

Performance stories – a comparison of the annual reports presented by the United States  
Veterans Health Administration and the United Kingdom National Health Service.

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Annual performance reports can tell researchers a great deal about the organizations they study. Sometimes it is the actual information provided which is of interest, in many cases however, it is the construction details and signals of intent contained in reports which the researcher should reveal to learn more about the organizations they examine. Public sector annual reports record activity, results and achievements. Typically they draw on a range of data including financial information prepared by accountants. Annual reports purport to be the most comprehensive account of an organizations performance. In the current context of new public management, annual reports are used to subtly legitimate performance in the sense referred to by Power, but are also frequently more explicitly political in intent.

Annual reports may well be incomplete, selective records of what was achieved and can also be constructed around intent to variously mislead, exaggerate or distort. (Skerbek 2005) It would be wrong however, to assume that the desired legitimizing effect is always achieved. In reality annual reports of the type under question may well fail to reach intended readerships. Those persons who do read them, whether in government, the wider political system or the media may also respond with skepticism or outright opposition to the portrayal of achievement contained in the annual report.

The annual report is a 'genre' in development. The effort to find an effective means of conveying performance stories is taking place in circumstances of performance anxiety engendered by aggressive new public management. For these reasons the narrative itself has become a worthy subject of investigation. This paper specifically strives to work out the part played by the style and quality of narrative in the impact made by annual reports.

The two organizations and their respective annual reports selected for scrutiny in this project – the United States Veterans Administration's (VA)/Veterans Health Administration (VHA) and the English National Health Service (NHS) make for good comparison. (The VHA is a

department of the VA which also provides a range of personal benefits to ex-military persons. The NHS in the UK is organized in four separate jurisdictions – England, Scotland, Wales and Northern Ireland. This paper refers to the English NHS). Both the VA/VHA and the NHS are large scale, taxation funded, free at point of use, integrated health care systems, (primary, secondary, mental and community health services under one organizational umbrella) with services delivered by their own staff. The NHS in England spent £76,000,000 (£76 bn) in 2005-6 on a patient population of around 50 million. The VHA spent \$33,000,000 (\$33bn) in 2005-6 on a population of 5.4 million ‘unique patients’ around spread across a much larger geographic area. The VA patient population is older and displays higher levels of morbidity in comparison with the NHS patient population.

While significant differences exist in terms of purpose, access and size, valid comparisons can be made. Both systems are subject to close political scrutiny and in the late 1990s, amidst widely reported fears of impending decay, both the VHA and the NHS underwent a programme of radical reform involving structural and organizational change, new resource allocation systems, explicit measurement and accountability for quality and value. (Tuohy 1999; Marshal, Shekelle, Davies and Smith 2003) The NHS has undergone three distinct phases of change since the mid 1980s initiated by Conservative and Labour governments. The VHA was subject to a major change programme initiated by the Clinton administration in the mid-1990s. Both health care systems can be said to have a legitimacy problem which is related to performance and performance representation. (Walshe 2003; Dixon 2000; Perlin, Kolodner and Roswell 2004; Smith 2005) While it is recognised that ‘performance’ is recorded in many different forms in both the VHA and NHS, specific attention is paid in this paper to comparing the 2002-5 series of annual reports written for public consumption. In the United States the Office of Management and Budget Department of Veterans Affairs publishes an *Annual Performance and*

*Accountability Report* (including VHA performance) and in the United Kingdom the NHS Chief Executive publishes the *Report to the NHS*.

The status of annual reports is variable. Annual reports may be less of an 'account of record' by which the organization's performance will be known and judged, than a single narrative competing with many others in a web of accountability and communication. It is not clear whether people outside the organization, or even within the organization, accord the annual report with the monopoly status it seeks. Among the factors which need to be considered are the competition from other reporting centres and the perceived status of the office of chief executive. In the case of the NHS, the degree of performance narrative competition is clearly high with the reporting space busy with statements made by a number of institutional actors at various points in the year. The VA annual report appears on the other hand to occupy a less busy reporting space with consequent implications for the authority of the narrative presented.

