Appendix D: Clinical evidence tables

Study	Hansen 2011[7]
Study type	Controlled before and after.
Number of studies (number of participants)	1 (n=~28,729).
Countries and setting	Conducted in Denmark; setting: a small municipality in which the ED provision at the local hospital is being removed compared to the rest of the county.
Line of therapy	Not applicable.
Duration of study	Intervention time: 5 years.
Method of assessment of guideline condition	Adequate method of assessment/diagnosis.
Stratum	Unselected population.
Subgroup analysis within study	Stratified then randomised: male/female strata.
Inclusion criteria	Have 1 of randomly selected dates of birth (37/365).
Exclusion criteria	Deceased persons and emigrants.
Recruitment/selection of patients	Sample drawn from the National Person Registry based on the individual person identification number assigned to all Danish residents.
Age, gender and ethnicity	Age - Other: not reported. Gender (M:F): not reported. Ethnicity: not reported.
Further population details	1. Rural versus urban: rural (nearest ED following closure 30 Km away). 2. UK versus non-UK: non-UK (Denmark).
Indirectness of population	No indirectness.
Interventions	(n=2300) Intervention 1: Access to ED - 24 hour access to ED. Access to the ED for 24 hours a day at the local hospital. Duration: 2 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear. (n=2300) Intervention 2: Reduced access to ED - restricted access without pre-planned diversion. ED hours reduced to 'day-time' only. Duration: 2 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear. Comments: No definition on what the day hours were.

Study	Hansen 2011[7]
	(n=2300) Intervention 3: Reduced access to ED - ED closure (without hospital closure). Full ED closure. Duration: 1 year. Concurrent medication/care: local hospital remained open. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear.
Funding	Academic or government funding (Danish Health Research Council, Sygekassernes Helsefond, and Aarhus University Research Foundation).

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: 24 HOUR ACCESS TO ED versus RESTRICTED ACCESS WITHOUT PRE-PLANNED DIVERSION.

Protocol outcome 1: Impact on other services as defined by the paper during the study period.
- Actual outcome for Unselected male population: In-person GP consultations per person during the intervention period; MD 0.13 (95%CI -0.26 to 0.52); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness ; Baseline details: Adjusted for age, cohabitation, educational level and family income- Actual outcome for Unselected female population: In-person GP consultations per person during the intervention period; MD- 0.02 (95%CI -0.35 to 0.31); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected male population: Telephone GP consultations per person during the intervention period; MD 0.11 (95%CI -0.26 to 0.48); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Unselected female population: Telephone GP consultations per person during the intervention period; MD -0.19 (95%CI -0.64 to 0.26); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected male population: Home visits by GPs per person during the intervention period; MD 0.03 (95%CI -0.06 to 0.12); Risk of bias: Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: Home visits by GPs per person during the intervention period; MD -0.07 (95%CI -0.17 to 0.03); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Unselected male population: Number of hospital admissions per person during the intervention period; MD 0.01 (95%CI -0.03 to 0.05); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: Number of hospital admissions per person during the intervention period; MD -0.02 (95%CI -0.06 to 0.02); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
Protocol outcome 2: Number of ED presentations during the study period.
- Actual outcome for Unselected male population: Number of ED presentations per person during the intervention period; MD 0.00 (95%CI -0.02 to 0.02); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: Number of ED presentations per person during the intervention period;

Study	Hansen 2011[7]
MD 0.00 (95%CI -0.01 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: 24 HOUR ACCESS TO ED versus ED CLOSURE (WITHOUT HOSPITAL CLOSURE) Protocol outcome 1: Impact on other services as defined by the paper during the study period. - Actual outcome for Unselected male population: In-person GP consultations per person during the intervention period; MD 0.03 (95%CI -0.42 to 0.48); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: In-person GP consultations per person during the intervention period; MD -0.26 (95%CI -0.61 to 0.09); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected male population: Telephone GP consultations per person during the intervention period; MD 0.31 (95%CI -0.09 to 0.71); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: Telephone GP consultations per person during the intervention period; MD -0.35 (95%CI -0.82 to 0.12); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected male population: Home visits by GPs per person during the intervention period; MD 0.04 (95%CI -0.05 to 0.13); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: Home visits by GPs per person during the intervention period; MD -0.12 (95%CI -0.23 to -0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected male population: Number of hospital admissions per person during the intervention period; MD -0.02 (95%CI -0.06 to 0.02); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: Number of hospital admissions per person during the intervention period; MD -0.04 (95%CI -0.04 to 0.12); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness Protocol outcome 2: Number of ED presentations during the study period. - Actual outcome for Unselected male population: Number of ED presentations per person during the intervention period; MD -0.01 (95%CI -0.04 to 0.02); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Unselected female population: Number of ED presentations per person during the intervention period; MD 0.01 (95%CI -0.01 to 0.03); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - High, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Quality of life during the study period; Patient and/or carer satisfaction during the study period; Mortality during the study period; Avoidable adverse events during the study period.

