Royal College of Emergency Medicine

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# RCEM Acute Insight Series:

# Capital Incentive Schemes

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## Acknowledgements

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# Executive Summary

Context

In the final month of 2024/25, NHS England (NHSE) allocated £150 million of operational capital to trusts that met or improved key Emergency Department (ED) performance targets – namely four-hour and 12-hour wait metrics. This built on similar schemes from the past, but has so far been the most extensive financial reward scheme, and for the first time included incentives tied to 12-hour performance.

The scheme covered four award categories related to either the highest or most improved performance, though the category covering Ambulance waiting times has been omitted from this analysis due to those funds only being available for Integrated Care Boards (ICBs).

National-level performance outcomes

The scheme came to an end in March, and between February and March 2025, 4-hour performance nationally rose from 73.4% to 75%, smaller than the 3.3 percentage point (pp) gain seen in the same period of 2024. Type-1 departments (major EDs) saw a 2.5pp increase to 60.9%, again below 2024's 4.4pp increase. 12-hour breaches in major EDs fell by 1.6pp to 9.7%, a slight improvement from the 1pp decrease seen in 2024. After the scheme's conclusion, both metrics worsened going into April 2025, whereas after the 2023/24 incentive scheme performance had continued to improve. It is unclear why there were smaller improvements in 2025 than in the previous year. It could be the residual effects of winter pressures were longer-lasting in 2024/25, or that most trusts simply did not make a last-minute push to receive the funds, especially since most categories focused on performance across the whole year. The fact that performance dipped post-incentive scheme does pose the worrying implication that trusts may have optimised for the incentive period, mobilising resources to hit targets only for the duration needed to secure funding, which in turn points to a possible risk of gaming.

Trust-level outcomes

When it came to trust-level outcomes, trusts that were already high-performers were repeatedly rewarded for maintaining already strong performance, suggesting that the scheme primarily recognised existing excellence rather than driving further improvement. A handful of these trusts were women's and children's trusts which, by virtue of their specialised services and narrower patient cohorts, are able to consistently achieve four-hour and 12-hour targets with minimal variability. In contrast, several trusts which typically sit lower in the overall rankings were able to achieve significant spikes in performance, with one in particular improving four-hour performance by over 20pp between February and March 2025. However, in the following months, it was these trusts that were most likely to experience steep declines in both ranking and performance once incentive funding was secured. Similar volatility was seen in 12-hour breach rates, though not to such a significant extent.

Inequitable distribution of funds

Due to the eligibility criteria established by NHSE for this incentive scheme, an additional advantage emerged for trusts that have type-3 ED performance data mapped onto their type-1 data. By mapping attendances and wait times from these integrated care pathways, these trusts are able to increase their apparent performance with minimal operational changes taking place in type-1 EDs. The rationale given by NHSE for why this eligibility criteria was mandated was based on patient care interests, incentivising trusts to focus on both four-hour performance and redirecting lower acuity patient away from type-1 EDs. This rationale is valid for operational benchmarking, but it introduces a distortion when used as a basis for competitive capital awards. When type-3 activity is mapped onto type-1 data, some trusts can appear to have markedly better performance without having implemented any changes within their type-1 EDs – the area the funds are intended to support. These trusts are essentially competing on different terms at the expense of the rest of the trust cohort; other trusts' type-1 performance may be stronger than those with mapped activity, but will still have missed out on potential capital gains due to this mandated eligibility criteria.

Based on this, the capital incentive scheme unintentionally rewarded trusts already positioned for success, while simultaneously it incentivised trusts to resort to temporary, resource intensive interventions to meet the success criteria of different scheme categories while fundamental issues such as bed availability remain unaddressed. This design may reinforce inequalities within the system and fails to drive enduring improvements. This highlights the need for a holistic approach that improves overall system resilience instead of simply prioritising immediate gains in performance and shining the spotlight on trusts that, by their specialist nature, are already high performers.

Recommendations for future models

This analysis finds that the capital incentive model, in its current format, is not effective and should be reconsidered. If either NHSE or the Department of Health and Social Care wishes to implement future competitive funding models, the Royal College of Emergency Medicine would recommend that these models:

1. Target systemic capacity improvements, such as focussing on improving delayed discharges, or reducing whole hospital occupancy to safe levels rather than short-term metric attainment.
2. Exclude or adjust for specialist trusts and trusts with type 3 mapped data to ensure fair levels of competition; or, move away from a competition angle entirely to foster greater cooperation in the health system.
3. Ensure that awards given for improvement or ranking of four-hour performance, are conditional on 12-hour waits also to ensure that admitted patients are not disadvantaged. Any hospital with waits of 24 hours or greater should be disqualified from receiving awards.
4. Aim to minimise short term gaming and unsustainable interventions, by awarding these over quarterly periods and years, rather than months.

# Introduction

April 2025 marked the end of the second Urgent and Emergency Care delivery plan. This included the provision of financial incentives for trusts and ICBs meeting A&E and ambulance performance targets. £150 million in operational capital was to be allocated in 2024/25, to incentivise higher performance in 2023/24, and there was the promise of another £150 million to bolster 2025/26 capital budgets. This followed from a previous incentive scheme in July 2023 for trusts achieving good performance in the third and fourth quarter of 2023/24.