Through a narrative analysis, significant differences are evident between the VA/VHA and NHS in the approaches adopted to communicate with audiences through annual reports. The project adapted a structured approach to performance narrative analysis as suggested by Corvellec (1997) and examined annual report narratives based around the following factors:

- Presentation - appearance, title, content
- Claimed audience
- Language
- Narrator perspective
- Narrative structure
- Monopoly rights on telling of story
- Evidence of multi-plot stories

- Extent of serialization

## **Analysis of NHS Report Series**

### **Presentation:**

#### Title

The latest document from the series of publications the project is focused on in is titled *Chief Executive's Report to the NHS December 2005*. The precise details of the title are important, since there is also a *Chief Executive's Report to the NHS May 2005*. For reasons that are not made clear two chief executive reports appear each year with no strong indication as to which has the more important status. It can be inferred from the relative length of the respective documents and from the range of content that in 2005, the end of financial year (April to March in the UK) report published in May (54 pages) is the annual report proper and the December report (26 pages) has year in-progress status. Both however, refer to the previous twelve months. Looking back it can be seen that in 2002 the March report (9 pages) is clearly described as an interim report, with a fuller report due in December (23 pages). In 2003 the May report (19 pages) refers to the previous twelve months, while the December report (24 pages) only deals with the first six months of the new financial year. In 2004 the May report (48 pages) refers to the previous twelve months as does the December report (52 pages). Strictly speaking therefore, given these inconsistencies it is questionable whether the May publication in the series is actually an annual report and the December report an interim report.

#### Appearance

The report comes each year in a cover featuring a simple abstract graphic in corporate NHS blue. In this respect a degree of consistency is observed. The general visual appearance conveyed through typography and design represents a source of continuity.

## Content

In contrast with the VA reports which contain a section dealing with performance measurement methodology it is noticeable that absent from the NHS report, its annexes or supplements are any explanations of the precise mechanisms of the performance system being used. No attempt is made to explain the concept of performance employed or the scheme employed to order data. Unlike the VA reports the NHS reports are entirely dedicated to health services. Notably the report makes little or no reference to the world outside the NHS. Scarce mention is made for example of local government or privately provided social services into which NHS patients may be discharged.

The reports are not consistently constructed around the same content headings. The May 2005 report has a contents page which indexes a Chief Executive Preface and a further six 'chapters', which are in turn broken down into two or three sub-sections, while the December report is based around 15 themes demoted only by sub-headings in a continuous text. The May 2004 report was based on a preface and four chapters. The May 2002 report was also a continuous text organised around sub-headings, but the December 2002 report used chapters. This aspect of the report series lacks any consistency.

The Chief Executive Reports in May are presented along a statistical supplement (around 37 pages). In December the report has a statistical supplement (again around 35-37 pages) with a further 'annex' in the form of an Autumn Performance Report. The Autumn Performance Report (around 35 pages) consists of an analysis of achievements against 34 Treasury Spending Review derived Public Service Agreement (PSA) targets. In 2002 the NHS chief executive needed 32 pages for his two reports. This rose to 43 pages in 2003. In 2004 100 pages were required. In 2005 the length was reduced 80 pages.

### **Claimed audience**

The reports address a 'primary audience' of 'professionals' according to the information pages presented on the Department of Health web pages which link to individual reports. The 2005 reports identify a further 'target audience' in the form of five categories of NHS Trust chief executive, NHS Trust board chairs and NHS trust communications leads along with the chief executives of local government and non-departmental public bodies (quangos). While NHS leaders will certainly be keen readers, as is the case of the VA report which is addressed to the President of the United States, it is not entirely clear whether this is the final audience the report is really aimed at. No reference is made to external audiences in the form of politicians or media commentators for example.

### **Language**

The language employed is much different from the dry NHS administrative style employed in the 1980s. The need to 'talk up' the NHS is evident in the language employed, which can be best identified as an NHS house style based on 'communications specialist' inputs laced with clinical and public health terminology and concepts. While the tone is mostly up-beat and focused on achievements there is also a notable tendency to qualify claims –'long waits are down ... only 30,000 people are waiting more than 13 weeks for outpatients appointments...', or sometimes to emphasise the 'promising' nature of an innovation.

