median (IQR): 35 (30-42)[3]	Median (IQR): 35 (30-42)[3]	VERY LOW	CRITICAL
Changes in mobility (measured using degrees of dorsiflexion; better indicated by higher values) at 6 weeks from baseline (intervention completion)												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	22	Median (IQR): 0 (-4-9)[3]	Median (IQR): 5 (0-10)[3]	VERY LOW	CRITICAL
Pain (measured using VAS; range 0-10; better indicated by lower values) at 6 weeks from baseline (intervention completion)												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	22	Median (IQR): 0 (0-6.3)[3]	Median (IQR): 6.3 (0-10)[3]	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference; VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.

3 According to the statistical analyses performed by the author, the median difference was not statistically significant

Table 48: Clinical evidence profile for scar, swelling and oedema management interventions: intermittent compression versus ice and elevation in ankle fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intermittent compression	Ice and elevation	Intermittent compression	Ice and elevation		
Patient acceptability (measured using VAS; range 0-100; better indicated by higher values) at 12 weeks post-operatively												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11	22	Median (IQR): 70 (59-76)[3]	Median (IQR): 80 (67-90)[3]	VERY LOW	CRITICAL
Patient acceptability (measured using VAS; range 0-100; better indicated by higher values) at 1 year from baseline												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	11	21	Median (IQR): 87 (54-100)[3]	Median (IQR): 90 (80-96)[3]	VERY LOW	CRITICAL
Changes in mobility (measured using degrees of plantar flexion; better indicated by higher values) at 6 weeks from baseline (intervention completion)												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12	22	Median (IQR): 35 (30-50)[3]	Median (IQR): 35 (30-42)[3]	VERY LOW	CRITICAL
Changes in mobility (measured using degrees of dorsiflexion; better indicated by higher values) at 6 weeks from baseline (intervention completion)												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12	22	Median (IQR): 10 (0-10)[3]	Median (IQR): 5 (0-10)[3]	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intermittent compression	Ice and elevation	Intermittent compression	Ice and elevation		
Pain (measured using VAS; range 0-10; better indicated by lower values) at 6 weeks from baseline (intervention completion)												
1 (Rohner-Spengler 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12	22	Median (IQR): 0 (0-11)[3]	Median (IQR): 6.3 (0-10)[3]	VERY LOW	IMPORTANT

CI: confidence interval; MD: mean difference; VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analyses performed by the author, the median difference was not statistically significant

Table 49: Clinical evidence profile for scar, swelling and oedema management interventions: low energy extracorporeal shockwave therapy versus placebo extracorporeal shockwave therapy

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Low energy ESWT	Placebo ESWT	Low energy ESWT	Placebo ESWT		
Pain (measured using Numerical Rating Scale; range 0-10; better indicated by lower values) (4 weeks from baseline, at intervention completion)												
1	randomise	serious[1]	no serious	no serious	very serious[2]	none	22	23	Median	Median	VERY	IMPORTAN

(Samhan 2019)	d trials		inconsistency	indirectness					(range): 2 (0-4)[3]	(range): 6 (5-9)[3]	LOW	T

ESWT: Extracorporeal schockwave therapy
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 2 Imprecision could not be assessed using GRADE default values due to the design of the study, and was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analyses performed by the author, the median was significantly lower in the intervention group (p<0.012, Mann-Whitney U test)

Splinting and orthotics

Table 50: Clinical evidence profile for splinting and orthotic interventions: thoracolumbosacral orthosis versus immediate mobilisation in rehabilitation for thoracolumbar burst fracture without neurological deficit

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Thoracolumbosacral orthosis	Immediate mobilisation	Relative	Absolute (95% CI)		
Changes in mobility (measured using Roland Morris Disability Questionnaire; range 0-24; better indicated by lower values) - Average of all follow-up time points (at discharge, 2 and 6 weeks, 3, 6, 12 and 24 months post-injury)												
1 (Bailey 2014)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	47	49	-	MD 1.1 lower (1.36 to 0.84 lower)	HIGH	CRITICAL
Patient acceptability (measured using Satisfactions with treatment score; scale 1-7; better indicated by higher values) - Average of all follow-up time points (at discharge, 2 and 6 weeks, 3, 6, 12 and 24 months post-injury)												
1 (Bailey 2014)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	47	49	-	MD 0.2 higher (0.16 to 0.24 higher)	HIGH	CRITICAL
Quality of life (measured using SF-36 Physical component score; scale not reported; better indicated by higher values) - Average of all follow-up time points (at discharge, 2 and 6 weeks, 3, 6, 12 and 24 months post-injury)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Thoracolumbosacral orthosis	Immediate mobilisation	Relative	Absolute (95% CI)		
1 (Bailey 2014)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	47	49	-	MD 2.5 higher (2.06 to 2.94 higher)	HIGH	IMPORTANT
Quality of life (measured using SF-36 Mental component score; scale not reported; better indicated by higher values) - Average of all follow-up time points (at discharge, 2 and 6 weeks, 3, 6, 12 and 24 months post-injury)												
1 (Bailey 2014)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	47	49	-	MD 1.4 higher (0.92 to 1.88 higher)	HIGH	IMPORTANT
Pain (average weekly pain measured using VAS; range 0-10; better indicated by lower values) - Average of all follow-up time points (at discharge, 2 and 6 weeks, 3, 6, 12 and 24 months post-injury)												
1 (Bailey 2014)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	47	49	-	MD 0.7 lower (0.8 to 0.6 lower)	HIGH	IMPORTANT

CI: Confidence interval; MD: mean difference; SF-36: 36 item short-form survey; VAS: VAS: Visual analogue scale

Table 51: Clinical evidence profile for splinting and orthotic interventions: metacarpophalangeal orthosis versus no orthosis in burn rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Metacarpophalangeal orthosis	No orthosis	Relative	Absolute (95% CI)		
Upper limb function (Grip strength of right hand, measured in kg; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	21	-	MD 1.1 higher (4.88 lower to 7.08 higher)	VERY LOW	CRITICAL
Upper limb function (Grip strength of left hand, measured in kg; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 0.5 lower (4.32 lower to 3.32 higher)	VERY LOW	CRITICAL
Upper limb function (Dominant hand writing measured using Jebsen-Taylor hand function test in secs; better indicated by lower values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	21	21	-	MD 4.2 lower (5.58 to 2.82 lower)	LOW	CRITICAL
Upper limb function (measured using MHOQ; range 0-100; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 21.2 higher (5.04 to 37.36 higher)	VERY LOW	CRITICAL
Quality of life (measured using Burn Specific Health Scale score; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	21	-	MD 8 higher (7.05 lower to 23.05	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Metacarpophalangeal orthosis	No orthosis	Relative	Absolute (95% CI)		
										higher)		
Changes in ADL (measured using FIM; range 18-126; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	21	21	-	MD 3.5 lower (9.74 lower to 2.74 higher)	VERY LOW	IMPORTANT
Changes in ADL (measured using MHOQ ADL Score; range 0-100; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	21	-	MD 10.4 higher (13.98 lower to 34.78 higher)	VERY LOW	IMPORTANT
Pain (measured using MHOQ Pain Score; range 0-100; better indicated by lower values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	21	-	MD 5.4 higher (14.39 lower to 25.19 higher)	VERY LOW	IMPORTANT
Patient acceptability (measured using MHOQ Aesthetics Score; range 0-100; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsiste	no serious indirectne	very serious[2]	none	21	21	-	MD 0 higher (20.4 lower	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Metacarpophalangeal orthosis	No orthosis	Relative	Absolute (95% CI)		
			ncy	ss						to 20.4 higher)		
Patient acceptability (measured using MHOQ Satisfaction with hand function score; range 0-100; better indicated by higher values) - 8 weeks (intervention completion)												
1 (Choi 2011)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	21	21	-	MD 3.3 higher (15.5 lower to 22.1 higher)	VERY LOW	CRITICAL