When it comes to performance metrics in Emergency Departments (EDs), the NHS set an operational standard in 2010 that 95% of patients attending A&E should be admitted, transferred, or discharged within four hours. This target has not been met nationally since July 2015. As part of efforts to improve waiting times, NHS England lowered the national target to the interim level of 76% in the 2023/24 planning guidance, raising it only to 78% a year later. Setting the target so low risks perversely incentivising trusts to prioritise patients who can be processed quickly at the expense of those who may be very sick. When the operational focus is shifted to 'quick wins' the cohort of patients requiring admission, and therefore more likely to breach the four-hour target anyway, can end up waiting upwards of 12 hours for the next stage of their care.

In recent years, capital incentive schemes have been one of the attempts to rectify this situation and drive efficiency. This analysis examines the effect of the most recent capital incentive scheme which planned to distribute additional funding to trusts with type 1 EDs for the financial year of 2025/26. A type 1 ED is a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. Funding was granted to trusts through the following schemes:

- **Scheme 1**:
    - **(a)** Top 10 organisations with the highest four-hour performance (admission/transfer/discharge) across 2024/25.
    - **(b)** Top 10 organisations with the most improved four-hour performance across 2024/25 compared to 2023/24.
- **Scheme 2**:
    - **(a)** Top 10 organisations with the lowest 12-hour performance (admission/transfer/discharge) across 2024/25.
    - **(b)** Top 20 organisations with the most improved 12-hour performance across 2024/25 compared to 2023/24.
- **Scheme 3**:
    - **(a)** Top 5 ICBs for Category 2 mean ambulance response times in 2024/25.
    - **(b)** Top 5 ICBs for most improved Category 2 mean? ambulance response time in 2024/25 compared to 2023/24.
- **Scheme 4**:
    - **(a)** Top 10 organisations with the highest four-hour performance in March 2025, which must exceed 78%.
    - **(b)** Top 10 organisations with the most improved four-hour performance in March 2025 compared to March 2024

This analysis will focus on schemes 1, 2, and 4. It is the first time that there has been a financial incentive focused on 12-hour performance. This is an encouraging development not only

because patients that wait longer than this amount of time tend to experience the most harm in EDs, but it also lessens the risk of incentivising trusts to prioritise less acute patients in order to meet the 4-hour target of 78% in March 2025. However, it is worth mentioning that this problem still exists, as trusts have the option of solely pursuing the schemes relating to four-hour performance.

## Impact on national A&E performance in England

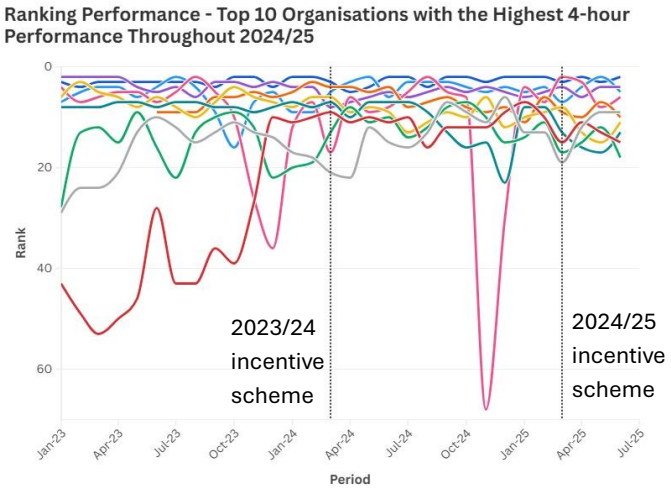
Four-hour performance rose from an average of 72% across all EDs in 2023/24 to 74% in 2024/25. This is encouraging improvement, especially as performance only improved by a single percentage point between 2022/23 and 2023/24, although at this rate of growth it would still take over 15 years for performance to reach the NHS constitutional standard of 95%. On the other hand, 12-hour waits from time of arrival did not improve in 2024/25, with the proportion of patients waiting this long increasing by 0.5 percentage points since 2023/24.

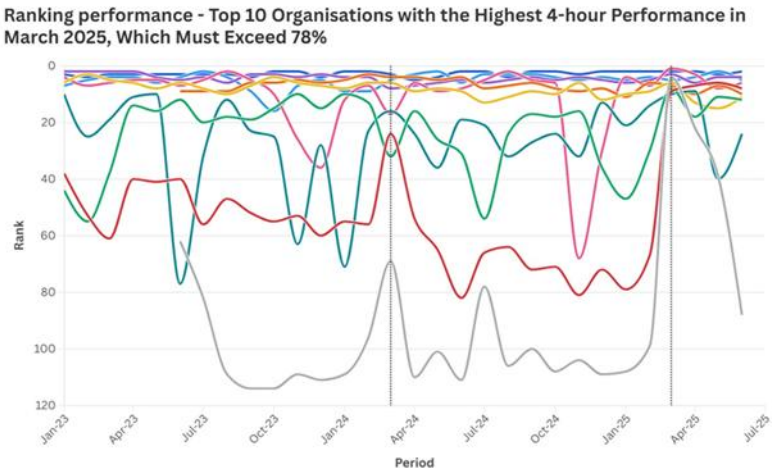
Between February and March 2025, national four-hour performance across all types of ED improved from 73.4% to 75%, marking an increase of 1.6 percentage points. Comparatively, 2024 saw a larger increase of 3.3 percentage points over the same period. In major EDs specifically, four-hour performance rose from 58.4% to 60.9% (2.5 percentage points) between February and March 2025, though again this was smaller than the 4.4 percentage point increase recorded in 2024. Meanwhile, the proportion of patients in Major EDs waiting 12 hours or longer from their time of arrival decreased from 11.3% to 9.7% between February and March 2025, a reduction of 1.6 percentage points. In 2024, when there was no cash reward tied to 12-hour performance, the corresponding improvement was one percentage point.