### **Narrator**

The series of reports reviewed all contain a preface from Chief Executive Sir Nigel Crisp. (The December 2005 report was Crisp's last as he resigned on 7 February 2006). In contrast with the VA there is clearly a strong sense of intended 'narrator presence'. In May 2005 for example Crisp is keen to emphasise that the NHS is a 'service in transition' halfway through the five years old *NHS Plan*. The need for building capacity in the form of recruiting staff and developing facilities

is he makes clear, still current. In making a conscious effort to focus attention on the 'future' there is an implied sense that the narrator is telling us to 'be patient' in relation to service improvement outcomes. In encouraging 'celebration' of achievement a damning portrayal of the NHS of the 'past' (dated it seems to pre-2000) is invoked – 'extraordinary long waiting lists, chaotic A&E, and very poor outcomes in some services'. Crisp's 2004 report on the other hand emphasises 'speed' with changes happening quicker than anticipated, patients seeing GPs being attended in A&E. In 2003 'sustained progress' is the dominant theme in the preface. In each report a sense of the narrator's engagement with the then current criticisms of the NHS is often detected. For example in 2004 the preface acknowledged the inability to measure productivity in overall terms, although also citing four ways in which it could be partially measured. This was also referred to in the 2003 preface with 'people' said to be erroneously judging value for money by the record of acute services alone. A very strong sense of a being engaged in a policy implementation struggle is conveyed by the narrator in the preface section. This is continued to some extent throughout the body of the reports.

### **Narrative structure**

As discussed above there is no basis in the content of the reports for a consistent narrative structure anchored around the presentation of a standards set of figures and accompanying comment in standard titled chapters. Where the VA report is concise and lucid, the NHS version is long-winded and confused. The narrative structure makes this failing inevitable. For example in May 2005 Chapter 2 introduces on page five, five 'key points' – 'faster more convenient services, 'more personal care and better patient experience', 'action on health promotion and protection', quality innovation and reform' and 'value for money' which are further broken down into 21 'indicators' of achievement. In Chapter Three it is felt necessary to introduce a further seven standards, which the Health Care Commission (quality regulation unit) will use to assess NHS organisations – 'safety', 'clinical and cost effectiveness', 'governance', 'patient focus',

'accessible and responsive care', 'care environment and amenities' and 'public health'. The narrative then takes the reader through a series of nine events or policy initiatives that are presented in positive terms. A sense of the choice process that has been used to select the stories is not readily conveyed. First to be discussed is the NHS response to the hospital infection problem with methicillin Staphylococcus aureus (MRSA). The second story is concerned with a new contract for general practitioners (GPs), the third with the implementation of a Modernisation Agency list of ten high impact changes (list not provided), the fourth with the establishment of a NHS Institute for Learning, Skills and Innovation, the fifth with NHS Connecting for Health (an IT programme), the sixth with new staff contracts, the seventh with NHS Foundation Trusts, the eighth with independent assessment of health care providers and the role of the healthcare Commission and finally the ninth deals with the procurement of private sector clinical services. Chapter four introduces a further series of ten stories based around innovations, specialisms or patient groups. A lack of sequence in the stories is apparent. The NHS is frequently accused of being reactive and having a 'wheeze of the week' approach to service innovation. The narrative structure of the report series may well strengthen this view.

Performance measures are presented in tables in Chapters Four to Seven. The number of performance measures used has risen steadily over the years from a starting figure of 28 in December 2002. In total 47 performance measures are used in the most recent 'annual report' of May 2005. In 2002 only 17 out of 2005 list of 47 were used. Over the three years 2003-2005 a reasonable degree of consistency has been established around roughly 40 indicators which have been used in all three of the May reports.

Based on the May 2005 report, Table 1. presents an analysis of the attributes of the 47 performance measures used. As can be seen the bulk of performance measures (91%) capture aspects of process. Only 9% of measures captured outcomes. The report does capture trends, with

89% of the measures used in 2005 being presented along with at least one previous year's performance. (In earlier years the extent to which trends are captured is not achieved to the same degree). In 2005 83% of the measures in the report captured outcome against mandated performance/or increase against a figure established in a plan. Only one performance measure (2%) captured patient/citizen satisfaction. None of the 47 performance measures could be directly related to a social value associated with the NHS.

Table 1 Analysis of performance measures used in Chief Executives report to NHS May 2005.

| Number of measures | Captures patient/citizen satisfaction | Captures social values | Captures outcome | Captures process | Captures trends | Captures outcomes against target |
|--------------------|---------------------------------------|------------------------|------------------|------------------|-----------------|----------------------------------|
| (47)               | 2%                                    | 0%                     | 9%               | 91%              | 89%             | 83%                              |

A narrative technique employed by both the NHS and VA is interspersing the performance narrative with individual organizational success stories from around England and the United States. Both organizations are trying to humanize their performance narratives with what are sometimes called 'vignettes' in the UK. For example the NHS report of May 2005 contains a story box about Wallasey Heart Centre in a chapter dealing with health promotion. The story explains the partnership model developed, the services offered and the claimed success rate of the project. The NHS has used similar vignettes since 2002, although initially presenting a series of stories in separate chapter back in 2002.