ADL: activities of daily living; CI: confidence interval; FIM: Functional independence measure; MD: mean difference; MHOQ: Michigan Hand Outcomes Questionnaire
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MID (for right hand grip strength +/- 4.05; for BSHS QoL +/-6.05; for MHOQ ADL score +/-13.8; for MHOQ Pain score +/- 13.8; for MHOQ Aesthetics score +/-2.2; for MHOQ Satisfaction score +/-8.85)
3 95% CI crosses 1 MID (for left hand grip strength +/-3.8; for MHOQ +/-8; for FIM +/-5.55)

Table 52: Clinical evidence profile for splinting and orthotic interventions: multi-axis shoulder abduction splint versus no splint in burn injury

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Shoulder splint	No splint	Relative	Absolute (95% CI)		

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Shoulder splint	No splint	Relative	Absolute (95% CI)		
Upper limb function (measured using shoulder abduction angle in degrees; better indicated by higher values) – 1 week (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	11	13	-	MD 5.8 higher (9.91 lower to 21.51 higher)	LOW	CRITICAL
Upper limb function (measured using shoulder abduction angle in degrees; better indicated by higher values) - 2 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11	13	-	MD 2.3 higher (13.19 lower to 17.79 higher)	VERY LOW	CRITICAL
Upper limb function (measured using shoulder abduction angle in degrees; better indicated by higher values) – 3 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11	13	-	MD 5.6 higher (10.81 lower to 22.01 higher)	VERY LOW	CRITICAL
Upper limb function (measured using shoulder abduction angle in degrees; better indicated by higher values) – 4 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	11	13	-	MD 7.8 higher (8.6 lower to 24.2 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Shoulder splint	No splint	Relative	Absolute (95% CI)		
Upper limb function (measured using shoulder flexion angle in degrees; better indicated by higher values) – 1 week (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	11	13	-	MD 17.2 higher (2.68 lower to 37.08 higher)	LOW	CRITICAL
Upper limb function (measured using shoulder flexion angle in degrees; better indicated by higher values) – 2 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	11	13	-	MD 17.1 higher (2.44 lower to 36.64 higher)	LOW	CRITICAL
Upper limb function (measured using shoulder flexion angle in degrees; better indicated by higher values) – 3 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	11	13	-	MD 13.6 higher (5.63 lower to 32.83 higher)	LOW	CRITICAL
Upper limb function (measured using shoulder flexion angle in degrees; better indicated by higher values) – 4 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	11	13	-	MD 7.3 higher (13.13 lower to 27.73 higher)	LOW	CRITICAL
Upper limb function (measured using shoulder external rotation angle in degrees; better indicated by higher values) – 1 week (from baseline)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Shoulder splint	No splint	Relative	Absolute (95% CI)		
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11	13	-	MD 2.5 higher (15.79 lower to 20.79 higher)	VERY LOW	CRITICAL
Upper limb function (measured using shoulder external rotation angle in degrees; better indicated by higher values) – 2 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11	13	-	MD 1.5 lower (21.17 lower to 18.17 higher)	VERY LOW	CRITICAL
Upper limb function (measured using shoulder external rotation angle in degrees; better indicated by higher values) – 3 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11	13	-	MD 8.2 lower (31.29 lower to 14.89 higher)	VERY LOW	CRITICAL
Upper limb function (measured using shoulder external rotation angle in degrees; better indicated by higher values) – 4 weeks (from baseline)												
1 (Jang 2015)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11	13	-	MD 1 higher (20.64 lower to 22.64 higher)	VERY LOW	CRITICAL

CI: confidence interval; MD: mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for shoulder abduction +/-10.7; for shoulder flexion +/-14.1)
3 95% CI crosses 2 MIDs (for shoulder abduction +/-10.7; for shoulder external rotation +/- 11.2)

Table 53: Clinical evidence profile for splinting and orthotic interventions: thoracolumbosacral orthosis versus immediate mobilisation in rehabilitation thoracolumbar burst fracture without neurological deficit

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Thoracolumbosacral orthosis	Ambulation encouragement	Relative	Absolute (95% CI)		
Changes in mobility (lumbar specific disability measured using revised Oswestry Disability Index score; range 0-100; better indicated by lower values) - At 6 months follow-up												
1 (Shamji 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	12	11	-	MD 3 higher (2.35 lower to 8.35 higher)	VERY LOW	CRITICAL
Pain (measured using VAS; range 0-10; better indicated by lower values) - At 6 months follow-up												
1 (Shamji 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	12	11	-	MD 1.2 higher (0.81 lower to 3.21 higher)	VERY LOW	IMPORTANT
Quality of life (measured using SF-36 physical component score; range 0-100; better indicated by higher values) - At 6 months follow-up												
1 (Shamji 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12	11	-	MD 0.4 higher (9.98 lower to 10.78 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Thoracolumbosacral orthosis	Ambulation encouragement	Relative	Absolute (95% CI)		
Quality of life (measured using SF-36 mental component score; 0-100; better indicated by higher values) - At 6 months follow-up												
1 (Shamji 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12	11	-	MD 3.3 lower (12.41 lower to 5.81 higher)	VERY LOW	IMPORTANT

CI: Confidence interval; MD: mean difference; SF-36: 36 item short-form survey; VAS: VAS: Visual analogue scale
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for Oswestry Disability Index +/-3.5; for VAS +/-1.05)
3 95% CI crosses 2 MIDs (for SF-36 physical component +/-6.65; SF-36 mental component +/-5.35)

Table 54: Clinical evidence profile for paraplegic gait orthosis plus functional training versus standard care

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Paraplegic gait orthosis plus functional training	Standard care	Relative (95% CI)	Absolute		

Changes in activity of daily living: modified Barthel Index (mBI; range 0-100; better indicated by higher values) [at 3 months follow-up after intervention completion]												
1 (Shuai 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	18	18	-	MD 33.94 higher (14.08 to 53.8 higher)	MODERATE	IMPORTANT

CI: Confidence interval; MD: Mean difference
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2.

