London Health Mission Personas

The personas presented in this document were developed by the Royal College of Art (RCA), one of the partners working with LOTI on the design phase of the London Health Mission.

They show the different needs of Londoners who may be at risk of being digitally excluded as more health and care services move online.

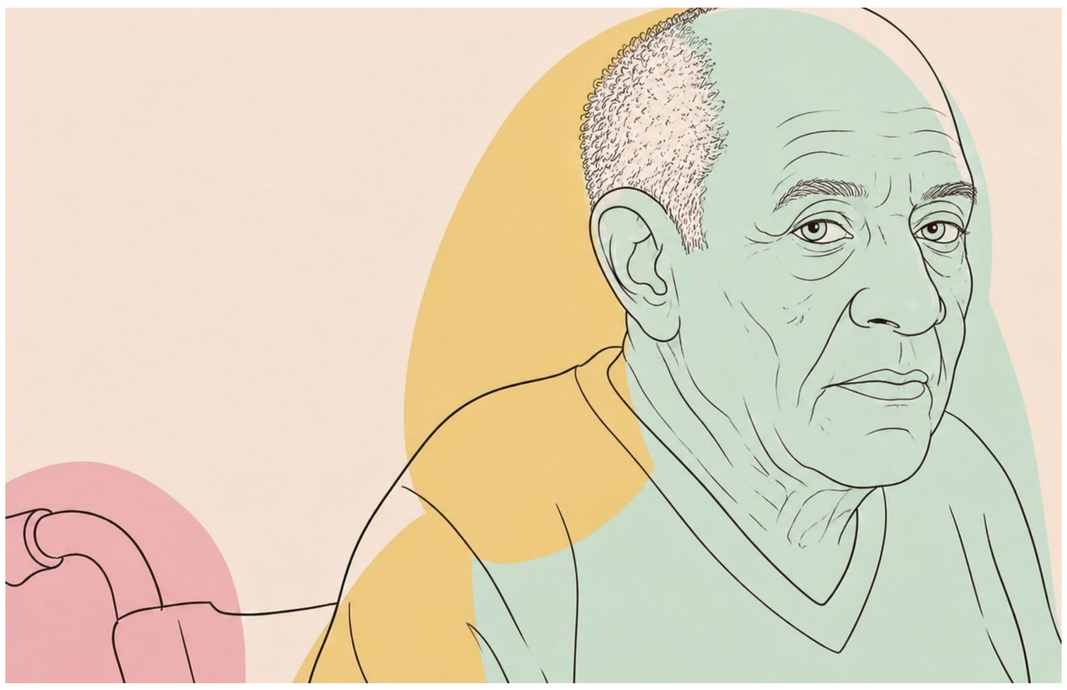
The personas are fictional. They draw on research by other Health Mission partners and on six years of LOTI's work on digital exclusion, including Get Online London. They don't cover every possible need or combination of needs.

They are designed to highlight the issues most relevant to the Health Mission so that it can take targeted action.

Royal College of Art

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MEET ARTHUR



Persona Summary: Arthur, 78 Lives in West London. He was 4 when his parents arrived at Tilbury on the Windrush, from the West Indies

Living Situation: Mencap supported living bungalow (shares with one other person, has his own tenancy agreement).

Support Level: Moderate/Consistent (24/7 onsite carers/support workers, with 1-to-1 support for community activities).

Learning Difficulty: Mild/Moderate learning disability (lifelong), early-stage mobility challenges, and mild memory loss associated with aging.

Internal Monologue: His carer" *You have to be his shield and his voice at the same time, otherwise, they just see a diagnosis and a 'bed blocker'*"

About Arthur

Arthur is a quiet, gentleman with a learning disability. He lived with his mother until her death 5 years ago. He then moved into a Mencap supported living bungalow, as maintaining his independence was important to him, but he required some support. He enjoys friendly banter with his carers once he trusts them. His support workers help him with personal care, medication management and cooking. He has arthritis, which most severely affects his knees, this means he mainly walks using a cane and uses a wheelchair for longer trips. He recently started experiencing memory issues and so had a health check for early signs of dementia with his GP, who has referred him to a Memory Clinic for diagnosis. Arthur struggles to describe internal pain and lacks mental capacity for specific medical decisions that were previously made by his mother; an independent mental capacity advocate is consulted when necessary and available.