### **Monopoly rights on telling of story**

Closer inspection of the reporting space reveals stiff competition for the Chief Executives report. In fact in 2005 at least five other annual reports are readily identifiable as serious competition to

the performance story presented by the Chief Executive of the NHS. The competition consists of the Department of Health Annual Report, the Chief Medical Officers Annual report, the Chief Inspector Annual Report, NHS Modernisation Board Annual Reports and the NHS Autumn Performance Report. In addition the Healthcare Commission provides an annual report on the performance of each individual NHS Trust, while from 2004 there has been a NHS Live Report which concentrates on local programmes designed to improve the patient experience.

### **Multi-plot stories**

It can be determined from the growing number of performance measures used, events and policies introduced that the Chief Executive of the NHS report series has developed rather too many plots. The NHS is a huge organization whose performance cannot realistically be evenly represented in even a 50 page document. Of some importance, giving in to a temptation to introduce more and more concepts has undermined efforts to develop a 'change' plot through the report series.

### **Serialization**

Annual performance reports are a series. The narrative should exploit the readers' interest in understanding how performance is developing on a year by year basis. While basically the same set of around 40 performance indicators are used in the reports presented in the three years 2003-2005, the narrative benefits of serialization are lost due to the number of new plots introduced each year. The inconsistent chapter structure of the report series also means performance measures are not readily located in a specified chapter on a year by year basis which also weakens the serialization effect.

### **Analysis of VA Report Series:**

## **Presentation**

### Title

The title of the VA annual report is *Office of Budget Department of Veterans Affairs FY 2005 Performance and Accountability Report*. The title in containing a reference to the financial year removes the doubts over status associated with the twice-yearly NHS reports reviewed. The title also conveys a message that this is a resource management orientated report.

### Appearance

The front cover of the 2005 report contains a highly stylised graphic featuring a group of wounded veterans positioned around a Washington War memorial. The graphic used on the cover differs each year but always has military references. The presentation of the narrative itself displays a high degree of conformity to a VA house style in the years 2002-2005, with fonts, colours and visual layout observably consistent.

## **Content**

In marked contrast to the NHS series a consistent four part report structure is maintained each year. A comprehensive table of contents is provided (roughly 2-3 pages of text per 'content item'). Part I is titled *Management Discussion and Analysis* and attempts to rationalise the performance story through reference to the VA Mission, the mission related basis of VA programmes and system of measuring performance, resource information, management structure and a summary of the Secretary's 'agenda' including 'performance shortfalls' and 'financial highlights'. Part I also includes a performance overview and performance results by strategic goals. (In this latter sub-section the importance of the narrative device of organising performance story content strictly in relation to VA strategic goals becomes evident). The scope of Part I was changed in 2004 to incorporate selected performance data. A further expansion of the scope of Part I in 2005 effectively created a self contained performance report, supported by

supplementary narrative detail contained Parts II, III and IV. The intended effect is to provide a more digestible performance summary for the reader. A performance scorecard based on 24 key measures located in Part I each year is another feature adding to ease of comprehension.

Part II is based around performance summaries by 'Departmental Objective' and consists of a measure by measure presentation of 130 indicators. This is the part of the report where a greater sense of the policy implementation context in which performance is located is made apparent. This achieved by providing a text based narrative to accompany each objective and associated measures. Part III is the financial section of the annual report and consists of short letter from the Chief Financial Officer written around technical accounting and management concepts, a series of consolidated financial statements and statements on budgetary resources and financing. An independent auditors report is also included. Part IV provides a list of definitions, abbreviations and acronyms, key officials and in 2005 a summary of the Improper Payments Act of 2002. The VA report series has not grown in size at the same rate as its NHS counterpart. Where the NHS reports grew by 150% in page length between 2002 and 2005, the VA reports exhibit a more modest growth rate of 29%. (255 pages in 2002 and 329 in 2005)

### **Claimed Audience**

The report is addressed to the President of the United States, President of the Senate and Speaker of the House of Representatives. The report is clearly written for an audience of politicians and media commentators. There is an assumed solidarity or patriotism in the VA mission. Where the NHS narrative is sometimes intended to be patient accessible the VA narrative is definitely not directed at the veterans themselves.