Study	Hsia 2012[8]
Study type	Retrospective cohort study.
Number of studies (number of participants)	1 (n=761,404).
Countries and setting	Conducted in USA; setting: all non-federal hospitals in California.
Line of therapy	Not applicable.
Duration of study	Intervention time: 10 years.
Method of assessment of guideline condition	Adequate method of assessment/diagnosis.
Stratum	Severely ill patients: time-sensitive conditions (AMI, Stroke, Sepsis, and COPD).
Subgroup analysis within study	Not applicable.
Inclusion criteria	AMI, Stroke, Sepsis and COPD patients.
Exclusion criteria	Patients who were not admitted through the ED; patients whose admitted hospital is more than 100 miles away from their mailing address and patients who were not admitted to their nearest hospital.
Recruitment/selection of patients	Patient level-data from the California Office of State-wide Health and Planning Development (OSHPD) Patient Discharge Data.
Age, gender and ethnicity	Age - Mean (SD): Group 1: 18-44 - 7.3%, 45-64 - 25.5%, 65-74 - 20.9%, 75-84 - 28.1%, >84 - 18.3%; Group 2: 18-44 - 8.0%, 45-64 - 28.5%, 65-74 - 20.5%, 75-84 - 26.0%, >84 - 17.1%; Gender (M:F): 125:147. Ethnicity: Group 1: White - 66.5%, Black - 7.5%, Hispanic - 15.2%, Other - 9.0%, Unknown - 1.7%; Group 2: White - 59.2%, Black - 14.1%, Hispanic - 17.7%, Other - 7.9%, Unknown - 1.1%.
Further population details	1. Rural versus urban: Not applicable/Not stated/Unclear 2. UK versus non-UK: non-UK (USA).
Indirectness of population	The majority of evidence did not differentiate between a reduction in ED opening hours, ED closures or whole hospital closures.
Interventions	(n=693,827) Intervention 1: Access to ED - undefined 'usual' access to ED. No increase in driving time to the nearest ED. Duration: 10 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear. (n=67,577) Intervention 2: Reduced access to ED - restricted access without pre-planned diversion. Increase in driving time to the nearest ED. Duration: 10 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear.

Study	Hsia 2012[8]
Funding	Academic or government funding (NIH/NCRR/OD UXSF-CTSI, Robert Wood Johnson Foundation, NIH/NHLBI).
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: UNDEFINED 'USUAL' ACCESS TO ED versus RESTRICTED ACCESS WITHOUT PRE-PLANNED DIVERSION. Protocol outcome 1: Mortality during the study period. - Actual outcome for severely ill patients: Mortality at in-hospital; OR 1.04 (95%CI 0.99 to 1.09); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Impact on other services as defined by the paper during the study period; Quality of life during the study period; Patient and/or carer satisfaction during the study period; Avoidable adverse events during the study period; Number of ED presentations during the study period.

