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From the disease to the person: Delivering quality of life through patient-centred cancer care

A Policy Brief of the Quality of Life and Patient Centred Care HORIZON Cluster

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Acknowledgements

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Introduction

Cancer touches the lives of millions of people across Europe. Around 2.7 million people were diagnosed with cancer in the European Union in 2024, and an estimated 1.27 million died from the disease (Joint Research Centre, 2025). Every minute, more than five people in the EU receive a cancer diagnosis, and with an ageing population, new cases are projected to rise by around 18% between 2022 and 2040 (OECD, 2025). As more people are diagnosed, and therapies become more effective, measuring success in cancer care should go beyond survival. While survival rates are improving, reporting these outcomes say little about how people live with cancer, through treatment, into survivorship, and towards the end of life.

Quality of life (QoL) is central to this broader understanding of cancer outcomes. It encompasses physical and psychological wellbeing, satisfactory interpersonal relationships, independence, and the ability to participate in daily life on one's own terms. Achieving these outcomes requires a shift in care models, putting patients' needs, preferences and priorities at the centre. Patient-centred care (PCC) is organised around each person's priorities, involving them in decisions about their treatment, and responding to their needs as these change over time. The principle, while widely endorsed across European cancer policy and clinical settings, has not yet become routine practice.

Why has this not happened? Among others, four key gaps can be identified on the road from intention to delivery: the lack of actionable QoL measurement, the fragmentation of care, the limited implementation of interventions aimed at preserving emotional functioning and physical independence for patients and survivors, and the persistent framing of palliative care as an end-of-life adjunct. As a result, what matters most to patients is often what falls through these gaps.

To bridge them, patients must become central actors in both clinical care and research, as partners in conducting research and in planning and organising health services. Patients can offer valuable input on how interventions are designed and implemented. Yet involvement often remains uneven, beginning only after priorities are set, and drawing on a narrow group of contributors. Implementing change is possible only when the people benefitting from it are also co-creating the evidence behind it.

This brief brings together what nine Horizon Europe projects - EUonQoL, EU NAVIGATE, INSPIRE, MyPath, PAINLESS, Pal-Cycles, PREFERABLE-II, RELEVIUM, and SERENITY - show about improving QoL, and sets out what policy changes are needed to make patient-centred care a reality.

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What the evidence shows

This section draws on the work of the Horizon Europe Quality of Life and Patient-Centred Care (QoL-PCC) cluster. Each project addresses a different gap in European cancer care, operating at every level, from population surveys to individual treatment choices. These projects aim to help people at different moments of the cancer trajectory, from active treatment, to survivorship, to the end of life. The evidence is organised around four themes, drawing upon the projects' own research and wider European literature.

Making quality of life actionable

Improving QoL is an explicit aim of Europe's Beating Cancer Plan (European Commission, 2021), yet it is rarely measured in ways that can inform decisions on a policy level. European cancer programmes and policies lack a unified tool for assessing QoL, restricting the capacity of policymakers to identify patient needs, address inequalities or evaluate service outcomes. Closing this gap requires a standardised instrument, co-designed with patients, that spans active treatment, survivorship and palliative care, and can be used across countries and languages. This is the purpose of the EUonQoL-Kit, developed within the EUonQoL project to enable cancer centres, registries and public health institutions to benchmark QoL for research and population-level assessment (Apolone et al., 2024). The Kit was developed through a co-design approach combining robust scientific evidence, including a systematic review showing that experiences of treatment and care matter to people surviving cancer (Amat-Fernandez et al., 2025), with wide stakeholder involvement (Nicklin et al., 2026; Sweegers et al., 2025).



It is now available to be administered electronically through the EUonQoL-Survey Hub in 29 languages.

On the other hand, the case for routine QoL assessment through patient-reported outcome measures (PROMs) is well established in clinical practice. European trial evidence shows that systematic symptom reporting can detect relapse earlier and improve survival (Denis et al., 2017), and the European Society for Medical Oncology (ESMO) recommends PROMs from active treatment to the end of life (Di Maio et al., 2022). The MyPath project is using patients' real-time reports of symptoms and preferences to generate individualised care pathways, including for pain and nutrition (Urrizola et al., 2025; Shkodra et al., 2025; Hustad et al., 2025). PROMs can also determine which intervention a person receives: the PREFERABLE-II project is testing live-remote exercise programmes tailored to each survivor's most burdensome complaint, agreed through shared decision-making, with QoL as a co-primary outcome (Hiensch et al., 2025). Similarly, the short-term rehabilitation intervention at the heart of the INSPIRE project is guided by goals set by patients in initial meetings with their rehabilitation practitioner, placing them in the driving seat of tailoring the intervention to their own goals and needs (Bayly et al., 2023). Measuring QoL does not in itself improve it: the problems that patients report need to trigger communication or intervention.