Daily Challenges

- **Independence:** Arthur takes pride in having his own keys and managing his own space, although he needs assistance with complex tasks.
- **Support Workers:** He has a familiar team of Mencap support workers who help him with personal care (showering), medication management, and cooking meals, particularly helping him maintain a healthier diet.
- **Mobility:** Due to arthritis, Arthur walks slowly with a cane and sometimes uses a wheelchair for longer trips.
- **Routine:** He enjoys waking up early, having tea, reading the newspaper (mostly looking at pictures), and tending to his small backyard flowerbed with help.

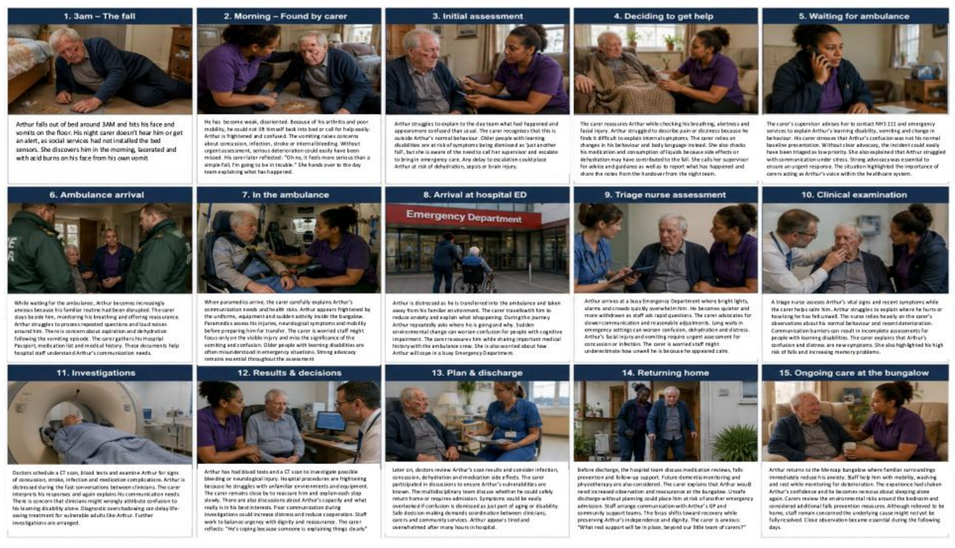
Social & Community Participation

- **Activities:** Arthur attends a local Mencap social club every Wednesday, where he enjoys playing bingo.
- **Community:** He likes going to the local café for a scone, a routine his support worker assists with to build his confidence in the community.
- **Isolation:** While he enjoys his own company, he can get lonely. His support workers help him build links with neighbors and local community members.

Challenges (Aging with Learning Difficulties)

- **Memory & Health:** Arthur is experiencing increasing memory issues and has recently undergone a health check to monitor for early signs of dementia, a common risk for his demographic.
- **Communication:** He can become overwhelmed by loud noises or fast-paced conversations and needs people to speak clearly and slowly.
- **Anxiety:** He gets distressed when his routine changes suddenly, such as if a familiar support worker is sick.

