Health Innovation Wessex

Independent evaluation of an Oncology Monitoring at Home service in Dorset

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Part of the Health Innovation Network

The evaluation team

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Disclaimer

This evaluation was completed before the announcement on 13 March 2025 that the management of the NHS would be brought back into the Department of Health and Social Care (DHSC). The evaluation description of the innovation, its deployment, and the evaluation findings were accurate at the time of publication. The government decision may, in the future, alter how the report's findings and recommendations are received in this new context. We raise this issue for the reader to note.

Health Innovation Wessex Data retention statement

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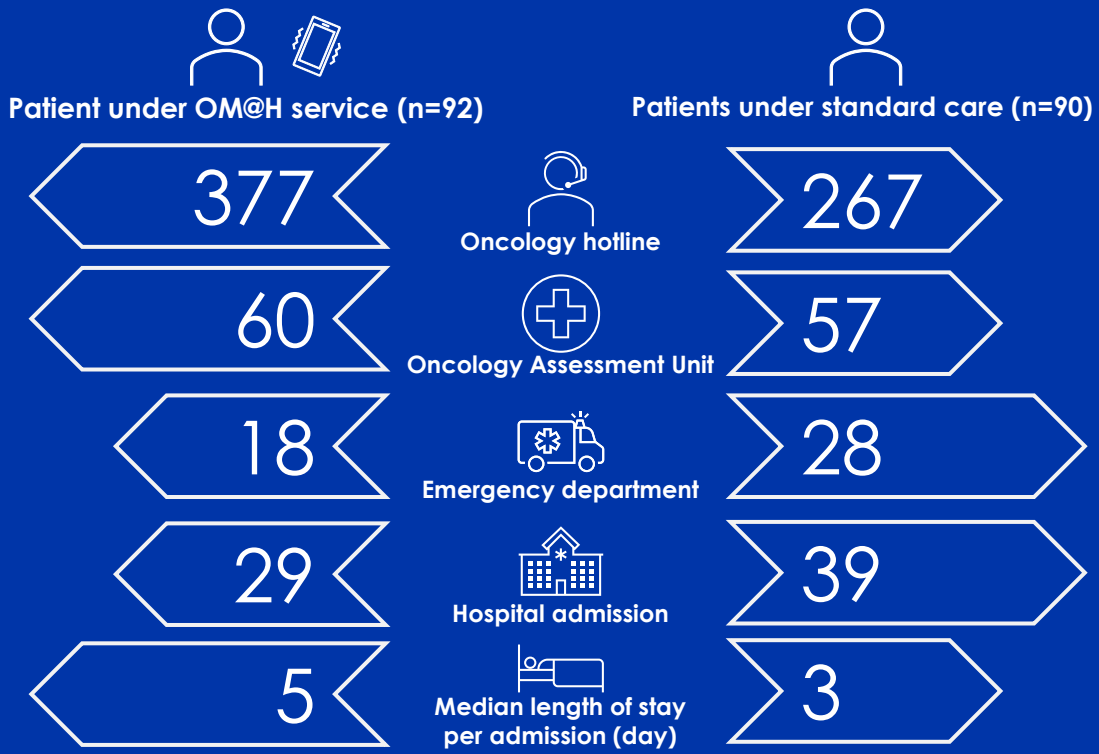
Background to the Oncology Monitoring at Home service

- **Oncology Monitoring at Home (OM@H)** was **a pilot remote monitoring service** for patients who began receiving active oncology treatment between April 2023 to November 2024*.
- A **bespoke software platform** was co-developed by the Acute Oncology clinical team and Inhealthcare Ltd.
- Patients used the **bespoke app** to report their **vital signs** (blood pressure, heat rate, temperature, oxygen saturation level and weight) and **symptoms** by answering series of tailored questions three times a week.
- A service evaluation was conducted as part of the **Health Innovation Wessex Real World Evaluation Programme 2024** to build a case for **developing a sustainable service**.
- **This evaluation is an observational project** with a limited sample size, **intended for exploratory analysis only**. The data are preliminary and not sufficient to draw any statistically significant conclusions at this stage. Therefore, further data collection and longer-term follow up are recommended.