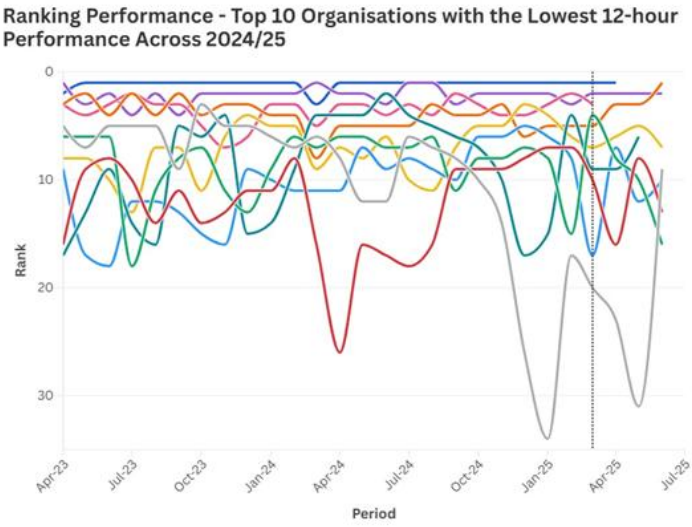
Given the data, it is questionable whether the incentive scheme had any meaningful impact on shifting waiting time metrics. The annual average for 12-hour performance was worse than the previous year, and while March 2025 saw a modestly larger improvement over March 2024, this gain was reversed in April. Contrastingly, 12-hour metrics improved between March and April 2024, despite the 2023/24 incentive scheme not even targeting 12-hour breaches. Four-hour performance is slowly improving, though still falls short of NHS England's 78% interim target.

The changes seen in these incentive periods do not necessarily fall outside of normal variability. Relatively large improvements are evident elsewhere without any apparent link to incentives, such as the 1.9 percentage point rise in 4-hour performance between December 2024 and January 2025 during the peak of winter pressures. Therefore, attributing observed performance gains to financial incentives lacks sufficient basis and appears coincidental rather than causal.

# Impact on Performance at a Trust Level




Across both 4-hour and 12-hour trust rankings, a consistent pattern emerges where a core group of trusts remains in or near the top 10 throughout 2023/24 and 2024/25. Specifically, at least six trusts in schemes 1a and 4a consistently held top positions for 4-hour performance, with only minor fluctuations—one of which saw a temporary decline in November 2024 before recovering. In scheme 2a, four trusts similarly maintained top 10 positions over the same period for 12-hour performance. For these trusts, the schemes seem to reward the maintenance of pre-existing high performance rather than incentivising any significant improvement. Since they are already performing at a high level, their performance shows little room or need for further increases, yet they remain eligible for financial rewards merely by sustaining status quo metrics. This could suggest the capital incentive scheme functions more as a recognition tool to celebrate already-capable trusts, rather than as a driver of transformational change for struggling ones which are more in need of attention.

The remaining trusts exhibited more volatility in rankings. This is particularly the case for scheme 4a, which sees three trusts rise significantly through the rankings to reach the top 10

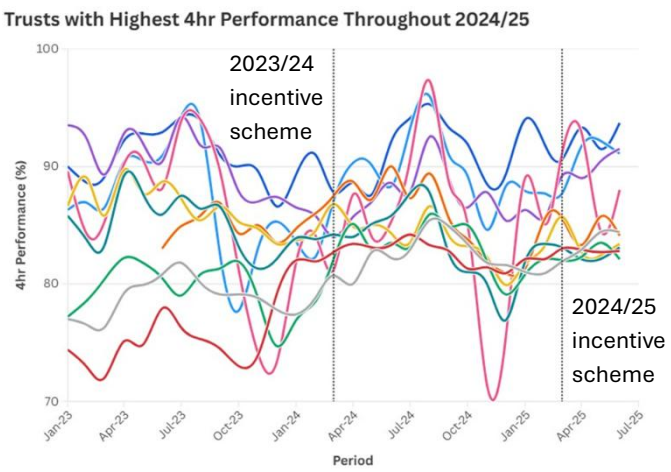
between January and March 2025. Similarly, among the trusts in scheme 2a, several have seen notable fluctuations throughout both 2023/24 and 2024/25, with one in particular experiencing a significant last-minute increase in February 2025, just before the incentive scheme deadline. It is not uncommon for 4-hour performance to increase as the winter months come to a close and pressures start to ease slightly; similar trends can be observed in 2019. However, the foreknowledge and timing of some improvements – especially for trusts historically falling outside of the top 10 – suggest the schemes inadvertently encourage performance gaming, at least in the specific case of scheme 4 which solely focuses on one-month performance. This dynamic undermines the scheme's intention to foster long-term, systemic improvements in ED performance. Instead, it risks perversely incentivising trusts to focus on short-term metrics manipulation. This is only exacerbated further by setting the 4-hour performance target so low at 78%, as it creates incentives for EDs to focus disproportionately on processing lower-acuity patients to move through the system quickly rather than addressing flow issues further down the line that affect high-acuity and complex cases.

