SACRED

EMPOWERING CARE, ENRICHING LIVES

Gap Analysis Report

Final version

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Glossary

ALZHEIMER'S DISEASE

A progressive neurodegenerative disorder and the most common cause of dementia, leading to memory loss, cognitive decline and behavioural changes. It requires coordinated, person-centred and interdisciplinary care to preserve autonomy and quality of life (WHO, 2017; Alzheimer's Disease International, 2023; Livingston et al., 2020).

COMMUNITY CARE

Community-based organisation of integrated care where older adults, informal networks and professionals co-produce support, prioritising meaningful life, participation and shared responsibility ("caring with") (RVS, 2020).

DEMENTIA

A progressive cognitive condition associated with multimorbidity, requiring personalised, multidimensional and integrated care to maintain autonomy and quality of life (Callahan et al., 2009; Draper et al., 2018; Bunn et al., 2017; Frost et al., 2020; Verstraeten et al., 2022).

FRAILTY

A multidimensional condition increasing the risk of dependency and adverse outcomes; northern European regions use clinical–functional definitions (RIVM, KCE), while southern contexts adopt more holistic views including social dimensions (PASSI d'ARGENTO; WHO, 2017; SACRED Consortium, 2025a)

HOLISTIC VISION

A comprehensive, person-centred approach addressing physical, psychological, social and spiritual needs, promoting dignity, autonomy and quality of life (SACRED consortium, 2025b).

INTEGRATED CARE MODEL

A coordinated, person-centred system uniting medical, social and community services to provide seamless, comprehensive support for older adults, reducing unnecessary hospitalisation and institutionalisation (Callahan et al., 2009; Bunn et al., 2017; Draper et al., 2018; Abdi et al., 2019; Frost et al., 2020; Verstraeten et al., 2022; Bakker, 2016; Bakker et al., 2023).

INTEGRATED METHOD

An evidence based effective integrated interdisciplinary method for prevention, treatment, welfare and care (Verstraeten et al., 2022; Bakker et al., 2023).

INTERVENTIONS

Evidence based approaches or therapies for specific needs or problems of the target groups of older adults.

INTERDISCIPLINARITY/ MULTIDISCIPLINARITY

A collaborative model in which professionals from medicine, nursing, psychology, social work and allied health fields jointly plan and deliver care; contrasted with multidisciplinary practice where professionals work in parallel without full coordination (SACRED consortium, 2025b).

LIFE COURSE PRINCIPLES

Principles recognising that past experiences shape current and future health and wellbeing, requiring the integration of biography and significant relationships into care planning (WHO-IPCHS, 2015; WHO, 2017; Zorginstituut Nederland, 2017).

MULTIMORBILITY

The coexistence of two or more chronic conditions in the same individual, interacting in ways that increase complexity, care needs and vulnerability, particularly in older adults. Multimorbidity requires coordinated, person-centred and interdisciplinary approaches to manage overlapping symptoms and treatments, and to preserve autonomy and quality of life (WHO, 2016; OECD, 2020; Salisbury et al., 2018).

OLDER ADULTS

Persons aged 60 years and older, including those with young onset dementia (<65), who increasingly prefer ageing in place and require support from both formal and informal caregivers (Callahan et al., 2009; Bunn et al., 2017; Draper et al., 2018; Abdi et al., 2019; Frost et al., 2020; Verstraeten et al., 2022).

SOCIAL APPROACH TO DEMENTIA

Perspective that centres personhood, social inclusion and supportive environments, complementing biomedical views and focusing on wellbeing and everyday participation (Brooker & Latham, 2015; WHO, 2017; Marulappa et al., 2022).

TRANSDISCIPLINARITY

An advanced form of collaboration that goes beyond interprofessional teamwork by integrating knowledge from other relevant disciplines as well as from patients, families and communities to co-create solutions in complex care (WHO-IPCHS, 2015; OECD, 2019; EC-ESCO, 2017).

Introduction

Demographic ageing, the projected doubling of dementia prevalence by 2040, and persistent fragmentation between health and social care systems are converging to redefine the requirements for integrated care across Europe. These trends are occurring alongside chronic resource constraints—limited budgets and workforce shortages—that are accelerating the shift towards community-based models in which informal caregiverss play a central, recognised role. Regional experiences, particularly from Southern Europe where family and community care are deeply embedded, provide valuable insights for adapting models in other contexts. Simultaneously, this can be seen as a consequence of lack of crucial facilities leading to under-care. At the same time, technological developments in telehealth, assistive devices, and digital monitoring are expanding the possibilities for supporting autonomy and coordination, while raising questions about equitable access, cultural adaptation, and the preservation of human interaction in care delivery. The low adherence in the performance of care as well as the low use of known evidence-based effective integral methods in all countries gives opportunities to optimize prevention, treatment, welfare and care.

Looking ahead, dementia care in Europe is undergoing a paradigm shift. Care provision is increasingly moving away from predominantly institutional frameworks towards community care, where formal and informal actors share responsibility for everyday life, autonomy and participation. This implies that professionals and students must acquire competencies to arrange effective integral care in community care as well as in institutions—primary care, neighbourhood networks, voluntary associations—while practising “caring with” older adults and their families, rather than “caring for” them.

The SACRED project is positioned within this evolving landscape. Its aim is to strengthen professional competencies for integrated, person-centred care of older adults with dementia and/or disabilities by identifying effective guidelines, methods and interventions as well as good practices, revealing critical gaps, and defining targeted training priorities. This is achieved through a multi-source analytical framework combining: (i) a comparative context analysis of six European regions, (ii) an inventory of evidence-based guidelines, methods and interventions, (iii) a compilation of good practices, and (iv) a transnational needs assessment capturing the perspectives of professionals, students, and older adults.

This report synthesises the findings of that analysis and is structured as follows: Section 1 describes the source documents and the evidence base underpinning the analysis; Section 2 presents the identification of gaps, detailing the current and desired states and the reasons for their persistence; Section 3 provides a qualitative synthesis, exploring interdependencies between gaps and their implications; Section 4 defines the use of methods and skills to be improved through e-learning, linking them to SACRED’s Key Competences; and Section 5 offers conclusions and outlines how these findings will inform the design of the project’s training platform.

1. Source documents

This report builds on four key documents developed within the SACRED project. Together, they offer a multi-perspective view of the current realities and future needs in integrated care for older adults. The context analysis sets the scene across regions; the inventories of evidence-based interventions and good practices explore what is currently being done; and the needs assessment brings in the voices of professionals, students, and older people. Each source is briefly presented below.

1.1. Current Situation

1.1.1. Context Analysis Report

The context analysis report (SACRED Consortium, 2025a) presents a comparative overview across six European regions based on desk research. It focuses on demographic profiles, definitions of frailty, healthcare system organisation, and living conditions of older adults. Key aspects such as cultural care norms and existing care structures are analysed to understand how integrated care model is conceptualised and implemented in different regions.

All regions recognise frailty as a multidimensional condition and show a growing reality for home-based care, with families—particularly women—playing a crucial caregiving role. However, approaches vary: the Netherlands and Belgium apply clinical and functional definitions within well-structured systems that integrate informal care, and the use of evidence based methods. While Italy and Greece face fragmentation, limited formal services, and heavy reliance on unpaid family support. Spain, represented by the Valencia and Canary Islands regions, offers a hybrid approach of home and institutional care but struggles with integration and workforce capacity. Healthcare systems differ in structure—from social insurance to decentralised national models—shaping access and equity. These disparities underscore the need for culturally sensitive, integrated care strategies and professional training that addresses both clinical, methodological competencies and sociocultural realities.

This analysis also raises questions about the availability and application of formal methods and interventions. Differences in national approaches and terminology highlight the complexity of achieving unified standards. It also reveals areas where further integration, clearer definitions, and better coordination are necessary.

1.1.2. Evidence-based Inventory

A total of 8 interdisciplinary, integral evidence-based guidelines, 5 methods and 14 interventions were compiled from all partners and reviewed. The interventions aim to improve care for older adults with dementia and/or disabilities by applying structured approaches based on psychiatric expertise, multi-disciplinary teamwork, and person-centred care principles (SACRED Consortium, 2025c).

Through a review and comparison of these evidence-based sources, we identified ten key competences that represent the shared foundation of high-quality interdisciplinary practice across Europe, that are depicted in Table 1. They represent core skills required for integrated, person-centred care and provide the framework for the gap analysis.

In line with these ten key competencies, the STIP-method is the most comprehensive approach currently available for interdisciplinary care and prevention for older adults with dementia and multimorbidity. It operationalizes the full cycle of evidence-based practice, from assessment to intervention and evaluation, in a way that is both scientifically grounded and practically applicable across disciplines. This operationalization is depicted more elaborately in Table 1.