Arthur's Story



Journey Map

Stage	Arthur's Experience	Carer Actions	What Could Go Wrong / Potential Risks
1. Discovery After Fall	Arthur is found on the floor frightened, vomiting residue nearby, bleeding from facial cut, unable to stand	Carer reassures Arthur, checks breathing/consciousness, calls for second staff member	Staff assume it was "just a fall"; head injury missed; delay in escalation, but very concerned about vomiting and fear food poisoning.
2. Initial Assessment	Arthur cannot clearly describe pain or symptoms	Carer observes baseline changes, checks mobility, confusion, speech, temperature, medication compliance	Arthur's inability to communicate masks stroke, sepsis, or intracranial bleed
3. Emergency Decision	Arthur becomes anxious and confused when routines change	Carer phones NHS 111 or 999 depending on symptoms; explains learning disability and vulnerabilities	Ambulance triage underestimates seriousness because Arthur sounds "stable"
4. Waiting for Ambulance	Arthur distressed by noise, blood, unfamiliar activity	Carer stays calm, cleans him, provides blanket, retrieves Hospital Passport and medication list	Arthur deteriorates while waiting; aspiration risk from further vomiting
5. Ambulance Arrival	Arthur overwhelmed by strangers and rapid questioning	Carer explains Arthur's communication needs and normal baseline	Paramedics talk only to carer and ignore Arthur; or dismiss carer expertise
6. Transport to Hospital	Arthur frightened leaving familiar environment	Familiar carer accompanies him if possible	Separation from support worker increases distress and confusion
7. Emergency Department Triage	Bright lights/noise increase agitation	Carer advocates for reasonable adjustments and urgent assessment	Long waits worsen dehydration, concussion, delirium, or infection
8. Clinical Examination	Arthur struggles to explain nausea, headache, pain, or dizziness	Carer describes behavioural changes and timeline of fall/vomiting	Diagnostic overshadowing: symptoms attributed to dementia or LD instead of acute illness
9. Investigations	Arthur distressed by scans, blood tests, cannulas	Staff use simple language, visual reassurance, capacity assessment	Capacity wrongly assumed absent or present without proper assessment
10. Decision Making	Arthur fatigued and confused	MDT involve carers and family in Best Interests process if needed	Consent errors; safeguarding concerns missed
11. Admission or Discharge	Arthur wants to return home quickly	Safe discharge planning with falls review and GP follow-up	Unsafe discharge back to bungalow without support increase
12. Recovery & Follow-up	Arthur anxious about sleeping alone again	OT/falls assessment, medication review, dementia review, environmental checks	Root cause never identified; repeat falls; untreated illness

MEET JAHANARA



Persona Summary : Jahanara Begum, 64

Background: Bengali (Sylheti), emigrated from Bangladesh to the UK in 2006. Lives in East London in a multi-generational household with her daughter, son-in-law, and two grandchildren.

Vision Status: Advanced macular degeneration (partially sighted/registered severely sight impaired), leading to night blindness, blurred central vision, and difficulty with low light.

Comorbidities: Type 2 Diabetes (requiring insulin), chronic hypertension, and osteoarthritis.

Internal Monologue: *"Back home, I was Jahanara. People came to me for advice. Here, I am just 'the lady who can't see' the doctors look at my daughter when they speak, as if I am not even sitting in the chair."*

About Jahanara

Fluent in Sylheti, basic conversational English. Prefers an interpreter but often relies on her daughter for appointments. Lives in Enfield in multi-generational household. Joined them in 2006 from Bangladesh. Has basic conversational English.

Now suffering from advanced macular degeneration, type 2 Diabetes, chronic hypertension, and osteoarthritis. Prefers an interpreter for GP visits but often relies on her daughter for appointments. She experiences high levels of loneliness despite being surrounded by family and struggles to manage her medication independently, unable to distinguish between her tablet boxes. Loathes the phone menu systems, digital booking systems is impossible for her, and missed retinal screening as she couldn't read the letters. Her pain from arthritis is dismissed as "just part of getting old", no treatment for her anxiety or depression, so fears seeking care.

Daily Challenges

Jahanara's world has shrunk to the interior of her daughter's house. While she is grateful for her family, she feels like a burden and misses the social fabric of her home town. She navigates her home by memory, but fears falling due to blurred vision, especially in the kitchen or on the stairs. She cannot read food labels, medicine packets, or her granddaughter's school drawings.