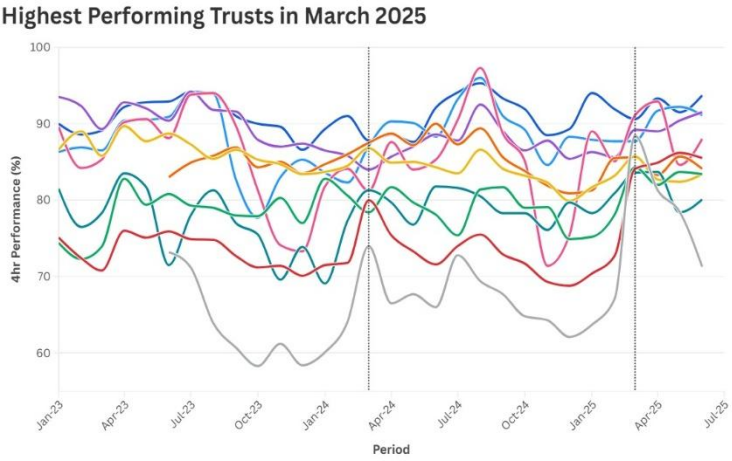
When examining actual performance figures, a more nuanced picture appears. Trusts with long-standing high ranks typically maintained 4-hour performance levels between 85-95% across the two-year period, showing little upward movement as March 2025 approached. This stability suggests these trusts had less incentive to chase marginal gains, likely due to their already secure positions.

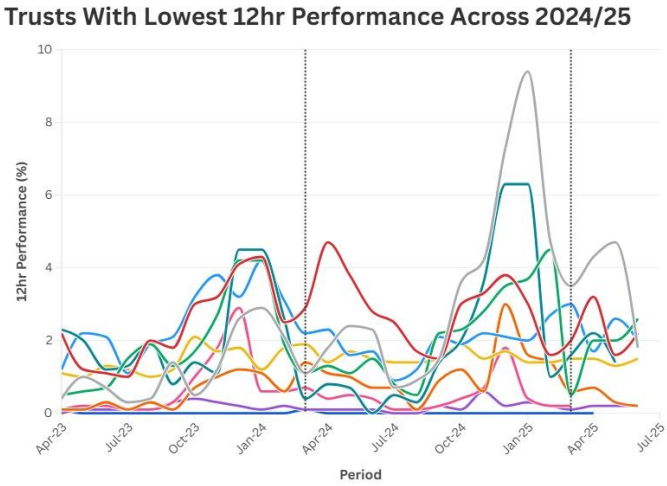
In contrast, trusts that climbed the rankings saw sharp and notable improvements in performance metrics. One trust in particular increased its 4-hour performance from 67.1% in February 2025 to 88.4% in March 2025, a 21.3 percentage point leap. Similar improvements were observed among 12-hour performance trusts, with steep declines in the proportion of patients waiting 12 hours or more leading up to March. While seasonal factors, such as the easing of winter pressures, might partially explain these patterns, the alignment with incentive scheme deadlines does suggest deliberate efforts to boost figures in time to qualify for funding.

Following March 2025, some immediate shifts occurred. In scheme 4a, three trusts that had surged into the top 10 fell out by April, experiencing performance drops ranging between 2.3 and 7.1 percentage points. Notably, the trust that had made the largest gains prior to March saw the steepest decline in subsequent months. A couple of trusts managed to sustain their increased performance levels following March 2025. However, in the majority of cases, trusts maintained similar levels of performance moving into April 2025 and the following months, especially in scheme 1a. For some trusts, their 4-hour performance actually decreased in the lead up to March 2025 before increasing again the following month, indicating that the incentive scheme had little to no effect on these trusts.

For 12-hour performance, a similar pattern emerged. While all top 10 trusts remained well below the national average of 10.4% leading into March 2025, some experienced increases in long-wait percentages immediately after the scheme concluded. It is encouraging however that by June 2025 all of the scheme 2a trusts had brought their 12-hour breaches down to below 4%, 4.8 percentage points below the national average of 8.8%; though, it must be said that most of these trusts were already averaging below 4% prior to the incentive scheme.