Table 1: Ten key competencies based on the evidence-based knowledge and the operationalization in the STIP-Method.

Key Competence	Description	Embedment in STIP-Method
Promote functioning by supporting autonomy and habituation	These are the general objectives to translate in personal, individual goals for integral (bio-psycho-social) methods.	STIP-Method as a whole is aimed at meeting individual needs and enhance quality of life of persons with dementia, multimorbidity and their family.
Collaborate with others through multi-, inter-, or transdisciplinary teamwork	Engage in effective teamwork across different professional backgrounds and sectors.	STIP-Method prerequisite: - Phase B (DSA-scan) - Phase C (I-GAS) - Step 3 & 4
Apply psychiatric expertise	Address (neuro) psychiatric symptoms and syndromes and emotional complexity using clinical knowledge.	STIP-Method prerequisite: - Phase B (DSA-scan different domains) - Phase C - Step 4
Work methodically, using structured and evidence-based approaches	Apply systematic, validated effective methods to care practices.	Whole STIP-Method
Integrate care by connecting physical, mental, and social dimensions	Deliver holistic care that bridges medical, psychological, and social aspects.	STIP-Method prerequisite: - Phase A (Biography) - Phase B (DSA-scan) - Phase C (I-GAS) - Step 1 to 4
Monitor implementation and the degree to which approaches are applied	Ensure interventions are properly implemented and executed (treatment fidelity).	STIP-Method prerequisite: - Phase C (I-GAS) - Phase D (MDO)
Know the person, their biography and relationships	Incorporate life history and significant relationships into care planning.	STIP-Method prerequisite: - Phase A (Biography) - Phase B (DSA-Scan: social domain system) - Step 1 to 4
Use and measure indicators to evaluate outcomes and progress	Employ measurable indicators to assess care effectiveness and progress.	STIP-Method prerequisite: - Phase A (NPI and others) - Phase D (MDO)
Explain life course principles at every level	Understand and communicate how past experiences shape current and future health and wellbeing.	STIP-Method prerequisite: - Phase A (Biography) - Phase B (DSA-scan) - Step 1 to 3

Organise access to knowledge so that information is available when needed	Ensure and finance timely and accessible sharing of information, training and best practices among professionals.	STIP-Method prerequisite: - Course of STIP-Method - Website Stichting Wetenschap Balans with open source materials - Virtual Platform (under construction)

1.1.3. Good Practices Inventory

Alongside the evidence-based guidelines, methods, and interventions, each pilot region provided examples of good practices that illustrate how integrated, person-centred care for older adults with dementia and multimorbidity is currently being developed and applied in practice.

These good practices represent diverse local approaches that have been identified within the pilot regions as promising ways of improving collaboration, prevention, and support. They differ in their degree of formal evaluation and scientific underpinning: some are grounded in established evidence or national frameworks, while others are practice-driven innovations that reflect emerging solutions in local care systems.

Although not all good practices have been systematically assessed or translated from existing theory or guidelines, each contributes insights into how integrated care is organised, adapted, and sustained in different contexts. Together, they form an evolving collection that complements the formal evidence base by highlighting practical experience, creativity, and learning within the SACRED partnership.

1.2. Desired Situation

1.2.1. Needs Assessment Report

The Needs Assessment was conducted as part of WP2 of the SACRED project, led by Odisee University of Applied Sciences, with contributions from all consortium partners across six European countries. These needs were collected by the pilot sites in Rotterdam, Syros, Flanders, Treviso, Tenerife, and Valencia, ensuring that the analysis reflects local realities as well as transnational patterns. It employed a mixed-methods approach, combining surveys, focus groups, and interviews with 57 professionals, 34 students, and 31 older adults. The professionals and students involved represented disciplines related to the care of older adults with dementia and multi-morbidity. A detailed description of the methodology and findings is available in the dedicated Needs Assessment Report (SACRED Consortium, 2025b).

Professionals highlighted a lack of formal training in relational and psycho-emotional care, especially in managing the emotional and behavioural challenges associated with dementia. While many had practical experience, they often felt unprepared to provide person-centred care or engage effectively with informal caregivers. They also expressed the need for more interdisciplinary collaboration and practical, ongoing training tailored to real-life scenarios.

Students reported a strong disconnect between theoretical instruction and the realities of care work. Many felt insufficiently trained to manage complex cases or to apply concepts such as

empathy, autonomy, and shared decision-making in practice. They called for more hands-on learning, including simulations and case-based exercises, to help bridge this gap.

Older adults generally valued the care they received but emphasised the importance of autonomy, emotional support, and being actively involved in decisions about their care. Some reported feeling misunderstood or excluded during care processes, and noted inconsistencies in coordination between providers. They stressed the need for better communication, more personalised attention, and services that support ageing in place.

In addition to identifying needs and challenges, the Needs Assessment also gathered concrete suggestions for the design of the e-learning platform. These include ensuring interactivity, incorporating case studies and simulations, offering flexible and multilingual formats, and addressing psycho-emotional care alongside clinical aspects.

2. Gap identification

The identification of gaps in SACRED is based on the combined analysis of evidence-based guidelines, methods and interventions, good practices, and contextual data, contrasted with the needs expressed by professionals, students, and older adults in the Needs Assessment. This process highlights specific areas where current practice does not fully meet the desired standards of care and support for older adults with dementia and/or disabilities.

The gaps identified span from microlevel competencies, such as communication, emotional support, and clinical skills, to meso-level- needs in teamwork and integration of informal caregivers, and macrolevel structural barriers affecting care delivery. Addressing these gaps will guide the integral development of targeted and practical e-learning content, ensuring it directly responds effectively to real world challenges and supports the improvement of the provision of integrated, -person-centreed- care.

Building on this analysis, the following sections detail each gap, presenting the current state, the desired state, the underlying reasons for its persistence, and the manifestations of the gap as observed in practice. For clarity, references to methods (M), interventions (I), guidelines (G), and good practices (GP) employ the coding system established in the SACRED Evidence-Based Interventions Inventory (SACRED Consortium, 2025c) and the SACRED Good Practices Inventory (SACRED Consortium, 2025d), using codes such as Mx, Ix, Gx, or country-specific prefixes (e.g., GR-GPx).

This structure ensures that each gap is presented with clear evidence, concrete examples, and a direct link to the competencies required for improving integrated, person-centred care.

2.1. Deficits in relational competencies to promote autonomy and emotional well-being

Current state

Although methods such as the *STIP Method: Personalized Integrated Stepped Care Method* (M1) and *Integrative Reactivation and Rehabilitation* (M2), interventions like *Counseling, life review* (I1) and *Validation* (I9), and good practices such as *Person Centred Approaching (P.C.A.) in Dementia* (GRGP6) exist, their use in daily care remains inconsistent and needs strengthening. The *Context Analysis* indicates that while some regions embed emotional and relational care as a core element, others focus predominantly on biomedical or functional outcomes, leading to a fragmented application of these approaches (SACRED Consortium, 2025a).

Desired state

The *Needs Analysis* shows a strong request from professionals and students for practical training in effective communication, managing emotional and behavioural challenges, and promoting autonomy within the context of a comprehensive integral method. Older adults themselves call for empathy, active listening, genuine interest, and the opportunity to participate actively in decision making (SACRED Consortium, 2025b, pp. 3, 5).

Why this gap exists

Relational and emotional skills are often undervalued compared to technical competencies, resulting in their marginal presence in formal training. Available resources are scattered, and there

is no systematic integration of these approaches into curricula or professional development, leading to variable uptake across contexts.

Manifestations of the gap

A first manifestation of this gap is the limited use of adapted verbal communication when interacting with older adults with cognitive impairment. While the *STIP-Method: Personalized Integrated Stepped Care Method* (M1) includes structured guidance on communication strategies, its use in practice is growing but not yet the general standard. This is echoed in the *Needs Analysis* (p. 3, Professionals: "Training in effective communication with people with cognitive impairment and their caregivers"), where professionals highlight the need for tailored verbal interaction.

Another manifestation is the insufficient application of nonverbal communication skills, such as body language, eye contact, and tone to convey empathy. The *PersonCentred Approaching (P.C.A.) in Dementia* (GRGP6) good practice demonstrates effective integration of nonverbal cues, but these are not systematically applied. The *Needs Analysis* indirectly reinforces this gap, as older adults request more empathetic, attentive, and personalised interactions (p. 7).

