Institution	Initiative	Description	Benefits
National University Health System (NUHS)	Nurse-on-Demand	This initiative boosts staffing agility by matching nurses to the right roles at the right time. Through a digital workflow, wards can quickly flag manpower gaps, allowing nurses who are off-duty or on their rest days to opt in and take up shifts in real time from a dedicated contingency pool. Since its pilot in two wards in Ng Teng Fong General Hospital (NTFGH) in April 2025, the initiative has expanded across NTFGH, as well as the Intensive Care Unit and Emergency Department by June 2026, and into Jurong Community Hospital wards from July 2026. Between April 2025 and April 2026, 408 contingency shifts were activated, with nearly half of staffing gaps covered through Nurse-on-Demand instead of staff callbacks. Supported by a growing pool of 90 nurses, the programme is reducing reliance on last-minute staffing arrangements and strengthening workforce responsiveness. There are plans to extend the scheme across all NUHS institutions, potentially including returning retirees and former nurses, to build a more flexible and resilient nursing workforce.	Nurse-on-Demand aims to improve workforce wellbeing and patient care by ensuring safe staffing levels while empowering nurses with greater autonomy and growth opportunities. By tapping on experienced nurses familiar with hospital systems, it minimises disruptions and maintains continuity of care, safeguarding patient safety even during sudden manpower shortages. Nurses benefit from flexible work options, fewer unscheduled callbacks, and opportunities for cross-department exposure, strengthening their adaptability and clinical skills. Early results show a 50 per cent reduction in callbacks in pilot wards, underscoring its effectiveness in supporting sustainable workforce practices and high-quality patient outcomes.
	Retaining nurses beyond retirement	To strengthen workforce sustainability and retain valuable clinical expertise, NUHS has introduced a structured initiative to rehire and redeploy retired nurses into roles that best match their skills, experience and capacity. Rolled out from May 2025,	The initiative enables retiring nurses to continue contributing in meaningful ways while transitioning into roles that align with their abilities and career aspirations. By retaining deep clinical

		the initiative takes a proactive approach by engaging nurses up to 24 months before retirement age to discuss post-retirement opportunities and career pathways. Rather than relying on ad hoc re-employment or automatically returning retirees to their previous roles, the programme focuses on matching nurses to roles that align with their abilities and organisational needs. NUHS is also developing a cluster-wide directory of suitable opportunities across its institutions, including positions such as mentors, educators, clinical auditors, counsellors, phlebotomists and wound care nurses. To date, 89 retired nurses have been rehired through the initiative, which builds on strong interest among the nursing workforce, with 98 per cent of surveyed retiring nurses indicating a willingness to continue working beyond retirement.	knowledge and institutional experience, NUHS strengthens continuity of care and provides additional support in areas such as education, mentorship, quality improvement and specialised clinical services. Patients benefit from access to experienced nurses who continue to guide care delivery and support high standards of practice, while younger nurses gain opportunities to learn from seasoned professionals. The programme also supports better workforce planning and smoother staffing transitions, helping to sustain a resilient nursing workforce in the face of growing healthcare demands.
National University Hospital (NUH)	Harmonised Compassionate Discharge	A structured workflow has been put in place by nurses at NUH since November 2025, with the implementation of the nurse-led Harmonised Compassionate Discharge pilot, ensuring consistent and coordinated support for end-of-life patients transitioning from hospital to home. It brings together coordinated care planning, structured conversations on goals of care, and close collaboration with hospice and community partners to ensure continuity of clinical support where needed. The structured support also includes arrangements for essential services such as	The initiative enables more patients to achieve their preferred goals of care by spending their final days in a familiar and comfortable environment surrounded by loved ones. Families benefit from the training, resources and support needed to confidently care for their loved ones at home, helping to ease anxiety and navigate the emotional and practical challenges of end-of-life care.

