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Here to listen

Open culture in the NHS
What leaders say

A GSL Report

Author
Russ Parkinson
Director of Strategy and Consultancy Services

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Foreword

The 2015 “Freedom to Speak Up Review” made clear that cultural openness in the NHS is essential. When people cannot speak up, or when those who receive concerns do not listen or act, failures occur. Though many initiatives have followed, there is little or no evidence that they have made any impact: in 2024 only 61.82% of NHS staff survey respondents said they felt safe to raise concerns, a decline of nearly four percentage points from 2020 when the question was first asked. “Feeling safe” is itself a low bar, far removed from creating an environment where people feel encouraged and confident to speak up.

The NHS now enters another period of significant change, including dismantling the National Guardian’s Office (NGO) – one of the initiatives that arose from the Freedom to Speak Up Review. As Dr Penny Dash noted in her 2025 review, the NGO had become *“too distant from the people it needs to support and influence.”* It also duplicates functions that are best led elsewhere, particularly by those with responsibility for actually leading and supporting the NHS workforce as they work tirelessly, under pressure, to deliver high quality and safe care.

Change brings both risk and opportunity: positive developments may stall, while normalised but ineffective practices may continue unchallenged. This moment, however, creates space to revisit the fundamentals of openness—an essential step if the NHS is to meet its aspiration, set out in the 2025 ‘10-year plan’, to become *“the most transparent healthcare system in the world.”*

The network of Freedom to Speak Up Guardians has grown way beyond what was ever originally expected – there are currently over 1,500 Guardians - and has become a powerful voice. Yet cultural openness is shaped most directly by senior leaders who set the tone, expectations, and organisational norms in which all NHS workers operate. Their views are often under-represented or not even sought. This report provides a voice for them.

Thank you

We wish to sincerely thank the senior leaders who participated in this work. We appreciate the pressures you are under and recognise that your time is precious.

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Methodology

We set out to seek the views of a range of senior NHS leaders about openness and speaking up. We invited 40 senior leaders to participate. The senior leaders we invited all had connections with the Guardian Service Ltd (GSL) either as clients, former clients, or as other stakeholders. They included CEOs, Directors of People, Chiefs of Staff, Chairs, NEDs, CMOs, and CNOs. This led to 13 interviews taking place during October and November 2025.

The interviews explored:

- Openness within the NHS
- Leadership behaviours that encourage openness
- Guidance and national direction
- CQC inspection of culture
- The purpose and future of the Guardian role

We committed to publish our findings in a non-attributable manner to encourage candour.

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Summary of findings

Leaders are being driven inwards by a closed system

Leaders agreed there is more infrastructure to support openness than a decade ago, and that this has helped normalise the language of "speaking up". Yet system-level behaviours were frequently described as running counter to openness. National bodies were often portrayed as resistant to challenge and punitive in their response to problems. This pushes leaders to focus inward - working to improve their local culture *despite*, not *because of*, wider system behaviours.

CQC inspection was widely described as "hit-and-miss", overly adversarial, and inconsistent. Many felt that the inspection environment encourages defensive behaviour, with a narrow focus on compliance rather than creating an environment of openness and learning.

Openness is an 'horizon concept'

At an organisational level, leaders commonly identified "pockets of resistance" or subcultures, often described as groups that are "disconnected from the norm". These appeared across departments, staff groups, and seniority levels.

Strikingly, leaders describing almost identical circumstances came to conclusions that were diametrically opposed. Some said their organisation was open *despite* subcultures; others described it as closed *because* of those subcultures. This highlighted the limitations of the binary language of "open" versus "closed", which is compounded by guidance and inspection that encourages binary judgements to be made.

Culture is better understood as an evolving ideal, always subject to challenge and interpretation, and always capable of improvement – this may be described as an 'horizon concept' or 'asymptotic ideal'. There need to be nuanced and balanced conversations at the Board level, otherwise, disharmony, misleading assessments, and unrealistic goals are set.

Getting the basics right creates open cultures

On leadership behaviour, participants consistently emphasised "the basics": regular appraisals, being known and visible, saying "hello" and "thank you", and "walking the

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floor". These deceptively simple actions were described as both indicators and drivers of openness—yet frequently overlooked in formal assessments. Overall, they represent actions that demonstrate proactive listening, curiosity and the creation of authentic human connection.