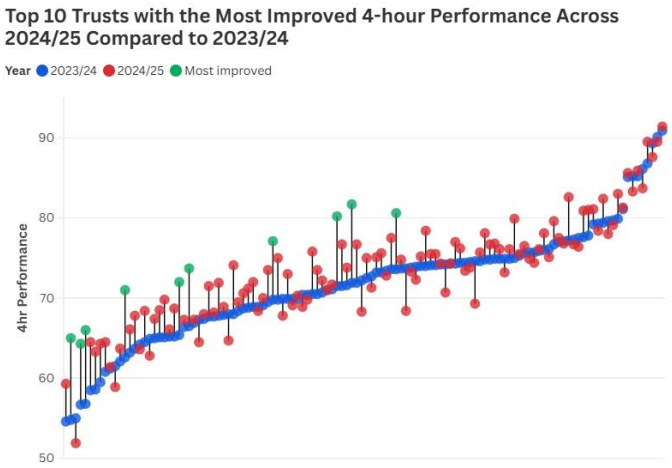


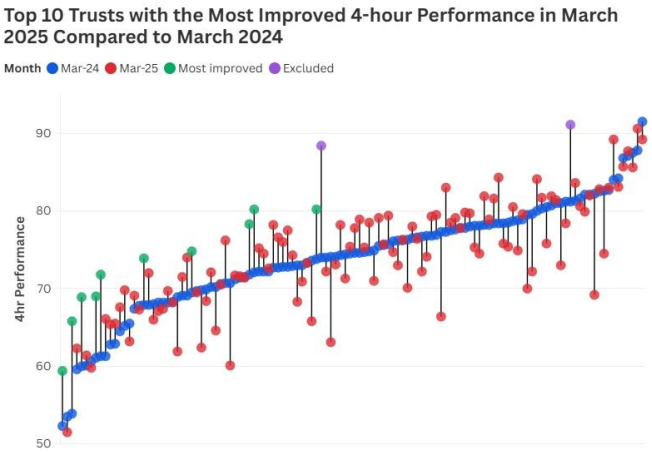



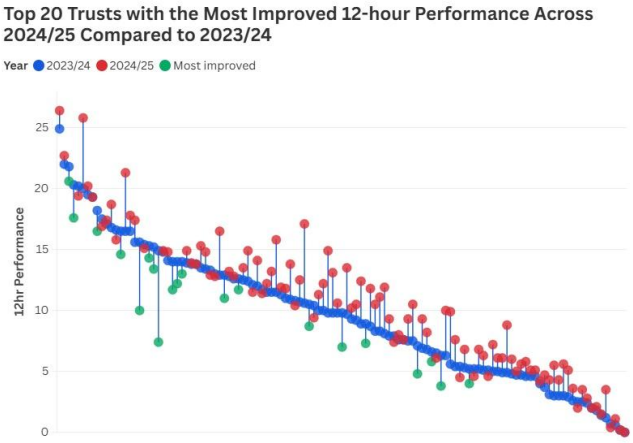




Across all three schemes, fluctuations in rank and performance post-March 2025 appear to reflect a combination of sustained operational performance in some trusts and short-term performance spikes in others. While the incentive schemes seem to have driven short-term gains for certain trusts, the drops in performance observed after the conclusion of the incentive scheme suggests that long-term, systemic improvements have not been embedded. This is most apparent in scheme 4, the scheme which only considers the highest performance in March 2025. In order to address this issue, any future capital incentive scheme should avoid assessing performance over a single-month period and instead aim to assess performance over longer durations.

# Impact on Improvement at a Trust Level



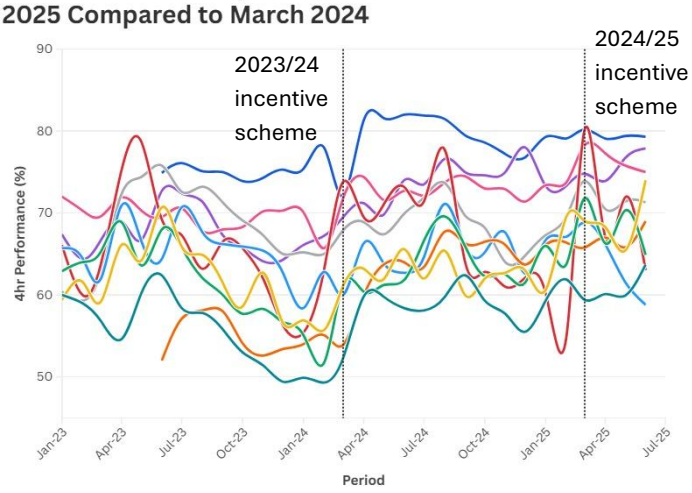




In scheme 1b, the top 10 trusts for 4-hour performance gains between 2023/24 and 2024/25 saw increases of 6.6 to 10 percentage points. Nine of these trusts were below the national average (72%) in 2023/24, with three consistently near the bottom of the rankings. After improvement, four trusts rose above the 2024/25 national average (74%), while six remained below it, some narrowly missing the benchmark by less than one percentage point.

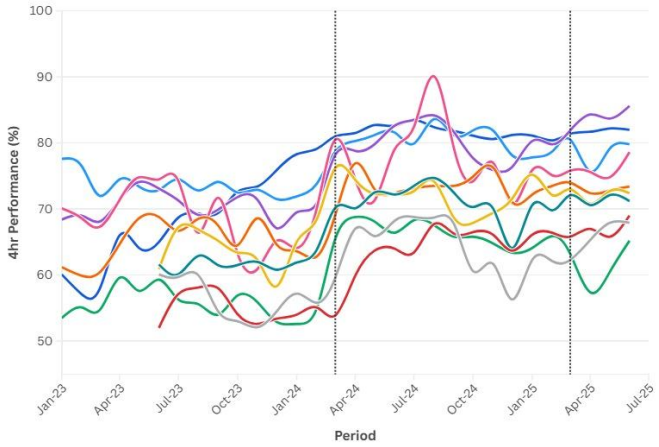
For scheme 2b, the 20 trusts with the largest improvements in 12-hour performance reduced their proportion of long-wait patients by 0.8 to 7.5 percentage points. A majority (14 trusts) were above the national average (9.9%) in 2023/24, including three that spent most of the year in the bottom 10. Two of these trusts made sufficient gains to move out of the lowest-performing group, but one remained among the worst performers. Despite the reductions, only nine of the 20 trusts managed to stay below the 2024/25 national average of 10.4% for 12-hour waits, while the rest exceeded it – sometimes significantly. The worst among them recorded a 2024/25 average of 20.6% for 12-hour waits, 10.2 percentage points above the

national average, highlighting the varying degrees of success in improving performance despite targeted funding.

