

Recommendations for healthcare transitions for childhood and adolescent cancer survivors 2025

General Principles	
	Transition of childhood cancer survivors is an active, planned, coordinated, comprehensive, multidisciplinary process to enable childhood and adolescent cancer survivors to effectively and harmoniously transfer from child-centred 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 caregivers, and promote a healthy lifestyle and self-management (A).
	We recommend that the institute assigns a transition coordinator with medical knowledge (D).
	We recommend that the transition coordinator and all other healthcare providers involved in the transition process: <ul style="list-style-type: none"> actively engage, inform, and empower survivors and their family/caregivers during the transition process (D); tailor their support throughout the transition process in response to the evolving needs and the development of the survivor (D); engage the survivor and their family/caregivers as equal partners in the transition process (E); strive for a close and trusting relationship with the survivor and their family/caregivers (C).
Transition Process	
Transition Policy	
	We recommend that a written transition policy is available at an institutional level, outlining the transition process, including the actual transfer and engagement of survivors, their family/caregivers, and healthcare providers in pediatric and adult care settings (D).
Transition Coordination	
	We recommend that a transition coordinator is assigned to every survivor and their family/caregivers, who: <ul style="list-style-type: none"> coordinates the transition process (D); has knowledge about the individual follow-up/survivorship care plan (H); supports the survivor and healthcare providers during the transition process (D); enhances the survivors' autonomy, their self-management and self-advocacy skills, and helps the survivor to become confident (D); intermediates between the survivor and the various practitioners (F); helps navigating through different health services and additional sources of support (D); contacts the survivor at least once after the transfer moment to the new (long-term survivorship/adult) service (F); proactively informs the survivor about peer support groups/patient organizations (D).
	We recommend that the transition coordinator is part of a multidisciplinary team, that: <ul style="list-style-type: none"> consists of relevant healthcare providers (from the current and new service) from physical, mental and social health services (D); remains consistent and stable over time (B); collaborates with primary care (B); communicates collaboratively and respectfully (D).
Transition Planning	
	We recommend that the transition coordinator: <ul style="list-style-type: none"> is introduced around the end of active treatment, when the follow-up plan is first introduced (F); stays involved in the transition process until the adult age and long-term survivorship care are reached (E).
	We recommend that the transition coordinator reviews the individual transition process: <ul style="list-style-type: none"> around transfer moments (E); at two occasions at developmental milestone ages during early and late teenagerhood (E); more often if needed based upon the survivor and their families/caregivers' needs (E).

Transition Plan	
	<p>We recommend that the transition coordinator develops an individual transition plan collaboratively with the survivor, their family/caregivers and all involved healthcare providers, that includes:</p> <ul style="list-style-type: none"> • prioritization of the individual needs and wishes of the survivor (D); • an individual transition readiness assessment (D); • an overview of the transition process (D); • an overview of all involved services (places of care and specific teams) (C); • the following topics (when relevant) (D): <ul style="list-style-type: none"> ○ personal goals, e.g., (future) education, employment, independent living ○ social environment, e.g., relationships, hobbies, attending events ○ future (health) concerns ○ lifestyle, e.g., healthy habits, nutrition, physical activity, diets, sleep, stress, alcohol/cigarette/drug use ○ medication, recommended follow-up and health screening ○ healthcare insurance ○ changing roles of family/caregivers ○ fertility and sexual health, e.g., body image, birth-control, sexual functioning
	<p>We recommend that the transition plan:</p> <ul style="list-style-type: none"> • is accessible for the survivor and their family/caregivers at any time, also after the transfer moment to the adult service (F); • is linked to or included in the follow-up/survivorship care plan, which includes a treatment summary and guideline-based follow-up recommendations (A); • is linked to the medical records of the survivor (H).
Transfer Moment	
	<p>We recommend that the actual transfer moment to the new (long-term survivorship/adult) service:</p> <ul style="list-style-type: none"> • happens during a period of relative stability after evaluating the survivor's readiness holistically, with e.g. a (self)evaluation checklist or a clinical interview (D); • is flexible with age, on a case-by-case basis, according to the survivor's mental and physical developmental stage (D); • ensures transfer of medical records and the sharing of the transition plan, that is linked to or included in the follow-up/survivorship care plan, between healthcare providers (D); • includes a joint consultation with the survivor, current and new healthcare provider and the transition coordinator (D).

Other conditions for a successful transition process and transfer moment	
Education and involvement of survivors and their family/caregivers	
	<p>We recommend that age and developmentally appropriate education and information materials (digital and paper-based) are actively provided and referred to, including information on:</p> <ul style="list-style-type: none"> • why the transition process is important (D); • what the transition process involves (D); • what to expect during and after the transition process (D); • the changing roles and responsibilities of the survivor and their family/caregivers (D).
Education of healthcare providers	
	<p>We recommend that the institute and international organizations (e.g., PanCare) provide formal, specialized, and ongoing training and education in transitional and long-term follow-up care to healthcare providers who are engaged in the transition process (D).</p> <p>We recommend that the transition from pediatric to adult healthcare services is included in the job description of all healthcare providers working across various pediatric and adult specialties involved in clinical care for survivors (E).</p>
E-health information systems	
	<p>We recommend the use of efficient, accredited e-health information systems to facilitate the transfer of information and collaborative communication (D).</p>
Evaluation of the transition process	
	<p>We recommend that the quality of the transition process is evaluated at an institutional level, prioritizing the needs of survivors, incorporating patient feedback, opinions, and personal experiences (D).</p>

Based on A: conclusions of evidence | B: conclusions of evidence and existing guideline recommendations | C: conclusions of evidence and needs and preferences assessment | D: conclusions of evidence, existing guideline recommendations, and needs and preferences assessment | E: Existing guidelines | F: Existing guidelines and needs and preferences assessment | G: Needs and preferences assessment | H: Expert opinion

Publication

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