		medical transport, timely provision of equipment (e.g. hospital beds, oxygen support and other care aids), and hands-on caregiver training to build confidence in home-based care. Where required, emotional support, advance care planning and linkage to community resources are also facilitated, ensuring a seamless and respectful transition that honours patients' wishes and care needs. As of March 2026, the pilot benefited 13 patients and saved 63 bed-days. 11 patients had documented Advance Care Planning (ACP) or Serious Illness Conversations (SIC), ensuring that care remained aligned with their goals and preferences.	For nurses, the programme strengthens their role as advocates, care coordinators and trusted guides, ensuring patients' wishes are respected and care remains seamless across settings. By providing compassionate support during a deeply meaningful transition, the initiative enhances the experience of both patients and their families, helping to create a more dignified and reassuring end-of-life journey.
Ng Teng Fong General Hospital (NTFGH)	Inpatient Virtual Operating Centre (iVOC)	This is a virtual command post introduced at NTFGH to streamline inpatient discharge by redesigning how coordination tasks are managed. Each day, patients scheduled for discharge are consolidated into a centralised workflow, where outstanding tasks are identified and categorised into those that require physical bedside care and those that can be performed virtually. A dedicated rostered virtual nurse then takes on these non-physical tasks in a coordinated and streamlined manner - including liaising with families, arranging transport, activating community services, coordinating medication readiness and providing discharge education. This allows other nurses to focus on clinical care and patient-facing responsibilities, while ensuring discharge processes	The model enhances the patient and caregiver experience by enabling earlier and better-coordinated discharge planning, reducing last-minute delays and providing clearer guidance for care at home. It also strengthens care transitions through more structured coordination with families and community services. For nurses, the initiative reduces administrative burden and fragmentation by redistributing non-physical tasks to a dedicated virtual role, allowing bedside nurses to focus more on direct patient care. At the same time, it creates opportunities for

		are managed more consistently and proactively across wards. First introduced in one inpatient ward in April 2025 and scaled to a second ward in October 2025, the model has demonstrated strong early outcomes, including an approximate 53 per cent relative increase in discharges before 1130hrs across both wards, alongside improved operational efficiency.	nurses to take on new roles in virtual coordination and caregiver engagement, building capabilities in communication, care planning and workflow management, while supporting a more sustainable and flexible nursing workforce.
Alexandra Hospital (AH)	Virtual Emergency Department (ED) – Post discharge follow-up	A nurse-led virtual workflow is being piloted under the broader Virtual Emergency Department (Virtual ED) initiative to extend care beyond discharge and support more continuous patient management. Since May 2026, nurses at AH have been conducting proactive follow-up calls to selected patients approximately 48 hours after discharge from the Urgent Care Centre (UCC). This focuses on higher-risk patients, such as those with abdominal pain, fractures or a higher likelihood of complications. During these calls, nurses assess patients' recovery, identify any new or worsening symptoms, reinforce care instructions and determine if further follow-up or escalation is required, including referral to a general practitioner or return to hospital. They also review patients' clinical histories, exercise judgement in selecting cases for follow-up, and coordinate care as needed.	This initiative enhances patient safety and reassurance by providing follow-up after discharge, helping to detect potential complications early and support recovery at home. It also improves patients' understanding of care instructions and enables timely intervention where needed, reducing unnecessary returns to the ED/UCC. For nurses, it expands their role beyond discharge, strengthening capabilities in tele-assessment, risk stratification and care coordination. With greater autonomy to review cases, determine follow-up needs and escalate appropriately, nurses are able to contribute more actively to patient outcomes.
National University Polyclinics (NUP)	Lactation Consultant Service	The Lactation Consultant Service brings specialised breastfeeding support into the community, enhancing access to expert care for mothers and	The service improves outcomes for both mothers and infants by enabling earlier identification and management

