Making Families Count
Improving healthcare through family engagement

# STRATEGIC PLAN, SPRING 2026

## 1. Introduction

Making Families Count (MFC) exists to help services improve care for people experiencing acute mental distress or crisis.

We work with families[1] in the aftermath of deaths by suicide, mental health homicides, and deaths of neurodiverse adults or adults with learning disabilities who have died in state care. We also work with families harmed while seeking mental health support for loved ones. We support families to use their painful experiences to contribute to improving care, so that people in acute distress or crisis can be met more effectively and compassionately.

We recognise the demands and constraints of organisations to engage openly and constructively with families. Our focus is on improving care so that it is more compassionate, humane, relational and curious, contributing to improved quality of lives and to learning when things have gone wrong.

We do not provide counselling or advocacy services.

## 2. Vision, Mission, Primary Task Purpose and Values

**The primary task** of MFC is to transform the lived experience of families affected by serious harm into shared learning that improves care and safety by focussing on how health and care organisations work with families and care for people in acute distress or crisis.

**Our vision** is that health and care organisations routinely engage with families as advocates and carers for their loved one, collaborating to provide safe and compassionate care.

**Our purpose** MFC exists to improve how health and care organisations engage with families, as advocates and carers for their loved ones, and, when things go wrong works with families to learn with them to improve future care and reduce harm

**Our mission** is to bridge the gap between services and families to reduce harm, strengthen safety practices, increase family inclusion, and improve compassionate care.

**The values that underpin our work**

[1] Note: We use the term family carers to mean anyone who is significant to the patient, including biological and non biological family and friends who may or may not live in the same household or even the same country.

- Power dynamics: we recognise the differential power dynamics that exist in coproduction to support effective collaboration.
- Authenticity: we encourage honest sharing of lived experiences to drive change
- Collaboration:  we work in partnership with families and healthcare professionals
- Compassion: we recognise the impact of distress, harm and bereavement on both families and professionals.
- Constructive challenge: we help healthcare organisations question and improve their systems, culture and practice
- Learning and improvement: we are committed to learning from families' experiences

## 3. Our strategic aims and objectives

Our aim is to improve safety in health and care by supporting families who have been bereaved or harmed due to gaps or failures in care, enabling them to influence safer care for the future.

Over the next three years we will:

- Work with families: Develop a clear and structured pathway to support families bereaved due to failures and gaps in healthcare
- Work with organisations: Provide training and consultancy delivered jointly by lived experience experts and experienced health professionals.
- Influence policy and practice: Advocate for improvements in policy and practice that lead to better outcomes and fewer preventable deaths

## 4. Our approach to our work

Our work with families and organisations creates a containing and structured environment in which grief, anger and moral distress can be thought about.  Through this reflective process, lived experiences can transform into moral authority rather than accusation and blame, and organisations can be more open and transparent. This makes learning and change possible.

We take a whole system approach working with leaders and organisations to identify, explore, challenge constructively when needed, and address systemic problems

MFC is unique in providing bridge between families who have suffered serious harm or lost loved ones, and the organisations responsible for improving care, to embed positive change.

## 5. The challenges of family engagement

The Duty of Candour and the new Patient Safety Incident Response Framework (PSIRF) require healthcare organisations to be open with families and engage with them compassionately.  And yet family engagement remains challenging and families continue to feel excluded in practice.

There are significant barriers including

- poor communication with families or understanding their experience, expertise and perspectives

- lack of recognition or understanding of families as partners in care
- failure to see or support families as safety observers
- the emotional intensity of traumatic bereavement for families and professionals
- staff fear blame, litigation and often feel unsupported following deaths or harm
- organisations can become defensive and the culture is closed

## 6. Our Ambitions for the next 5 – 10 years

We aim
- To grow MFC as a nationally recognised not for profit organisation for family inclusion and engagement in health and social care
- To place traumatised families at the heart of our work and support them to engage effectively with services
- To provide strong leadership and culture change consultancy and facilitation to health and care organisations
- To influence policy and practice to improve patient safety and quality improvements with appropriate partner organisations
- To work collaboratively with organisations that share our ambitions, including Royal Colleges, Regulators, Voluntary organisations and Safety bodies
- To develop a stable financial base and an efficient organisational infrastructure

Our work with families will support families bereaved by death or harm in health and care services, helping to contain the impact of loss, reduce further harm, and enable families to be met with understanding, dignity, and care.

We will also support family members who wish to develop the skills and confidence to contribute to service improvements as consultants and facilitators.

Our work with health and care organisations will help to improve leadership and culture by co-creating and testing training and consultancy programmes with NHS Trusts.

Through this work, MFC will support organisations to create conditions in which practitioners are supported to involve families thoughtfully when someone is acutely unwell and/or when harm has occurred.

Over the next three years our focus will be on work with families affected by care provided by mental health and learning disability organisations.

## 7. Critical factors that could affect our success

We have identified the following factors that could derail our work:
- Mission drift: the needs of traumatically bereaved and seriously harmed families can be overwhelming which could shift our focus away from improving services. To mitigate this, we keep discussions focussed on learning and change and directing families to therapeutic and legal support when appropriate.

- Fear: Clinicians may fear anger from families and avoid engagement. We address this by delivering training jointly with experienced professionals and lived-experience experts, demonstrating that collaboration is possible.
- Spreading ourselves too thin. The need is enormous and we are a small organisation. We therefore prioritise work with mental health and learning disability services.
- Funding challenges. Funding for not-for-profits is highly competitive. We maintain a flexible structure and collaborate with partners wherever possible.

## 8. Governance

Our Board has recently expanded to include a wider range of skills and experience.
The Board meets regularly to review progress and holds an annual strategic planning day.

## 9. Measuring our impact

We want to see traumatised families having a stronger influence on how services are designed, delivered and evaluated, leading to safer and more compassionate care.
Success will be measured through:

- Influence: Evidence that families have greater involvement in service development and evaluation. We will use existing metrics and measures used by the organisations we work with.
- Engagement: A core group of at least 50 families working with local services; Training delivered to leaders in 15 health organisations; 10,000 launches of the *Life Beyond the Cubicle* interactive e-learning resource
- Feedback: Continuous learning from families' experiences through storytelling and feedback.

## 10. Finance and funding

Our income currently comes from sales of training, grant funding and individual donations. The financial pressures in the NHS has made training income less reliable. We are therefore increasing our focus on grants and donations.

We plan to grow from a turnover of under £40k per year to a turnover of around £100k a year within three-years.

Our model remains efficient: we have the support of some dedicated and highly skilled volunteers, we use freelance consultants who have a range of skills that we require to deliver our plans, we pay facilitators when we have funded work, we have no office or equipment. As we grow we will require a small staff team; the Board will keep this under close review over the coming years.

## 11. Collaboration

MFC carries out specialist work that is not done by other organisations. As a very small, organisation we are most effective when working with other organisations who share our

goals.  We will continue to collaborate wherever possible to achieve meaningful and lasting improvements in health and care services.