Strengthening, balance, proprioception, vestibular rehabilitation and training

Table 55: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Extended physical therapy + exercise therapy versus home exercise training in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extended physical therapy + exercise therapy	Home exercise training	Relative	Absolute (95% CI)		
Change in mobility (measured using Modified Physical Performance Test score; range 0-36; better indicated by higher values) - 3 months (during intervention)												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	44	39	-	MD 2.8 higher (0.38 lower to 5.98 higher)	LOW	CRITICAL
Change in mobility (measured using Modified Physical Performance Test score; range 0-36; better indicated by higher values) - 6 months (intervention completion)												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsist	no serious indirectne	serious[2]	none	37	43	-	MD 5.7 higher (2.74 to	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extended physical therapy + exercise therapy	Home exercise training	Relative	Absolute (95% CI)		
			ency	ss						8.66 higher)		
Changes in mobility (measured as number of participants not using assistive device for gait if required at baseline) - Time point not reported												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19/33 (57.6%)	11/35 (31.4%)	RR 1.83 (1.04 to 3.24)	261 more per 1000 (from 13 more to 704 more)	LOW	CRITICAL
Changes in ADL (measured using Functional Status Questionnaire score; range 0-36; better indicated by lower values) - 3 months (during intervention) (Better indicated by lower values)												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	41	-	MD 2.1 higher (0.13 lower to 4.33 higher)	LOW	IMPORTANT
Changes in ADL (measured using Functional Status Questionnaire score; range 0-36; better indicated by lower values) - 6 months (intervention completion) (Better indicated by lower values)												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	43	-	MD 2.5 higher (0.07 to 4.93 higher)	LOW	IMPORTANT
Changes in ADL (measured using Instrumental Activities of Daily Living score; range 0-14; better indicated by higher values) - 3 months (during intervention)												
1 (Binder	randomis	serious[1]	no	no	serious[2]	none	45	41	-	MD 0.7	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Extended physical therapy + exercise therapy	Home exercise training	Relative	Absolute (95% CI)		
2004)	ed trials		serious inconsistency	serious indirectness						higher (0.34 lower to 1.74 higher)		
Changes in ADL (measured using Instrumental Activities of Daily Living score; range 0-14; better indicated by higher values) - 6 months (intervention completion)												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	43	-	MD 0.6 higher (0.5 lower to 1.7 higher)	LOW	IMPORTANT
Changes in ADL (measured using Basic Activities of Daily Living score; range 0-14; better indicated by higher values) - 3 months (during intervention)												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	41	-	MD 0.4 higher (0.11 lower to 0.91 higher)	LOW	IMPORTANT
Changes in ADL (measured using Basic Activities of Daily Living score; range 0-14; better indicated by higher values) - 6 months (intervention completion)												
1 (Binder 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	41	43	-	MD 0.4 higher (0.13 lower to 0.93 higher)	LOW	IMPORTANT

ADL: Activities of daily living; CI: Confidence interval; MD: Mean difference

1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for modified Physical Performance Test score +/-4.1; for assistive devices 0.8 and 1.25; for Functional Status Questionnaire +/-2.75; for Instrumental Activities of Daily Living +/-1.3; for Basic Activities of Daily Living +/-0.65)

Table 56: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Physiotherapy + gym session + mobility versus physiotherapy only in general trauma rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + gym session + mobility	Physiotherapy only	Relative (95% CI)	Absolute		
Patient acceptability (measured as number of patients reporting very satisfied with treatment[1]) - Time point not reported												
1 (Calthorpe 2004)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	serious[3]	none	28/41 (68.3%)	16/41 (39%)	RR 1.75 (1.13 to 2.71)	293 more per 1000 (from 51 more to 667more)	VERY LOW	CRITICAL
Changes in mobility (measured using number of participants reporting problems in mobility domain on EQ-5D) - At 6 months following injury												
1 (Calthorpe 2004)	randomised trials	serious[4]	no serious inconsistency	no serious indirectness	very serious[5]	none	14/34 (41.2%)	20/39 (51.3%)	RR 0.80 (0.48 to 1.33)	103 fewer per 1000 (from 267 fewer to 169 more)	VERY LOW	CRITICAL
Pain (measured using number of participants reporting problems in pain/discomfort domain on EQ-5D) - At 6 months following injury												
1 (Calthorpe 2004)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[5]	none	17/34 (50%)	23/39 (59%)	RR 0.85 (0.55 to 1.30)	88 fewer per 1000 (from 265 fewer to 177 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants reporting problems in self-care domain on EQ-5D) - At 6 months following injury												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + gym session + mobility	Physiotherapy only	Relative (95% CI)	Absolute		
1 (Calthorpe 2004)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[5]	none	10/34 (29.4%)	10/39 (25.6%)	RR 1.15 (0.54 to 2.42)	38 more per 1000 (from 118 fewer to 364 more)	VERY LOW	IMPORTANT
Changes in ADL (measured using number of participants reporting problems in usual activity domain on EQ-5D) - At 6 months following injury												
1 (Calthorpe 2004)	randomised trials	very serious[2]	no serious inconsistency	no serious indirectness	very serious[5]	none	12/34 (35.3%)	10/39 (25.6%)	RR 1.38 (0.68 to 2.78)	97 more per 1000 (from 82 fewer to 456 more)	VERY LOW	IMPORTANT

CI: Confidence interval; EQ-5D: EuroQol 5 dimensions; MD: Mean difference; OR: Odds ratio
1 Study reported satisfaction with treatment as a choice between not satisfied, somewhat satisfied, satisfied or very satisfied. Odds ratio was calculated by dichotomising answers into not satisfied/somewhat satisfied/satisfied compared and very satisfied
2 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
3 95% CI crosses 1 MID (for number participants reporting vert satisfied with treatment 0.8 and 1.25)
4 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
5 95% CI crosses 2 MIDs (for number participants reporting problems in any given domain on EQ-5D 0.8 and 1.25)

Table 57: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Physiotherapy + gym session + mobility versus physiotherapy only in general trauma rehabilitation (outcomes reported as medians (IQR) and analysed appropriately)

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + gym session + mobility	Physiotherapy only	Physiotherapy + gym session + mobility	Physiotherapy only		
Changes in mobility (measured using measured by modified Iowa Level of Assistance score; range 0-36; better indicated by lower values) - At day 3												
1 (Calthorpe 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	43	44	Median (IQR): 7 (1-15)[3]	Median (IQR): 10 (4-19)[3]	VERY LOW	CRITICAL
Changes in mobility (measured using measured by modified Iowa Level of Assistance score; range 0-36; better indicated by lower values) - At day 5												
1 (Calthorpe 2004)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	43	44	Median (IQR): 7.5 (2-15)[4]	Median (IQR): 16 (4-24)[4]	VERY LOW	CRITICAL
Quality of life (measured using Glasgow Outcome Scale-Extended; range 0-8; better indicated by higher values) - Part of 6-monthly routinely collected data (exact time point unclear)												
1 (Calthorpe 2004)	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[2]	none	34	39	Median (IQR): 6 (3.7)[6]	Median (IQR): 6 (5-6)[6]	VERY LOW	IMPORTANT
Quality of life (measured using SF-12 Physical component score; range 0-100; better indicated by higher values) - Part of 6-monthly routinely collected data (exact time point unclear)												
1 (Calthorpe 2004)	randomised trials	very serious[5]	no serious inconsistency	no serious indirectness	very serious[2]	none	25	32	Median (IQR): 36 (29-49)[7]	Median (IQR): 33 (26-56)[7]	VERY LOW	IMPORTANT
Quality of life (measured using SF-12 Mental component score; range 0-100; better indicated by higher values) - Part of 6-monthly routinely collected data (exact time point unclear)												
1 (Calthorpe 2004)	randomised trials	very serious[5]	no serious inconsist	no serious indirectn	very serious[2]	none	25	32	Median (IQR): 54 (37-58)[8]	Median (IQR): 55 (50-58)[8]	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + gym session + mobility	Physiotherapy only	Physiotherapy + gym session + mobility	Physiotherapy only		
			ency	ess								

IQR: Interquartile range; SF-12: 12 item short-form survey;
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels. Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
3 According to the statistical analyses performed by the author, the median difference was statistically significantly higher in the intervention group (p<0.02, ANOVA). However, the pre-defined MID of 8.5 was not exceeded so the difference is not clinically important.
4 According to the statistical analyses performed by the author, the median difference was statistically significantly higher in the intervention group (p<0.04, ANOVA). The pre-defined MID of 8.5 was reached and so the difference is clinically important.
5 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
6 According to the statistical analyses performed by the author, the median difference was not statistically significant between groups (p=0.65, ordinal logistics regression analysis)
7 According to the statistical analyses performed by the author, the median difference was not statistically significant between groups (p=0.96, unclear which statistical test was used)
8 According to the statistical analyses performed by the author, the median difference was not statistically significant between groups (p=0.37, unclear which statistical test was used