### **Language**

The VA is an organization in its own right but one which has a close association with the military. This is reflected in certain respects in the reports it produces. To claim that the VA report employs a military language pattern would be an exaggeration, rather the report series is written in administrative American-English, with a slight military accent. This is detected in two ways, firstly in the apparent inclination to state strategic goals, objectives and measures in short terse sets of words – reminiscent of the narrative idiom of military strategy and secondly through the element of patriotism conveyed through the language employed in the report. Scrutiny of the VA report series reveals an inclination to write in the present tense, conveying a sense of action. An assertive tone is denoted by the frequent use of the phrase ‘we will...’. Notably there is little resort to the abstract nouns (eg partnership) that pepper the NHS report.

### **Narrator**

The Secretary for Veterans Affairs R. James Nicholson is the ‘narrator’ providing the covering letter for the annual report. In his letter there is also no acknowledgement of the type of policy implementation story featured in the NHS narrative which through reference to plans, timescales, progress and obstacles tacitly acknowledges a struggle to enact change. Where the NHS reports use text to contextualise performance the VA reports typically do not, allowing objectives and measures to ‘speak for themselves’. Where the NHS Chief Executive preface provides a sense of personal engagement with policy implementation and reaction to specific issues, the VA Secretary is more assertive in listing quantifiable VA achievements. A degree of patriotic solidarity with the US military is also conveyed in the letter. The narrator tone intended appears to be one of qualified satisfaction with the VA progress against precisely understood targets.

### **Narrative Structure**

The VHA is dealt with as an integral part of an annual performance report which discusses all VA programmes including pensions, re-entry into civilian life, disability compensation, education support, home purchase and retention, insurance and burials. Presenting such a wide ranging annual report represents a major narrative challenge. An obvious 'solution' in presentational terms would have been to devote separate chapters to each of the major VA programmes. Instead a much more complex narrative is attempted whereby the VHA performance story is integrated with other VA programme stories. On the face of it this seems an unwieldy means of presenting a performance story with health pensions, educational and other programmes seemingly muddled together. This conclusion however, would ignore the compelling impact of a narrative structure based around the VA's four strategic goals (SGs) – SG 1 Restoration and Improved Quality of Life for Disabled Veterans, SG2 Smooth Transition to Civilian Life, SG3 Honoring Serving and Memorializing veterans and SG4 Contributing to the Nation's Well-being. The narrative structure adopted by the VA is heavily based on mission and 'associated' strategic goals. In contrast to the NHS the VA draws on a highly disciplined narrative scheme in which performance measures are associated with patriotic sounding strategic goals. The casual reader might think the strategic goals were written by Abraham Lincoln himself, given the sense of authority and dignity implied. In comparison with the NHS report there is generally less text based narrative used in constructing the narrative. The structure is more heavily reliant on tables and numbers. A sense of precision and control is perhaps associated with expressing stories in terms of percentages. This is emphasised by the 5 year time series that is used to demonstrate progress and the ability to link an activity to a financial 'obligation' and a calculation as to the percentage of total VA resources consumed. The report is of course published by the VA Office of Budget rather than the VA as a whole perhaps explaining the intention to cost activities referred to more clearly.

The narrative is structured around a hierarchical performance measurement system- four strategic goals supported in 2005 by 21 strategic objectives, supported by 130 performance measures/associated targets, 24 of which are designated mission critical. Of the 130 up to 30 were

health services related in each of years reviewed. The scheme has been replicated throughout the years examined in this project. The narrative accordingly develops around a performance sequence moving down through mission- goals – objectives and measures. Health services were in 2005 accounted for by a total of 29 measures. Each performance measure is associated with a specific SG and objective. Of these 29, 13 in turn were used in relation to five objectives in the ‘Department Level Summary’ presented in Part I. In this scheme the health services performance of the VHA is accounted for as follows:

SG1 - one health service related objective supported by two measures.

SG 2 - one health service related objective supported by two measures.

SG 3 - one health service related objective supported by eleven measures.

SG 4 - two health service related objective supported by five measures.

The bulk of the health services measures relate to SG3. Strategic Goal 3 is concerned with Honoring, Serving, and Memorializing Veterans. Most of the performance measures (7) are used to support Objective 3.1 – ‘Provide high-quality, reliable, accessible, timely and effective health care that maximises the health and functional status for all enrolled veterans with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care’. There is an implicit suggestion that a moral purpose can be quantified. The brief narrative explanation of the strategic goal emphasises a confidence in the VA’s role in setting national standards of excellence in quality and safety in the health care industry, the development of veteran focused care systems and technology strategies. The apparent intention to convey an impression that the operational performance measures used equate naturally with the moral purpose grounded strategic goal never wavers throughout the series. This is an important narrative ploy in the VA series.