These measurements can inform and influence decisions. For instance treatments started earlier in the illness often persist by default near the end of life. The SERENITY project has shown this for antithrombotic therapy, where treatment plans are rarely reviewed in a structured way against patients' changing goals (Baddeley et al., 2026; Goedegebuur et al., 2023; Jagosh et al., 2025; Martens et al., 2025). Shared decision-making tools offer a route to make QoL priorities explicit in such choices.



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Ensure continuity of care and navigation across care transitions

Transitions in advanced cancer care are multidimensional, and health system fragmentation makes them harder to navigate. A transition can involve changes in place of care, in goals of care, and in who holds clinical responsibility. These changes often coexist (Payne & Hasselaar, 2023), and each can be a point at which information, decisions, and accountability are left behind.

Transitions are not consistently addressed through European guidance. A review of professional guidelines across eight countries, conducted within the PAL-CYCLES project, found that continuity between oncology and palliative care was addressed in general terms, but inconsistently in relation to primary care involvement, communication with patients and families, and advance care planning (Garralda et al., 2026). Coordination, communication and collaboration are the essential facilitators of patient-centred transitions (Hooley et al., 2024), although their delivery is heavily dependent on context. PAL-CYCLES also found that differences in how countries organise care affect service availability, oncology–palliative care integration and information sharing. Project findings show some settings still rely on paper-based transfer of patient information (Radojičić et al., 2026).

Another recurring barrier to care is ambiguity. As shown in the SERENITY project, management of long-term treatments near the end of life spans multiple specialties with blurred responsibilities, so earlier prescribing decisions often roll over without reassessment (Baddeley et al., 2026). SERENITY therefore calls for proactive review at key transition points, with responsibility explicitly handed over.

Ultimately, health system fragmentation and a lack of care continuity remain core shortcomings. Navigation offers one possible response to these issues. Such programmes remain scarce in Europe, and evidence on their effectiveness and implementation is limited (Stodolska et al., 2026). The EU NAVIGATE project has adapted a Canadian patient navigation intervention and is implementing and evaluating it to support older patients with cancer and their family carers throughout the illness trajectory, across supportive, palliative and end-of-life care, in six European countries (Smets et al., 2024; Van Campe et al., 2025). Digital infrastructure is a further enabler, as illustrated by the MyPath project, which is integrating patient-centred care pathways with existing electronic medical records across nine European cancer centres (Urrizola et al., 2025).

Living well and independently

For many people with advanced cancer, loss of function is itself a major source of suffering, with mobility loss in particular often going unrecognised (Petrasso et al., 2026). The INSPIRE project highlights that functional ability extends beyond physical

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capacity to identity, relationships and participation in daily life. Whether people keep that ability depends on several factors, among them function, nutrition, physical activity, pain, and, potentially, access to dedicated rehabilitation services to meet their goals and needs.

In a Danish randomised trial, early, integrated palliative rehabilitation improved QoL in patients with newly diagnosed advanced cancer (Nottelmann et al., 2021). Research by the INSPIRE team has further shown that personal functional goals can be achieved even among people with deteriorating health (Maddocks et al., 2025). Allied health professionals are central to delivering this.

Support for independence also extends beyond the individual to the family carers on whom many older people rely. For older people with cancer and their family carers, the EU NAVIGATE project is testing navigation designed to support, educate and empower them (Miranda et al., 2024).

Nutrition is equally central to function, yet often overlooked. Malnutrition is estimated to affect between 20% and 70% of people with cancer, yet nutritional care is not systematically integrated into routine practice (Hustad et al., 2025). The RELEVIUM project is testing a combined approach to pain, cachexia, nutrition, and physical activity in advanced pancreatic cancer (Hillen et al., 2025).

Physical activity plays a similar role, both during and beyond treatment. PREFERABLE-II is evaluating whether personalised exercise, delivered live-remotely by exercise professionals, improves QoL and is cost-effective for cancer survivors (Hiensch et al., 2025; Zopf et al., 2025). Health professionals also need support to make this routine: rehabilitation professionals report limited knowledge and confidence in applying physical activity and rehabilitation guidelines for people with cancer (Neher et al., 2021).

