



## Definition and Derivation of Baseline Characteristics and Outcomes

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## 1 Version

Date	Version	Comments
06-Jun-2020	0.1	Initial version
08-Jun-2020	0.2	Minor updates
09-Jun-2020	1.0	First released version

## 2 Scope

This document describes the definition and derivation of the primary, secondary and other outcomes of the RECOVERY trial for the published trial analyses. It should be read alongside the study protocol which defines the study outcomes briefly, and the Statistical Analysis Plan (SAP) which describes the statistical methods used to analyse these outcomes. The SAP refers to this document (see Section 2.6.4 Detailed derivation of outcomes) which provides detail on how the outcomes are defined, captured and derived.

Most outcomes have more than one potential source which improves completeness of capture but also will inevitably identify discrepancies between different sources. This document describes the principles for how such discrepancies are resolved; the rules for this were developed blind to results. Further details of the methods are described in the RECOVERY trial internal operating procedure for identifying data discrepancies.

## 3 Abbreviations

ADDE	Annual District Death Extract
CCDS	Critical Care Dataset
CHESS	COVID-19 Hospitalisation in England Surveillance System
CPAP	Continuous Positive Airway Pressure
CRP	C-reactive protein
ECMO	Extra-corporeal membrane oxygenation
eCRF	Electronic Case Report Form
FCE	Finished Consultant Episode
FU	Follow-up
HESAPC	Hospital Episode Statistics Admitted Patient Care
HFNO	High-flow nasal oxygen
ICD-10	International Classification of Diseases 10 <sup>th</sup> edition
ICNARC	Intensive Care National Audit and Research Centre
IMV	Invasive mechanical ventilation
NHSCR	NHS Central Register (Scotland)
NIV	Non-invasive ventilation
NRS	National Records of Scotland
ONS	Office for National Statistics (ONS)

OPCS-4	Office of Population Censuses Surveys Classification of Surgical Operations and Procedures 4th revision
PDS	Patient Demographic Service
PEDW	Patient Episode Database for Wales
RRT	Renal replacement therapy
PHE	Public Health England
SAP	Statistical Analysis Plan
SICSAG	Scottish Intensive Care Society Audit Group
SMR	Scottish Morbidity Record
SUSAPC	Secondary Use Service Admitted Patient Care
UKRR	UK Renal Registry
WDSD	Welsh Demographic Service
WRRS	Welsh Results Reporting Service

## 4 Data sources

### 4.1 Electronic case report forms

#### 4.1.1 Main randomisation

The Randomisation eCRF is completed by hospital staff after patients (or a legal representative) have given consent to participate in the trial. It collects the following participant information:

- Identifiers
  - First name, family name
  - NHS number
  - Date of birth
  - Sex (male/female/unknown)
- Inclusion criteria
  - COVID-19 symptom onset date
  - Date of hospitalisation
  - Requirement for oxygen<sup>1</sup>
  - Requirement for invasive mechanical ventilation (IMV) or extra-corporeal membrane oxygenation (ECMO)
- Comorbidities
  - Diabetes
  - Heart disease
  - Chronic lung disease
  - Tuberculosis
  - HIV
  - Severe chronic liver disease

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<sup>1</sup> NHS England advice published on 9 April 2020 stated that the usual oxygen target saturation for prescribed oxygen should change from 94-98% to 92-96% in the first instance. Hospitals may further reduce this to 90-94% if clinically appropriate according to prevailing oxygen demands. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0256-specialty-guide-oxygen-therapy-and-coronavirus-9-april-2020.pdf>. Guidance on admission to hospital was similar in Scotland. <https://www.nhs.uk/guidance/259232/covid-19-gps-national-supporting-guidance-for-scottish-general-practice.pdf> although hospital guidelines in Scotland did not specify a target oxygen saturation.