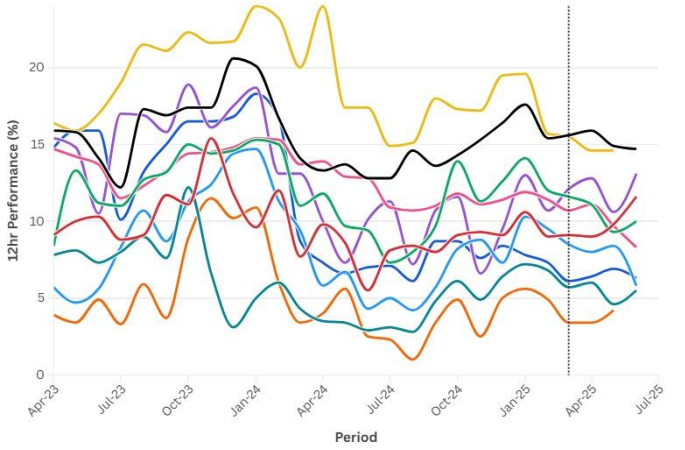
**Trusts with Most Improved 4hr Performance in March 2025 Compared to March 2024**



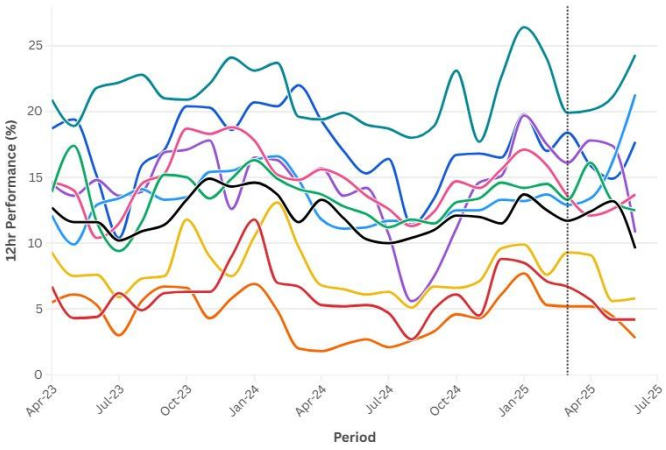

**Trusts with Most Improved 4hr Performance Across 2024/25 Compared to 2023/24**




**Trusts with Most Improved 12hr Performance in 2024/25 Compared to 2023/24 (1)**




**Trusts with Most Improved 12hr Performance in 2024/25 Compared to 2023/24 (2)**




The bottom two graphs both represent scheme 2b, which has been split in order to make the data more accessible, but this also reveals another trend which might explain differences in trust behaviour. The lefthand represents the top half of scheme 2b while the righthand represents the bottom half; the former appears to show much clearer lines of improvement over the last two years, while the latter data has a more sporadic nature, making it harder to see improvements. The righthand graph also shows that two trusts' 12-hour performance starts to worsen following the 2024/25 incentive scheme, with one trust going from 12.9% in March to 21.3% in June. By comparing trusts within one of the award schemes, it raises the question of whether changes in performance are down to the promise of external funds, or whether internal operational factors play a larger role, rendering the incentive scheme largely redundant as a tool of driving long term improvements.

While year-on-year improvements were achieved across a number of underperforming trusts, these gains were often insufficient to bring performance in line with national averages. In many

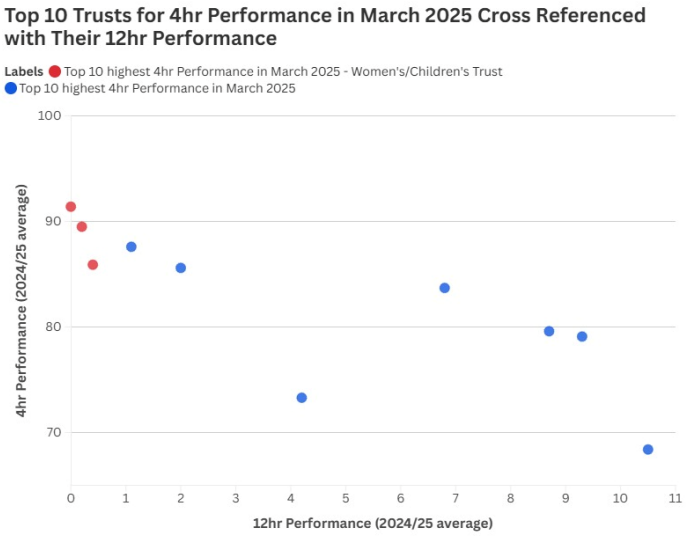
cases, trusts made meaningful strides from very low baselines yet continued to fall short of acceptable standards. This suggests that while the incentive model successfully encouraged short-term action among struggling providers, it may not have been sufficient to drive the level of systemic change needed to lift performance to sustainable, high-quality levels.