Ultimately, pain can undermine all of these gains. Around 20% of people with cancer pain do not respond adequately to the standard WHO analgesic approach (Fallon, 2008). The PAINLESS project is testing home-based, remotely supervised neuromodulation as an alternative for this group (Antal et al., 2025), and is developing a tool to predict which patients are likely to develop pain (Carrillo-de-la-Peña et al., 2024).

Palliative care: more than end-of-life care

Palliative care should be offered early in the illness trajectory and not be equated with end-of-life care. Integrating palliative care with oncology improves symptom control and QoL, supporting better use of healthcare resources (Kaasa et al., 2018).

European evidence is promising. In Belgium, early and systematic integration of palliative care improved QoL even where psychosocial support was already part of standard oncology care (Vanbutsele et al., 2018). More broadly, a systematic review of early versus delayed palliative care found that early palliative care

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consistently improved QoL and reduced symptom burden in advanced cancer, although several trials showed no significant effect, highlighting variation in outcomes and challenges in implementation (Creangă-Murariu et al., 2025). Europe is also not a health system monolith: the capacity to integrate palliative care varies widely between European countries (Sánchez-Cárdenas et al., 2024).

The QoL-PCC cluster points to three features of a modern model of implementing palliative care.

First, palliative care should begin earlier, with proactive transitions from oncology, an approach the PAL-CYCLES project has adapted for implementation across seven European countries (Hooley et al., 2026). The RELEVIUM trial likewise aims to improve early access to multidisciplinary palliative care for people with advanced pancreatic cancer, with a primary goal of improving QoL (Hillen et al., 2025).

Second, it should be properly resourced. Research by the INSPIRE team found limited integration of palliative rehabilitation across five European countries, with insufficient funding, unclear care pathways and competence gaps among the barriers (Stene et al., 2024).

Third, it should be closer to home, as illustrated by the PAINLESS project, which is testing pain treatment that patients self-administer at home under remote supervision (Antal et al., 2025). Home-based palliative care has been shown to reduce total costs, particularly when indirect costs such as productivity losses and family expenses are included (Maresova et al., 2024).

None of these changes can be judged without data on how people live with advanced illness. The EUonQoL-Kit includes a survey version for people in need of palliative care, informed by a systematic review of what matters to them (Lizano-Barrantes et al., 2026; Nicklin et al., 2026). Collected routinely at population level, such data would show where palliative care is reaching people early, where it is not, and whether the changes set out in this brief are improving QoL in practice.

Patient and public involvement in QoL-PCC research

Why patient and public involvement matters

Patient and Public Involvement (PPI) is increasingly recognised as a cornerstone of high-quality health research. By involving patients, caregivers, and citizens as partners rather than passive subjects, research can better address real-world needs, improve implementation, and increase societal impact.

Experiences from several European research projects that are part of the QoL-PCC Cluster demonstrate that patient perspectives frequently challenge assumptions made by researchers and healthcare professionals. During two dedicated meetings of this cluster on the topic of PPI, participants reported that patients' input directly influenced intervention design, training materials, research priorities, and implementation strategies. Such examples illustrate that meaningful involvement can lead to tangible improvements in both research outcomes and healthcare practice.

Key challenges across Europe

1. Moving towards patient involvement throughout the whole research cycle

Several projects highlighted that involving patients only after proposals have been developed significantly limits their influence on research decisions. Where engagement occurred primarily through dissemination activities, opportunities to shape priorities, study design, recruitment strategies, data analysis and implementation approaches were in various cases missed. Participating projects suggest that early involvement can help identify unmet needs, reveal implementation barriers, and improve the acceptability of interventions. Meaningful PPI therefore requires shared decision-making throughout the research lifecycle, from agenda setting to dissemination.

2. Persistent inequalities in participation

Ensuring diversity remains one of the greatest challenges for PPI in Europe. Many projects relied heavily on contributors who were highly educated, digitally skilled, proficient in English, and already connected to research or patient networks. As a result, groups that often experience health inequalities, including ethnic minorities, people with low health or digital literacy or limited access to digital technology, vulnerable patients, rural populations, and individuals with limited language skills, remain underrepresented. While statistical representativeness may not be the primary goal of PPI, research partnerships should nevertheless strive to include a broad range of experiences and perspectives. Achieving this requires patient

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education that ensures equitable access to PPI. The same principle applies to trial participation: the INSPIRE project included a dedicated work package on equity, inclusivity and access, requiring all recruiting sites to develop equitable recruitment plans, adapted throughout recruitment, to reach people who may be underrepresented in trials and health research (Nottelmann et al., 2026).