Table 58: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Progressive resistance training + routine care versus routine care only in SCI rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Progressive resistance training + routine care	Routine care only	Relative	Absolute(95% CI)		
Patient acceptability (measured using COPM participant perception satisfaction score; range 1-10; better indicated by higher values; better indicated by higher values) – 8 weeks (intervention completion)												
1 (Glinsky 2008)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	15	16	-	MD 0.1 lower (1.83 lower to 1.63 higher)	LOW	CRITICAL
Patient acceptability (measured using COPM participant perception satisfaction score; range 1-10; better indicated by higher values) - Difference between baseline and 8 weeks												
1 (Glinsky 2008)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	15	16	-	MD 0.40 lower (1.74 lower to 0.94 higher)	LOW	CRITICAL
Changes in ADL (measured using COPM participant perceptions score; range 1-10; better indicated by higher values) – 8 weeks (intervention completion)												
1 (Glinsky 2008)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[1]	none	15	16	-	MD 0.3 lower (1.88 lower to 1.28 higher)	LOW	IMPORTANT
Changes in ADL (measured using COPM participant perceptions score; range 1-10; better indicated by higher values) - Difference between baseline and 8 weeks												
1 (Glinsky 2008)	randomised trials	no serious risk of	no serious inconsiste	no serious indirectne	very serious[1]	none	15	16	-	MD 0.3 lower (1.81	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Progressive resistance training + routine care	Routine care only	Relative	Absolute(95% CI)		
		bias	ncy	ss						lower to 1.21 higher)		

ADL: Activities of daily living; CI: Confidence interval; COPM: Canadian Occupational Performance Measure; MD: Mean difference
1 95% CI crosses 2 MIDs (for COPM Satisfaction +/-0.8; for COPM Perception +/-1.05)

Table 59: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Physiotherapy + strengthening exercises versus physiotherapy + motor exercises in injurious falls rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + strengthening exercises	Physiotherapy and motor exercises	Relative	Absolute (95% CI)		
Upper limb function (measured as hand grip strength in kilo pascal; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	23	-	MD 4.63 lower (19.55 lower to 10.29 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + strengthening exercises	Physiotherapy and motor exercises	Relative	Absolute (95% CI)		
Upper limb function (measured as hand grip strength in kilo pascal; better indicated by higher values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 3.05 lower (20.24 lower to 14.14 higher)	LOW	CRITICAL
Changes in mobility (measured with Timed Up and Go in seconds; better indicated by lower values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	24	23	-	MD 10.46 lower (16 to 4.92 lower)	MODERATE	CRITICAL
Changes in mobility (measured with Timed Up and Go in seconds; better indicated by lower values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 3.5 lower (10.67 lower to 3.67 higher)	LOW	CRITICAL
Changes in mobility (measured using velocity in m/sec; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	24	23	-	MD 0.2 higher (0.1 to 0.3 higher)	MODERATE	CRITICAL
Changes in mobility (measured using velocity in m/sec) - At 3 months follow up												
1 (Hauer	randomi	serious[1]	no	no	no	none	23	22	-	MD 0.17	MODER	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + strengthening exercises	Physiotherapy and motor exercises	Relative	Absolute (95% CI)		
2001)	sed trials		serious inconsistency	serious indirectness	serious imprecision					higher (0.06 to 0.28 higher)	ATE	
Changes in mobility (measured using chair-rise time in sec; better indicated by lower values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	24	23	-	MD 6.15 lower (8.94 to 3.36 lower)	MODERATE	CRITICAL
Changes in mobility (measured using chair-rise time in sec; better indicated by lower values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 4.28 lower (7.89 to 0.67 lower)	LOW	CRITICAL
Changes in mobility (measured maximal box step in cm; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	23	-	MD 8.62 higher (0.56 lower to 17.8 higher)	LOW	CRITICAL
Changes in mobility (measured maximal box step in cm; better indicated by higher values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 7.01 higher (2.12 lower to 16.14 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + strengthening exercises	Physiotherapy and motor exercises	Relative	Absolute (95% CI)		
Changes in mobility (measured using stair flight in cm; better indicated by lower values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	23	-	MD 9.31 lower (14.68 to 3.94 lower)	LOW	CRITICAL
Changes in mobility (measured using stair flight in cm; better indicated by lower values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 6.18 lower (10.74 to 1.62 lower)	LOW	CRITICAL
Changes in mobility (measured using physical/sports activity score; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	24	23	-	MD 13.17 higher (11.13 to 15.21 higher)	MODERATE	CRITICAL
Changes in mobility (measured using physical/sports activity score; better indicated by higher values) - 3 months follow-up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	22	-	MD 2.81 higher (0.04 to 5.58 higher)	LOW	CRITICAL
Changes in mobility (measured using total physical activity score; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsist	no serious indirectn	no serious imprecisi	none	24	23	-	MD 13.68 higher (11.16 to	MODERATE	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + strengthening exercises	Physiotherapy and motor exercises	Relative	Absolute (95% CI)		
			ency	ess	on					16.2 higher)		
Changes in mobility (measured using total physical activity score; better indicated by higher values) - 3 months follow-up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	22	-	MD 3.71 higher (0.03 to 7.39 higher)	LOW	CRITICAL
Changes in mobility (measured as incidence of falls) - 3 months follow up (covering 6 month recall)												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45% of 23 participants	60% of 21 or 22 participants	RR 0.753 (0.455 to 1.245)[3]	Not reported	LOW	CRITICAL
Changes in ADL (measured using Tinetti Performance Orientated Mobility Assessment score; range 0-28; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	23	-	MD 4.37 higher (2.05 to 6.69 higher)	LOW	IMPORTANT
Changes in ADL (measured using Tinetti Performance Orientated Mobility Assessment score; range 0-28; better indicated by higher values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 2.95 higher (0.19 to 5.71	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + strengthening exercises	Physiotherapy and motor exercises	Relative	Absolute (95% CI)		
										higher)		
Changes in ADL (measured using Barthel ADL Index score; range 0-100; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	23	-	MD 1.82 higher (2.32 lower to 5.96 higher)	LOW	IMPORTANT
Changes in ADL (measured using Barthel ADL Index score; range 0-100; better indicated by higher values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 0.47 higher (3.76 lower to 4.7 higher)	LOW	IMPORTANT
Changes in ADL (measured using Lawton Instrumental ADL Index score; range 0-8; better indicated by higher values) - At 3 months follow up												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	22	-	MD 0.59 higher (0.42 lower to 1.6 higher)	LOW	CRITICAL
Changes in ADL (measured using Lawton Instrumental ADL Index score; range 0-8; better indicated by higher values) - Intervention completion												
1 (Hauer 2001)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	23	-	MD 0.95 higher (0.04 lower to 1.94 higher)	LOW	IMPORTANT

ADL: Activities of daily living; CI: Confidence interval; cm: centimetre; MD: Mean difference; RR: Relative risk; secs: seconds

1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for hand grip strength +/-14.475; for Timed Up and Go +/-4.03; for chair rise time +/-2.36; for maximal box step +/- 7.875; for stair flight +/-6.97; for physical/sports activity score +/-2.32; for total physical activity score +/-2.67; for incidence of falls 0.8 and 1.25; for Tinetti Performance Orientated Mobility Assessment +/-2.115; for Barthel ADL Index +/-4.165; for Lawton Instrumental ADL Index +/-0.895)
3 According to the statistical analyses performed by the author, the relative risk was not significant (p = 0.2, chi-square).