		infants. Rolled out at Tengah Polyclinic in February 2026, the service is an expansion of NUP's Lactation Support Service, which has been building nursing capabilities in breastfeeding management since 2021. Delivered by trained lactation consultants, the service provides comprehensive assessment and management of more complex breastfeeding challenges, including low milk supply, pain, mastitis and engorgement. Since its launch, the service has expanded from one to four more polyclinics at Bukit Batok, Bukit Panjang, Clementi and Choa Chu Kang. It supported 60 mothers between February and May 2026, with plans to scale to all eight NUP polyclinics by end 2026.	of breastfeeding challenges, supporting continuity of care closer to home. Mothers benefit from timely, evidence-based guidance without needing hospital visits, reducing delays in care and improving their ability to continue breastfeeding. For nurses, the initiative strengthens professional capabilities in lactation management, counselling and early intervention, while expanding their roles in delivering specialised care within the community. Together, this enhances patient experience, promotes better maternal and child health outcomes, and supports a more integrated, community-centric model of care.
NUHS Population Health and Community Care	Step-up/Step-down (Shared Care) model	The nurse-led Step-Up and Step-Down (Shared Care) model aims to strengthen care beyond the hospital by partnering closely with community stakeholders. Step-Up Care focuses on early detection and timely intervention, championing a community-based model. Community partners such as Active Ageing Centres (AACs), Community Case Management Service and trained volunteers, known as Village Chiefs, act as a first line of support by monitoring residents and flagging early signs of deterioration. Through a clear escalation pathway, these concerns	This shared care model enables a more proactive and personalised approach to care, where nurses make decisions based on a longitudinal understanding of residents' health, functional status and social circumstances, rather than reacting to isolated clinical events. It strengthens alignment of care goals across healthcare and community partners, improves communication pathways, and supports better prioritisation of risk

		are relayed to NUHS community nurses, who promptly assess and triage residents, providing home-based support or arranging early clinical reviews as needed. Residents may also be directed to appropriate care settings, including community health posts, general practitioners, or direct admissions to services such as NUHS@Home, community hospitals, hospice inpatient and home care services, bypassing the Emergency Department where appropriate. Step-Down care supports residents after hospital discharge or those with ongoing chronic conditions. Nurses provide continued clinical oversight, monitoring and care coordination in collaboration with community partners including hospice care providers and community case management services, ensuring sustained support in the community. In this model, NUHS community nurses play a central role as the first responders and clinical anchors within the community. They independently assess residents, make clinical decisions, and lead coordination across healthcare and community partners to ensure continuity of care. Between November 2024 and December 2025, the model has managed over 580 clinical escalations, with 83 per cent resolved without requiring emergency department visits, and a further 10 per cent directly admitted to appropriate care settings,	incorporating both medical and social factors. For residents and caregivers, this translates into earlier intervention, more continuous support from a multidisciplinary team, and greater confidence in managing health conditions, resulting in improved quality of life. Early identification of deterioration reduces unnecessary emergency department visits and hospital admissions, while more consistent monitoring supports better chronic disease control. For nurses, the model expands their role beyond episodic care, enabling them to work more collaboratively with community partners and contribute to coordinated care planning. By shifting from a provider-centric to a resident-centric approach, the model ensures care is tailored to what matters most to individuals, while allowing care intensity to be adjusted dynamically based on their needs.

		demonstrating its effectiveness in enabling early intervention and reducing unnecessary hospital utilisation.	
NUHS@Home	Portable infusion pump for intravenous antibiotic delivery	NUHS@Home nurses have introduced a new approach to delivering intravenous (IV) antibiotics for patients with conditions such as cellulitis, one of the top three diagnoses managed under NUHS@Home. Traditionally, patients require IV antibiotics up to three times a day - each session lasting about an hour - resulting in multiple nursing visits that can disrupt daily routines. To address this, nurses introduced a lightweight, user-friendly portable infusion pump that delivers medication safely at pre-set timings without requiring a nurse to be present for each dose. Since its rollout in March 2026, the initiative has reduced nursing visits from three 45-minute sessions to a single daily visit, while maintaining treatment effectiveness. To date, 35 patients have been treated using the pump, primarily those requiring three-times daily antibiotics, out of 93 cellulitis admissions in March and April 2026. With overall cellulitis cases rising from 318 in 2024 to 548 in 2025, the initiative supports growing demand by streamlining care delivery while enabling patients to receive treatment more conveniently at home.	The initiative enhances patient experience by allowing individuals to recover comfortably at home with less disruption to their daily routines. Previously, patients receiving IV antibiotics needed to remain relatively immobile during three daily infusions, which could take up to two hours. With the lightweight portable infusion pump delivering antibiotics at preset timings, patients can move about freely and carry out daily activities while receiving treatment. This provides greater convenience and independence while maintaining safe and effective care. Reducing nursing visits from three to one also frees up nurses' time to support one to two additional patient visits daily, helping to meet growing demand for home-based care. The use of the infusion pump further upskills nurses in new care technologies, strengthening their capabilities in delivering efficient, patient-centred treatment in the community.