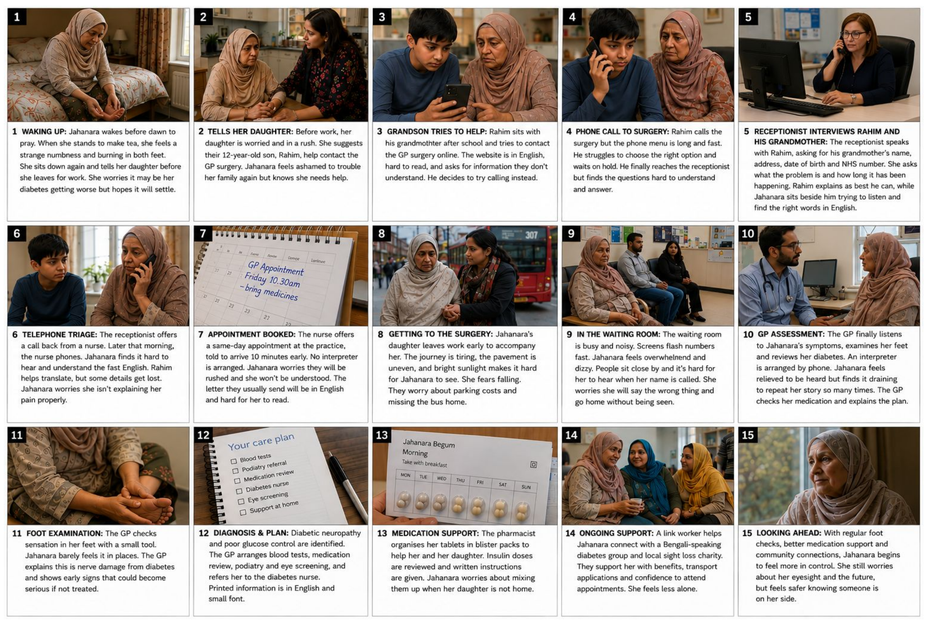
Spends most of the day sitting, watching Bengali TV channels, or performing prayers. She experiences high levels of loneliness despite being surrounded by family.

She struggles to manage her medication independently because she cannot distinguish between her tablet boxes.

Health and Wellbeing Impact

- Jahanara's struggle with NHS digital services is not just a technology gap; it is a complete barrier to her autonomy and healthcare safety. She is trapped between the cultural expectation of being a respected elder and the modern reality of being a digitally excluded patient.
- Jahanara has significant difficulty managing her health due to "remote-by-default" and digital-first GP practices.
- Telephone Barriers: She struggles to understand phone menu systems in English and feels anxious trying to explain complex symptoms over the phone to a receptionist.
- Digital Exclusion: She cannot use the GP's online booking app or email systems. She has missed two diabetic retinal screenings because she didn't read the letters.
- Transportation & Time: Getting to the GP requires her daughter to take time off work. When they arrive, the lack of in-person, in-language translation makes her feel rushed and unheard.
- Her pain from arthritis is dismissed as "part of getting old" or that her depression/anxiety is not treated, leading to a fear of seeking care.

