Within the EU-CAYAS-NET project, a clinical practice guideline has been developed to enhance transition practices in Europe. This evidence-based guideline focuses on a structured and personalized approach, increasing the chance of a successful transition to long-term follow-up care tailored to individual risks. By combining scientific knowledge, clinician experiences, and patient feedback, the guideline ensures that CAYA cancer survivors receive ongoing, age-appropriate care that meets their specific medical and psychosocial needs, ultimately improving long-term health outcomes and quality of life.

Recommendations for transition of care for childhood and adolescent cancer survivors

Visual Summary EN

European Network of Youth Cancer Survivors

Definition of transition

"Transition of childhood and adolescent cancer survivors is an active, planned, coordinated, comprehensive, multidisciplinary process to enable childhood and adolescent cancer survivors to effectively and harmoniously transfer from child-centered to adult-oriented healthcare systems. The transition of care process should be flexible, developmentally appropriate and consider the medical, psychosocial, educational and vocational needs of survivors, their families and care-givers, and promote a healthy lifestyle and selfmanagement."[1]

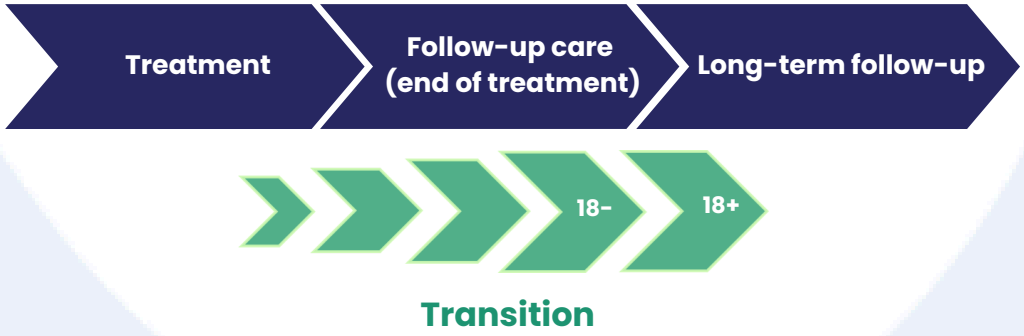
[1] Mulder RL, van der Pal HJH, Levitt GA, Skinner R, Kremer LCM, Brown MC, Bárdi E, Windsor R, Michel G, Frey E. Transition guidelines: An important step in the future care for childhood cancer survivors. A comprehensive definition as groundwork. Eur J Cancer. 2016 Feb;54:64-68. doi: 10.1016/j.ejca.2015.10.007. Epub 2015 Dec 28. PMID: 26735352.

Guideline Group

The guideline is developed by a panel with members from 15 European countries; including:

- Guideline specialists
- CAYA cancer survivors
- Medical doctors
- Nurses
- Psychologists

Methodology



Content of the guideline

- I. General principles
- II. Transition process
  - a. Transition policy
  - b. Transition coordination
  - c. Transition planning
  - d. Transition plan
  - e. Transfer
- III. Other conditions for a successful transition & transfer
  - a. Education of survivors & parents
  - b. Education of healthcare provider
  - c. E-health information systems
  - d. Evaluation of the transition process

I. We recommend that the institute assigns a **transition coordinator** with medical knowledge (e.g. a nurse practitioner or other healthcare provider)

II. We recommend that the transition coordinator develops an **individual transition plan** collaboratively with the survivor, its parents/caregivers and all involved healthcare providers

III. We recommend that age- and developmental stage appropriate **information materials** (digital and in print) are actively provided and referred to, including information on:

- why the transition process is important
- what the transition process involves
- what to expect during and after the transition process
- the changing roles and responsibilities of the survivor and its parents/caregivers

& more recommendations

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