A third manifestation is the lack of structured techniques for active listening and empathy. The *STIP-Method: Personalized Integrated Stepped Care Method* (M1)) encourages life story work and deep listening, yet this is not consistently embedded in care delivery. Older adults in the *Needs Analysis* (p. 7) explicitly mention "empathy" and "active listening" to their life story as essential qualities they wish to see in professionals.

The fourth manifestation is difficulty in providing emotional support in challenging situations, such as behavioural changes or end-of-life care. While *Validation* (I9) (as part of the STIP-Method) offers a framework for acknowledging emotions and reducing distress, it is not widely implemented. Students in the *Needs Analysis* (p. 5) call for "practical training in emotional support" to prepare for these scenarios.

A fifth manifestation is the limited promotion of autonomy in everyday routines. Although some methods, like M1 and M2, incorporate elements of shared decision-making, the *Needs Analysis* (p. 7, Older adults) shows that people want greater involvement in decisions affecting their daily life.

Finally, there is insufficient integration of biography and relationships into care planning. The STIP-Method emphasises the use of personal history to guide care, yet its adoption is uneven. Students in the *Needs Analysis* (p. 5) stress the need to promote to "adapt care to biography" as a way to ensure relevance and personalisation.

Related Key Competences

Promote using a evidence based effective integral method focussed on functioning by supporting autonomy and habituation; Know the person, their biography and relationships; Integrate care by connecting physical, mental, and social dimensions.

2.2. Limited use of nonpharmacological interventions and cultural adaptation in care

Current state

Tools such as *STIP-Method: Personalized Integrated Stepped Care Method* (M1), *Snoezelen – multisensory stimulation* (I7), the *Specialised Centre of Dementia (CSD)* (IT-GP3), and the *High Protection Alzheimer's Home Service (SAPAD)* (M5) offer robust frameworks for improving quality of life. However, the *Context Analysis* reveals that adoption is still inconsistent, often limited to specific projects or pilot sites, with significant variation in how frailty and dementia care are conceptualised across regions.

Desired state

The *Needs Analysis* (pp. 3, 5) calls for professionals and students to using a method to be able to implement non-pharmacological interventions effectively, adapt them to each person's biography and cultural background, and integrate physical, mental, and social dimensions into care.

Why this gap exists

In some healthcare systems, care remains dominated by biomedical models that give less weight to nonpharmacological options. Lack of use of available standardised protocols, limited awareness, and insufficient training in cultural and biographical adaptation contribute to low and uneven implementation. However, lack of management and consistent policies of these issues in care organisations play a crucial role.

Manifestations of the gap

A first manifestation is the limited integration of nonpharmacological interventions into standard care. The *STIP-Method: Personalized Integrated Stepped Care Method* (M1)provides a structured, evidence-based approach, but its use is restricted to certain contexts. The *Needs Analysis* (p. 3, Professionals) notes a clear "need for more training in nonpharmacological interventions."

Another manifestation is the uneven application of multisensory stimulation techniques. *Snoezelen* (I7) is well established as an intervention to improve mood and engagement in people with dementia, yet the *Context Analysis* shows that its use is neither systematic nor adapted to all care settings. Students in the *Needs Analysis* (p. 5) mention the importance of learning such techniques as part of their practical training.

A third manifestation is the lack of cultural adaptation in intervention design and delivery. The *Specialised Centre of Dementia (CSD)* (IT-GP3) offers examples of tailoring care to cultural norms and preferences, but these remain isolated practices. The *Needs Analysis* (p. 5, Students) calls for care to be "adapted to the person's biography, culture, and context."

The fourth manifestation is the underuse of biographical information to personalise interventions. While the *High Protection Alzheimer's Home Service* (M5) integrates life-history work into its care plans, this approach is not consistently replicated. Both professionals and students in the *Needs Analysis* (pp. 3, 5) highlight the importance of integrating personal history into care to increase relevance and effectiveness.

Finally, there is a gap in integrating physical, mental, and social dimensions of care into non-pharmacological strategies. Multiple methods in the *current state* encourage this holistic approach, yet it is often applied partially. The *Needs Analysis* (pp. 3, 5) explicitly states the need to "integrate physical, mental, and social dimensions" in intervention planning.

Related Key Competences

Apply psychiatric, clinical and psychosocial expertise within an integral method; Integrate care by connecting physical, mental, and social dimensions; Know the person, their biography and relationships.

2.3. Lack of interprofessional coordination and limited integration of informal caregivers

Current state

Resources such as the *STIP-Method: Personalized Integrated Stepped Care Method* (M1), interventions like *Powerless in Daily Living (PDL) Care* (I10), and good practices like the *Case Management Nurse of Chronic Patients* (ES-GP1) provide concrete guidance. Yet, the *Context Analysis* shows that collaboration between professions and the integration of informal caregivers is far from systematic, with marked differences between regions.

Desired state

The *Needs Analysis* (pp. 3, 5) highlights the need to improve coordination among professional roles and to train teams to work effectively with informal caregivers, ensuring they are meaningfully involved in care planning and delivery.

Why this gap exists

Professional silos, unclear role definitions, and the absence of structured training on how to involve informal caregivers create practical and cultural barriers. In many contexts, informal and formal care remain separate spheres, limiting the benefits of an integrated approach.

Manifestations of the gap

A first manifestation is the limited implementation of structured interdisciplinary protocols. The *Implementation Strategy for Interprofessional Collaboration in Primary Care* (M7) outlines clear procedures for teamwork, but adoption in practice is patchy. This is reflected in the *Needs Analysis* (p. 3, Professionals), where improving coordination between roles is a recurring demand.

Another manifestation is the uneven application of multidisciplinary guidelines in care provision. The *Multidisciplinary guideline regarding collaboration in care provision* (M8) specifies how health and social care providers should coordinate, yet its recommendations are not consistently followed. Professionals in the *Needs Analysis* (p. 3) report that unclear responsibilities often lead to duplication or gaps in care.

A third manifestation is the underuse of structured roles for care coordination, such as the *Case Management Nurse* (ES-GP1), which improves continuity of care for complex patients. The *Needs Analysis* (p. 5, Students) stresses the importance of training in these coordination roles as part of integrated care delivery.

The fourth manifestation is the limited involvement of informal caregivers in care planning and decision-making. The *Powerless in Daily Living (PDL) Care* approach (I10) demonstrates how to integrate caregivers in supporting autonomy, yet the *Needs Analysis* (pp. 3, 5) reveals that caregivers are still too often excluded from planning processes.

Finally, there is the lack of tools and training for effective communication across professional and informal care boundaries. While the *current state* includes examples of case meetings and shared

documentation systems, the *Needs Analysis* (pp. 3, 5) confirms that communication breakdowns remain a major barrier to truly integrated care.

Related Key Competences

Using a evidence based effective integral method by collaborating with others through multi-, inter-, or transdisciplinary teamwork; Integrate care by connecting physical, mental, and social dimensions; Organise access to knowledge so that information is available when needed.

2.4. Limited accessibility, flexibility, and relevance of training provision

Current state

Initiatives such as the *Prevention and Reactivation Care Programme (PReCaP)* (I13), the *EARLYDEM* project (IT-GP5), and the *Final Report on Integrated Care* (M9) illustrate the availability of high-quality training content. However, the *Context Analysis* reveals considerable disparities in access, format, and language availability between regions, as well as limited tailoring to diverse learner profiles.

Desired state

According to the *Needs Analysis* (pp. 4, 6), professionals and students prefer training that is practical, interactive, modular, multilingual, and directly applicable to their professional context.

Why this gap exists

Training provision often reflects institutional priorities rather than learner needs, leading to gaps in accessibility and relevance. Structural issues such as rigid schedules, lack of online options, and insufficient multilingual materials further limit participation.

Manifestations of the gap

A first manifestation is the unequal access to training opportunities across regions and institutions. The *EARLYDEM* good practice (IT-GP5) and the *Prevention and Reactivation Care Programme (PReCaP)* (I13) illustrate accessible training models, yet the *Context Analysis* notes wide disparities in availability. The *Needs Analysis* (p. 4, Professionals) highlights this as a concern, with requests for more equitable access to learning opportunities.

Another manifestation is the lack of flexibility in training formats. While the *Final Report on Integrated Care* (M9) advocates for adaptable training delivery, in practice many programmes remain bound to rigid schedules and in-person attendance. The *Needs Analysis* (p. 6, Students) calls for modular, flexible, and asynchronous options to accommodate diverse learner needs.

A third manifestation is the limited availability of multilingual content. The *Context Analysis* shows that training materials are often available only in the dominant national language, which restricts participation for professionals and caregivers from different linguistic backgrounds. The *Needs Analysis* (pp. 4, 6) includes repeated demands for multilingual resources to improve accessibility.