Jahanara's Story



Journey Stage	What Happens	Jahanara's Experience	Family Experience	Potential Risks	Opportunities for Better Care
1. Symptoms Begin at Home	Jahanara wakes with numbness and burning in her feet and tells her daughter before work.	Fear, uncertainty, guilt about "causing trouble."	Daughter feels rushed and conflicted about leaving for work.	Delayed help-seeking, falls risk, diabetic complications missed.	Clear community education about diabetic "red flag" symptoms.
2. Reliance on Grandson	Daughter asks 12-year-old Rahim to help contact the GP.	Embarrassed and dependent.	Child becomes interpreter and navigator.	Safeguarding concerns, inaccurate communication, emotional burden on child.	Family support workers and interpreter access without reliance on children.
3. Accessing the GP Surgery	Rahim tries online forms and phone systems.	Frustration and exclusion from "digital-first" systems.	Rahim struggles with complex instructions and long waits.	No appointment obtained, symptoms minimised, abandonment of care-seeking.	Accessible phone line, Bengali translation, non-digital booking options.
4. Reception Triage	Receptionist asks urgent clinical questions in English.	Feels unheard and anxious.	Rahim forced to explain symptoms beyond his understanding.	Serious symptoms categorised as routine.	Staff training in inclusive communication and vulnerability recognition.
5. Telephone Assessment	Nurse conducts telephone triage.	Difficulty understanding rapid English; feels invisible.	Grandson tries to fill communication gaps.	Neuropathy, vascular problems, or stroke symptoms underestimated.	Automatic interpreter booking for telephone consultations.
6. Travelling to the Appointment	Daughter leaves work early to accompany her.	Feels like a burden; anxious about travel and falling.	Financial and work stress for daughter.	Missed appointment, injury during travel.	Community transport support and home visits for vulnerable patients.
7. Waiting Room Experience	Busy surgery environment overwhelms her.	Disorientation, sensory overload, shame.	Daughter attempts to advocate.	Patient leaves before being seen, distress escalates.	Quiet waiting spaces and sight-loss aware navigation support.
8. GP Consultation	GP assesses her with interpreter support.	Relief at finally being spoken to directly.	Daughter relieved but exhausted from advocacy role.	Clinician may still focus narrowly on symptoms only.	Holistic assessment considering social isolation and accessibility needs.
9. Diagnosis	Diabetic neuropathy and poor diabetic control identified.	Fear about future deterioration and blindness.	Family worries about increasing care needs.	Medication errors, worsening mobility, untreated depression.	Coordinated multidisciplinary diabetes care plan.
10. Immediate Treatment Begins	Medication adjusted; referrals made.	Confused by medication changes but hopeful.	Daughter becomes medication organiser.	Wrong dosages, poor adherence, missed follow-up.	Tactile blister packs, pharmacist review, home medication support.
11. Specialist Referrals	Referred to podiatry, diabetic nurse, eye screening.	Overwhelmed by multiple appointments and letters.	Family must coordinate logistics.	Missed referrals due to inaccessible communication.	Large-print/audio/Bengali appointment systems.
12. Home Safety Review	Occupational therapy assesses home.	Feels vulnerable admitting difficulties.	Family recognises extent of her risks.	Falls, unsafe stairs, poor lighting.	Home adaptations and mobility support.
13. Social & Emotional Support	Connected to Bengali-speaking community services.	Begins feeling less isolated.	Reduced emotional pressure on family.	Depression remains hidden if engagement fails.	Social prescribing and culturally appropriate peer support.
14. Ongoing Diabetes Management	Regular monitoring and foot checks introduced.	Gains some confidence managing condition.	Family workload stabilises somewhat.	Repeated exclusion if systems revert to digital-only communication.	Long-term personalised access plans documented in GP records.
15. Longer-Term Outcome	More coordinated care develops over time.	Feels more visible, respected, and safer.	Family relationships improve under less pressure.	Services stop, funding gaps, relapse into isolation.	Sustained continuity of care and proactive outreach.

MEET AALIYAH



Persona Summary: Aaliyah, 34, living in Tower Hamlets, East London

Education: BA (Hons) Advertising, Marketing Communications & Public Relations from London Metropolitan University

Personal Situation: Living back at parents' home with her mother and younger brother. Claiming Universal Credit. Receiving limited mental health support through her GP, topped up with self-help materials she researches online.

She started university in 2020 during the pandemic, so much of her degree was delivered remotely. Despite these difficulties she graduated with a 2:1 and was determined to pursue a future in London's creative industries.

Work Situation: She found the job of her dreams but then lost it. She is back home and is increasingly anxious about her prospects and the accumulated £57,400 of student debt

About Aaliyah

After graduating, Aaliyah secured a junior social media assistant role at a small digital agency in Shoreditch. At first she was excited - the hybrid working felt modern and flexible and she enjoyed creating content, learning how to manage real campaigns and applying her learning from her degree. She really believed this was the beginning of her career and that she would be able to gain promotion and very soon be leading a campaign.

However, within months the agency reduced staff after losing clients, her immediate boss was preoccupied and day to day guidance and expectations became unclear. With remote working, communication happened mainly on Slack and email, and she spent hours in front of her screen with an inbox and to-do list that was filling up faster than she could cope with. Aaliyah felt constantly judged and behind and her boss was unsympathetic, and she became terrified of making mistakes. Her manager described her as "quiet" and "lacking confidence", and criticized her in front of her colleagues on a weekly progress call. After repeated panic attacks before work calls, she resigned.