Openness is not possible when areas for improvement are treated as failure

Leaders were sceptical about regulatory or performance frameworks that seek to encourage openness because they believed that they would be implemented in a way that disincentives candour and reflection. Simply put, it was felt that being honest about areas that could be improved would be met with a punitive response. This mirrors the dilemmas felt by any frontline worker when they are considering raising an issue: *will I be blamed?*

Until leaders can safely acknowledge imperfection, openness will remain constrained.

Prescriptive guidance creates work, not improvement

National guidance on speaking up has helped create a shared language. However, participants felt it had become overly detailed with every element being interpreted as mandatory. It has led to a "tick-box" mentality that stifles creativity and innovation. Leaders wanted broader principle-based guidance that can be adapted locally. They are asking for guidance focused on outcomes not minutiae such as time allocations or pay levels for Guardians.

The Guardian role has evolved but remains valuable

Participants unanimously supported retaining the Guardian role. They noted its scope has shifted beyond patient safety concerns (national data shows only 17.8% of 2024/25 cases relate directly to safety) and now involves handling a wide range of behavioural and relational issues. Some were concerned that this drift "dilutes" the role or leads managers to use Guardians as a "point of convenience". Others saw this as evidence of unmet organisational need.

Despite debate, the Guardian's impartiality, independence, integrative perspective, and ' "finger on the pulse" insight were widely valued. Several participants emphasised that only an independent Guardian can create the perception and reality of impartiality that is critical to the creation of trust that a Guardian must build with the workforce.

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Recommendations

Based on what we have heard, GSL makes the following recommendations:

Opening up a closed system

National bodies should evaluate how their own approaches incentivise or inhibit openness. Current practice is often perceived as punitive, focused on evidence of failure, and inattentive to nuance and local context.

Incentivising openness at the local level

Guidance and inspections should avoid binary judgements and recognise openness as an ongoing, 'horizon concept' or 'asymptotic ideal'. Boards should define what openness means locally, describe their aspirations, agree their measurements and align communication accordingly.

Leadership that focuses on the basics

Leadership frameworks should support leaders to model openness through behaviours that demonstrate visibility, curiosity, personal connection, and everyday appreciation of their colleagues.

Leadership frameworks that encourage transparency

Assessment of leadership must foster safe spaces for honest reflection and peer support, not fear of punitive judgement.

Guidance not prescription

Future guidance should remain principle-based and outcome-focused, with room for local interpretation and innovation.

Re-articulating the Guardian role

The Guardian role should be redefined around its boundary-spanning, sense-making, impartial, and trust-building functions. Its purpose should be understood as supporting cultural openness for the benefit of staff and patients.

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Discussion

Openness within the NHS: perceptions and measurement

What is an open culture?

Participants offered no single definition of openness, but there was a strong consensus around observable behaviours: inclusive decision-making; staff feeling able to "show up as themselves"; Boards hearing concerns directly; leaders encouraging speaking up; the ability to have difficult conversations; and leaders being visible through "walking the floor" and attending inductions.

Indicators of a closed culture included fear of reprisal for speaking up, scepticism that speaking up leads to change, and resistance to "diversity of thought".

How do leaders assess openness?

Leaders use a wide range of indicators:

- Board behaviours
- Guardian reports (sometimes described as a "blunt instrument" but valued for the soft intelligence they bring)
- Staff networks and representatives
- Staff survey responses
- Retention, sickness, grievances
- Patient feedback

Many recognised the importance of perception-based assessments, aligning with GSL's definition of open culture: *an open culture is one where everyone believes that they have a voice, that voice is heard, and things happen as a result*.

There were mixed views about the weight that could be put on the NHS staff survey as a reliable indicator of culture. These were related to a sense that response rates were low and a belief that the survey was more likely to be representative of those who had strong views (positive or negative). All participants, however, recognised helpful indicators of speaking up from within the survey, including the People Promise indicator "we each have a voice that counts".

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How open is the NHS?

Most participants considered their own organisation to be open, whilst recognising the existence of subcultures where less openness prevailed. These subcultures were described in two main ways: those that existed within departments or services, and those that existed within the workforce. The latter included descriptions of varying levels of openness between differing management levels, clinical disciplines, seniorities and protected characteristic. Participants frequently described openness at senior levels being greater than that at the middle management level. However, participants also recognised the complexities and competing pressures that come with 'middle' positions within the hierarchy and the relatively greater freedom they felt that their own seniority afforded them.