A weakness in the VA series is the inclusion of a performance scorecard, a set of key performance measures and a Department Level Summary with selected performance measures. In other words there are three separate but overlapping sets of ‘crucial’ performance measures competing for attention.

Based on the 2005 report, Table 2. presents an analysis of the attributes of the 13 performance measures used in the Department Level Summary. As can be seen the bulk of performance measures (77%) capture aspects of process. However in comparison with the NHS, the VA range of performance measures is proportionately more outcomes orientated (23%). The narrative structure captures trends, with 84% of the measures used in 2005 being presented along with at least one previous year’s performance. In 2005 77% of the measures in the report captured outcome against mandated performance/or increase against a figure established in a plan. Significantly more performance measures in the VA report succeed in capturing patient/citizen satisfaction (23%) than is the case with the NHS (2%). None of the 13 performance measures could be directly related to a social value associated with the VA.

Table 2: Analysis of performance measures used in VA report 2005.

| Number of measures | Captures patient/citizen satisfaction | Captures social values | Captures outcome | Captures process | Captures trends | Captures outcomes against target |
|--------------------|---------------------------------------|------------------------|------------------|------------------|-----------------|----------------------------------|
| 13                 | 23%                                   | 0%                     | 23%              | 77%              | 84%             | 77%                              |

While both the NHS and VA employ story boxes to bring humanity and local connections to the performance story the VA is prepared to use individual patients in its vignettes. For example in 2005 the story of the swift recovery facilitated by VA staff of a Marine Corps Corporal of British origin, seriously injured in Iraq who barely able to speak on return to the VA Medical Center at

Palo Alto California ends with the happy conclusion of the young man's restored ability to speak freely at his citizenship swearing-in ceremony.

### **Monopoly rights on story**

In comparison with the NHS the VA annual report series has a relatively clear field in which to make its impact. No significant other report existed in 2005 to challenge *Office of Budget Department of Veterans Affairs FY 2005 Performance and Accountability Report* as the account of record.

### **Multi-plot stories**

The VA uses around 30 health services performance measures in its annual reports. If a performance measure can be taken to indicate a 'plot', then compared with the NHS with around 50 performance 'plots', the VA has in this respect created a less complicated narrative. This conclusion is reinforced by the disinclination on the part of the VA to refer to as many events and initiatives as the NHS does in its reports.

### **Serialization**

The VA report series has a stronger sense of serialization than its NHS counterpart. This is related to the sense of permanency implied in relation to strategic goals, objectives and measures. An element of illusion may be at work. While trend data is included in 77% of the performance measures used in 2005 Department Level Summary, only 7 of the measures featured in the equivalent Department Level Summary 2003. (One measure moved from SG3 in 2003 to SG1 in 2005).

## **Conclusions**

In technical terms the performance stories of the NHS and VA/VHA are constructed very differently. This has been established in clear terms by the analysis presented above. The degree to which the form and quality of the performance narrative impacts on the legitimacy achieved by the respective organizations is unclear. The possibility that the unwieldy narrative developed in the NHS series undermines efforts to create a sense of achievement cannot be discounted. On the other hand the style of the NHS narrative may reflect the difficulties in both achieving change and measuring change in a £76bn organization. The VA/VHA is generally thought to have achieved a considerable degree of success in managing a change programme over the past decade. The relative coherence of annual report narratives may reflect the successful leadership programme enacted.

Certain aspects of the narratives examined could be said to impart a degree of integrity to the performance claims made while other elements of the reports are clearly a liability in this respect. Organizational credibility and legitimacy are negotiated in many different ways. Annual performance reports are part of this process. Annual performance reports are written for multiple audiences. A problem which this project has so far been unable to resolve is the question of who reads annual reports. The narratives developed in the reports suggest that both organizations have primarily an informed 'insider' audience in mind. Insiders will include officials, staff, politicians and media commentators. It is interesting to speculate on the sense which each type of reader makes of the performance stories presented in annual reports. The ability to specify received meaning in relation to performance claims remains an elusive ambition for new public management orientated organizations. Annual performance reports represent a good source of evidence in respect of contemporary efforts to manage meaning.

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