Study	Liu 2014[9]
Study type	Retrospective cohort study.
Number of studies (number of participants)	1 (n=162,468,92).
Countries and setting	Conducted in USA; setting: all non-federal hospitals in California.
Line of therapy	Not applicable.
Duration of study	Intervention time: 11 years.
Method of assessment of guideline condition	Adequate method of assessment/diagnosis.
Stratum	Unselected population.
Subgroup analysis within study	Not applicable.
Inclusion criteria	All admissions.
Exclusion criteria	Admissions not made via the ED, patients under 18 and patient's ZIP code not in California.
Recruitment/selection of patients	Patient level-data from the California Office of State-wide Health and Planning Development (OSHPD) Patient Discharge Data.
Age, gender and ethnicity	Age - Mean (SD): Group 1: 18-44 - 20.0%, 45-64 - 28.4%, 65-74 - 16.7%, 75-84 - 21.3%, >84 - 13.7%; Group 2: 18-44 - 22.6%, 45-64 - 31.4%, 65-74 - 15.5%, 75-84 - 18.4%, >84 - 12.1%; Gender (M:F): 841:727. Ethnicity: Group 1: White - 59.3%, Black - 9.2%, Hispanic - 21.1%, Other - 8.8%, Unknown - 1.6%; Group 2: White - 50.2%, Black - 13.0%, Hispanic - 25.0%, Other - 10.5%, Unknown - 1.3%.
Further population details	1. Rural versus urban: Not applicable/Not stated/Unclear 2. UK versus non-UK: non-UK (USA).

Study	Liu 2014[9]
Indirectness of population	The majority of evidence did not differentiate between a reduction in ED opening hours, ED closures or whole hospital closures.
Interventions	(n=12198459) Intervention 1: Access to ED - undefined 'usual' access to ED. Hospital Service Area with no ED closures - geographic area affected by an ED closure defined as the Hospital Service Area (HSA). HSAs are groups of ZIP codes organised by the Dartmouth Atlas Project to reflect hospitalisation patterns of Medicare beneficiaries. Duration: 11 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear. Comments: Each hospital was assigned to a Hospital Service Area using hospital ZIP codes and the 1999-2010 ZIP code-HSA crosswalk files from the Dartmouth Atlas Project. (n=4048433) Intervention 2: Reduced access to ED - ED closure (without hospital closure). Hospital Service Area with no ED closures - geographic area affected by an ED closure defined as the Hospital Service Area (HSA). HSAs are groups of ZIP codes organised by the Dartmouth Atlas Project to reflect hospitalisation patterns of Medicare beneficiaries. Duration: 11 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU. Comments: does not account for ED closure versus full hospital closure. Level of original access not mentioned.
Funding	Academic or government funding (National Center for Advancing Translational Sciences, National Institutes of Health to the University of California San Francisco, and the Robert Wood Johnson Foundation).
RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: UNDEFINED 'USUAL' ACCESS TO ED versus ED CLOSURE (WITHOUT HOSPITAL CLOSURE). Protocol outcome 1: Mortality during the study period. - Actual outcome for Unselected population: Mortality at in-hospital; OR 1.05 (95%CI 1.02 to 1.07); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Impact on other services as defined by the paper during the study period; Quality of life during the study period; Patient and/or carer satisfaction during the study period; Avoidable adverse events during the study period; Number of ED presentations during the study period.

Study	Shen 2012[11]
Study type	Retrospective cohort study.
Number of studies (number of participants)	1 (n=156,354,6)

Study	Shen 2012[11]
Countries and setting	Conducted in USA; setting: all Medicare and Medicaid hospitals in the USA.
Line of therapy	Not applicable.
Duration of study	Intervention time: 9 years.
Method of assessment of guideline condition	Adequate method of assessment/diagnosis.
Stratum	Severely ill patients: Myocardial Infarction population.
Subgroup analysis within study	Not applicable.
Inclusion criteria	Diagnosis code of 410.0x or 4.10.x1.
Exclusion criteria	Patients who were not admitted through the ED (23%); patients whose admitted hospital is more than 100 miles away from their mailing address or were admitted to hospitals whilst away from home (11%); ZIP codes that experienced multiple changes in distance to their closest ED during the study period (3%) and ZIP codes that do not have patients both before and after the access change occurred (1%).
Recruitment/selection of patients	All Acute Medical Infarction patients from 1996 – 2005 contained within the MedPAR database.
Age, gender and ethnicity	Age - Mean (SD): Group 1: 78.56 (7.87); Group 2: 78.43 (7.85); Group 3: 78.33 (7.80); Group 1: 77.53 (7.66). Gender (M:F): 49:51. Ethnicity: White: 87%; African American: 9%; Other non-white: 4%.
Further population details	1. Rural versus urban: Not applicable/Not stated/Unclear (author states: patients who experience large increase in driving time are mostly in rural communities). 2. UK versus non-UK: non-UK (USA).
Indirectness of population	The majority of evidence did not differentiate between a reduction in ED opening hours, ED closures or whole hospital closures.
Interventions	(n=141,861,3) Intervention 1: Access to ED - undefined 'usual' access to ED. No increase in driving time to the nearest ED. Duration: 9 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear. (n=141746) Intervention 2: Reduced access to ED - restricted access without pre-planned diversion. Increase in driving time to the nearest ED less than 10 minutes. Duration: 9 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear. (n=26817) Intervention 3: Reduced access to ED - restricted access without pre-planned diversion. Increase in driving time to the nearest ED 10-30 minutes. Duration: 9 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not