*See Appendix A for more details on the OM@H service

Oncology Monitoring at Home - Service utilisation

- Patients who used the OM@H service made **41% more hotline calls** but accessed the **emergency department 36% less** and had **26% fewer hospital admissions** compared to patients under standard care



(Figures based on the pilot sample size of 90 case-matched patients)

Oncology Monitoring at Home – patients' views

Patients who used the OM@H service participated in an evaluation to **share their experience and views** about the service. Their **feedback included** the following:

- The OM@H service felt **comforting**, **reassuring**, and **provided confidence** as **a layer of safety** that someone was monitoring their health.
- Patients felt **validated** and **encouraged** to call the hotline for advice and help.
- There was a **sense of control** and patients **felt more honest** in reporting their signs and symptoms compared to a face-to-face consultation.
- Reporting vital signs and symptoms online via the OM@H service required **minimal effort.**

Patients said:

> *"**It was good** to do the blood pressure and temperature and everything. **To see that everything was ticking along**…."*

> *"The equipment was **quite straightforward** and once done a couple of times **it's just routine**."*

See slides 14 (OM@H brings an added layer of confidence and safety) and 21 (Perceived earlier recognition of health deterioration) for more details on patient experience and views on OM@H service.

Oncology Monitoring at Home – staff views

Clinical staff who were involved in the **delivery of the OM@H service** shared their views and experience as part of the evaluation. Their **feedback included** the following:

- Staff perceived that the OM@H service can **detect earlier signs of health deterioration**
- There were **mixed views** on the value of **OM@H** and recognised that **"one size doesn't fit all"**.
- **The suitability** of the OM@H service may be influenced by **individual patient factors** such as personal preference and circumstance around oncology treatment and patient needs.
- **Limited interoperability** and **staff access** hindered the wider use of OM@H data provided by the patients.

Staff said:

> *"Low oxygen saturation level (reported on OM@H) enabled the acute oncology team to **intervene and treat** (a patient) for a chest infection **earlier than they would have known about it** because the patient hadn't realised that they were that unwell."*

> *"There's some patients that actually wouldn't want to do that because… they **don't want to be reminded**… that they've got cancer… And I think that there are other patients that thrive.. and they feel in control and they **like to know exactly what's happening**."*

See slides 14 (OM@H brings an added layer of confidence and safety), 23 (Implementation challenges with service uptake) and 24 (Impact of interoperability challenges on staff and patients) for more details on staff views on OM@H service.

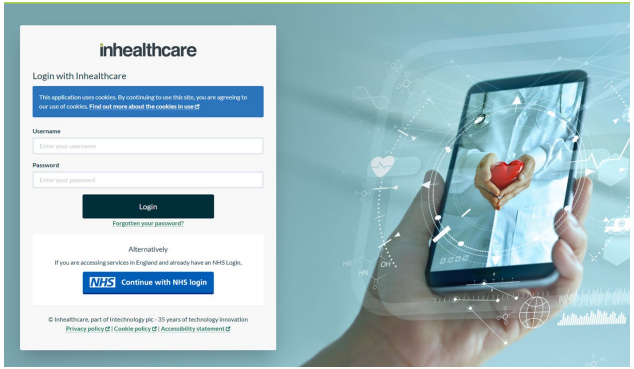
Conclusions

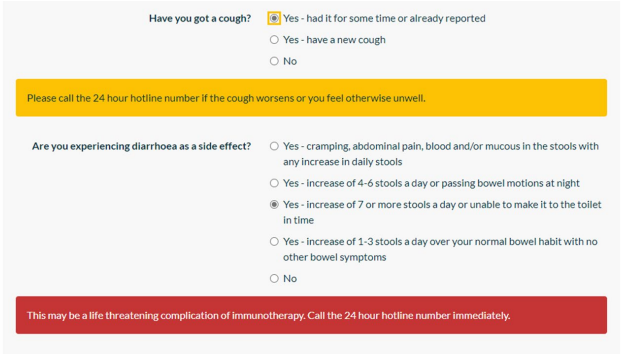
The **preliminary evaluation** of OM@H showed that:

- Both patients and staff valued the **additional touchpoint** of OM@H to potentially **detect early signs of health deterioration**.
- Patients felt that **reporting vital signs and symptoms** online via OM@H service required **minimal effort**
- Staff had **mixed views** on the value of **OM@H**.
- Further exploration of service usage and preference is recommended to help identify **for whom, how and why** the OM@H service can **benefit patients**.