Table 60: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Self-exercise programme + standard rehabilitation versus standard rehabilitation only in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-exercise programme + standard rehabilitation	Standard rehabilitation only	Relative	Absolute (95% CI)		
Changes in mobility (measured using discharge motor FIM score; range 13-91; better indicated by higher values) - At discharge (time point not reported)												
1 (Kasuga 2019)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	146	229	-	MD 17.6 higher (13.75 to 21.45 higher)	LOW	CRITICAL
Changes in mobility (measured using motor FIM score gain; range 13-91; better indicated by higher values) - At discharge (time point not reported)												
1 (Kasuga 2019)	observational studies	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	146	229	-	MD 9.7 higher (6.47 to 12.93 higher)	VERY LOW	CRITICAL

CI: Confidence interval; FIM: Functional independence measure; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per ROBINS-I
2 95% CI crosses 1 MID (for motor FIM gain +/-8.35)

Table 61: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Physiotherapy + strength training versus physiotherapy only in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Physiotherapy + strength training	Physiotherapy only	Relative	Absolute (95% CI)		
Changes in mobility (measured with Timed Up and Go in seconds; better indicated by lower values) - Intervention completion												
1 (Kronborg 2017)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	39	39	-	MD 1.5 higher (3.27 lower to 6.27 higher)	HIGH	CRITICAL
Changes in mobility (measured with Timed Up and Go in seconds; better indicated by higher values) - Gain during intervention												
1 (Kronborg 2017)	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	39	39	-	MD 2.90 higher (0.99 lower to 6.79 higher)	HIGH	CRITICAL

CI: Confidence interval; MD: Mean difference

Table 62: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Unstable core training versus stable core training in SCI rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Unstable core training	Stable core training	Relative	Absolute (95% CI)		
Changes in mobility (measured using stride length, units not reported; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Liu 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	14	15	-	MD 0.11 higher (0.02 lower to 0.24 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using cadence, units not reported; better indicated by higher values) - 12 weeks (intervention completion) (Better												
1 (Liu 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	14	15	-	MD 0.13 higher (0.21 lower to 0.46 higher)	LOW	CRITICAL
Changes in mobility (measured using comfortable walking speed, units not reported; better indicated by higher values) - 12 weeks (intervention completion)												
1 (Liu 2019)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	14	15	-	MD 0.14 higher (0.01 lower to 0.29 higher)	VERY LOW	IMPORTANT

CI: Confidence interval; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for stride length +/-0.085; for comfortable walking speed +/-0.0795)

Table 63: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Balancing exercises versus standard physiotherapy in hip fracture rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balancing exercises	Standard physiotherapy	Relative	Absolute (95% CI)		
Changes in mobility (measured using WOMAC physical sub-score; range 0-100; better indicated by lower values) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 25.4 lower (28.72 to 22.08 lower)	MODERATE	CRITICAL
Changes in mobility (measured using WOMAC physical sub-score; range 0-100; better indicated by lower values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 25.3 lower (30.19 to 20.41 lower)	MODERATE	CRITICAL
Changes in mobility (measured using WOMAC stiffness sub-score; range 0-100; better indicated by lower values) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 22.5 lower (30.5 to 14.5 lower)	MODERATE	CRITICAL
Changes in mobility (measured using WOMAC stiffness sub-score; range 0-100; better indicated by lower values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 23.8 lower (33.69 to 13.91 lower)	MODERATE	CRITICAL
Pain (measured using WOMAC pain sub-score; range 0-100; better indicated by lower values) - 3 weeks from baseline (intervention completion)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balancing exercises	Standard physiotherapy	Relative	Absolute (95% CI)		
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 37.6 lower (42.9 to 32.3 lower)	MODERATE	IMPORTANT
Pain (measured using WOMAC pain sub-score; range 0-100; better indicated by lower values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 26.5 lower (33.69 to 19.31 lower)	MODERATE	IMPORTANT
Pain (measured using SF-36 bodily pain domain sub-score; range 0-100; better indicated by higher values) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 26.9 higher (11.75 to 42.05 higher)	MODERATE	IMPORTANT
Pain (measured using SF-36 bodily pain domain sub-score; range 0-100; better indicated by higher values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 37 higher (23.88 to 50.12 higher)	MODERATE	IMPORTANT
Pain (measured using current pain intensity numerical rating score; range 0-10; better indicated by lower values) - 3 weeks from baseline												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balancing exercises	Standard physiotherapy	Relative	Absolute (95% CI)		
(intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 3.5 lower (4.12 to 2.88 lower)	MODERATE	IMPORTANT
Pain (measured using current pain intensity numerical rating score; range 0-10; better indicated by lower values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 2.9 lower (3.49 to 2.31 lower)	MODERATE	IMPORTANT
Quality of life (measured using SF-36 physical function domain sub-score; range 0-100; better indicated by higher values) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	26	-	MD 18.10 higher (5.45 to 30.75 higher)	LOW	IMPORTANT
Quality of life (measured using SF-36 physical function domain sub-score; range 0-100; better indicated by higher values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 28.1 higher (16.78 to 39.42	MODERATE	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balancing exercises	Standard physiotherapy	Relative	Absolute (95% CI)		
										higher)		
Quality of life (measured using SF-36 physical role domain sub-score; range 0-10; better indicated by higher values 0) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 32.6 higher (16.34 to 48.86 higher)	MODERATE	IMPORTANT
Quality of life (measured using SF-36 physical role domain sub-score; range 0-100; better indicated by higher values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	26	-	MD 24.8 higher (8.14 to 41.46 higher)	LOW	IMPORTANT
Quality of life (measured using SF-36 general health domain sub-score; range 0-100; better indicated by higher values) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 19.4 higher (10.35 to 28.45 higher)	MODERATE	IMPORTANT
Quality of life (measured using SF-36 general health domain sub-score; range 0-100; better indicated by higher values) - 12 months after discharge from hospital												
1 (Monticon	randomised trials	serious[1]	no serious inconsiste	no serious indirectne	no serious imprecisio	none	26	26	-	MD 19.7 higher	MODERATE	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balancing exercises	Standard physiotherapy	Relative	Absolute (95% CI)		
e 2018)			ncy	ss	n					(8.3 to 31.1 higher)		
Quality of life (measured using SF-36 mental health domain sub-score; range 0-100; better indicated by higher values) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	26	-	MD 10.2 higher (1.19 lower to 21.59 higher)	LOW	IMPORTANT
Quality of life (measured using SF-36 mental health domain sub-score; range 0-100; better indicated by higher values) - 12 months after discharge from hospital												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	26	-	MD 20.7 higher (8.79 to 32.61 higher)	LOW	IMPORTANT
Changes in ADL (measured using FIM score; range 8-126; better indicated by higher values) - 3 weeks from baseline (intervention completion)												
1 (Monticone 2018)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 16.3 higher (9.65 to 22.95 higher)	MODERATE	IMPORTANT
Changes in ADL (measured using FIM score; range 18-126; better indicated by higher values) - 12 months after discharge from hospital												
1	randomise	serious[1]	no serious	no serious	no serious	none	26	26	-	MD 20.8	MODER	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balancing exercises	Standard physiotherapy	Relative	Absolute (95% CI)		
(Monticone 2018)	d trials		inconsistency	indirectness	imprecision					higher (13.86 to 27.74 higher)	ATE	

ADL: Activities of daily living; CI: Confidence interval; FIM: Functional independence measure; MD: Mean difference; SF-36: SF-36: 36 item short-form survey; WOMAC: Western Ontario and McMaster Universities Osteoarthritis Index
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for SF-36 physical function +/-6.95; for SF-36 physical role +/-8.45; for SF-36 mental health +/-12.7)