- Severe kidney impairment (eGFR <30 mL/min/1.73m<sup>2</sup> or on dialysis)
- Pregnancy

#### 4.1.2 Second randomisation

The Second Randomisation eCRF is completed by hospital staff when they wish to randomise participants between tocilizumab or standard care alone if they fulfil the protocol-defined oxygenation and inflammation criteria. It collects the following participant information:

- Inclusion criteria
  - Requirement for oxygen
  - Current level of ventilation support (none/CPAP/NIV/HFNO/IMV/ECMO)
  - Latest CRP
- Other information
  - Latest ferritin and creatinine

#### 4.1.3 Convalescent plasma safety eCRF

This eCRF is completed by hospital staff as soon as possible after 72 hours post-main randomisation for participants who entered the convalescent plasma comparison. It collects the following information:

- Adherence to convalescent plasma allocation (number of units received, whether any were stopped early)
- Adverse events
  - Sudden worsening of respiratory status
  - Severe allergic reaction
  - Temperature ≥39C (or rise ≥2C above baseline)
  - Sudden hypotension
  - Clinical haemolysis
  - Thrombotic event

#### 4.1.4 Follow-up

The FU eCRF is completed by hospital staff at the earliest of (i) discharge from acute care (see Section 6.3 below), (ii) death, or (iii) 28 days after the main randomisation. It collects the following information from date of randomisation onwards:

- Adherence to randomised allocation, and receipt of other study treatments or remdesivir (and number of days of treatment)
- COVID diagnostic test result
- Vital status and underlying cause of death (COVID, other infection, cardiovascular, other; if other, a free text description is collected)
- Date of discharge
- Requirement for assisted ventilation (CPAP, NIV, HFNO, IMV, ECMO) and number of days of assisted ventilation and IMV/ECMO separately
- Occurrence of major cardiac arrhythmia (atrial flutter/fibrillation, supraventricular tachycardia, ventricular tachycardia [including torsades de pointes], ventricular fibrillation or bradycardia requiring intervention) (from 12 May 2020)
- Requirement for renal replacement therapy

## 4.2 Registries and NHS datasets

### 4.2.1 Hospital admissions datasets

#### 4.2.1.1 *Secondary Use Service Admitted Patient Care*

The SUSAPC dataset is a repository of data hosted by NHS Digital that relates to in-patient care provided in England, which aims to enable reporting and analyses to support the NHS in the delivery of healthcare services. These data are submitted on a regular basis by NHS hospital trusts and at pre-arranged dates during the year. Submissions are consolidated, validated and cleaned and then incorporated into the HESAPC dataset. Data may be incomplete in places and is not quality assured to the same extent as HES, but is available more rapidly.

In the SUSAPC dataset, each record contains data relating to a continuous period of care under one consultant known as a Finished Consultant Episode (FCE). FCEs can be grouped together to form 'Spells'. Each spell is a continuous periods of inpatient care within one hospital. Each FCE contains data about the patient (e.g. sex, ethnicity), the specialty providing the care (e.g. cardiology), ICD-10 diagnostic and OPCS-4 procedure codes, along with dates for each procedure and details about the admission and discharge and other data.

For the main RECOVERY analyses the following data are used;

- Ethnicity
- Sex
- Date of admission and discharge
- Start and end date of the FCE
- Discharge method and destination (which may indicate death of participant)
- Diagnoses recorded during FCE (ICD-10 coded)
- Procedures performed during FCE (OPCS-4 coded) and corresponding dates

Linked SUSAPC data are imported to the RECOVERY trial database on a weekly basis.

#### 4.2.1.2 *Hospital Episode Statistics Admitted Patient Care*

HESAPC contains data relating to admissions to NHS hospitals in England and is produced from the SUSAPC following a number of cleaning and validation steps. For participants in England, HESAPC is available for the 5 year period prior to enrolment in the study. For the main RECOVERY analyses these data are used to identify prior medical conditions on the basis of recorded ICD-10 and OPCS-4 codes (excluding the admission during which the patient was randomised). Linked HESAPC data are imported to the RECOVERY trial database quarterly.

#### 4.2.1.3 *NHS Central Register Scottish Morbidity Record One*

The NHSCR SMR01 data set holds episode level data on hospital inpatient and day case discharges from acute specialities from hospitals in Scotland. The data fields used in the RECOVERY trial are equivalent to those used in SUSAPC and HESAPC. Linked NHSCR-SMR01 data are imported on a weekly basis.

#### 4.2.1.4 *Patient Episode Data Wales*

PEDW contains data relating to admissions to NHS hospitals in Wales. Linked data for RECOVERY participants recruited via sites in Wales will be available for future analysis.