Background - Oncology Monitoring at Home service

- The Oncology Monitoring at Home (OM@H) service was a **remote health monitoring system** offered to patients undergoing active cancer treatment (see Appendix A for more details on the service).
- Patients remained **under the hospital care** from the comfort and familiarity of **their own home**.
- **Dorset HealthCare University NHS Foundation Trust** hosted the service and the clinical teams at **University Hospitals Dorset NHS Foundation Trust** delivered the care to the patients.
- OM@H was set up as **a pilot service** (between 2023 and 2025) with a dedicated patient care pathway to enable:
  - Patients to **report their vital signs and symptoms** online.
  - Patients to gain **appropriate advice at home** by senior nurses trained in acute oncology care.
  - Earlier recognition for when hospital input was **urgently required** or when their symptom could be **safely managed at home**.
- Referrals to OM@H were made by any clinicians delivering oncology care. The service had a capacity to care for **up to 35 patients** at any one time.





Patient pathways - OM@H service and standard care

This diagram illustrates **the key differences** in the **OM@H service** and **standard care**

Patients under OM@H service:

- Patient's **signs and symptoms available** on OM@H platform
- Patients feel **assured and validated** to call the hotline
- **Improved chance to manage** symptoms at home and onward care is **advised as necessary**
- Patient can still **choose to not call** the hotline for help

OM@H service

Patient reports signs and symptoms

OM@H advises patient based on RAG rating system

Patient calls the hotline as advised

Patient does not call the hotline

Standard care

Patient at home with no reporting

Patient calls hotline if unwell or concerned

Patients under standard care:

- The hotline team **may not have information** on patient's current signs and symptoms or the reason for calling
- Deterioration of patient's health is **potentially left undetected** if patient calls hotline when only feeling unwell or concerned.

Oncology hotline

Oncology Assessment Unit

Emergency department

Hospital admission

Preliminary service evaluation of OM@H - Methods

A **preliminary service evaluation** was conducted as part of the **Health Innovation Wessex Real World Evaluation Programme 2024** to build a case for **developing a sustainable service**.

The evaluation used a **mixed methods approach** to explore the impact and implementation of the OM@H service*.

Concurrent data collection process:

- Health Innovation Wessex (HIW) conducted audio-recorded **qualitative interviews** with:
  - **Six** (7%) of the 92 **patients** under OM@H (two males and four females)
  - **Four** (44%) of the nine **staff** across the services (both clinicians and service support staff)
- The OM@H clinical team supplied anonymised patient case-matched data to HIW.

Integrated data analysis process:

- An iterative process was applied to analyse both qualitative and quantitative data
- HIW collaborated with the clinical lead to synthesise the data to facilitate clinically meaningful insights.

*Further detail of the evaluation methods is described in Appendix B

Case-matched criteria and patient demographics

Table 1: Age, gender, treatment intent and number of different performance stage for patients under OM@H service and standard care

		OM@H	Standard care
		(n=92)	(n=90)
Age		66	65
	Range	(27 - 88)	(39 - 83)
Gender			
	Female	49	52
	Male	43	38
Treatment Intent			
	Palliative	41	41
	Neo-adjuvant	17	17
	Adjuvant	34	32
Performance Stage at Cycle Day 1			
	0	64	74
	1	26	15
	2	2	1

Descriptive overview of the data

Table 2: Types of chemotherapy drug combination used to treat patients under OM@H service and standard care

Chemotherapy drug combination	OM@H (n=92)	Standard care (n=90)
capecitabine + oxaliplatin	20	20
cyclophosphamide + docetaxel + epirubicin	15	15
carboplatin + paclitaxel	7	7
pembrolizumab	7	6
docetaxel	5	5
5-FU + docetaxel + oxaliplatin	4	4
5-FU + irinotecan	3	4
5-FU + irinotecan + oxaliplatin	2	4
Other*	29	25

*Combinations of drugs which were used to treat less than three patients

Table 3: Types of tumour site for patients under OM@H service and standard care

Tumour Site	OM@H (n=92)	Standard care (n=90)
Lower GI	35	34
Breast	24	24
Oesophageal	6	7
Ovarian	5	6
Bladder	4	3
Endometrial	3	3
Prostate	3	3
Renal	3	1
Other*	9	9
Total	92	90

*lung, pancreas, head and neck, testicular and gastric

Evaluation question 1:

Does the service empower patients to know when to seek advice, and as a result lead to reduced anxiety and improved wellbeing?