Table 64: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Strengthening training programme versus usual care in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Strengthening training programme	Usual care	Relative	Absolute (95% CI)		
Changes in mobility (measured using improvement of distance achieved in 2MWT in m; better indicated by higher values) - Intervention completion												
1 (Rau 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	29	-	MD 11.22 higher (1.77 to 20.67	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Strengthening training programme	Usual care	Relative	Absolute (95% CI)		
										higher)		
Changes in mobility (measured using improvement of walking speed in m/min; better indicated by higher values) - Intervention completion												
1 (Rau 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	29	-	MD 6.14 higher (1.31 to 10.97 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using Locomotor Capability Index score; scale 0-42; better indicated by higher values) - Intervention completion												
1 (Rau 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	29	-	MD 0.1 lower (2.44 lower to 2.24 higher)	VERY LOW	CRITICAL
Changes in mobility (measured with Timed Up and Go in seconds; better indicated by lower values) - Intervention completion												
1 (Rau 2007)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	29	-	MD 0.77 higher (0.54 lower to 2.08 higher)	VERY LOW	CRITICAL

2MWT: 2 minute walk test; CI: Confidence interval; m: metre; MD: Mean difference; min: minute
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for 2MWT +/-9.76; for improvement of walking speed +/-5.075; for Locomotor Capability Index +/-2.34; for Timed Up and Go +/-1.365)

Table 65: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Home exercise versus no home exercise in hip fracture rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Home exercise	No home exercise	Relative	Absolute (95% CI)		
Quality of life (measured using changes in the EQ-5D-3L index value; scale not reported; better indicated by higher values) - Between baseline and 6 months												
1 (Renerts 2019)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	very serious[3]	none	60	60	-	MD 0.02 higher (0.12 lower to 0.16 higher)	VERY LOW	IMPORTANT
Quality of life (measured using changes in the EQ-5D-3L index value; scale not reported; better indicated by higher values) - Between 6 months and 12 months												
1 (Renerts 2019)	randomised trials	very serious[1]	no serious inconsistency	serious[3]	serious[4]	none	60	59	-	MD 0.1 lower (0.2 lower to 0 higher)	VERY LOW	IMPORTANT
Quality of life (measured using changes in the EQ-5D-3L index value; scale not reported; better indicated by higher values) - Between baseline and 12 months												
1 (Renerts 2019)	randomised trials	very serious[1]	no serious inconsistency	serious[2]	serious[4]	none	60	59	-	MD 0.12 higher (0.03 lower to 0.27 higher)	VERY LOW	IMPORTANT

CI: Confidence interval; EQ-5D-3L: EuroQol 5 dimensions and 3 levels; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Study marked down for indirectness because drop out is only reported for the whole RCT population (4 arms, baseline N = 173, at 6 months N = 120, at 12 months N = 119). For the purposes of analysis, we have assumed dropout was equal between the study arms but cannot be certain.
3 95% CI crosses 2 MIDs (for EQ-5D-3L Index value +/-0.074)
4 95% CI crosses 1 MID (for EQ-5D-3L Index value +/-0.074)

Table 66: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: HIPFIT (High intensity progressive resistance training) versus standard care in hip fracture rehabilitation (outcomes reported as means (SD) and analysed appropriately)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	HIPFIT	Standard care	Relative	Absolute (95% CI)		
Changes in mobility (measured by use of assistive devices) - 12 months follow-up (Better indicated by lower values)												
1 (Singh 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	62	62	-	MD 1.2 lower (2.13 to 0.27 lower)	LOW	CRITICAL
Changes in ADL (measured using ALSAR skills score; range 0-22; better indicated by lower values) - 12 months follow-up												
1 (Singh 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	62	62	-	MD 0.70 higher (1.25 lower to 2.65 higher)	LOW	IMPORTANT
Changes in ADL (measured using NHANES score; range 0-3; better indicated by lower values) - 12 months follow-up												
1 (Singh 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	62	62	-	MD 0.03 lower (0.31 lower to 0.25 higher)	MODERATE	IMPORTANT

ADL: Activities of daily living; ALSAR: Assessment of Living Skills and Resources; CI: Confidence interval; MD: Mean difference; NHANES: National Health and Nutrition Examination Survey
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (use of assistive devices +/-1.5; for ALSAR score +/-1.8)

Table 67: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: HIPFIT (High intensity progressive resistance training) versus standard care in hip fracture rehabilitation (outcomes reported as medians (range) and analysed appropriately)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	HIPFIT	Standard care	HIPFIT	Standard care		
Changes in ADL (measured using FIM score; range 18-126; better indicated by higher values) - 12 months follow-up												
1 (Singh 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	62	62	Median (range): 106.7 (56-126)[3]	Median (range): 101.5 (34-126)[3]	VERY LOW	IMPORTANT
Changes in ADL (measured using Katz ADL score; range 0-12; better indicated by lower values) - 12 months follow-up												
1 (Singh 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	62	62	Median (range): 0.5 (0-9)[4]	Median (range): 1.0 (0-12)[4]	VERY LOW	IMPORTANT

ADL: Activities of daily living; FIM: Functional independence measure
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 Imprecision could not be assessed using GRADE default values due to no reporting of SD and no published MIDs so was instead assessed using the sample size: The result was not downgraded if n≥400, if n=399-200, the result was downgraded 1 level, and if n<200 the result was downgraded by 2 levels.
3 According to the statistical analyses performed by the author, the median difference was not significantly different between groups (p=0.84, unclear which statistical test was used)
4 According to the statistical analyses performed by the author, the median difference was not significantly different between groups (p=0.06, unclear which statistical test was used)

Table 68: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Physical activity enhancing programme (PEP) + standard care versus standard care only in hip fracture rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	PEP + standard care	Standard care only	Relative	Absolute (95% CI)		
Changes in mobility (Overall physical activity measured using International Physical Activity Questionnaire; scale not reported; better indicated by higher values) - 6 week												
1 (Suwanpasu 2014)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	23	23	-	MD 961.37 higher (461.42 to 1461.33 higher)	LOW	CRITICAL

CI: Confidence interval; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2

Table 69: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Twice per week exercise programme versus no exercise programme in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise programme	No exercise programme	Relative	Absolute (95% CI)		
Changes in mobility (measured using Sit-to-stand test in seconds; better indicated by lower values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	100	50	-	MD 15.8 lower (18.5 to 13.1 lower)	MODERATE	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise programme	No exercise programme	Relative	Absolute (95% CI)		
Changes in mobility (measured using 6MWT in m; better indicated by higher values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	100	50	-	MD 56.5 higher (23.93 to 89.07 higher)	LOW	CRITICAL
Changes in mobility (measured using maximum velocity in m/sec; better indicated by higher values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	100	50	-	MD 0.07 higher (0.03 lower to 0.17 higher)	LOW	CRITICAL
Changes in mobility (measured Timed Up-and-Go test in sec; better indicated by lower values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	100	50	-	MD 6.5 lower (9.51 to 3.49 lower)	LOW	CRITICAL
Changes in mobility (measured using step height in cm; better indicated by higher values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas	randomised trials	serious[1]	no serious	no serious	serious[2]	none	100	50	-	MD 9 higher	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise programme	No exercise programme	Relative	Absolute (95% CI)		
2011)			inconsistency	indirectness						(5.06 to 12.94 higher)		
Quality of life (measured using the SF-12 Physical component score; range 0-100; better indicated by higher values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	100	50	-	MD 0.1 higher (1.79 lower to 1.99 higher)	MODERATE	IMPORTANT
Quality of life (measured using the SF-12 Mental component score; range 0-100; better indicated by higher values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	100	50	-	MD 1 lower (4.01 lower to 2.01 higher)	LOW	IMPORTANT
Changes in ADL (measured using Nottingham Extended ADL score; range 0-66; better indicated by higher values) - 3 months from baseline (intervention completion, 6 months post-injury)												
1 (Sylliaas 2011)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	100	50	-	MD 4.9 higher (0.48 to 9.32 higher)	LOW	IMPORTANT