## 4.2.2 Mortality datasets

### 4.2.2.1 *Patient Demographic Service*

The PDS is the electronic database of NHS patient details such as name, address, date of birth and NHS Number for patients in England. For RECOVERY it is used to provide information on fact and date of death. It provides both 'informal' notifications of death (which occur when a health care provider is informed of their patients death and records the reported date of death in their electronic data systems) and 'formal' notifications of death (which are provided by the Office for National Statistics).

### 4.2.2.2 *Office for National Statistics Mortality data*

The ONS mortality data contains information related to a person's death taken from the death certificate for all deaths registered in England and Wales. The following data are provided

- The underlying cause of death
- Contributory causes of death
- Other conditions recorded on the death certificate but not contributing to death
- Whether a post-mortem took place

Clinical data are recorded using ICD-10 codes. Linked ONS mortality data are imported into the RECOVERY trial via a monthly extract from NHS Digital.

### 4.2.2.3 *Welsh Demographic Service*

WDS data are the electronic database of NHS patient details for patients in Wales and are similar to PDS (4.2.2), providing fact and date of death (including formal or informal notifications). Linked data for RECOVERY participants recruited via sites in Wales will be available for future analysis.

### 4.2.2.4 *National Records of Scotland Mortality Data*

The NRS mortality data contain information related to a person's death taken from the death certificate for all deaths registered in Scotland. The data provided includes the date of death and the underlying and contributory causes of death coded in ICD-10. Linked data are imported into the RECOVERY trial database on a weekly basis.

## 4.2.3 COVID specific datasets

### 4.2.3.1 *Public Health England Second Generation Surveillance data*

The SGSS is an application that captures, stores and manages routine laboratory surveillance data on infectious diseases and antimicrobial resistance from laboratories across England. Once the reports have been loaded into SGSS, each record is subject to a number of validation processes, and local LIMS codes are translated to SGSS codes to standardise the data for analysis. The data is stored in a central database within PHE and details of tests indicating SAR-CoV-2 have been made available to NHS Digital for dissemination for a limited time period. For each test, the following data are available

- Date the sample was collected
- Date the result was reported
- Organism identified (only SARS-CoV-2)

Linked PHE SGSS data are imported into the RECOVERY trial on a weekly basis.

### 4.2.3.2 *Public Health Scotland COVID-19 laboratory antigen test positive list*

This dataset may be available at a later date.

#### *4.2.3.3 Welsh Results Reporting Service Pathology Data*

The WRRS contains all Pathology Test Results for Wales in a single database. Tests indicating a positive SAR-CoV-2 antigen linked to the trial participants are requested. These data will be available for future analyses.

#### *4.2.3.4 COVID-19 Hospitalisation in England Surveillance System*

PHE has established the COVID-19 Hospitalisation in England Surveillance System (CHES), which collects epidemiological data (demographics, risk factors, clinical information on severity, and outcome) on COVID-19 infection in patients requiring hospitalisation and ICU/HDU level care. This dataset has been made available to NHS Digital for dissemination for a limited time period. For RECOVERY the following information is used;

- Date of ICU/HDU admission and discharge
- Use of respiratory support during the admission (including oxygen via cannulae or mask, high flow nasal oxygen, non-invasive ventilation, invasive mechanical ventilation and ECMO)
- Complications during the admission (including viral pneumonia, secondary bacterial pneumonia, ARDS, unknown, and other co-infections)

The CHES dataset is imported into the RECOVERY trial on a weekly basis.

#### *4.2.3.5 GPES Data for Pandemic Planning and Research (COVID-19)*

This dataset may become available at a later date.

### *4.2.4 Intensive Care Datasets*

#### *4.2.4.1 Intensive Care National Audit and Research Centre*

The ICNARC Case Mix Programme is the national clinical audit covering all NHS adult, general intensive care and combined intensive care/high dependency units in England, Wales and Northern Ireland, plus some additional specialist and non-NHS critical care units. Data are collected about the first 24 hours in ICU/HDU and at discharge from the ICU/HDU with a further data collection point after discharge from hospital. For RECOVERY, the following data recorded at discharge from ICU/HDU are used:

- Date of admission to and discharge from ICU/HDU
- Use of Advanced Respiratory Support (ARS), Basic Respiratory Support (BRS) or Renal Support during the admission
- The number of days of ARS, BRS or Renal Support during the admission
- Date of death (if relevant)

Linked ICNARC data is requested for hospitals recruiting to RECOVERY and are imported weekly.