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OM@H brings an added layer of confidence and safety

Overall, patients valued a **sense of control** and felt **more open** in reporting their vital signs and symptoms from the comfort of their home compared to a face-to-face consultation at a clinic.

- Both staff and patients felt that OM@H provides an **added layer of safety**.
- Patients felt that OM@H service was **comforting**, **reassuring**, and **provided confidence** that someone is monitoring their health.
- Patients reported feeling **validated** and **encouraged** to call the hotline when the system alerted them after recording their vital signs and symptoms.

*"If somebody is regularly doing their observations… the **staff can actually see** that there might be a problem and then they can **say to the patient** ring the (hotline) number."* (Staff, S2)

*"I think it was brilliant. It was a **layer of confidence**. If I wasn't sure about a symptom… There was a **level of reassurance** there that I was **under the care** had anything gone wrong or untoward."* (Patient, P2)

*"It's made me feel **a lot better** ringing them because I… didn't want to bother them. But because of it being flagged up red, I thought, OK, they want me to ring. So it was **quite reassuring**. I quite liked it. It made me feel like **I wasn't wasting their time**."* (Patient, P1)

Managing the increased traffic to the oncology hotline

- Staff and patients recognised the implications of the OM@H service on **demand to the oncology hotline** and on **staff capacity** to manage the increase in calls.
- The OM@H service automatically **identified and advised** the patient to call the hotline when the reported signs and symptoms were **out of expected range.**
- Patients and staff noted that the hotline often connects to a messaging service and patients **wait for the callback** by the hotline team.
- The service utilisation data supports the **perceived increase** in hotline calls and OAU visits.

*"If there's temperature suddenly raised, then (OM@H advises to) phone the hotline. If they had any side effects, diarrhoea, vomiting or whatever, phone the hotline. So everything was **defaulted back to phone the hotline**."* (Staff, S3)

*"…Occasionally the acute oncology team said, 'you know, this is **an unnecessary call**. We know the patient and we know that this isn't an issue and yet the system has alerted us and got the patient to ring us equally'…. Sometimes **it's helpful**, sometimes **it's a hindrance** or saps resource." (Staff, S1)*

*"…I would say without fail, whatever I rung the hotline for something trivial, they **take a message** and will call back… But it was always that and then, I don't know, within 6 hours I will get **a phone call back**."* (Patient, P4)

Service utilisation by patients under the OM@H service

41% more use of 24/7 oncology hotline

	OM@H (n=92) Mean(Range)	Standard Care (n=90) Mean(Range)
Number of hotline calls per patient	4 (0-13) ↑	3 (0-27)
In-hours hotline calls per patient (8AM-5PM Mon-Fri)	3 (0-11) ↑	2 (0-16)
Out of hours hotline calls per patient	1 (0-12) =	1 (0-11)
Number of OAU visits per person	1 (0-4) =	1 (0-6)
Average number of cycles achieved	5.0 ↑	4.9

Higher number of hotline calls than standard care:
Patients under OM@H had **41% more hotline calls** (377 vs. 267) for both in-hours and out of hours calls. On average, patients under OM@H will make 4 calls per patients during the data capture period* while patients under standard care will make roughly 3 calls per patients. **Over 79% of calls are made during the working hours** for patients under OM@H are in hours calls and 73% are made from patients under standard care.

Slightly more frequent visits to the Oncology Assessment Unit (OAU) and more treatment cycles achieved than standard care:
Patients under OM@H service had **slightly more OAU visits** (60 vs. 57) compared to patients under standard care. Additionally, on overage, patients under OM@H completed **slightly more cycles** than patients under standard care. These findings require further data collection to validate.

* Data is collected either up to 3 Dec 2024 or 21 days after the last day of patient's last cycle, whichever comes first.

Service utilisation by patients under the OM@H service

Fewer visits to Emergency Department:
Overall, patients under OM@H made **36% fewer visits** (18 vs. 28) to emergency department (ED) compared to those under standard care. **82% (75) of patients under OM@H service did not use ED** compared to 77% (69) of patients under the standard care. ED visits due to OAU being unavailable at the time (either at capacity or out of hours) were 28% fewer by patients under OM@H compared to those under standard care.