6MWT: 6 minute walk test; ADL: Activities of daily living; CI: Confidence interval; cm: Centimetre; m: metre; MD: Mean difference; min: minute; sec: Seconds; SF-12: 12 item short-form survey
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for 6MWT +/- 41.8; for maximum velocity over 10m +/-0.1; for Timed Up and Go +/-4; for step height +/-6.5; for SF-12 mental component +/-3.95; for Nottingham ADL +/-4.55)

Table 70: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Once per week exercise programme versus no exercise programme in hip fracture rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise programme	No exercise programme	Relative	Absolute (95% CI)		
Changes in mobility (measured using Sit-to-stand test in seconds; better indicated by lower values) - 3 months from baseline (intervention completion, 9 months post-injury)												
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	47	-	MD 10 lower (11.49 to 8.51 lower)	MODERATE	CRITICAL
Changes in mobility (measured using 6MWT in m; better indicated by higher values) - 3 months from baseline (intervention completion, 9 months post-injury)												
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	47	-	MD 108 higher (85.24 to 130.76 higher)	MODERATE	CRITICAL
Changes in mobility (measured using maximum velocity in m/sec; better indicated by higher values) - 3 months from baseline (intervention completion, 9 months post-injury)												
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsiste	no serious indirectne	very serious[2]	none	48	47	-	MD 0.5 higher (0.62	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise programme	No exercise programme	Relative	Absolute (95% CI)		
			ncy	ss						lower to 1.62 higher)		
Changes in mobility (measured Timed Up-and-Go test in sec; better indicated by lower values) - 3 months from baseline (intervention completion, 9 months post-injury)												
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	47	-	MD 3.5 lower (3.9 to 3.1 lower)	MODERATE	CRITICAL
Changes in mobility (measured using step height in cm; better indicated by higher values) - 3 months from baseline (intervention completion, 9 months post-injury)												
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	47	-	MD 2.8 higher (0.61 lower to 6.21 higher)	MODERATE	CRITICAL
Quality of life (measured using the SF-12 Physical component score; range 0-100; better indicated by higher values) - 3 months from baseline (intervention completion, 9 months post-injury)												
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	47	-	MD 3.4 higher (2.33 to 4.47 higher)	MODERATE	IMPORTANT
Quality of life (measured using the SF-12 Mental component score; range 0-100; better indicated by higher values) - 3 months from baseline (intervention completion, 9 months post-injury)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise programme	No exercise programme	Relative	Absolute (95% CI)		
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	48	47	-	MD 4.4 higher (1.78 to 7.02 higher)	LOW	IMPORTANT
Changes in ADL (measured using Nottingham Extended ADL score; range 0-66; better indicated by higher values) - 3 months from baseline (intervention completion, 9 months post-injury)												
1 (Sylliaas 2012)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	48	47	-	MD 4.4 higher (2.24 to 6.56 higher)	MODERATE	IMPORTANT

6MWT: 6 minute walk test; ADL: Activities of daily living; CI: Confidence interval; cm: centimetre; m: metre; MD: Mean difference; min: minute; sec: seconds; SF-12: 12 item short-form survey
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MIDs (for maximum velocity over 10 m +/-0.35)
3 95% CI crosses 1 MID (for SF-12 mental component +/-1.9)

Table 71: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Computer-assisted rehabilitation therapy versus standard rehabilitation in traumatic hand injury rehabilitation

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Computer-assisted rehabilitation therapy	Standard rehabilitation	Relative	Absolute (95% CI)		
Upper limb function (measured using total active hand motion in degrees; better indicated by higher values) - 4 weeks from baseline (intervention completion)												
1 (Xiao 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	25	-	MD 13.34 lower (123.9 lower to 97.22 higher)	VERY LOW	CRITICAL
Upper limb function (measured using total active hand motion in degrees; better indicated by higher values) - Difference before-after training												
1 (Xiao 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	26	-	MD 2.5 higher (34.3 lower to 39.3 higher)	LOW	CRITICAL
Upper limb function (measured as hand grip strength in kg; better indicated by higher values) - 4 weeks from baseline (intervention completion)												
1 (Xiao 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	25	-	MD 1.63 higher (0.15 lower to 3.41 higher)	VERY LOW	CRITICAL
Upper limb function (measured as hand grip strength in kg; better indicated by higher values) - Difference before-after training												
1 (Xiao 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	25	-	MD 1.97 higher (1.77 to 2.17 higher)	LOW	IMPORTANT
Upper limb function (measured using 2-point pinch strength in kg; better indicated by higher values) - 4 weeks from baseline (intervention completion)												
1 (Xiao	randomis	very	no	no	serious[2]	none	26	25	-	MD 0.48	VERY	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Computer-assisted rehabilitation therapy	Standard rehabilitation	Relative	Absolute (95% CI)		
2018)	ed trials	serious[1]	serious inconsistency	serious indirectness						higher (0.2 to 0.76 higher)	LOW	
Upper limb function (measured using 2-point pinch strength in kg; better indicated by higher values) - Difference before-after training												
1 (Xiao 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	25	-	MD 0.35 higher (0.14 to 0.56 higher)	LOW	CRITICAL
Upper limb function (measured using upper extremity function index score; scale not reported; better indicated by higher values) - 4 weeks from baseline (intervention completion)												
1 (Xiao 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26	25	-	MD 4.77 higher (2.12 lower to 11.66 higher)	VERY LOW	CRITICAL
Upper limb function (measured using upper extremity function index score; scale not reported; better indicated by higher values) - Difference before-after training												
1 (Xiao 2018)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	26	25	-	MD 8.61 higher (7.24 to 9.98 higher)	LOW	CRITICAL

CI: Confidence interval; kg: kilogram; MD: Mean difference
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for hand motion +/-114.65; for hand grip strength +/-1.19; for 2 point grip strength +/-0.245; for upper extremity function index +/-6.345)

Table 72: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Proprioceptive neuromuscular facilitation versus traditional prosthetic training in transfemoral amputation rehabilitation

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Proprioceptive neuromuscular facilitation	Traditional prosthetic training	Relative	Absolute (95% CI)		
Changes in mobility (measured using percentage weight bearing; better indicated by higher values) - At intervention completion (time point not reported)												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	25	25	-	MD 10.87 higher (7.63 to 14.11 higher)	LOW	CRITICAL
Changes in mobility (measured using percentage weight bearing; better indicated by higher values) - Difference before-after training												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	25	25	-	MD 8.24 higher (4.49 to 11.99 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using stride length in cm; better indicated by higher values) - At intervention completion (time point not reported)												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 5.88 higher (0.3 lower to 12.06 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using stride length in cm; better indicated by higher values) - Difference before-after training												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsiste	no serious indirectne	no serious imprecisio	none	25	25	-	MD 6.54 higher (5 to 8.08	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Proprioceptive neuromuscular facilitation	Traditional prosthetic training	Relative	Absolute (95% CI)		
			ncy	ss	n					higher)		
Changes in mobility (measured using amputated side step length in cm; better indicated by higher values) - At intervention completion (time point not reported)												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 1.52 higher (1.05 lower to 4.09 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using amputated side step length in cm; better indicated by higher values) - Difference before-after training												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 1.54 lower (2.69 to 0.39 lower)	VERY LOW	CRITICAL
Changes in mobility (measured using sound side step length in cm; better indicated by higher values) - At intervention completion (time point not reported)												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 4.36 higher (1.7 to 7.02 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using sound side step length in cm; better indicated by higher values) - Difference before-after training												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	25	25	-	MD 5 higher (3.24 to 6.76 higher)	LOW	CRITICAL
Changes in mobility (measured using cadence with self-selected comfortable gait in steps/min; better indicated by higher values) - At												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Proprioceptive neuromuscular facilitation	Traditional prosthetic training	Relative	Absolute (95% CI)		
intervention completion (time point not reported)												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 5.96 higher (1.64 to 10.28 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using cadence with self-selected comfortable gait in steps/min; better indicated by higher values) - Difference before-after training												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 6.48 higher (4.48 to 8.48 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using cadence of fast gait in steps/min; better indicated by higher values) - At intervention completion (time point not reported)												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 5.96 higher (1.64 to 10.28 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using cadence of fast gait in steps/min; better indicated by higher values) - Difference before-after training												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	25	25	-	MD 6.88 higher (4.92 to 8.84 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Proprioceptive neuromuscular facilitation	Traditional prosthetic training	Relative	Absolute (95% CI)		
Changes in mobility (measured using velocity in cm/sec; better indicated by higher values) - At intervention completion (time point not reported)												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 4.51 higher (0.24 lower to 9.26 higher)	VERY LOW	CRITICAL
Changes in mobility (measured using velocity in cm/sec; better indicated by higher values) - Difference before-after training												
1 (Yigiter 2002)	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	25	-	MD 5.12 higher (3.07 to 7.17 higher)	VERY LOW	CRITICAL