3. Fragmented infrastructure and capacity

The availability of PPI support structures varies substantially across Europe. Some institutions benefit from established patient advisory boards, dedicated staff, training programmes, and national networks. Others have limited experience with PPI and lack the resources needed to support meaningful involvement. These disparities make it difficult to establish equitable participation in multinational research projects. Consortia often depend on institutions with stronger PPI infrastructures, while contributors from other regions face barriers to engagement. A lack of clarity and agreement on the reimbursement of PPI contributors further widens these disparities.

4. Inconsistent ethical and regulatory approaches

Projects repeatedly reported uncertainty regarding ethical review requirements for PPI activities. In some countries, ethics approval is required for most forms of patient engagement, while in others PPI is considered distinct from research involving participants. This variation creates administrative burdens and may discourage meaningful involvement. Cluster projects emphasised the importance of distinguishing between patients acting as research partners and patients participating as research subjects. Greater clarity and consistency at European level could reduce confusion and support more effective implementation.

Implications for EU Policy

The experiences shared across European research projects point to the need for a more coherent and supportive policy framework for PPI. A coordinated European approach would help ensure that patients and citizens are not merely consulted but actively shape the future of healthcare research and innovation in cancer.

First, stronger incentives are needed from research funders. Although many European programmes encourage PPI, its impact is often underreported because involvement activities are not systematically monitored, resourced, or assessed. Funding programmes should explicitly recognise and reward high-quality PPI throughout the research process, and account for the reimbursement of PPI contributors for their time and insights, rather than rewarding research teams as a whole. Second, investment in infrastructure is essential. Building sustainable PPI requires more than project-based activities. It depends on long-term national and regional support structures, training opportunities, patient networks, and mechanisms for knowledge exchange across countries. Third, the lack of common standards creates inconsistencies in quality and practice. Existing frameworks, such as established reporting guidelines and national PPI standards, provide a useful foundation but require adaptation for multilingual and multinational European research settings.

Recommendations

For national actors

National policymakers

1. Early palliative referral

Set national criteria for early referral to palliative care within cancer plans and pathways.

2. Reimburse supportive care

Include rehabilitation, nutrition, exercise programmes, symptom management and psychosocial support in standard reimbursement for cancer care.

3. Support care at home

Adapt reimbursement and procurement rules to support home-based and remotely supervised care, including patient self-monitoring.

4. Fund navigation and coordination

Fund navigation and care coordination roles that support patients and family carers across settings.

5. Connect health records

Invest in interoperable health records shared across hospital, primary and community care.

6. Measure QoL nationally

Adopt a national framework for measuring QoL at population level, to monitor inequalities and evaluate services.

7. Protect shared decisions

Guarantee patients' right to share in decisions about their care, including whether to continue treatments started earlier in their illness, through national patients' rights legislation and cancer plans, and monitor how consistently shared decision-making is applied.

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Recommendations

For national actors (continued)

Hospital and care managers

8. Collect PROMs and act on results

Embed PROM collection into electronic record systems and care workflows, and ensure that the problems patients report are acted upon.

9. Clarify care transitions

Assign clear organisational responsibility for patients at each care transition, with formal handover procedures between services.

10. Equip staff for shared care

Provide staff with the time, tools and training needed for shared decision-making, and with education to incorporate rehabilitation and physical activity programmes into care.

11. Build multidisciplinary teams

Include allied health professionals in multidisciplinary oncology and palliative care teams.

12. Co-design services

Involve patients and family carers in the design of services and technologies.

Professional bodies and education institutions

13. Strengthen education and training

Integrate rehabilitation and exercise across all stages of cancer care, evidence-based symptom management (both pharmacological and non-pharmacological) and shared decision-making into undergraduate curricula and continuing professional development.

Research organisations

14. Embed PPI throughout research

Embed PPI throughout the entire research cycle, rather than limiting involvement to consultation or dissemination.

15. Build supportive environments

Create supportive environments based on respect, trust, transparency, and shared decision-making.