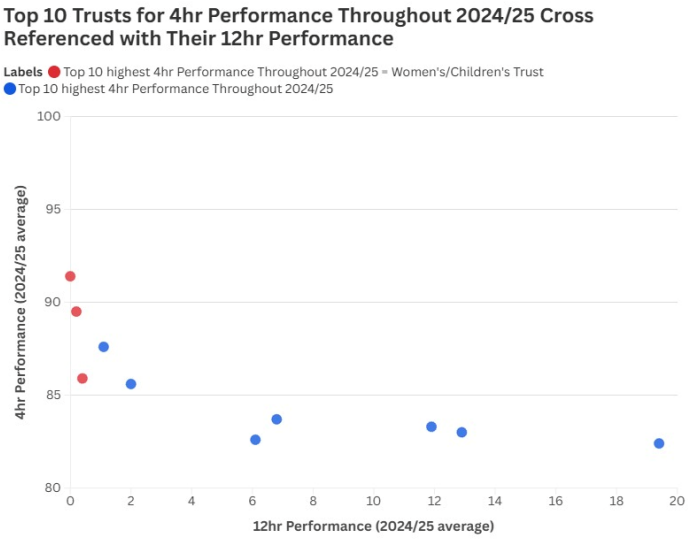
The results raise important questions about the design and expectations of improvement-focused schemes. Targeting improvement rather than absolute performance is a valuable approach, but its effectiveness depends on the depth of change that trusts are supported to make. Without parallel investment in workforce, flow management, and operational resilience, the risk remains that these performance gains are temporary and vulnerable to reversal once incentive periods end.

Incentives alone cannot deliver transformation. Without sustained and holistic support, the urgent and emergency care system will continue to cycle between short-lived improvements and recurring challenges. A long-term, integrated approach is essential to achieve and maintain the high-quality, resilient care patients deserve.

## Creating Further Divisions

It is apparent from the incentives based on performance that there are some trusts which are consistently able to maintain both a high rank and high performance with seemingly little difficulty. As figures 4.1 and 4.2 show, three of these high-performing trusts are women's and/or children's trusts. These trusts are specialist type 1 trusts – designated for their focus on highly specialised, integrated services in women's health and/or paediatrics.




Although Women's and Children's trusts fulfil a vital role in delivering highly specialised and complex care, their performance metrics must be considered in the context of their patient demographics. Unlike general acute trusts that manage a broad spectrum of health needs across whole populations, these specialist trusts primarily handle a smaller, more defined patient population, allowing for more streamlined care pathways and targeted resource allocation. This narrower service scope contributes to their ability to consistently achieve high performance standards.

Including specialist Women's and Children's trusts in broad incentive schemes that financially reward the highest-performing NHS organisations risks creating further divisions between the best and the worst performers, thereby undermining the schemes' intended purpose. Performance-based funding disproportionately favours trusts whose service model inherently supports higher performance outcomes, rather than addressing operational pressures or driving meaningful improvement.

Finally, when establishing the eligibility criteria for assessing 4-hour performance, NHSE stated they would use acute footprint data, which "maps type 3 activity from local independent type 3 departments to the relevant local type 1 acute ED". The table below highlights how a third (11) of the 33 trusts awarded for 4-hour performance had much better performance from having their data mapped with type 3 activity.

Some of these changes are marginal, with one trust only seeing an increase of 0.7, though some trusts see changes upwards of 7 percentage points. It must be stated that given how close some trusts' performance is in relation to each other, a small uplift could be the difference between being in or out of the top 10 for their respective incentive scheme.

| Trust | 4hr performance before mapping (2024/25 average) | 4hr performance after mapping (2024/25 average) | Difference (percentage points) |
|---|---|---|---|
| A | 83% | 83.7% | **0.7** |
| B | 71.2% | 73.7% | **2.5** |
| C | 78.3% | 81.7% | **3.4** |
| D | 69.1% | 73.3% | **4.2** |
| E | 78% | 83% | **5** |
| F | 80.7% | 85.9% | **5.2** |
| G | 83.1% | 89.5% | **6.4** |
| H | 74.8% | 82.4% | **7.6** |
| I | 55.2% | 64.3% | **9.1** |
| J | 63% | 73.5% | **10.5** |
| K | 65.8% | 83.3% | **17.5** |

The two tables below show that half of the trusts in scheme 1a and three trusts in scheme 4a had type 3 activity mapped onto their type 1 data. For most of these trusts (six out of eight), their position in the top 10 for their respective scheme was contingent on their mapped activity, without which they would not have been eligible for funding.

Scheme 1a

| Trust | Rank before mapping | Rank after mapping | Difference |
|---|---|---|---|
| A | 5 | 2 | **3** |
| B | 11 | 5 | **6** |
| C | 21 | 9 | **12** |
| D | 37 | 10 | **27** |
| E | 93 | 8 | **85** |

Scheme 4a

| Trust | Rank before mapping | Rank after mapping | Difference |
|---|---|---|---|
| A | 8 | 6 | **2** |
| B | 15 | 9 | **6** |
| C | 22 | 5 | **17** |

While these care pathways are increasingly important and should be celebrated, including these trusts in incentive schemes provides an advantage to organisations whose metrics have been elevated through data aggregation, rather than through internal service improvements. In contrast, it inadvertently disadvantages trusts without a type-3 service. This undermines the fairness of such schemes, as trusts facing the full brunt of emergency demand without the benefit of mapping are effectively penalised. There is also the risk of this mapping driving perverse behaviour in the sense that trusts may decide to prioritise processing lower acuity cases quicker in order to boost type 3 (and therefore overall) performance. While these 'quick wins' are more likely to be seen within four hours and redirected to the necessary type 3 department, the more complex cases with higher acuity would then be left waiting in struggling type 1 departments, posing a significant risk to patient health and safety. Similarly, women's and children's trusts, already have integrated care pathways established with type 3 trusts are

less likely to require additional financial incentives to maintain high performance, making the allocation of scarce resources to these organisations inequitable and inefficient.

## Discussions with clinicians working in departments with marked improvement.

We received informative feedback from clinicians in a variety of departments.

*'The success in March really was a combination of multiple different interventions all working together. The main focus was on improving flow/discharges and this was achieved by intense scrutiny of decision making and challenging the wards to get patients home, alongside changes to the way community beds were utilised. Personally, I was surprised by how well this worked, with flow to the adult wards occurring before 4hrs for the first time in months. This was reflected in the admitted performance jumping'*

*But there were also other changes*

- *Increased use of children's assessment areas rather than them reviewing patient in ED*
- *Surgical SDEC [same day emergency care] more actively pulling patient to their unit*
- *An extra porter in ED*
- *Reallocation of a clinical support worker to ED to reduce wait for cannulation/bloods*
- *An ops manager in ED until 22:00 to help keep trouble shoot.*
- *Early intervention team being based in ED with more direct reviews.*

*What we saw was that once flow started and the ED became decompressed it started to function more efficiently, with reduced WTBS [waiting to be seen] and also an improvement in non-admitted performance. '*

The success described above demonstrates that the underlying constraints typically found within UEC (beds, staffing, demand) were not insurmountable; they were just managed differently. It is also made clear that no single measure can explain the improvement. It was instead a combination, or a trust-specific adoption, of several various levers that tipped the system into flow.

Shifts in focus and decision-making led to rapid and significant improvement, which raises the question of why organisations do not always operate at this level of efficiency, especially as these interventions are not expensive. March 2025 was described above as a period of "intense scrutiny". Leaders were visible, data was being tracked, and wards were challenged daily, implying that without this level of managerial focus, drift will occur and performance will drop. Furthermore, many interventions relied on different teams (surgical SDEC, children's services, ED ops), though normally these teams act semi-independently with their own priorities to consider. This implies that without the special circumstances provided by the March-specific incentive schemes that allows trusts to override regular constraints, the system defaults back to fragmented departmental priorities and low leadership visibility.

The fact that performance rose so quickly shows the problem is not *capability* but *organisational will and structure*. The real question, therefore, and subsequently the real task, is how to embed these mechanisms into everyday operations instead of falling back on them as temporary fixes. Incentive schemes in their current form cannot achieve this task. While they may incline trusts to adopt structural changes in order to hit performance metrics, the short-term nature of the rewards is not enough to cement these changes, as shown by

performance decreases once the incentive period ends. Capital incentive schemes can buy effort and superficial performance boosts, but not long-term coordination.

## Future of the Incentive Scheme programme

While the 2024/25 incentive programme was intended to drive performance improvements across trusts, the evidence suggests that its impact has been both limited and short-lived, if noticeable at all. The inability to separate incentive influence from that of seasonal variation, as well as inconsistent responsiveness across trusts to the implementation of the schemes, suggests that the programme failed to generate any lasting change it might have aimed for. Furthermore, most of the significant performance gains that occurred prior to the awarding of the incentives deteriorated almost immediately afterward, highlighting how these incentives motivate perverse behaviour that does not accurately reflect reality on the ground. When it comes to the improvement-based incentives, whether a trust places in the top or the bottom half of their respective group reveals different trends in the data, with the bottom half appearing to have a much less stable path of progression. This leaves room for debate over whether limited external funding has a larger impact on performance than internal factors.

The structure of the incentive scheme itself raises concerns about fairness and effectiveness. Trusts with specialist service models, such as Women's and Children's trusts, consistently outperform their more generalised counterparts – not necessarily through operational excellence, but due to narrower service scopes and more predictable patient flows. Similarly, trusts benefiting from data aggregation where type 3 activity is mapped to type 1 acute performance gain numerical advantages that do not reflect equivalent internal improvements. A crucial pitfall that must be avoided is trusts placing more emphasis on type 3 departments improving their performance in order to compensate for the continuous struggle that type 1 departments are facing.

Given these findings, there is little justification for the continuation of an incentive structure in its current form that appears to only deliver occasional short term fixes and lacks meaningful impact on trust performance. Future schemes should incentivise long term behaviour change rather than short term performance improvements that can be gamed. Moreover, rather than risk the entrenchment of existing disparities, future approaches must prioritise equitable systemic support over superficial rewards, ensuring that resources are directed where they can drive genuine, lasting improvements in emergency care delivery.

If the DHSC persists in conducting Capital Incentive Schemes in their current format, then RCEM recommends:

1. Target systemic capacity improvements, such as focussing on improving delayed discharges, or reducing whole hospital occupancy to safe levels rather than short-term metric attainment.
2. Exclude or adjust for specialist trusts and trusts with type 3 mapped data to ensure fair levels of competition; or, move away from a competition angle entirely to foster greater cooperation in the health system.
3. Ensure that awards given for improvement or ranking of four-hour performance, are conditional on 12-hour waits also to ensure that admitted patients are not disadvantaged. Any hospital with waits of 24 hours or greater should be disqualified from receiving awards.
4. Aim to minimise short term gaming and unsustainable interventions, by awarding these over quarterly periods and years, rather than months.