Some comments were illustrative of how leaders perceive that subcultures arise. For instance, one participant discussed culture within "the consultant body" being such that people are not encouraged to "listen to the contrary voice" as a consequence of training as a specialist. The concept of "institutionalisation" surfaced in various forms, with parts of an organisation where there is low staff turnover and some degree of isolation from the rest of the workforce being described as areas where closed cultures arise.

We noted that, when describing organisational openness, leaders who described their organisations as generally open, and those that described their organisation as generally closed or "not as open as I would like it to be" were, in fact, describing the same thing – a level of openness but with exceptions to this. Within a Board environment this may result in the appearance of disunity where individual Board members may use the same evidence and draw the same conclusion but describe this in markedly different ways: "open despite exceptions" or "closed because of those exceptions". This leads to the conclusion that care must be exercised around Board discussions of culture with conversations describing this in binary terms being misleading, potentially confusing and even creating a point of conflict. This underlines the importance of nuanced discussion, clear measurement, and informed communication. Inevitably, even the most open organisations should draw the conclusion that improvement is possible and, perhaps, all leaders should be reaching the conclusion that "my organisation is not as open as I would like it to be": cultural an "horizon concept" and the goal is to seek incremental improvement.

When looking beyond their own organisation, many participants described a sense of being under constant scrutiny and that this, alongside the emphasis on meeting targets, created a dynamic that was driving against openness. One participant described the situation as

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"deflating". It was felt that NHSE was not "kind" in its approach and lacked openness and transparency. It was described as demanding, disjointed, and inconsistent in its communications. Just as culture is led from the top in an organisation, there was a clear sense that the same applies when looking at the NHS as a system, with NHSE being in the position of leading this.

The impact that inquiries and investigations had on the system was noted by several participants. It was felt that, rather than being interpreted as highlighting areas for improvement and lessons to be learnt, these were received with a degree of fear that shuts down openness. Recently published research ("Investigating the Investigators", Roger Kline OBE, December 2025) supports these views – the "weaponisation" of investigations described in that report is recognised and felt by senior leaders.

Leadership: incentivising behaviours that create openness

When considering how openness may be incentivised, a range of behaviours were described. These may be summarised as actions that represent authenticity, humility, build trust, and demonstrate curiosity. The ability to have difficult conversations was particularly highlighted, with participants presenting examples where they felt these were avoided to the point that people are "moved on" rather than having lapses in behaviour discussed.

Whilst the behaviour of Board members was universally recognised as important, it was noted that most workers' experience of the culture of their organisation was through their line manager. This was described as "pivotal" and underlines the importance of Board-level behaviours extending to line-managers.

Concerns were expressed about how leadership regulation regimes would be implemented. It was consistently felt that a punitive approach would be taken and that the daily pressures and complexities of leadership in the health environment would not be acknowledged. Participants favoured a regime that took a qualitative approach, with continuous feedback and elements of peer-to-peer learning. Participants said that they needed space for honest reflection but there were concerns that regulation creates a system that focussed on demonstrating compliance rather than on-going learning.
The 'Seven Principles of Public Life' (the Nolan principles) were considered by several participants to be a good starting point for a leadership framework – or even sufficient in themselves.

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Clinical leadership was recognised by several participants as distinct from other forms of leadership. This was described as an area in which expertise within a tightly controlled environment is developed. This contrasts with leadership of an NHS organisation where there is more ambiguity and uncertainty involved – which can be described as a VUCA environment (volatile, uncertain, complex, ambiguous). This led several participants to conclude that transition from clinical leadership to a more general leadership role can be difficult.

Guidance: what is needed to support open culture

Existing guidance on speaking up, specifically the NHSE guide for leaders and planning and reflection tool, were generally described as helpful. Guidance to date was particularly valued for establishing a shared language and expectations, though it was felt that NHSE, CQC and NGO guidance was not always aligned. It was also felt that the specific content of guidance, rather than the ability to meet it, was often treated as a requirement and not upholding it to the letter was often seen as a failing.

Overwhelmingly, participants were seeking guidance that provides room for interpretation and local adaptation. One participant described this as providing "the autonomy to run my organisation".

Whilst all participants noted the limits of nationally produced e-learning training modules, many thought they did raise awareness of speaking up and normalise the concept. However, it was felt that they would not incentivise anyone to speak up if the prevailing culture drove against this. So, e-learning may best be described as a communication device rather than an effective means of creating culture change.