#### *4.2.4.2 Scottish Intensive Care Society Audit Group*

SICSAG collects data from all general adult Intensive Care Units, Combined Units and the majority of High Dependency Units in Scotland using the WardWatcher system. The following data are used in the RECOVERY trial:

- Date of admission and discharge from ICU/HDU
- Used of mechanical ventilation via endotracheal tube or tracheostomy and use of haemofiltration for each day of during admission

Linked SICSAG data are imported into the RECOVERY trial on a weekly basis.

#### 4.2.4.3 Critical Care dataset

In England and Wales the key data collected by ICNARC is available in the CCDS from NHS Digital or the SAIL datalink Wales. The ICNARC data is available in a more timely manner and is the primary source of information about ICU/HDU care for participants in England and Wales, but the CCDS may be used where participants are transferred outside the hospital in which they were randomised.

#### 4.2.5 Disease specific registries

##### 4.2.5.1 UK Renal Registry

Data from the UK Renal Registry may be available at a later date.

## 5 Baseline characteristics

Baseline characteristics for the trial cohort are obtained from the first randomisation eCRF. Where fields are missing, they may be supplemented by data from the linked health care data. Generally corrections to the randomisation eCRF data are not made. Exceptions to this would include key participant identifiers (Date of birth, NHS or CHI number, sex) or cases where information is missing. For example, if a site later report that the date of birth was entered incorrectly, this would be confirmed with the site (recorded in the trial data query system) and updated (with appropriate audit trail).

### 5.1 Additional baseline characteristics

Some baseline characteristics that are not collected on the randomisation eCRF may be extracted from registry data or other sources. These include:

- Ethnicity (White, BAME [Mixed, Asian or Asian British, Black or Black British, Other Ethnic Groups], Unknown) from linked health care records.
- Confirmed SARS-CoV-2 diagnostic test from linked health care records. In the absence of such data for a participant, the data from the randomisation eCRF may be used.
- Comorbidity score: It is possible to calculate comorbidity and frailty scores (e.g. Charlston Comorbidity Score) from prior linked hospital admissions data and this will be done for future exploratory analyses (not specified in the trial SAP).
- Risk: The risk of death by 28 days can be modelled using available baseline characteristics (in the overall trial population) and a risk score derived. Participants will be divided into thirds based on this score (such that each third has approximately the same number of deaths), with the tertiles rounded to clinically-relevant values. For the main trial analyses the groups will defined as risk of death by 28 days of <30%; ≥30 ≤45%; and >45%.

## 6 Outcomes

### 6.1 All-cause mortality

The primary outcome is all-cause mortality at 28 days after randomisation. All-cause mortality will also be assessed at 6 months and other later time points.

#### 6.1.1 Sources

Information on death may come from the following sources:

- FU eCRF (for deaths within first 28 days after randomisation)
- PDS (for participants in England)

- PDS Wales ((or participants in Wales)
- SUSAPC (for participants in England)
- SMR01 (for participants in Scotland)
- PEDW (for participants in Wales)
- ONS mortality data (for participants in England and Wales)
- NRS mortality data (for participants in Scotland)

In general, the primary source will be considered ONS (which includes formal death notification within PDS) and NRS mortality data as these are the official national death registries.

## 6.1.2 Discrepancies

### 6.1.2.1 *Fact of death*

The ONS and NRS mortality data will be considered the defining source for fact of death. In order to allow rapid analysis of results, other sources (e.g. informal death notification via PDS, report of death on the FU eCRF, report of death from SUSAPC) are used for DMC and interim analyses. Cases where these reports are not later substantiated by ONS or NRS are individually reviewed and are not considered as deaths, unless a suitable explanation exists.