16. Evaluate PPI impact

Monitor and evaluate the impact of PPI systematically to demonstrate added value and support continuous improvement.

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Recommendations

For EU-level actors

The European Commission

1. Measure QoL in quality assurance

Ensure that the ongoing update of supportive and palliative care requirements across all European Cancer Quality Assurance Schemes includes routine QoL measurement through PROMs.

2. Track QoL inequalities

The European Cancer Inequalities Registry should host comparable, population-level QoL indicators.

3. Connect PROMs across care settings

The European Health Data Space should support interoperability of PROMs and information transfer across care settings.

4. Safeguard digital health and AI

Ensure EU digital health and AI policies safeguard patient benefit, safety and equity.

European research funders

5. Sustain proven interventions

Support the rollout and scaling of evidence-based interventions established through EU-funded programmes, to ensure sustainability beyond the research project lifecycle.

6. Require early-stage PPI

Require early-stage PPI in funded health research programmes, including proposal development and priority setting.

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Recommendations

For EU-level actors (continued)

European research funders (continued)

7. Create a Patient Advisory Service

Establish a European Patient Advisory Service that funding applicants can consult during proposal development. Such a service would provide timely access to patient perspectives.

8. Fund meaningful involvement

Provide dedicated budget lines for contributor remuneration, training, coordination, accessibility measures, and evaluation.

9. Develop European PPI guidance

Develop European PPI principles and guidance, including practical recommendations for multinational research projects and for involvement from the proposal development stage.

10. Build European PPI capacity

Support a European PPI capacity-building network to reduce disparities between countries and strengthen collaboration.

11. Assess PPI quality and impact

Include PPI quality and impact as part of proposal evaluation and project reporting requirements.

12. Prioritise implementation research

Prioritise implementation research in survivorship and palliative care within Horizon Europe and the Cancer Mission.

About the Cluster

The Quality of Life and Patient-Centred Care (QoL-PCC) cluster brings together nine Horizon Europe projects: EUonQoL, EU NAVIGATE, INSPIRE, MyPath, PAL-CYCLES, PAINLESS, PREFERABLE-II, RELEVIUM and SERENITY. Together, they span the cancer care continuum, from active treatment and survivorship to the end of life.

Each project addresses a different gap in European cancer care, including the measurement of quality of life, care navigation, rehabilitation, symptom management, treatment decisions and transitions to palliative care. Their shared aim is to make patient-centred care a routine reality.

Coordinated by EUonQoL, the cluster provides a forum for exchanging evidence, comparing implementation experiences and aligning policy messages. This brief is the cluster's joint contribution to European and national decision-maker.

EU-NAVIGATE

EU Navigate
Supporting older people with cancer

EU NAVIGATE is implementing and evaluating a navigation intervention for people with cancer in old age and their family caregivers. The project runs from September 2022 to August 2027 and is coordinated by Vrije Universiteit Brussel (Belgium). The consortium brings together partners from 6 countries.

'A fast-growing number of older people with cancer and their family experience a myriad of physical, psychosocial and spiritual needs, as well as practical challenges in their daily life. Many have challenges in timely accessing the necessary health and social care services, such as supportive and palliative care. We need a sustainable strategy to meet these challenges. Navigation interventions using specially-trained navigators hold promise; EU NAVIGATE implements and evaluates their potential in several EU countries.'



Lieve Van de Block
Principal Investigator of EU NAVIGATE

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EUonQoL is aimed at developing the EUonQoL-kit a patient-centred unified set of PROMs for the assessment of quality of life among cancer patients and survivors in Europe. The project runs from January 2023 to Decembre 2026 and is coordinated by Fondazione IRCCS Istituto Nazionale dei Tumori – Milano (Italy). The consortium brings together partners from 13 countries.

'Every major transformation in healthcare begins with accurate measurement. Today, the true benchmark of high-quality cancer care is not only adding years to a patient's life, but ensuring quality and dignity in the life they live. EUonQoL was created to give a voice to people with a lived cancer experience through scientifically validated measurement tools. By systematically capturing their daily challenges, priorities, and outcomes, EUonQoL empowers clinicians, researchers, and policymakers to deliver interventions that are truly targeted, effective, and responsive to patient needs.'



Cinzia Brunelli
Principal Investigator of EUonQoL

INSPIRE is testing an integrated rehabilitation intervention for people living with incurable cancer. The project runs from September 2022 to August 2026 and is coordinated by Hospices Civils de Lyon (France) and King's College London. The consortium brings together partners from seven countries.