Daily Challenges

- Aaliyah's Typical Day - Wakes late after poor sleep, checks emails anxiously but avoids replying. She scrolls LinkedIn and compares herself to peers, starts job applications but rarely finishes them.
- She promises herself tomorrow will be different but eels guilty by evening for "doing nothing"

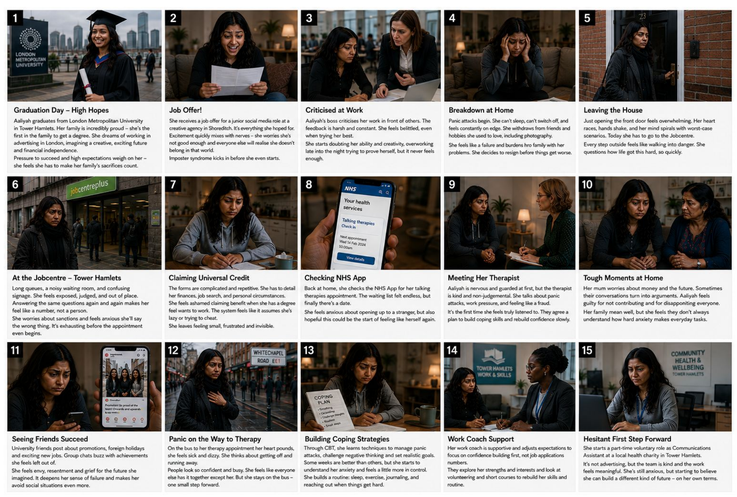
Financial

- Claiming Universal Credit and back home as she couldn't afford to live in her own flat
- Frequently worries about transport costs and helping her mother with bills
- Avoids social activities because she cannot afford them
- Feels ashamed about being financially dependent again and burdened in the future by her debt.

Health and Wellbeing Impact

- Aaliyah experiences generalized anxiety, panic attacks and insomnia, She is constantly "doom scrolling" late into the night
- She is in fear of interviews and phone calls, low self-worth linked to employment status and has been prescribed antidepressants but is inconsistent taking them because she worries they "mean she's failing."
- Her mother is supportive but worried. She encourages her to "just apply for anything" and does not fully understand anxiety and "why she's not helping herself"…compares Aaliyah to cousins who are working

Aaliyah's Story



Journey Map

Stage	Aaliyah's Experience	Key Stakeholders	What Helps	Potential Risks / What Might Go Wrong
1. Struggling at Work	Junior marketing role becomes overwhelming. Panic before meetings. Increasing self-doubt.	Employer, line manager, colleagues	Supportive supervision, mental health awareness, reduced pressure	Performance criticism worsens anxiety. She resigns abruptly without support.
2. Withdrawal at Home	Sleeps poorly, avoids messages, isolates socially. Tells family she is "burnt out."	Parents, friends	Emotional reassurance, non-judgmental listening	Family interprets her behaviour as laziness or lack of effort.
3. Crisis Point	Panic attacks increase. She stops applying for jobs entirely.	GP, NHS primary care	Early recognition of anxiety and depression	GP offers only medication with little follow-up.
4. Initial Diagnosis & Acceptance	Reluctantly accepts she needs help. Feels ashamed about benefits.	GP, NHS Talking Therapies	Validation that anxiety is real and treatable	She disengages due to stigma or long waiting lists.
5. Universal Credit Claim	Begins claiming benefits after savings run out. Finds system intimidating.	Department for Work and Pensions, Jobcentre work coach	Compassionate work coach, reduced conditionality	Fear of sanctions increases panic and avoidance.
6. Mental Health Assessment	Discusses anxiety openly for the first time.	NHS therapist, mental health practitioner	CBT, behavioural activation, practical coping strategies	Therapy feels too clinical or disconnected from real life.
7. Social Isolation Deepens	Friends progress in careers while she feels "left behind."	Friends, online networks	Peer support groups, structured activity	Doom scrolling and comparison worsen hopelessness.
8. Social Prescribing Referral	Connected to local women's wellbeing and creative confidence programme.	Social prescriber, voluntary sector organisations	Gentle routine-building and social connection	She feels programmes are "not for people like me."
9. First Re-engagement	Starts attending weekly sessions and volunteering occasionally.	Community mentors, charity staff	Positive reinforcement and low-pressure participation	Missed sessions trigger shame and withdrawal again.
10. Employment Support	Works with employability coach on confidence rather than immediate jobs.	Employability adviser, Jobcentre, local authority	Mock interviews, CV support, realistic goals	Pressure to apply for unsuitable jobs undermines progress.
11. Attempted Return to Creative Sector	Applies for marketing roles again but finds agency culture intimidating.	Recruiters, employers	Flexible interviews and supportive employers	Multiple rejections reactivate anxiety and imposter syndrome.
12. Reframing Success	Begins accepting that recovery matters more than status.	Therapist, family, mentor	Identity work and values-based coaching	Feels she has "failed" because career path changed.
13. Transitional Employment	Takes part-time admin and communications role in a community health charity.	Charity employer, colleagues	Structured supervision, psychologically safe workplace	Fear of relapse causes hypervigilance and stress.
14. Stabilisation	Develops confidence through predictable work and supportive colleagues.	Employer, NHS, family	Routine, purpose, social contact	Funding cuts or insecure contracts threaten stability.
15. Sustainable Future	Works in communications and outreach for a community wellbeing organisation — not advertising, but meaningful and manageable.	Employer, local community	Long-term mentoring and career development	Continuing grief about "lost ambitions" remains unresolved.