### 6.1.2.2 *Date of death*

The ONS and NRS data will be considered the defining source for date of death. In order to allow rapid analysis of data, other sources may be used. Where data sources are discrepant the following hierarchy is applied;

- ONS/NRS (most reliable for date of death), then
- Linked hospital admissions data, then
- FU eCRF , then
- PDS informal death notification (least reliable for date of death)

## 6.2 Cause-specific mortality

The cause of death for the 28 day analysis will be the underlying cause of death as provided by ONS. The causes of death will be categorised as follows:

- Non-vascular death
  - Death from infection
    - Death from COVID-19
    - Death from other infection
  - Death from cancer
  - Death from other medical causes
  - External deaths
- Vascular death
  - Cardiac death
  - Stroke death
  - Other vascular death
- Unknown death

The ICD-10 codes contributing to these categories are shown in Appendix 1.

## 6.3 Time to discharge

Time to discharge (which is a more accurate term for duration of admission because only the period from randomisation onwards is relevant) is defined as the number of days a participant remained in hospital for acute care after randomisation. Discharge excludes transfer to

another acute hospital, but might include transfer to community hospital for rehabilitation or a hospice for end-of-life care.

#### 6.3.1 Sources

Information on date of discharge may come from the following sources:

- FU eCRF
- SUSAPC (for participants in England)
- PEDW (for participants in Wales)
- SMR01 (for participants in Scotland)

#### 6.3.2 Discrepancies

Linked hospital admissions data will be used if date of discharge is discrepant with FU eCRF data. If no linked hospital admissions data are available and the FU eCRF indicates discharge without a date, the date of completion for the FU eCRF will be used.

### 6.4 Use and duration of ventilation

Assisted ventilation can be broadly divided into

- i. Invasive mechanical ventilation (IMV) which includes ECMO (a secondary outcome in combination with all-cause mortality)
- ii. Non-invasive ventilation which includes CPAP, NIV and HFNO (which are included in the subsidiary outcomes)

Information on non-invasive ventilation was collected because at the time the trial was designed there were concerns that the availability of mechanical ventilators would be insufficient to meet demand, so some patients would be treated with non-invasive ventilation when in other circumstances they would have received invasive mechanical ventilation. In reality this situation did not occur, so the emphasis of the analyses (and efforts to resolve discrepancies) is on invasive mechanical ventilation.

#### 6.4.1 Sources

Information on ventilation may come from the following sources:

- FU eCRF
- SUSAPC
- ICNARC
- SICSAG
- CHES
- CCDS

However, the coding of ventilation is different in each source.

#### 6.4.2 Discrepancies

Use and duration of invasive mechanical ventilation is recorded on the FU eCRF and is used as the primary source of data for this outcome.

Since there is often a substantial delay in receiving the SUSAPC data and the coverage of ICU/HDU units is not complete in the ICNARC and SICSAG data, the absence of a record in these datasets should not be assumed to indicate that the patient did not receive assisted ventilated. However, where data is missing from the FU eCRF and a complete record is available within the SUSAPC or other hospitalisation dataset between randomisation and hospital discharge with no evidence of IMV use, it is reasonable to infer that the participant did not receive IMV.

Use of advanced respiratory support (ARS) in the ICNARC data is considered to be equivalent to IMV, however only the dates of admission and discharge from ICU/HDU and the number of days of ARS are provided. If these dates span either the date of randomisation or the censoring date for the 28 day outcome analyses (i.e. date of randomisation plus 28 days) then it is not possible to determine the duration of ARS from this dataset, but it may be possible to determine the fact of ARS, depending on the number of days recorded. In SUSAPC assisted ventilation outcomes are identified from OPCS-4 procedure codes (Appendix 2). Only the date of initiation of assisted ventilation may be recorded so it is possible to ascertain use of, but not duration of, assisted ventilation from this dataset. SICSAG provides data on daily use of organ support and therefore can provide information on both the use and duration of assisted ventilation.

Use of specific subcategories of non-invasive ventilation (e.g. CPAP) is recorded in the CHES data, which will be used to supplement the data from the FU eCRF for these subsidiary outcomes.