CQC inspection: assessing open culture and future focus

Leaders felt that CQC inspections often treated openness in rigid, binary terms with the same evidence leading to radically differing conclusions depending on the personalities of those involved in an inspection. It was also felt that the "snapshot" indicators frequently used by CQC inspectors were misleading and prone to being assessed in isolation without regard for broader cultural context. It was commonly felt that the manner in which inspections were carried out was adversarial, that exceptions to overall patterns and trends were given undue emphasis, and that whilst a mass of supporting evidence was produced, only a fraction was used. Given this, whilst the difficulty of assessing culture

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was recognised, it is unsurprising that participants largely felt that CQC inspection of culture was unpredictable and opaque.

When asked what a successful and appropriate inspection of cultural openness should look like, participants emphasised that a breadth of indicators should be considered and that these should be triangulated. Important indicators included Guardian case numbers and reports, staff survey results, grievance numbers, sickness rates, evidence that the Board is listening to concerns and providing responses. For many this emphasised the importance of CQC inspectors speaking to staff side and staff representative groups, holding focus groups, making observations over a period of time, and having open conversations with the Board.

The FTSU Guardian role: value and future direction

Many participants felt the Freedom to Speak Up Guardian role had lost its initial focus on patient safety. Participants recognised a shift towards handling behavioural or other workplace relations matters. This is backed by national data that shows that only 17.8% of cases handled by Guardians related to patient safety and quality issues (2024/25 figures). One participant described the role as now being that of a "workplace relations manager". Some participants felt that the role had been "diluted" and potentially undermined creating improvement in line management and HR practices. This led to the conclusion that Guardians are left managing the symptoms of less-than-perfect line management, even being used as a "point of convenience" for managers unwilling to handle difficult issues. In contrast, it was also recognised that some managers may have lost their confidence in handling such matters and so referred them on to a Guardian because they felt unable to deal with them. Overall, it was acknowledged that there was a risk that the Guardian role could become a "catch-all" for management concerns rather than a "safety-net" for patient safety issues.

Despite these risks many benefits were recognised. Chief amongst these were various descriptions of impartiality and the ability to act, and to be seen to act, objectivity. Additionally, the value of having access to someone who could provide space and support in matters that were often complex and emotionally charged – and above all to listen - was acknowledged. It was felt that these skills and functions went beyond what could reasonably be expected of line managers, particularly where they were close to, or even implicated in, a situation.

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Alongside this, a Guardian's ability to surface issues that might not otherwise be seen, and to spot individual cases that illustrated systemic issues, was recognised. Being able to highlight common issues, trends, having knowledge of workforce sentiment, and the ability to offer impartial and balanced insight and challenge were aspects of the role that were described as of immense value but not clearly recognised or articulated in national guidance.

All participants saw a future for the Guardian role, with one participant stating that they "could not imagine a world without them". Many believed that the role, and the concept of speaking up, is now simply "part of the fabric" of the NHS.

Several participants support the notion of Guardian arrangements always being provided independently of the organisation they support. This was seen as a means of providing assurance about impartiality. One participant acknowledged this by simply stating that they "cannot provide an independent and impartial view of their own organisation" themselves.

These observations lead to the conclusion that there should be some continuity and change in the Guardian role. The role has evolved over the 10-year period since its introduction and there is a clear belief that the combination of functions and skills embodied in it are unique and valuable.

In all cases, those we interviewed expressed the view that guidance around the Guardian role should be descriptive but not prescriptive. One participant stated that they believed that a "more prescriptive approach is less effective". This was because it was felt that there should be some consistency in how the role is understood but more scope for local implementation.

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Definitions

We use a number of terms in this document, some of which have multiple interpretations. This is what we mean by these terms:

Open culture

An open culture is one where everyone has a voice, that voice is heard, and things happen as a result. As perception is reality, a truly open culture is one where everyone believes that this is the case.

Transparency

Transparency refers to the accessibility of decisions and the decision-making processes that inform them. An organisation may be transparent but not open to hearing the voice of its workforce and those it serves. Transparency is not a synonym for openness.

Horizon concept

This refers to cultural openness as a state that can be perceived but never fully reached. It indicates that an organisation is never entirely open, and any level of openness can be improved upon.

Asymptotic ideal

This refers to common indicators of cultural openness as illustrative of closeness to an ideal state of openness despite often being communicated in a binary manner. This can lead to the same indicators being used to reach diametrically opposed conclusions.

VUCA

An acronym for an environment which is Volatile, Uncertain, Complex and Ambiguous. It is based on the leadership theories of Warren Bennis and Burt Nanus.

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