Fewer hospital admissions but longer stay:
Patients under OM@H had **26% fewer hospital admissions, but the average length of stay per patients was higher** compared to those under standard care. However, a longer stay under the OM@H could be influenced by an exceptionally extended hospitalisation (32 days) in the dataset which was not excluded to maintain transparency.

	OM@H (n=92) Count(Range)	**Standard Care** (n=90) Count(Range)
Number of ED visits	18 (0-2)	28 (0-4)
Number of visits due to OAU unavailability*	13 (0-1)	18 (0-4)
Number of hospital admissions	29 (0-3)	39 (0-6)
Median length of hospital stay per admission (day)	5 (1-32)	3 (1-28)

36% fewer ED visits and 26% fewer hospital admissions

* Patients accessed ED instead of OAU because OAU was either at full capacity or it was outside of OAU operating hours.

Tumour site sub-analysis

- Patients under OM@H service showed an **increase in number of hotline calls** for **8 out of 13** tumour types compared to the patients under standard care.
- Patients under OM@H service who were treated for **oesophageal, lung, testicular** cancers showed a **decrease in ED visits.**
- Patients under OM@H service who were treated for **bladder, renal** and **pancreatic** cancers showed an **increase in ED visits** compared to standard care.
- **Further investigation is needed** to understand tumour-specific impacts on secondary care utilisation given the small sample data.

Table 4: Tumour site sub-analysis on service utilisation (hotline calls and ED visits) between patients under OM@H and standard care

Tumour Site	**Difference in hotline calls** between patients under OM@H and standard care	**Difference in ED visits** between patient under OM@H and standard care
Lower GI (n=69)	1	0
Breast (n=48)	0	0
Oesophageal (n=13)	2	-1
Ovarian (n=11)	7	0
Bladder (n=7)	2	1
Endometrial (n=6)	2	-1
Prostate (n=6)	1	0
Lung (n=4)	-4	-2
Renal (n=4)	3	0
Pancreas (n=4)	0	1
Head and Neck (n=4)	-1	0
Biliary (n=2)	-5	0
Testicular (n=2)	4	-1

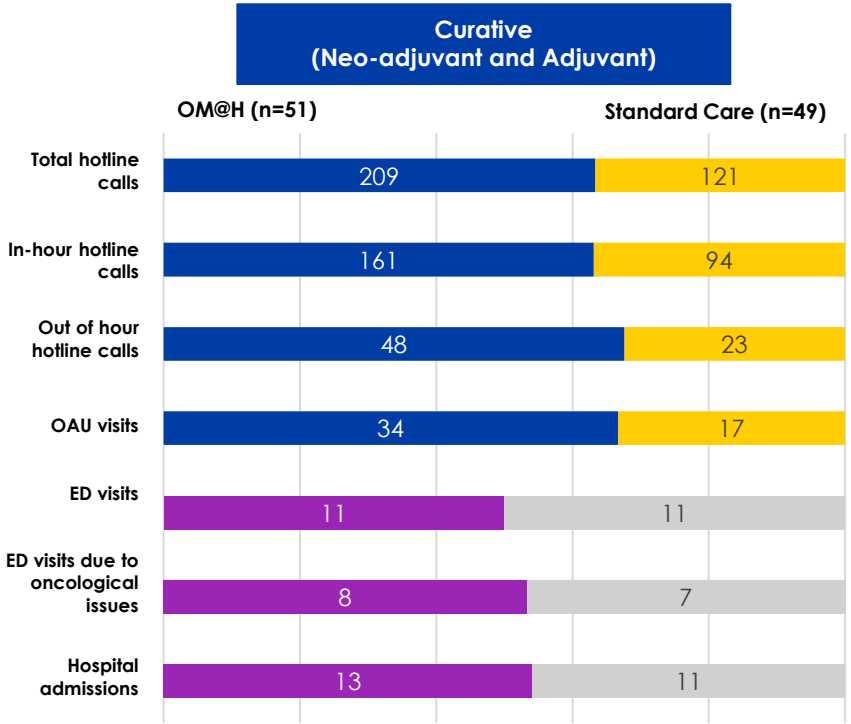
Positive values = patients under OM@H had **more** hotline calls or ED visits compared to those under standard care