The fourth manifestation is the insufficient alignment of training content with practical needs. While EARLYDEM and PReCaP include applied components, many training offers focus on theory without enough workplace relevance. Professionals and students in the *Needs Analysis* (pp. 4, 6) emphasise that content should be directly applicable to daily practice to ensure uptake and impact.

Related Key Competences

Use and measure indicators to evaluate outcomes and progress; Organise access to knowledge so that information is available when needed; Work methodically, using structured and evidence-based approaches.

2.5. Structural barriers hindering the implementation of integrated care

Current state

The *Integrated care for older people Guidelines (WHO)* (G7), the *Open Protection Centres for the Elderly – KAPI* (GR-GP1), and the *Multidisciplinary Consideration Unit* (NL-GP1) illustrate existing frameworks. The *Context Analysis* identifies persistent challenges, including fragmented systems, regional disparities, and shortages of trained staff.

Desired state

The *Needs Analysis* (pp. 3, 5, 7) reflects a shared expectation across professionals, students, and older adults for improved system-level coordination, equitable service access, and adequate resourcing to support sustainable integrated care.

Why this gap exists

These issues are embedded in governance, funding, management and policies in care organisations and resource allocation structures, which are beyond the immediate scope of training interventions. Differences in infrastructure, policy frameworks, and regional investment priorities exacerbate disparities and hinder uniform implementation.

Manifestations of the gap

A first manifestation is the fragmentation of health and social care systems, which hinders the delivery of integrated services. The *Integrated Care for Older People Guidelines* (G13, WHO) advocate for seamless pathways, yet the *Context Analysis* reports persistent disconnections between sectors. The *Needs Analysis* (p. 3) calls for better coordination between levels and regions.

Another manifestation is the existence of regional disparities in service availability and quality. The *Open Protection Centres for the Elderly – KAPI* (GR-GP1) illustrate a strong community model, but such resources are unevenly distributed. The *Needs Analysis* (p. 3) explicitly mentions reducing inequalities in access to services as a priority.

A third manifestation is the shortage of trained staff and material resources. The *Multidisciplinary Consideration Unit* (NL-GP1) shows the benefits of adequate staffing for integrated care, yet the *Context Analysis* highlights workforce shortages and limited education as a widespread constraint. In the *Needs Analysis* (p. 7), professionals and older adults point to resource limitations as a major barrier to quality care.

The fourth manifestation is the limited capacity to scale and sustain good practices due to governance and funding constraints. While the *current state* includes proven interventions, systemic barriers prevent their expansion. The *Needs Analysis* (pp. 3, 5) suggests the need to address these structural issues to ensure long-term sustainability of improvements.

Related Key Competences

Monitor implementation and the degree to which approaches are applied and methods are used; Integrate care by connecting physical, mental, and social dimensions; Organise budgets and access to knowledge so that information and skills are available when needed.

Gap	Current state sources	Needs Analysis	Related Key Competences
Deficits in relational competencies to promote autonomy and emotional well-being	M1 - STIP-method M2 – IRR I1 - Counseling, life review I9 – Validation GR-GP6 - Person-Centred Approaching (P.C.A.) in Dementia	"Professionals request training in effective communication with people with cognitive impairment and their caregivers" "Students highlight the need for practical training in emotional support and autonomy"; "Older adults ask for empathy, active listening, and involvement in decisions"	Promote functioning by supporting autonomy and habituation Know the person, their biography and relationships Integrate care by connecting physical, mental, and social dimensions
Limited use of non-pharmacological interventions and cultural adaptation in care	M4 - STA OP! I7 – Snoezelen IT-GP3 - Specialised Centre of Dementia (CSD) M5 - High Protection Alzheimer's Home Service (SAPAD)	"Need for more training in non-pharmacological interventions" "Adapt care to the person's biography, culture, and context" "Integrate physical, mental, and social dimensions"	Apply psychiatric, clinical and psychosocial expertise Integrate care by connecting physical, mental, and social dimensions Know the person, their biography and relationships
Lack of interprofessional coordination and limited integration of informal caregivers	M7 - Implementation Strategy for Interprofessional Collaboration in Primary Care M8 - Multidisciplinary guideline regarding collaboration in care provision I10 - Powerless in Daily Living (PDL) Care ES-GP1 - Case Management Nurse of Chronic Patients	"Improve coordination between professional roles" "Train professionals to work with informal caregivers" "Include informal caregivers in planning and care delivery"	Collaborate with others through multi-, inter-, or transdisciplinary teamwork Integrate care by connecting physical, mental, and social dimensions Organise access to knowledge so that information is available when needed
Limited accessibility, flexibility, and relevance of training provision	I13 - Prevention and Reactivation Care Programme (PReCaP) IT-GP5 – EARLYDEM M9 - Final Report on Integrated Care	"Preference for practical, interactive, and flexible training" "Need for modular and multilingual formats"	Use and measure indicators to evaluate outcomes and progress Organise access to knowledge so that information is available when needed

		"Training should be directly relevant to professional practice"	Work methodically, using structured and evidence-based approaches
Structural barriers hindering the implementation of integrated care	G7 - Integrated care for older people Guidelines (WHO) GR-GP1 - Open Protection Centres for the Elderly (KAPI) NL-GP1 - Multidisciplinary Consideration Unit	"Reduce inequalities in access to services" "Improve coordination between levels and regions" "Mitigate impact of staff and resource shortages"	Monitor implementation and the degree to which approaches are applied Integrate care by connecting physical, mental, and social dimensions Organise access to knowledge so that information is available when needed

Table 2: Summary of identified gaps

Note: References to methods (M), interventions (I), guidelines (G), and good practices (GP) correspond to the SACRED Evidence-Based Interventions and Good Practices Inventories; see Annex 1 for details.

3. Qualitative analysis of Gaps identified

The analysis of the five identified gaps shows that, although they operate at different levels — micro, meso, and macro — they are closely connected and influence each other, and demonstrate the important integrating role of using a evidence based effective integral method.

At the micro level, there are three gaps directly related to professional practice. The first, on relational competencies, affects the ability to communicate effectively, provide emotional support, and promote autonomy. The second, on the use of non-pharmacological interventions and cultural adaptation of care, requires applied clinical skills and the sensitivity to integrate a person's biography and context into care. The fourth, on the accessibility and relevance of training, determines whether professionals can realistically acquire and apply these competencies.

At the meso level, the third gap relates to coordination between different professional roles and the integration of informal caregivers. This depends on team structures, clarity of roles, and an organisational culture that values both formal and informal care.

At the macro level, the fifth gap reflects the structural barriers that shape all the others: fragmented systems, regional inequalities, and shortages of human and material resources. These contextual constraints mean that, even when progress is made in professional and organisational competencies, the impact is uneven.

From the complete review of evidence — methods, interventions, good practices, and contextual analysis — clear patterns emerge. Relational communication is a common thread in Gaps 1, 2, and 3, and is a determining factor even in technically focused interventions. Integration of the physical, mental, and social dimensions is explicit in Gaps 1 and 2, but also underlies the need for teamwork and overcoming structural barriers. Access to knowledge and resources appears repeatedly, whether as the need for clear, available information at the point of care or as a limitation caused by a lack of tools.

The causes sustaining these gaps are varied. Some are training related, such as the low presence of relational and nonpharmacological skills in initial and continuous education, or the absence of supervised practice to apply what is learned. Others are organisational, such as the lack of clear protocols for interdisciplinary work or the limited involvement of informal caregivers in care planning. And others are structural, linked to territorial inequalities, funding, and workforce availability.

The impact of these gaps is direct on care quality and continuity. Limited relational and technical competencies reduce trust and the engagement of older adults with their care plans. Poor coordination between professionals and caregivers leads to fragmented pathways. And structural barriers generate inequalities in access to services and training, hindering the spread of good practices.

For the design of SACRED's e-learning, these findings imply that training must be based on a evidence-based, integral method like STIP-Method, combine practical modules that strengthen relational and technical skills simultaneously, include case studies and simulations of interdisciplinary collaboration, offer flexible and multilingual formats, and raise awareness of system limitations and how to address them in professional practice.

This qualitative analysis not only highlights the scope and complexity of the gaps but also reveals the relationships and dependencies between them. Understanding these dynamics is essential for determining where training efforts can have the greatest impact. The next section prioritises the gaps based on their urgency, potential for improvement through e-learning, and their influence on the broader system of integrated, person-centred care. This prioritisation will serve as the foundation for structuring SACRED's training content and implementation roadmap.