ADL: Activities of daily living; CI: Confidence interval; cm: centimetre; MD: Mean difference; min: minute; sec: seconds
1 Very serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 1 MID (for percentage weight bearing +/-2.62; for stride length +/-3.585; for amputated side step length +/-2.255; sound side step length +/-2.795; for self-selected gait cadence +/-4.75; for fast-gait cadence +/-4.085; for velocity +/-4.395)

Table 73: Clinical evidence profile for strengthening, balance, proprioception, vestibular rehabilitation/training interventions: Circuit resistance training + standard care versus standard care only

Quality assessment	No of patients	Effect	Quality	Importance

No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CRT + standard care	Standard care only	Relative	Absolute (95% CI)		
Upper body function (measured using Total work/Body weight (J/kg), left side, 180/sec, extension; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	13	13	-	MD 10.1 lower (34.56 lower to 14.36 higher)	VERY LOW	CRITICAL
Upper body function (measured using Total work/Body weight (J/kg), left side, 180/sec, flexion; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 12.1 higher (0.65 lower to 24.85 higher)	LOW	CRITICAL
Upper body function (measured using Total work/Body weight (J/kg), left side, 60/sec, extension; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 14.7 higher (8.96 lower to 38.6 higher)	LOW	CRITICAL
Upper body function (measured using Total work/Body weight (J/kg), left side, 60/sec, flexion; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	13	13	-	MD 39.50 higher (19.24 to 59.76 higher)	MODERATE	CRITICAL
Upper body function (measured using Total work/Body weight (J/kg), right side, 180/sec, extension; better indicated by higher values) (6 weeks												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CRT + standard care	Standard care only	Relative	Absolute (95% CI)		
from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	13	13	-	MD 5.10 higher (17.96 lower to 28.16 higher)	VERY LOW	CRITICAL
Upper body function (measured using Total work/Body weight (J/kg), right side, 180/sec, flexion; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 10.67 higher (3.02 to 18.32 higher)	LOW	CRITICAL
Upper body function (measured using Total work/Body weight (J/kg), right side, 60/sec, extension; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 8.6 higher (13.47 lower to 30.67 higher)	LOW	CRITICAL
Upper body function (measured using Total work/Body weight (J/kg), right side, 60/sec, flexion; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsiste	no serious indirectne	serious[3]	none	13	13	-	MD 30.8 higher (6 to 55.6	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CRT + standard care	Standard care only	Relative	Absolute (95% CI)		
			ncy	ss						higher)		
Upper body function (measured using Peak torque/Body weight (Nm/kg), left side, 180/sec, extension; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	13	13	-	MD 1.1 lower (11.75 lower to 9.55 higher)	VERY LOW	CRITICAL
Upper body function (measured using Peak torque/Body weight (Nm/kg), left side, 180/sec, flexion; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 5.6 higher (0.38 lower to 11.58 higher)	LOW	CRITICAL
Upper body function (measured using Peak torque/Body weight (Nm/kg), left side, 60/sec, extension; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 4.8 higher (7.87 lower to 17.47 higher)	LOW	CRITICAL
Upper body function (measured using Peak torque/Body weight (Nm/kg), left side, 60/sec, flexion; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim	randomis	serious[1]	no	no	serious[3]	none	13	13	-	MD 13.50	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CRT + standard care	Standard care only	Relative	Absolute (95% CI)		
2016)	ed trials		serious inconsistency	serious indirectness						higher (4.76 to 22.24 higher)		
Upper body function (measured using Peak torque/Body weight (Nm/kg), right side, 180/sec, extension; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	13	13	-	MD 1 higher (12.8 lower to 14.8 higher)	VERY LOW	CRITICAL
Upper body function (measured using Peak torque/Body weight (Nm/kg), right side, 180/sec, flexion; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	13	13	-	MD 9.9 higher (6.57 to 13.23 higher)	MODERATE	CRITICAL
Upper body function (measured using Peak torque/Body weight (Nm/kg), right side, 60/sec, extension; better indicated by higher values) (6 weeks from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	13	13	-	MD 3.3 higher (11.63 lower to 18.23 higher)	VERY LOW	CRITICAL
Upper body function (measured using Peak torque/Body weight (Nm/kg), right side, 60/sec, flexion; better indicated by higher values) (6 weeks												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	CRT + standard care	Standard care only	Relative	Absolute (95% CI)		
from baseline, at intervention completion)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 7.9 higher (0.54 lower to 16.34 higher)	LOW	CRITICAL
Overall quality of life (measured using QoL scale) (6 weeks from baseline, at intervention completion; better indicated by higher values)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 28.5 lower (101.1 lower to 44.1 higher)	LOW	IMPORTANT
Changes in ADL (measured using total FIM score; range 18-126) (6 weeks from baseline, at intervention completion; better indicated by higher values)												
1 (Yildirim 2016)	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	13	-	MD 7 higher (1.41 lower to 15.41 higher)	LOW	IMPORTANT

ADL: Activities of daily living; CRT: Circuit resistance training; FIM: Functional Independence Measure; MD: Mean difference; QoL: Quality of life
1 Serious risk of bias in the evidence contributing to the outcomes as per RoB 2
2 95% CI crosses 2 MID (for Total work/Body weight [left/180/extension] +/- 9.6; Total work/Body weight [right/180/extension] +/- 12.2; Peak torque/Body weight [left/180/extension] +/- 5.4; Peak torque/Body weight [right/180/extension] +/- 6.95; Peak torque/Body weight [right/60/extension] +/- 7.35)
3 95% CI crosses 1 MID (for Total work/Body weight [left/180/flexion] +/- 7.05; Total work/Body weight [left/60/extension] +/- 12.1; Total work/Body weight [left/60/flexion] +/- 11.1; Total work/Body weight [right/180/flexion] +/- 4.6; Total work/Body weight [right/60/extension] +/- 14.45; Total work/Body weight [right/60/flexion] +/- 10.9; Peak torque/Body weight [left/180/flexion] +/- 4.9; Peak torque/Body weight [left/60/extension] +/- 8.5; Peak torque/Body weight [left/60/flexion] +/-7.4; Peak torque/Body weight [right/60/flexion] +/- 15.75; QoL scale +/- 45. 9; FIM +/- 3.65)