MEET JAMES



Persona Summary: James, 80, the Silent Generation. Lives in Kidbrooke

Current Status: Recently widowed; his late wife, Jane, managed all household bills and any digital tasks.

Living Situation: Moved to a quiet suburb of London ten years ago. He relocated from his home in Paddington 2 years ago, meaning he is unfamiliar with local amenities and cut off from his long-standing community roots. Now lives alone in a two-bedroom flat. The property is increasingly difficult for him to maintain,

Internal Monologue: "I spent forty years with barely a worry, my wife and I were a team. At work people came to me for the answers, but now, I'm defeated by this little glass screen.

About James

James is a retired civil engineer and was recently widowed. His late wife, Jane, managed all household admin, utilities and digital tasks. His adult son lives about an hour's drive away but "is busy, and has his own life", leaving him with no immediate, face-to-face support network. His identity is deeply rooted in being a provider, competent, self-sufficient, and proud - which makes his current isolation particularly jarring. He considers himself "fairly robust for his age" but he admits he is experiencing a gradual decline in mobility. He suffers from moderate osteoarthritis, which causes chronic pain and stiffness, particularly in his hands and knees. His vision is starting to concern him a little, "these days I need lots of light, and sometimes use a magnifying glass". He is registered at the local GP surgery, which is currently overstretched and heavily prioritizes digital triage (e.g. e-consult platforms). James prefers booking appointments face-to-face or via telephone, but he routinely faces long hold times or is told that "to secure an appointment he's better requesting online."

Comorbidities:

- **Mild Hearing Loss:** Exacerbates difficulties when using automated telephone systems.
- **Low vision:** His vision is deteriorating. He does not have a Certificate of Vision Impairment (CVI) but has not had an eye examination in several years, so is a bit worried they might tell him he can't drive anymore.
- **Anxiety**: Stemming from grief, isolation, and a growing fear of losing his independence.