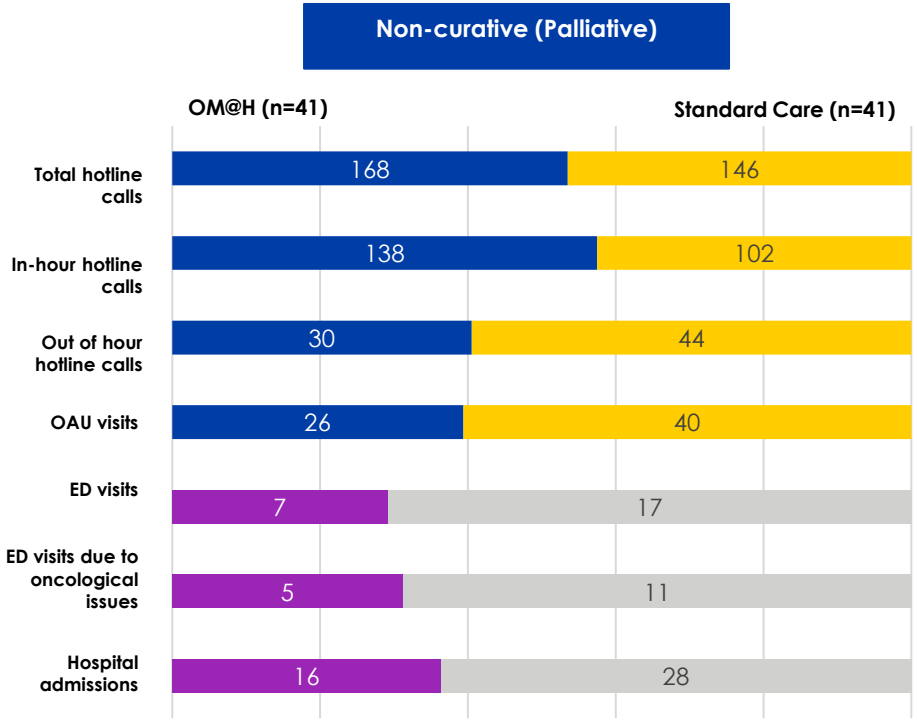
Negative values = patients under OM@H had **fewer** hotline calls or ED visits compared to those under standard care

*Sample size (*n*) includes both groups (minor imbalance of 1 patient at most)

Treatment type sub-analysis

Patients under OM@H service **had fewer ED visits and hospital admissions** compared to patients under standard care.





Neo-adjuvant therapy: Treatment given before the main treatment (e.g. surgery) to reduce the tumour size or improve outcome; **Adjuvant therapy:** Treatment given after the main treatment to reduce the risk of cancer returning; **Palliative therapy:** Treatment to prioritise symptom relief and improve patient's quality of life, rather than curing the disease.

Evaluation question 2:

Does the service enable earlier recognition of deteriorating health and cancer treatment toxicity symptoms, leading to improved health outcomes?

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Perceived earlier recognition of health deterioration

Patients and staff who participated in the evaluation interviews noted how OM@H service **influenced the recognition** of health deterioration earlier than the standard care.

- Staff **perceived** that the OM@H service **can detect earlier signs** of health deterioration.
- Patients felt the OM@H service **encouraged them** to **regularly report** their signs and symptoms even if they feel well themselves.
- Patients noted that if they **were not under OM@H**, they would probably not contact clinicians until they feel unwell, **missing the opportunity for clinicians** to intervene early.

*"…for example, low oxygen saturation level (reported on OM@H) enabled the acute oncology team to intervene and treat (a patient) for a chest infection **earlier** than they would have known about it because the **patient hadn't realised** that they were that unwell."* (Staff, S1)

*"…Unless I was **feeling particularly ill** and thought, 'my blood pressure feels funny,' I probably wouldn't have done it (if it wasn't for OM@H)."* (Patient, P1)

Evaluation question 3:

Was the OM@H service successfully implemented?

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Implementation challenges with service uptake

There were **two main challenges** with **identifying and inviting patients** onto the OM@H service:

1. Capacity to support patient recruitment was limited to the working hours of **one part time member of staff**
2. Staff had **mixed views** on the **appropriateness** of remote monitoring for patients who were on cancer treatments, particularly for those on the **palliative care** pathway.

Overall, staff **perceptions of patient suitability** and **needs** may have influenced their decision to refer patients to the OM@H service.

*"(Staff allocated for patient recruitment) works 2.5 days a week and… there probably **could have been more recruitment** had there been more of (staff) and had more time..."* (Staff, S4)

*"…Not everybody thinks it's a great idea… one of [the] specialist nurses sort of said, 'we look after our own patients, **they know to contact us**, they don't need to do that blood pressure or whatever'."* (Staff, S3)

*"…a lot of the palliative patients **wouldn't be asked** to do any observations (under standard care)... I think that they have a very limited time here and… You're **not being able to enjoy your last few months** on this Earth, because you're concentrating on giving information. What's that going to achieve?"* (Staff, S2)

Impact of interoperability challenges on staff and patients

- As a pilot service, the OM@H service platform was built on bespoke software which did **not have the interface capability** with other patient record systems used by the relevant clinical staff.
- The challenges of OM@H **platform interoperability** and **limited access to the data** were **hampering** staff to easily check the patient-reported vital signs and symptoms.
- Consequently, patients felt a **sense of disconnect** between OM@H, oncology and wider health care services as the clinical staff did **not seem to be aware** of the OM@H service.

*"(OM@H) might have had more of an impact **if I'd had easy access** to the data. So in order for me to access the data that (patients) are inputting, I would have had to use another password, **another system** and **I don't have time** in a (clinic) to do that."* (Staff, S1)

*"It felt really **completely separate** because I'd go into the chemotherapy [unit] once every three weeks and in between I would just fill in the details (on OM@H) three times a week. **It didn't really map together**."* (Patient, P2)

*"I go along for my checkups. They say, 'Let's do your blood pressure.' So I say, 'I've already done it this morning… on the (OM@H) system…' 'Oh well, it wasn't accepted…' **Other (staff) didn't seem to know**."* (Patient, P3)

Conclusions

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Conclusions from the evaluation

- There were trends to show **increased use of the oncology hotline and OAU**, which consequentially may have **reduced the use of upstream services** (e.g. ED, hospital admission) as patients were **treated earlier** for their symptoms.
- Both staff and patients valued the **additional touchpoints** with the OM@H service to **potentially detect early signs** of health deterioration.
- Patients also noted that reporting their signs and symptoms on the OM@H platform **needed minimal effort.**
- Staff recognised that **"one size doesn't fit all."** They had **mixed views** on the **perceived suitability** of the OM@H service on some patients.
- **Limited interoperability** and **staff access hindered** the wider use of OM@H data provided by the patients.
- **Further evaluation** is recommended to:
  - Build evidence on the impact of the OM@H service on **upstream services** (e.g. OAU, ED and hospital admission)
  - **Optimise** who **OM@H** may be beneficial for, how and why**.**

Considerations for the OM@H service based on the evaluation insights

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Considerations based on feedback

Resource and staffing:

- Explore pathway opportunities of **repositioning OM@H service** within the acute oncology department to accommodate **increased hotline activities** observed from the OM@H service.

Service delivery:

- Support the staff in shared decision-making process with patients to ensure **all eligible patients** are invited to the OM@H service.

Interoperability of the system:

- Consider incorporating the **widely-used digital scoring system for vital signs** to help improve information exchange across different clinical systems.

*"I think if they'd employed their own staff to monitor the platform **within their department** and maybe sat in the oncology hotline place as well… them **actually managing it** as opposed to (the wider remote monitoring service team) because… I think that that would be a big tick for the others to see that **there is a benefit** to this."* (Staff, S3)

*"Let's talk to the patient, see what **kind of a person** they are."* (Staff, S2)

Reflections and suggestions for sustainable delivery

Functionality improvements:

- Introduce a **free-text field** option for patients to include short comments
- Review and update the OM@H **question fields**.

Considerations for further evaluation and monitoring:

- Clarify **data transparency and ownership** with the future service platform provider to overcome the lack of access to data
- Routine capture of the perception of avoided services
- Consider a **mechanism to profile** patients under OM@H to explore how OM@H may be beneficial for who, how and why.