## 6.5 Major cardiac arrhythmia

Major cardiac arrhythmias are defined as either:

- i. Atrial flutter or fibrillation
- ii. Supraventricular tachycardia
- iii. Ventricular tachycardia (including torsades de pointes)
- iv. Ventricular fibrillation
- v. Significant bradycardia (requiring intervention)

### 6.5.1 Sources

Information on cardiac arrhythmias is collected on the FU eCRF (but only for those eCRFs completed from 12 May 2020 onwards when these outcomes were added). It may be possible to derive such information from the linked hospitalisation data, but because diagnostic codes other than the primary diagnosis include both new and previous diagnoses, information from this data source is limited to acute arrhythmias such as ventricular tachycardia and ventricular fibrillation.

## 6.6 Renal replacement therapy

Renal replacement therapy (RRT) includes haemodialysis, haemofiltration (and their combination) and peritoneal dialysis. (Kidney transplantation is not relevant in this case.) Patients already receiving renal replacement at baseline will be identified using linked hospitalisation data.

### 6.6.1 Sources

- FU eCRF
- Linked hospitalisation data (SUSAPC, HES, PEDW, SMR01)
- ICNARC
- SICSAG
- CHES
- UKRR

### 6.6.2 Discrepancies

Use of RRT is collected on the FU eCRF. Use of RRT is also identified within the linked hospitalisation data from relevant OPCS-4 codes (Appendix 2). Use of RRT in the ICNARC, SICSAG and CHES datasets is handed in the same way as ARS (see section 6.4.2). Further information on renal outcomes may become available from the UK Renal Registry data.

## 7 Appendix 1: Cause-specific mortality categories

Category	Label	ICD-10 codes <sup>1</sup>
COVID-19	DTH_COVID	U07.1;U07.2
Other infection	DTH_OTHER_INFECTION	A00*-A99*;B00*-B99*; G00*-G08*; H60*; H62.0-H62.4; H65*-H67*; I33.0; J00*-J22*; J350; J36*-J37*;J39.0; J39.1; J40*-J42*; K61*; K63.0; K67*; L03*-L04*; M00*-M018*; M462*-M465*; M490*-M493*; M600*; M650*- M651*; M710*; M711*; M730*; M731*; M86*; M866*-M869*; M900*; N75.1; O23*; O26.4; O85*; O86.0-186.3; O86.8; O91*; O98*; P35*-P39*; U04; U04.9
Infection	DTH_INFECTION	DTH_COVID or DTH_OTHER_INFECTION
Cancer	DTH_CAN_ANY	C00*-C97*
Other medical	DTH_OTHMED	DTH_NONVASC not (DTH_CAN_ANY or DTH_INFECTION or DTH_EXTERNAL)
External causes	DTH_EXTERNAL	S00*-Y98*
Non-vascular	DTH_NONVASC	DTH_INFECTION or DTH_CAN_ANY or DTH_OTHMED or DTH_EXTERNAL
Cardiac	DTH_CARDIAC	I00*-I09*; I11*; I13*; I20*-I25*; I271; I27.8; I27.9; I30.9-I32.0; I32.8; I33.9-I51.5; I51.7-I52*
Stroke	DTH_STR_ANY	I60*-I66*; I69*
Other vascular	DTH_OTH_VASC	I10*; I15*; I26*; I27.0; I27.2; I28*; I51.6; I67*; I68*; I70*-I83*; I86*-I97*; I98.0, I98.1; I99*
Vascular	DTH_VASC	DTH_CARDIAC or DTH_STR_ANY or DTH_VASC
Unknown	DTH_UNK	R00*-R99*

<sup>1</sup> For example, I2\* includes all codes beginning with I2.

ICD-10 5<sup>th</sup> edition (implemented in the NHS in 2016)

## 8 Appendix 2: OPCS-4 and ICD-10 codes used to identify assisted ventilation and other outcomes in the linked hospitalisation data

<b>Outcome</b>	<b>code</b>	<b>Code type</b>	<b>Description</b>
Use of CPAP	E85.6	OPCS	Continuous positive airway pressure
Use of NIV	E85.2	OPCS	Non-invasive ventilation NEC
Use IMV	E85.1	OPCS	Invasive ventilation
Use of ECMO	X58.1	OPCS	Extracorporeal membrane oxygenation
Use of RRT	X40.1	OPCS	Renal dialysis
	X40.3	OPCS	Haemodialysis NEC
	X40.4	OPCS	Haemofiltration

(OPCS and ICD-10 codes used to identify serious arrhythmia and other non-fatal outcomes to be added at a later date.)