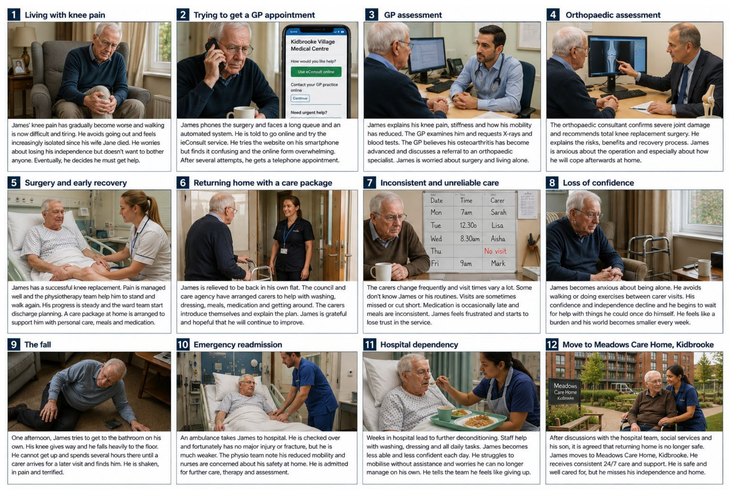
Daily Challenges

- Severe Digital Exclusion: He owns a basic smartphone but only uses it for voice calls, text messages, and occasional browsing of internet.
- Crisis-Driven Engagement: He avoids digital systems (NHS App, council tax portals, parking permits) entirely until a hard deadline or an urgent medical need forces his hand.
- Psychological Barriers to Help: He belongs to a generation that views personal struggles as private and is highly reluctant to "bother" healthcare professionals with non-medical issues like digital literacy.
- Simple tasks like renewing a parking permit or checking a blood test result now require an online account. What used to take a five-minute conversation now feels like an insurmountable barrier.
- He finds typing and clicking small links tricky, leading to frequent input errors, and things taking much longer than he thinks they should.
- Because he only logs on during a crisis, every digital interaction is charged with urgency. This pressure induces panic, making him highly susceptible to rushing, making mistakes, or abandoning the task altogether.

Health Impact

- As physical mobility declines and digital barriers increase, James's world shrinks. The loss of his wife, and digital connection prevents him from exploring local community groups
- **Spikes in Chronic Stress:** The anxiety of receiving a letter warning him of an overdue payment or a missed medical appointment creates prolonged periods of high blood pressure and poor sleep.
- **Delayed Care:** Rather than navigating an online triage form for a worsening health issue, James will wait until his condition deteriorates significantly,

James Story



Journey Map

Journey Stage	What Happens	James' Experience	Family Experience	Potential Risks	Opportunities for Better Care
1. Living with Worsening Knee Pain	James' osteoarthritis becomes progressively worse. Walking, shopping and using public transport become increasingly difficult.	James experiences increasing pain and stiffness but delays seeking help. Having always been independent, his world gradually shrinks	His son notices that James is becoming less mobile but assumes he is coping. Living an hour away makes it difficult to see the gradual decline.	• Delayed help-seeking • Reduced mobility • Falls risk • Social isolation • Deteriorating mental wellbeing	• Earlier intervention • Proactive frailty identification • Community support referral • Social prescribing
2. Trying to Access the GP	James attempts to book an appointment at Kidbrooke Village Medical Centre.	Long telephone queues and online-first booking systems create barriers. James struggles when directed towards eConsult and online services.	His son occasionally helps by telephone but cannot always be available.	• Digital exclusion • Missed appointments • Delayed diagnosis • Increasing frustration with healthcare	• Alternative access routes • Telephone-first support • Digital inclusion assistance • Care navigation
3. GP Assessment and Referral	The GP diagnoses worsening osteoarthritis and refers James to Orthopaedics.	James feels relieved someone is listening but worries about what surgery might mean for his future independence. He does not fully disclose how isolated he feels	His son is pleased that treatment is progressing but remains unaware of the extent of James' anxieties.	• Social needs overlooked • Anxiety unrecognised • Lack of holistic assessment	• Frailty assessment • Discussion of home circumstances • Early discharge planning
4. Orthopaedic Assessment and Surgical Decision	The consultant recommends a total knee replacement.	James understands that surgery may relieve his pain, but he becomes preoccupied by how he will manage afterwards. The prospect of depending on others is frightening.	His son reassures him but has concerns about how recovery will work in practice.	• Fear causing treatment delay • Poor preparation for recovery • Unidentified care needs	• Shared decision-making • Pre-operative care planning • Family involvement
5. Surgery and Hospital Recovery	James undergoes successful knee replacement surgery. Rehabilitation begins on the ward.	Initially James feels optimistic. The physiotherapy team encourage him to mobilise and he starts imagining a return to normal life.	His son is relieved the operation has gone well and expects recovery to be straightforward.	• Over-optimistic discharge planning • Underestimation of support needs	• Comprehensive discharge assessment • Rehabilitation planning • Home environment review
6. