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Understanding Challenges in the Current Implementation of Urgent Care Centres (UCCs) and Exploring Care Redesign Opportunities in Expanding Community-Anchored Care Capabilities in Singapore: A two-phase qualitative study

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Aim / Objectives

Phase One:

To identify implementation challenges and roles of past Urgent Care Centre's (UCC) in Singapore's pre-emergency care (PEC) landscape and explore various UCC care models practical in Singapore.

Phase Two:

To build consensus on the most viable model and prioritize actionable implementation strategies.

Background

- Emergency departments (EDs) globally are increasingly strained[1].
- UCCs are viable solutions. In Singapore, public UCCs in were implemented locally to address urgent but non-life-threatening conditions[2] and reduce ED crowding[3].
- Public adult UCCs in Singapore faced several implementation challenges, resulting in UCC service restructure[4] and discontinuation[5]. Their absence results in unmet healthcare needs and uncertainty around its role and future in Singapore.
- Research gap: Existing studies have yet to explore which implementation strategies are viable locally. Thus, this study informs future UCC redesign locally and in other similar healthcare systems.

Intervention

Phase One: 1-to-1 Semi-structured interviews

Phase two: 2 Consensus-building workshops

- 26 participants (18 clinicians, 4 enabling units and 4 regulators), 14 participants continued to phase two while the rest declined
- Recruitment was done via purposive and snowball sampling which ceased when data saturation was reached
- Interview guide was crafted based on the Consolidated Framework for Implementation Research (CFIR)
- Workshops were structured using the Nominal Group Technique (NGT) to ensure equal participation[6]
- Interviews and workshops were transcribed using Trint and thematic analysis was conducted on Atlas.ti via Braun and Clark's six steps
- Thematic analysis was guided by the Hexagon tool

Results/Discussions

Theme 1. Unmet urgent care needs across levels

Patient-level mismatch
- Conditions requiring short-term observation

Clinician-level constraints
- Risk management concerns in standalone GP practice

System-level inefficiencies
- Absence of a clearly defined intermediate urgent care tier

Theme 2. Barriers to effective UCC utilization

Patient-related barriers
- Preference for one-stop hospital-based services

Provider-related barriers
- Limited integration into PEC pathways

System-level constraints
- Unclear role definition
- Unsustainable cost–revenue structures

Theme 3. Model configurations for urgent care delivery

Polyclinic-Integrated UCC
- Capabilities: Extended operating hours, expanded access to lab and rad
- Workforce model: UCC staffing separate from routine polyclinic personnel

Enhanced GP/GP+
- Capabilities: Extended operating hours, point-of-care testing (POCT) and decentralized diagnostics
- Workforce model: GP-led with defined urgent care competencies

Theme 4. Implementation enablers

Operational enablers
- Strategic geographic siting aligned to demand

Financial enablers
- Funding mechanisms to align stakeholder incentives

System-level enablers
- Clear system-wide definition of UCC's role
- IT interoperability and data sharing

92% of stakeholders agree that UCC still has a role.

Recommendations for sustainable implementation:
- Reduce operational costs by limiting physical space and diagnostic services to essential tests
- Have staff matched to case complexity to improve cost efficiency i.e. employ non-specialists

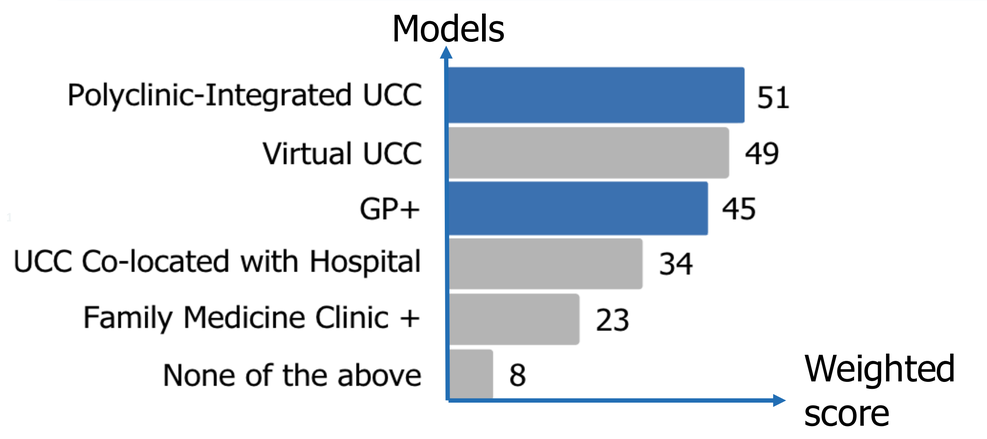


Figure 1. Aggregated rankings of UCC models from two consensus-building workshops using the weighted-scoring system. Scores were summed, with each participant's answer given equal weightage. The bars in blue represents models unpacked in results.

There is consensus on primary care-led brick-and-mortar UCC being the most viable model for local implementation.
- Recommendations to encourage GP buy-in: provide support via tele-consults with ED physicians and expand GP bandwidth e.g. professional development opportunities on urgent care management
- Required enablers and capabilities for implementation: extended operating hours, expanded IT integration and uniform UCC implementation

Virtual UCC ranked second overall.
- Potentially lower will to implement compared to brick-and-mortar UCCs
- Possible reasons: higher risks considering UCCs' patient types and potential duplication with existing telehealth services

Findings underscore the need to integrate UCC within existing ecosystems.
- There is a need to develop afferent and efferent pathways, including Hospital@Home as a potential efferent pathway for UCCs.

Conclusion

- Stakeholders agree that UCCs still have a role to play in Singapore's PEC landscape, with primary care-led brick-and-mortar UCCs ranked as the most viable.
- Though not discussed in detail, virtual UCC ranked second when results were aggregated, showing evidence of emerging interests and prompting for further research.
- Embedding UCCs within community-based acute care pathways may enhance their sustainability and value, including positioning UCCs as gateways for patients to access Hospital@Home.

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