*"I suggested the possible addition of a small… free (text) format box so people could ask **a brief question** or **make a remark**."* (Patient, P6)

*"…if (patients) were inputting their observations, then the (staff) on the other end could see that actually there was a drop in their blood pressure or they were a bit more tachycardic or something, and then they would be able to… hopefully to **stop (hospital) admission**. **I'd love to see the data** if that's happened, because if it did, that would be great because obviously the Open Access Unit is literally **full every day with patients**."* (Staff, S2)

Recommendations for evaluation and monitoring opportunities to consider in the future

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Future evaluation and monitoring

The following guidance suggests additional data that could provide more information on the impact of OM@H and inform future developments or commissioning decisions:

An exploration of **patient characteristics and activity data** collected by the OM@H platform to help:

- **Profile patient engagement** by demographics, treatment site and treatment types
- **Identify any pattern** in the use of upstream service utilisation per patient case

A simple **capacity estimate** of the hotline and OAU teams. For example:

$$\boldsymbol{Estimated\ hotline\ capacity(number\ of\ calls)} =$$

$$\frac{\boldsymbol{Available\ staff\ time\ (total\ hrs)}}{\boldsymbol{Average\ hotline\ call\ time\ (x\ hrs)}} - [\boldsymbol{Number\ of\ OM@H\ patients} \times \boldsymbol{Proportion\ of\ patient\ calling\ the\ hotline}\ (\%)]^{*}$$

Consider a **budget impact assessment** to evaluate the financial consequence of increased hotline calls and OAU visits and reduction in ED visits and hospital admission.

Consider additional data gathering methods to help build clinical impact, for example:

- Staff to record their **perception of onward care utilisation** (e.g. "*Has the current hotline call potentially affected the use of OAU, ED or hospital admission?*")
- Include a patient questionnaire *"Where would you have gone for help if you were unable to contact the hotline?"*

*Proportion of patients calling the hotline can be estimated from historical data (e.g. same month from last year)

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Appendix A: Details of the OM@H service

The OM@H service was a **remote health monitoring system** offered to patients undergoing active cancer treatment. The service was established as **a pilot service** with **dedicated patient care pathway** developed to run in conjunction with the standard care pathway.

The service structure

- OM@H service sat under the wider Remote Monitoring Service hosted by **Dorset HealthCare University NHS Foundation Trust**.
- The clinical team at **University Hospitals Dorset NHS Foundation Trust** delivered the care to the patients as and when required.
- Patients reported **vital signs** (blood pressure, heart rate, temperature, oxygen saturation level and weight) and **symptoms** by answering series of tailored questions, **three times a week**.

The triage system

- Patient symptoms were graded as **green, amber or red** in accordance to the UK Oncology Nursing Society 24 Hour Triage guidelines.
- For **Green** and **Amber** alerts, patients received **self-care advice** automatically via the app.
- For **Red** alert, patients were automatically advised to **call the hotline** to receive tailored advice from the oncology nurses.

Senior nurses from the remote monitoring team ensured patients **called the hotline** as per triage system. If the hotline was not accessed, the nurses **followed-up with the patient** to offer support. If required, the relevant information was **relayed to the acute oncology team** to facilitate appropriate continuity of care

Appendix B: Evaluation methodology

The evaluation of the pilot OM@H service used a mixed methods approach to incorporate quantitative and qualitative data collection and analyses.

Qualitative data collected:

- Six patients and four staff were interviewed individually. Details of participants were kept to minimum to protect them being potentially identified in this report.

Quantitative data collected:

- 90 anonymised clinical and service utilisation data supplied by the clinical team were case matched to 1:1 ratio between patients under OM@H and standard care.
- Patient utilisation data was collected from patient's on-boarding date to 03/12/2024.
- HIW independently verified the case-matching process using covariate balance check.*

Integrated mixed methods data analysis process:

- Interview transcripts were processed and analysed following the six-phase thematic analysis process (Braun & Clarke, 2006).
- Patient-case data was processed using Microsoft Excel and programming language Python.

Data limitations:

- A low number of patient interviews conducted due to challenges in contacting patients during within the data collection period·
- Access to data held within OM@H platform data could not be arranged within the data collection period.

*Covariate balance check: A process to validate whether the key characteristics (age, gender, treatment type, tumour site and chemotherapy regimen) of the matched groups are truly similar and comparable.