The following table synthesises the qualitative analysis of the five identified gaps. It highlights the level at which each gap operates (micro, meso, or macro), their key interdependencies, and illustrative examples of current and desired states. This overview provides a structured reference to understand how the gaps are interconnected and how they collectively influence the delivery of integrated, person-centred care.

Gap	Level	Key Interdependencies	Example Current State	Example Desired State
Gap 1 – Relational competencies	Micro	Enables adoption of non-pharmacological interventions (Gap 2) and supports teamwork (Gap 3)	M1 – STIP-method I9 – Validation	"Effective communication with people with cognitive impairment and their caregivers" "Empathy, active listening, involvement in decisions"
Gap 2 – Non-pharmacological & cultural adaptation	Micro	Depends on relational competencies (Gap 1) and informs coordination practices (Gap 3)	M4 – STA OP! I7 – Snoezelen	"Need for more training in non-pharmacological interventions" "Adapt care to the person's biography, culture, and context"
Gap 3 – Interprofessional coordination	Meso	Relies on competencies from Gaps 1 and 2 Enhanced by training accessibility (Gap 4)	ES-GP1 – Case Management Nurse I10 – PDL Care	"Improve coordination between professional roles" "Include informal caregivers in planning and delivery"
Gap 4 – Training accessibility	Micro/Meso	Supports implementation of Gaps 1–3 It's constrained by Gap 5 structural barriers	IT-GP5 – EARLYDEM I13 – PReCaP	"Preference for practical, interactive, and flexible training" "Need for modular and multilingual formats"
Gap 5 – Structural barriers	Macro	Affects feasibility of all other gaps Training can raise awareness but not remove barriers	G7 – WHO Integrated Care Guidelines GR-GP1 – KAPI	"Reduce inequalities in access to services" "Improve coordination between levels and regions" "Mitigate impact of staff and resource shortages"

Table 3: Summary of qualitative analysis of gaps

Note: References to methods (M), interventions (I), guidelines (G), and good practices (GP) correspond to the SACRED Evidence-Based Interventions and Good Practices Inventories; see Annex 1 for details.

4. Skills to improve

The skills identified in this section derive directly from the analysis of the five main gaps and their detailed *manifestations*. They represent concrete, observable, and trainable competencies that can be developed through SACRED's e-learning platform. The selection of skills is intended to bridge the gap between the current reality of care provision (*current state*) and the needs expressed by professionals, students, and older adults in the Needs Analysis (*desired state*).

Each skill was selected according to the following principles:

- Direct link to gap manifestations: every skill corresponds to one or more specific manifestations identified during the gap analysis.
- Alignment with Key Competences: each skill supports the development of one or more of the Key Competences defined for SACRED.
- Trainability: the skill can be effectively taught, practised, and assessed in a training environment.
- Practical relevance: the skill has a direct impact on the quality of care and can be applied in real world professional contexts.

The skills have been cross-referenced with the methods, interventions, and good practices documented in the *current state*. This ensures that:

- ✓ When a skill is already addressed by existing resources, the e-learning will focus on integrating, adapting, and disseminating those resources to a wider audience.
- ✓ When no suitable resource exists in the current state, the e-learning will develop new content to fill that gap.

For instance, in *Gap 1 – Relational competencies*, the manifestation "Adapted verbal communication" leads to the skill *Adapt verbal communication to cognitive status*, which can be supported by resources in the *STIP-method: Personalized Integrated Stepped-Care Method* (M1).

The following table summarises the key skills to improve for each gap, their alignment with the Key Competences, and the elements from the *current state* that can be leveraged to support them:

Gap	Skills to Improve	Key Competences	Current State Elements
Gap 1 – Relational competencies	Adapt verbal communication to cognitive status *(WHO, 2017; EC-ESCO, 2017)* Apply non-verbal communication techniques to convey empathy *(EC-ESCO, 2017; WHO-IPCHS, 2015))* Use active listening strategies *(EC-ESCO, 2017; OECD, 2018)* Provide emotional support in difficult situations *(EC-ESCO, 2017; WHO-IPCHS, 2015)* Support autonomy in daily care planning *(WHO, 2017; WHO-IPCHS, 2015; EC-ESCO, 2017)* Integrate biography and social context into care *(WHO-IPCHS, 2015; NL-Kwaliteitskader, 2017)*	Promote functioning by supporting autonomy and habituation Know the person, their biography and relationships Integrate care by connecting physical, mental, and social dimensions	M1 – STIP-method M2 – Integrative Reactivation and Rehabilitation I1 – Life review I9 – Validation GR-GP6 – Person-Centred Approaching
Gap 2 – Non-pharmacological & cultural adaptation	Select and apply appropriate non-pharmacological interventions *(WHO, 2017; EC-ESCO, 2017)* Adapt interventions to individual biography and cultural background *(WHO-IPCHS, 2015; OECD, 2019)* Combine physical, mental and social dimensions in care planning *(WHO, 2017; WHO-IPCHS, 2015)*	Apply psychiatric, clinical and psicosocial expertise Integrate care by connecting physical, mental, and social dimensions Know the person, their biography and relationships	M2 – IRR M4 – STA OP! M5 – SAPAD I7 – Snoezelen IT-GP3 – Specialised Centre of Dementia
Gap 3 – Interprofessional coordination	Apply structured protocols for interprofessional collaboration *(WHO-IPCHS, 2015; EC-ESCO, 2017)* Communicate effectively across professional roles *(EC-ESCO, 2017; WHO-IPCHS, 2015)* Engage informal caregivers in decision-making and care delivery *(WHO-IPCHS, 2015; OECD, 2018)*	Collaborate with others through multi, inter or transdisciplinary teamwork Organise access to knowledge so that information is available when needed	I10 – PDL Care ES-GP1 – Case Management Nurse
Gap 4 – Training accessibility	Access training in flexible and modular formats *(EC-DigCompEdu, 2017; OECD, 2020)* Navigate multilingual training platforms *(EC-DigCompEdu, 2017; OECD, 2021)* Apply learning content to real-world practice *(EC-ESCO, 2017; EC-LLL, 2006)*	Use and measure indicators to evaluate outcomes and progress Organise access to knowledge so that information is available when needed	IT-GP5 – EARLYDEM I13 – PReCaP
Gap 5 – Structural barriers	Identify structural limitations in care systems *(WHO-IPCHS, 2015; OECD, 2023)* Adapt practice to resource-constrained environments *(WHO, 2017; OECD, 2023)* Advocate for equity and coordination in service delivery *(WHO-IPCHS, 2015; EC-ESCO, 2017)*	Explain life course principles at every level Monitor implementation and the degree to which approaches are applied	G7 – WHO Guidelines on Integrated Care GR-GP1 – KAPI

			NL-GP1 – Multidisciplinary Consideration Unit

Table 4: Summary of skills to improve

Note: References to methods (M), interventions (I), guidelines (G), and good practices (GP) correspond to the SACRED Evidence-Based Interventions and Good Practices Inventories; see Annex 1 for details.

Indicative Roadmap for Addressing Gaps

Although the specific competences to be addressed through the SACRED e-learning platform will be chosen collectively during WP3, the evidence presented in this report points towards a logical progression for tackling the identified gaps. This proposed sequence is not a definitive plan but a reflection of how the relevance, urgency, trainability, and interdependence of the competences naturally align.

The starting point would be to consolidate the foundational competences at the micro level, those that shape the quality of daily interactions between caregivers and older adults. Strengthening the ability to adapt verbal and non-verbal communication to cognitive status, practising active listening strategies, and supporting autonomy in daily care planning would provide an immediate and visible impact on care relationships.

Once these essential interpersonal skills are in place, attention could turn to broadening care towards integrated and culturally adapted approaches. This would involve developing the capacity to tailor interventions to an individual's biography and cultural background, while also combining physical, mental, and social dimensions in care planning. Such skills build on the communication and autonomy-support competences established in the first stage.

The next step would naturally lead to strengthening interprofessional coordination. Competences in applying structured protocols for collaboration, communicating effectively across professional roles, and engaging informal caregivers in decision-making become far more effective when the foundations of communication and personalisation have already been addressed.

In parallel, it would be important to ensure that training content is accessible and applied effectively. This means equipping professionals with the ability to apply learning directly to practice, offering training in flexible and modular formats, and navigating multilingual platforms with ease. These cross-cutting competences enhance the reach and impact of any learning intervention.

Finally, the roadmap points towards addressing systemic and structural challenges. Competences such as adapting practice to resource-constrained environments and advocating for equity and coordination in service delivery require sustained effort and are more likely to succeed once progress has been made in the earlier phases. By sequencing the development of competences in this way, the SACRED project can move from strengthening individual capacities to influencing organisational practices and, ultimately, contributing to system-level change.