Study	Shen 2012[11]
	applicable/Not stated/Unclear. (n=3187) Intervention 4: Reduced access to ED - restricted access without pre-planned diversion. Increase in driving time to the nearest ED over 30 minutes. Duration: 9 years. Concurrent medication/care: not applicable. Further details: 1. Planned diversion to other hospital versus non-planned diversion for example, straight to AMU: Not applicable/Not stated/Unclear.
Funding	Academic or government funding (Robert Wood Johnson Foundation, the National Institute of Health/National Center for Research Resources, University of California, San Francisco Clinical and Translational Science).

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: UNDEFINED 'USUAL' ACCESS TO ED versus RESTRICTED ACCESS WITHOUT PRE-PLANNED DIVERSION.

Protocol outcome 1: Mortality during the study period.
- Actual outcome for Severely ill patients: Mortality at 7 days; RD 0.01 (95%CI 0 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Severely ill patients: Mortality at 30 days; RD 0 (95%CI 0 to 0); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Severely ill patients: Mortality at 90 days; RD 0 (95%CI 0 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Severely ill patients: Mortality at 180 days; RD 0 (95%CI 0 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Severely ill patients: Mortality at 1 year; RD 0 (95%CI 0 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness

RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: UNDEFINED 'USUAL' ACCESS TO ED versus RESTRICTED ACCESS WITHOUT PRE-PLANNED DIVERSION.

Protocol outcome 1: Mortality during the study period.
- Actual outcome for Severely ill patients: Mortality at 7 days; RD 0 (95%CI -0.02 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Severely ill patients: Mortality at 30 days; RD -0.01 (95%CI -0.02 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Severely ill patients: Mortality at 90 days; RD -0.01 (95%CI -0.02 to 0); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness
- Actual outcome for Severely ill patients: Mortality at 180 days; RD -0.01 (95%CI -0.02 to 0.01); Risk of bias: All domain - High, Selection - High, Blinding - Low,

Study	Shen 2012[11]
Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Severely ill patients: Mortality at 1 year; RD -0.01 (95%CI -0.02 to 0); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness RESULTS (NUMBERS ANALYSED) AND RISK OF BIAS FOR COMPARISON: UNDEFINED 'USUAL' ACCESS TO ED versus RESTRICTED ACCESS WITHOUT PRE-PLANNED DIVERSION. Protocol outcome 1: Mortality during the study period. - Actual outcome for Severely ill patients: Mortality at 7 days; RD 0.04 (95%CI -0.01 to 0.09); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Severely ill patients: Mortality at 30 days; RD 0.06 (95%CI 0.01 to 0.11); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness. - Actual outcome for Severely ill patients: Mortality at 90 days; RD 0.01 (95%CI -0.03 to 0.06); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness - Actual outcome for Severely ill patients: Mortality at 180 days; RD 0.03 (95%CI -0.02 to 0.08); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness- Actual outcome for Severely ill patients: Mortality at 1 year; RD 0.02 (95%CI -0.01 to 0.05); Risk of bias: All domain - High, Selection - High, Blinding - Low, Incomplete outcome data - low, Outcome reporting - Low, Measurement - Low, Crossover - Low, Subgroups - Low; Indirectness of outcome: No indirectness	
Protocol outcomes not reported by the study	Impact on other services as defined by the paper during the study period; Quality of life during the study period; Patient and/or carer satisfaction during the study period; Avoidable adverse events during the study period; Number of ED presentations during the study period.