CaringSG: A continuity layer for care across home and healthcare settings

1. Problem Statement

Singapore can support up to 17,100 patients under the Home Care model. For many frail elderly transitioning from hospital to home, the most critical period is between visits at home - where daily care (medications, vitals, wound care, mobility and basic activities of daily living) is executed by caregivers, often without standardised workflows or clinician-readable documentation[1]. As a result, when community nurses and doctors visit, they face a visibility gap: key events and trends between visits are missing or fragmented, forcing clinicians to rely on recall and partial notes. This increases the risk that early deterioration signals are missed and care decisions are made with incomplete context.

Root cause: Patients and caregivers lack a standard, low-effort way to execute, remember and capture care routines in a clinician-readable format.

Why now: As ageing-in-place expands, more care execution shifts to households. More families will need support in becoming effective caregivers and advocates for their loved ones.

2. Proposed Solution

CaringSG is a caregiver-facing mobile app for guided, low-effort logging that generates a standardised clinician summary (<60s) usable across care settings. It turns discharge/home-care plans into checklists and reminders for caregivers, and gives clinicians a fast snapshot of adherence, trends and flagged changes.

Over time, CaringSG is designed to integrate with NEHR to support continuity across transitions (hospital discharge, home care visits, primary care).

3. MVP hypothesis, metrics[2], scope and key trade-offs

MVP goal: validate (H1) sustained caregiver logging[3] and (H2) consistent clinician review.

H1 Metrics: Daily logging adherence ≥60%[4], 1-month retention ≥60%, Caregiver CSAT≥4/5
H2 Metrics: Visits where clinician reports logs influenced decisions ("Usefulness") ≥60%, Self-reported time saved, Clinician CSAT≥4/5

North Star: % of home care visits where the clinician summary is viewed pre/during visit
This metric aligns both caregiver and clinician workflows, ensuring data logged is valuable and translates to input for better patient care.
Kill criteria: Caregiver Day-28 retention <60%, clinician summary viewed in <80% of visits

4. Development, launch and rollout strategy

Phase 0. Goal: Validation of Problem Statement and prioritisation of MVP features
- Qualitative research with Home Care teams (in-depth interviews, ethnography)
- Concept testing with Home Care teams using low-effort prototype mobile app

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[1] Sources: Community care nurse and personal experiences
[2] Metrics are indicative. Subject to benchmarking during Phase 0 discovery
[3] Assumes frequent logging translates from higher adherence to care routines
[4] To improve baseline where 60% of elderly patients do not adhere to their medication regime

Phase MVP. Goal: Test PMF, Validate H1 and H2
- Pilot with MVP with at least 2 Home Care teams in 1 community care hospital, ~100 patients
- In person training of Home Care teams on use of app and how to onboard caregivers/patients
- Quantitative research with in-app collection of metrics + Post-survey
- Qualitative research with Home Care teams (in-depth interviews, ethnography)
- Entry point for caregivers: Onboarding done by Home Care team as part of first/next visit
- Iteration loop: weekly check-ins with participating teams; deploy fortnightly updates during the pilot to remove workflow friction and improve adoption.

Phase 2. Goal: Validate that CaringSG is generalisable across different care workflows
- Pilot with MVP with 50% of Home Care teams from 2 community care hospitals

Phase 3+. Goal: Wider roll out and integrations
- NEHR integration
- Roll out to all community hospitals and engage AIC for rollout to other care settings such as elder care centres and identification of other points of entry

5A. App Feature Prioritisation
For the MVP, feature selection prioritises high coverage (“big wins first”): low-effort, high-frequency routines that apply to most patients and caregivers, and compress into a <60s clinician summary that fits visit workflows. Specialised routines and step-by-step guidance content (e.g. knowledge base) are deferred to Phase 2 after retention and clinical usefulness are validated. System and device integrations (e.g., escalations, NEHR, devices) are deferred to Phase 3+ due to higher delivery complexity and governance risk.

MVP Features: High % of patients covered, no knowledge base, no integrations
Patient: Medication/BP/Glucose/Urine Logs, 4 Languages, Notifications, Short notes, Alarms
Clinicians: Patient summary (adherence %, simple trend view), drill down
MVP Safety boundary: no diagnosis/triage - structured logs and simple trends only
MVP Scope boundary: supports routine adherence and visit prep - excludes appointments, billing, and non-home-care workflows

Phase 2 Features: Med % of patients covered, knowledge base required, no integrations
Patient: Wound care, physiotherapy, including pictorial/video step by step guidance

Phase 3 Features: Low % of patients covered, knowledge base required, integrations started
Patient: Escalations integration, Bulk Update (elder day care centre workflow), NEHR integration

5B. Non-functional requirements

1) Patient Consent: Patients must consent to having their health data logged on their behalf by a caregiver and for data to be shared and processed by healthcare institutions and workers via approval with their Singpass. 2) Audit: All access to records must be logged.

6. Tech Stack

- Mobile (iOS + Android): React Native to ship one codebase quickly
- Backend API: REST service to fetch routines and sync caregiver logs for clinician viewing
- Data store: relational DB (e.g., PostgreSQL) for routines/logs + access control
- Offline-first: local storage (e.g., SQLite) with background sync