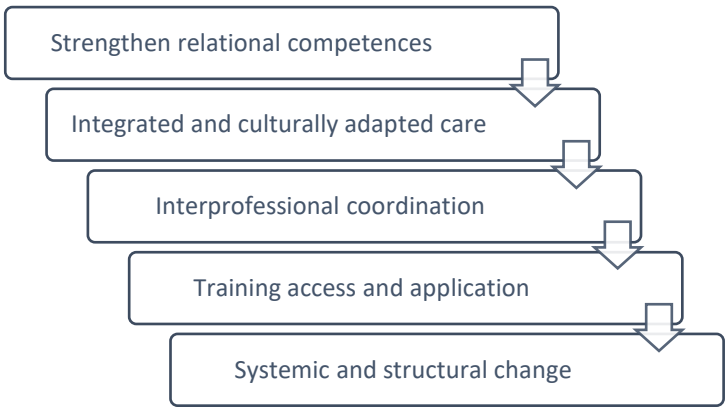

Figure 1 Roadmap to e-learning platform

5. Conclusions

The SACRED gap analysis confirms that, across diverse European contexts, the current provision of integrated care for older adults with dementia and/or disabilities is shaped by a complex interplay of micro-, meso-, and macro-level factors. While innovative methods, interventions, and good practices are in place, their implementation remains inconsistent, with significant disparities between regions and professional settings. Five priority gaps were identified: deficits in relational competencies; limited use and adaptation of non-pharmacological interventions; insufficient interprofessional coordination and integration of informal caregivers; barriers to accessible, flexible, and relevant training; and structural constraints limiting the delivery of integrated care.

These gaps are interdependent. Relational and communication skills underpin the effective use of non-pharmacological approaches and the coordination of care teams; accessible and context-relevant training is essential to develop and sustain these competencies; and structural constraints influence the feasibility of change in all other areas. The analysis also shows that some gaps can be directly addressed through targeted e-learning, while others—particularly structural barriers—require systemic action beyond the scope of training, though awareness-raising and advocacy remain relevant.

The evidence from the context analysis, intervention and good practice inventories, and the needs assessment points towards a desired model of integrated care that is person-centred, culturally sensitive, inclusive of informal caregivers, and capable of leveraging technology without undermining human interaction. This model must be resilient to demographic pressures, resource limitations, and the growing diversity of both care recipients and providers, including migrant care workers.

Based on these findings, the next phase of the SACRED project will focus on designing and implementing an e-learning platform that:

- ✓ Prioritises the development of high-impact, trainable competencies linked to the identified gaps;
- ✓ Offers flexible, modular, and multilingual formats to reach diverse learner profiles;
- ✓ Integrates practical, case-based learning to bridge the gap between theory and real-world application;
- ✓ Addresses regional specificities while promoting transnational transferability of skills and approaches.

By grounding the e-learning strategy in this evidence base, SACRED aims to strengthen the capacity of professionals and students to deliver high-quality integrated care, support the active participation of informal caregivers, and contribute to the sustainability and equity of care systems in the coming decades.

n this context, it is also essential to look ahead to how dementia care will continue to evolve within increasingly community-based environments, where social connections and informal support play a central role.

A gradual paradigm shift is taking place in dementia care, moving away from a focus on formal care and support toward a more personalized approach—one that asks: What does a person need

to live a meaningful life? Increasingly, dementia care and support are being provided within communities, where formal and informal caregivers play more balanced and complementary roles.

Professionals and students (the professionals of the future) need to learn how to build meaningful relationships with both patients and informal caregivers in community-based settings. They must also understand the implications of delivering more personalized care within these dynamic community contexts. In addition, professionals and students require new communication skills to effectively engage with all participants in this constantly evolving environment.

As community care continues to expand, it is valuable to look at regions where informal care already plays a central role in integrated care—such as in Southern Europe. What lessons can we learn from their experiences? And how can these insights be applied to the development of the SACRED e-learning modules?

Ultimately, the findings of this Gap Analysis highlight not only the need for enhanced skills and integration, but also the importance of embracing new paradigms in dementia care. Future e-learning and training initiatives should incorporate the principles of community care and the social approach to dementia, ensuring that professionals are prepared for more person-centred, participatory, and sustainable models of care.

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Annex 1 – Good Practices List

Country	Good Practice	Description	Code
Belgium	YOUNG-D	General practice project addressing young-onset dementia.	BE-GP1
	Connected care in young onset dementia	Integrated care models in nursing homes for young-onset dementia.	BE-GP2
	Project Odette	Coordinated dementia care with emphasis on family involvement.	BE-GP3
	Familiezorg Oost-Vlaanderen	Day care centres and family support for young-onset dementia.	BE-GP4
	Huis Perrekes	Residential facility offering holistic dementia care, blending daily life with care routines.	BE-GP5
France	Alzheimer's Villages	Residential communities replicating a normal village environment for people with dementia.	FR-GP1
	Respite and support services for informal caregivers	Services offering respite, counselling and training for family caregivers.	FR-GP2
Greece	Open Protection Centres for the Elderly – KAPI	Community centres providing preventive, social and health support for older adults.	GR-GP1
	Day Care Centre for the Elderly – KEFI	Municipal day care services for socialisation and daily activities.	GR-GP2
	Day Hospitalisation / KD-IF	Day health care centres providing integrated psychogeriatric support.	GR-GP3
	INTRINSIC digital platform	Digital psychogeriatric care model connecting primary care and psychiatry via telehealth.	GR-GP4
	Early diagnosis of Mild Cognitive Impairment – Population screening	Screening initiative for early detection of cognitive decline.	GR-GP5
	Person-Centred Approaching (P.C.A.) in Dementia	Care approach using life stories, memory tools and non-verbal communication.	GR-GP6
Italy	The SuPer project	Digital training programme for multidisciplinary teams around Parkinson's disease.	IT-GP1
	Ogni Vita è un Capolavoro	Nursing home project promoting personalised care: "Every life is a masterpiece."	IT-GP2
	Specialised Centre of Dementia – CSD	Dedicated centre for dementia care, integrating medical and non-pharmacological interventions.	IT-GP3
	Mildsight Project	Pilot focused on visual/cognitive rehabilitation for older adults with dementia.	IT-GP4
	EARLYDEM	Programme for early diagnosis of dementia, involving professionals, families and awareness campaigns.	IT-GP5
	Alzheimer Cafés	Informal community meetings for families, patients and professionals.	IT-GP6
Netherlands	Amarijn (STIP-Method in nursing homes)	Implementation of the STIP method in nursing homes for stepwise, personalised dementia care.	NL-GP1
	Multidisciplinary Consideration Unit	Hospital-based consultation unit for frail older patients, ensuring multidisciplinary decisions.	NL-GP2
	MESO	Primary care geriatric specialist model aimed at improving continuity of care.	NL-GP3
	Sociale Benadering	Approach to dementia focusing on social context, daily life and relationships.	NL-GP4
	DZEP geronto-psychiatrie Korsakoff	Specialised programme for older adults with Korsakoff syndrome.	NL-GP5
	Dementia Case Managers	Community-based nurses coordinating dementia care and supporting families.	NL-GP6
	Dementia Networks	Regional collaborative networks linking professionals, municipalities and families.	NL-GP7

	Dementia Friendly Hospitals	Hospital units adapting environment and protocols for people with dementia.	NL-GP8
	Ketenzorg Dementia	Integrated regional care pathway for dementia.	NL-GP9
Spain - Tenerife	Integral attention and caregiving (Tenerife)	Community-based integrated support model in several municipalities.	TN-GP1
	Friendly and accessible city (Tenerife)	Urban initiative adapting public spaces for older adults and people with disabilities.	TN-GP2
Spain- Valencia	Case Management Nurse of Chronic Patients	Specialised nursing role coordinating chronic and multimorbid patients' care.	ES-GP1
	Integral Cognitive Stimulation Centre (Valencia)	Day centre offering cognitive therapies for older adults with dementia.	ES-GP2
	ValueCare Project	IT-supported value-based care methodology for older adults with dementia and multimorbidity.	ES-GP3
	Protocol for reception of elderly in dependency (IVASS, Valencia)	Standardised admission procedures in day centres for dependent older adults.	ES-GP4
	Protocol for handling elderly in dependency (IVASS, Valencia)	Guidelines for staff on daily management of dependent older adults.	ES-GP5

Table 5: Good practices identified in the R2.1 Report on EBIs, GPs and Context Analysis

Annex 2 – Detailed Evidence Supporting Each Gap

Gap 1: Deficits in relational competencies to promote autonomy and emotional well-being

Current State

Based on Evidence-Based Interventions, Methods, Good Practices, and Context Analysis.

Type	Code	Name	Source reference / link	Short description
Method	M1	STIP-method: Personalized Integrated Stepped-Care Method	JMIR Research Protocols	Structured method to integrate stepped care, focusing on tailored interventions based on patient needs, including communication and emotional support.
Method	M2	IRR: Integrative Reactivation and Rehabilitation	The American Journal of Geriatric Psychiatry	Integrative approach combining reactivation, rehabilitation, and psychosocial support, with emphasis on improving relational interactions.
Intervention	I1	Counseling, life review	PhD-Thesis – Vrije Universiteit Amsterdam	Guided sessions focusing on personal life narratives to strengthen emotional well-being and autonomy.
Intervention	I9	Validation	—	Communication technique for people with cognitive impairment, focusing on empathy and acknowledging feelings rather than correcting facts.
Good Practice	GR-GP6	Person-Centred Approaching (P.C.A.) in Dementia	Dementia UK	Comprehensive person-centred approach, using life stories, memory boxes, music therapy, and non-verbal communication to support identity and autonomy.
Good Practice	IT-GP6	Alzheimer Cafés (Italy)	https://www.alzheimercafe.it/	Community meetings that strengthen interaction, peer support and communication among professionals, families and persons with dementia.
Good Practice	IT-GP2	Ogni Vita è un Capolavoro (Italy)	https://www.israaa.it/ogni-vita-e-un-capolavoro/	Personalised residential care model integrating daily life and care to promote autonomy and meaningful relationships.
Good Practice	BE-GP5	Huis Perrekes (Belgium)	https://huisperrekes.be/	Holistic dementia care embedded in ordinary daily living to nurture stable, trusting relationships.

Good Practice	NL-GP4	Sociale Benadering (Netherlands)	https://socialebenaderingdementie.nl/	Social-context approach to dementia focusing on everyday life, inclusion and supportive communication.
Good Practice	NL-GP6	Dementia Case Managers (Netherlands)	MISSING	Community-based case managers coordinating care and providing relational/communication support to families.
Context	—	Context Analysis	SACRED Context Analysis	Identifies disparities in prioritising relational/emotional care; some systems prioritise functional/clinical aspects over person-centred relational skills.

Table 6: Resources identified in relation to Gap 1

Desired State

Direct citations from Needs Analysis interviews, focus groups, or surveys.

Stakeholder group	Quote	Source location
Professionals	"Professionals request training in effective communication with people with cognitive impairment and their caregivers."	Needs Analysis – Professionals – Training needs
Students	"Students highlight the need for practical training in emotional support and autonomy."	Needs Analysis – Students – Training needs
Older adults	"Older adults ask for empathy, active listening, and involvement in decisions."	Needs Analysis – Older adults – Advice for professionals

Table 7: The interviewees' responses regarding the gap 1

Observations

Evidence consistently shows that emotional and relational skills are underrepresented in formal training and professional development, despite being central to person-centred care. Relational competencies underpin other care aspects (technical interventions, teamwork, integration of caregivers).

Gap 2: Limited use of non-pharmacological interventions and cultural adaptation in care

Current State

Type	**Code**	**Name**	**Source reference / link**	**Short description**
Method	M4	STA OP!: Stepwise, Multidisciplinary Intervention for Pain and Challenging Behaviour in Dementia	J Am Geriatr Soc.	Structured multidisciplinary approach to manage pain and behavioural issues without medication, including environmental and psychosocial adjustments.
Method	M5	High Protection Alzheimer's Home Service (SAPAD)	Luoghi di Cura	Home-based service for advanced Alzheimer's patients, integrating

				personalised care plans with non-pharmacological therapies.
Intervention	I7	Snoezelen – Multisensory stimulation	International Journal of Nursing Studies Advances	Multisensory environment used to stimulate cognitive function and emotional well-being in dementia care.
Good Practice	IT-GP4	Mildsight Project (Italy)	**MISSING**	Pilot on visual and cognitive rehabilitation for older adults with dementia, focusing on non-pharmacological approaches.
Good Practice	IT-GP2	Ogni Vita è un Capolavoro (Italy)	https://www.israa.it/ogni-vita-e-un-capolavoro/	Personalised residential care programme based on biography, art and creativity, promoting autonomy and well-being.
Good Practice	GR-GP2	Day Care Centre for the Elderly – KEFI (Greece)	https://alzheimerathens.gr/en/day-care-center-kefi/	Municipal day care services offering social activities, therapy and psychogeriatric support for older adults.
Good Practice	ES-GP4	Integral Cognitive Stimulation Centre (Valencia, Spain)	https://www.ivaneuro.com/	Day centre providing structured cognitive and social stimulation programmes for people with dementia.
Good Practice	NL-GP2	Amarijn – STIP Method (Netherlands)	https://www.stip-method.nl/	Implementation of the STIP method in nursing homes to deliver stepwise, personalised non-pharmacological care.
Good Practice	IT-GP3	Specialised Centre of Dementia (CSD)	ISRAA	Specialised centre offering a range of non-pharmacological therapies, cognitive stimulation, and culturally adapted care.
Context	—	Context Analysis	SACRED Context Analysis	Highlights uneven adoption of non-pharmacological interventions, with variation in definitions and integration of cultural aspects across regions.

Table 8: Resources identified in relation to Gap 2

Desired State

Stakeholder group	Quote	Source location
Professionals	"Need for more training in non-pharmacological interventions."	Needs Analysis – Professionals – Training needs
Students	"Adapt care to the person's biography, culture, and context."	Needs Analysis – Students – Training needs
All	"Integrate physical, mental, and social dimensions."	Needs Analysis – All – Desired care approach

Table 9: The interviewees' responses regarding the gap 2

Observations

Variability in the uptake of non-pharmacological interventions stems from differences in clinical culture, training, and available resources. Cultural and biographical adaptation is often seen as optional rather than core, leading to inconsistent application.

Gap 3: Lack of interprofessional coordination and limited integration of informal caregivers

Current State

Type	Code	Name	Source reference / link	Short description
Intervention	I10	Powerless in Daily Living (PDL) Care	—	Care approach to support autonomy and engagement of people with advanced dementia through daily activities.
Good Practice	ES-GP1	Case Management Nurse of Chronic Patients	Consejo General de Enfermería	Nursing role specialised in coordinating care pathways for chronic and complex patients.
Good Practice	ES-GP6	Protocol for Reception in IVASS Day Centres (Spain)	MISSING	Standardised admission protocol fostering cooperation among health-care, social and support teams.
Good Practice	NL-GP1	Multidisciplinary Consideration Unit (Netherlands)	https://www.reinierdegraaf.nl/	Hospital-based consultation unit enabling multidisciplinary decision-making for frail older patients.
Good Practice	NL-GP7	Dementia Networks (Netherlands)	https://www.dementiezorgvoorelkaar.nl/	Regional collaborative networks linking professionals, municipalities and family organisations.
Good Practice	NL-GP6	Dementia Case Managers (Netherlands)	MISSING	Community-based nurses coordinating dementia care and supporting families across care levels.
Good Practice	BE-GP2	Connected Care in Young Onset Dementia (Belgium)	https://www.odisee.be/en	Integrated model connecting nursing homes and hospitals to ensure continuity for young-onset dementia cases.
Good Practice	GR-GP4	INTRINSIC Digital Platform (Greece)	https://synergasia.uoa.gr/	Digital psychogeriatric platform linking primary care and psychiatry via tele-consultation and shared monitoring.
Context	—	Context Analysis	SACRED Context Analysis	Shows regional differences in how formal and informal care are integrated into care planning.

Table 10: Resources identified in relation to Gap3

Desired State

Stakeholder group	Quote	Source location

Professionals	"Improve coordination between professional roles."	Needs Analysis – Professionals – Challenges
Professionals	"Train professionals to work with informal caregivers."	Needs Analysis – Professionals – Training needs
All	"Include informal caregivers in planning and care delivery."	Needs Analysis – All – Desired approach

Table 11: The interviewees' responses regarding the gap 3

Observations

Professional silos and lack of clear role definitions limit teamwork and integration of informal caregivers. Informal care is often undervalued in formal systems, despite its crucial role in continuity of care.

Gap 4: Limited accessibility, flexibility, and relevance of training provision

Current State

Type	Code	Name	Source reference / link	Short description
Method	M9	Final Report on Integrated Care	Zorg en Gezondheid	Comprehensive report summarising lessons learned and strategies for integrated care delivery.
Intervention	I13	Prevention and Reactivation Care Programme (PReCaP)	BMC Geriatrics	Programme focused on preventing functional decline in older adults through early intervention and reactivation strategies.
Good Practice	IT-GP5	EARLYDEM	EARLYDEM	E-learning and awareness programme for early detection of dementia, targeting professionals, caregivers, and the general public.
Good Practice	IT-GP1	The SuPer Project (Italy)	https://www.israa.it/super-project/	Digital training programme for multidisciplinary teams dealing with Parkinson's and neurodegenerative diseases.
Good Practice	GR-GP4	INTRINSIC Digital Platform (Greece)	https://synergasia.uoa.gr/	Digital psychogeriatric platform connecting primary care and psychiatry via telehealth to improve access to expert knowledge.
Good Practice	BE-GP1	YOUNG-D (Belgium)	https://www.odisee.be/en	Educational project for general practitioners on young-onset dementia, with blended learning activities.
Good Practice	BE-GP4	Familiezorg Oost-Vlaanderen (Belgium)	https://www.familiezorg-oostvlaanderen.be/	Organisation providing training and digital resources for family caregivers and care professionals.
Context	—	Context Analysis	SACRED Context Analysis	Reveals disparities in access to training, with regional and institutional variations in

				availability, content, and format.

Table 12: Resources identified in relation to Gap 4

Desired State

Stakeholder group	Quote	Source location
Professionals	"Preference for practical, interactive, and flexible training."	Needs Analysis – Professionals – Learning preferences
Students	"Need for modular and multilingual formats."	Needs Analysis – Students – Learning preferences
All	"Training should be directly relevant to professional practice."	Needs Analysis – All – Training expectations

Table 13: The interviewees' responses regarding the gap 6

Observations

Training is often designed without adapting to learner availability, language needs, or context, limiting uptake and impact.

Gap 5: Structural barriers hindering the implementation of integrated care

Current State

Type	Code	Name	Source reference / link	Short description
Guideline	G7	Integrated care for older people Guidelines (WHO)	WHO	WHO guideline for community-level interventions to maintain intrinsic capacity in older age.
Good Practice	GR-GP1	Open Protection Centres for the Elderly – KAPI	Municipality of Palaio Faliro	National network of centres providing social, medical, and recreational support to older adults.
Good Practice	NL-GP1	Multidisciplinary Consideration Unit	Reinier de Graaf Hospital	Hospital-based multidisciplinary consultation unit for frail older patients.
Good Practice	NL-GP9	Ketenzorg Dementia (Netherlands)	https://www.dementiezorgvoorelkaar.nl/	Integrated regional care pathway for dementia linking professionals, municipalities and families.
Good Practice	ES-GP6	IVASS Protocols (Valencia, Spain)	MISSING	Standardised protocols for reception and daily management in public day centres for dependent older adults.
Good Practice	TN-GP1	Friendly and Accessible City – San Cristóbal de La Laguna (Spain)	https://www.aytolalaguna.es/ayuntamiento/areas-municipales/bienestar-social/	Urban initiative adapting public spaces and services for older adults and people with disabilities.
Good Practice	IT-GP3	Specialised Centre of	https://www.israa.it/centro-specialistico-demenze/	Centralised facility integrating medical and non-pharmacological interventions

		Dementia (CSD) (Italy)		with specialised staff and infrastructure.
Context	—	Context Analysis	SACRED Context Analysis	Identifies fragmentation of systems, regional disparities, and workforce shortages as persistent issues.

Table 14: Resources identified in relation to Gap 5

Desired State

Stakeholder group	Quote	Source location
All	"Reduce inequalities in access to services."	Needs Analysis – All – Challenges
All	"Improve coordination between levels and regions."	Needs Analysis – All – System improvements
All	"Mitigate impact of staff and resource shortages."	Needs Analysis – All – Resource needs

Table 15: The interviewees' responses regarding the gap 5

Observations

These barriers are structural and require systemic solutions. Training can only indirectly influence them by fostering awareness and advocacy.

Annex 3 – Proposed Competence Classification for SACRED e-Learning Decision-Making

Purpose and Methodological Approach

This annex provides a structured proposal for classifying the competences identified in the SACRED gap analysis, with the purpose of supporting the consortium in the future selection of skills to be addressed through the e-learning platform (WP3). The intention is not to predetermine training content, but to present an evidence-based framework that can guide a collective decision.

The classification is based on four qualitative criteria:

Relevance

This criterion reflects the degree to which a competence, if strengthened, would substantially improve the quality of care, integration of services, and person-centredness. A competence was rated *high* when its improvement was expected to have a direct and transformative effect on integrated care delivery; *medium* when the effect was supportive but more limited or indirect; and *low* when its contribution to overall care quality was marginal.

Urgency

Urgency captures how strongly and how often the competence was prioritised in the Needs Assessment by professionals, students, and older adults across the pilot sites. Competences were rated *high* when they were consistently highlighted across sites and groups as immediate priorities; *medium* when they appeared in several sites or groups but without universal emphasis; and *low* when they were only occasionally mentioned or considered of secondary importance.

Trainability via e-learning

This criterion assesses the feasibility of developing the competence through digital training approaches such as interactive modules, simulations, or case-based learning. Competences were rated *high* when they could be effectively taught and practiced in e-learning formats; *medium* when e-learning could support them but required complementary face-to-face training; and *low* when they were not realistically trainable through digital methods alone.

Interdependence

Interdependence refers to the extent to which a competence is foundational for the development of other competences, or whether it is more specialised and stand-alone. A competence was rated *high* when it acted as a prerequisite enabling several others; *medium* when it was useful but not essential for related competences; and *low* when it was largely independent, with limited influence beyond its specific scope.

The table below presents the qualitative ratings (High, Medium, Low) assigned to each competence across the four criteria. These ratings were derived through triangulation of evidence from the Gap Analysis, the Current State (methods, interventions, good practices), and the Needs Assessment:

Gaps identified	Skills	Relevance	Urgency	Trainability via e-learning	Interdependence
Gap 1 – Relational competencies	Adapt verbal communication to cognitive status	High	High	High	High
	Apply non-verbal communication techniques to convey empathy	High	High	High	Medium
	Use active listening strategies	High	High	High	High
	Provide emotional support in difficult situations	High	Medium	Medium	Medium
	Support autonomy in daily care planning	High	High	Medium	High
	Integrate biography and social context into care	High	Medium	Medium	High
Gap 2 – Non-pharmacological & cultural adaptation	Select and apply appropriate non-pharmacological interventions	High	High	Medium	Medium
	Adapt interventions to individual biography and cultural background	High	High	Medium	High
	Combine physical, mental and social dimensions in care planning	High	Medium	Medium	High
Gap 3 – Interprofessional coordination	Apply structured protocols for interprofessional collaboration	High	High	High	High
	Communicate effectively across professional roles	High	High	High	High
	Engage informal caregivers in decision-making and care delivery	High	Medium	Medium	High
Gap 4 – Training accessibility	Access training in flexible and modular formats	Medium	High	High	Medium
	Navigate multilingual training platforms	Medium	Medium	High	Low
	Apply learning content to real-world practice	High	Medium	High	High
Gap 5 – Structural barriers	Identify structural limitations in care systems	High	Medium	Low	High
	Adapt practice to resource-constrained environments	High	Medium	Medium	High
	Advocate for equity and coordination in service delivery	High	Medium	Low	High

Table 16: Competencies related to the identified gaps, classified according to the proposed assessment

Applying the criteria above, competences were considered potential priorities when they scored *High* in Relevance and at least two of the remaining three criteria were also *High*. This yields the following list:

- **Gap 1 – Relational competencies:**
  - Adapt verbal communication to cognitive status
  - Use active listening strategies
  - Support autonomy in daily care planning
- **Gap 2 – Non-pharmacological & cultural adaptation:**
  - Adapt interventions to individual biography and cultural background

- **Gap 3 – Interprofessional coordination:**
    - Apply structured protocols for interprofessional collaboration
    - Communicate effectively across professional roles
- **Gap 4 – Training accessibility:**
    - Apply learning content to real-world practice
- **Gap 5 – Structural barriers:**
    - Adapt practice to resource-constrained environments

These competences are not only highly relevant to improving the quality and person-centredness of care, but also feasible to deliver via e-learning and central to enabling other skills. They address critical aspects such as effective communication, coordination, cultural adaptation, and adaptability to resource constraints — all of which are recurring needs across pilot sites and target groups.

This selection is not final; it is intended as a starting point for consortium discussion, providing a clear, evidence-informed shortlist to be validated, adapted, or expanded during WP3 planning activities.