'High quality rehabilitation focuses on what matters to each person, and how they can be supported to live fully to experience the best quality of life possible'



Matthew Maddocks
Principal Investigator of INSPIRE

MyPath MyPath

MyPath is developing and imp lementing innovative patient-centred care pathways for cancer patients. The project runs from September 2022 to August 2027 and is coordinated by Oslo University Hospital (Norway). The consortium brings together partners from 10 countries

'MyPath will contribute to better Patient Centered Care through implementation of evidence based care pathways with digital support in daily clinical practice'



Stein Kaasa
Principal Investigator of MyPath

PAL-CYCLES Pal-Cycles

PAL-CYCLES is developing, adapting, implementing and evaluating a transitional palliative care programme for patients with advanced cancer, adaptable to local cultures and healthcare systems. The project runs from September 2022 to August 2027 and is coordinated by Radboud University Medical Center (the Netherlands). The consortium brings together partners from nine countries.

'Within this European project we aim to investigate transitional palliative care for advanced cancer patients across Europe, which sought to impact on accessible and high-quality care for cancer patients with palliative care needs.'



Jeroen Hasselaar
Principal Investigator of PAL-CYCLES

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PAINLESS

PAINLESS is addressing pain relief in palliative care of cancer using home-based neuromodulation and predictive biomarkers. The project runs from June 2022 to November 2027 and is coordinated by the University of Santiago de Compostela (Spain). The consortium brings together partners from ten countries.

'Around half of people with cancer experience pain, and for one in five, medication offers limited relief. Uncontrolled pain undermines quality of life, yet few non-pharmacological alternatives are available. We need safe treatments that patients can use at home, and better tools to understand their pain and predict who will benefit. Home-based neuromodulation and predictive biomarkers hold promise; PAINLESS investigates their potential across several European countries.'



Maria-Teresa Carillo de la Pena
Principal Investigator of PAINLESS

PREFERABLE-II

PREFERABLE-II is a project aiming to make personalised exercise-based supportive care more accessible to cancer survivors. The project is developing and evaluating a live-remote exercise intervention tailored to each individual's most burdensome side effect. Beyond evaluating its (cost-)effectiveness, PREFERABLE-II addresses the practical, ethical and legal barriers to implementation and develops recommendations, communication standards and training to support integration into routine cancer care. The project runs from November 2022 to November 2027 and is coordinated by UMC Utrecht (the Netherlands). The consortium brings together partners from seven countries.

'For people living with and beyond cancer, quality of life is about more than surviving the disease. It is about being able to live as fully and independently as possible. We want every cancer survivor to have access to exercise support tailored to their needs, wherever they live.'



Anne May
Principal Investigator of PREFERABLE-II

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RELEVIUM

RELEVIUM is tackling quality of life of advanced pancreatic cancer patients through an AI-guided multimodal intervention, combining pain and cachexia management, nutrition and physical activity. The project runs from September 2022 to November 2026 and is coordinated by University Medical Center Mainz (Germany). The consortium brings together partners from ten countries.

'The quality of life of advanced pancreatic cancer patients is improved significantly by reducing pain and cachexia. Through highly personalised nutrition, physical activity, and pain management strategies, in addition to the chemotherapy treatment, RELEVIUM's mission is to empower patients, helping them and their caregivers to navigate this challenging period. The digital tools enable patients to self-manage their disease and also facilitate patient-doctor communication in the future.'



Markus Möhler
Principal Investigator of RELEVIUM

SERENITY

SERENITY is developing a shared decision-making process to facilitate treatment decisions regarding the appropriate use of antithrombotic therapy in cancer patients at the end of life. The project runs from September 2022 to September 2027 and is co-led by Leiden University Medical Centre (the Netherlands) and Cardiff University (United Kingdom). The consortium brings together partners from eight countries.

'There is no second chance to improve care for dying patients, yet much end-of-life care lacks robust evidence. Antithrombotic therapy management, affecting up to 80% of cancer deaths, exemplifies this gap. Poor management risks harm, diminished quality of life, and complex bereavement. SERENITY will provide an evidence-based, patient-centred, implementable solution to improve practice, inform policy, and enhance cancer end-of-life care across Europe.'





Frederikus A. (Erik) Klok and Simon Noble
Principal Investigators of SERENITY

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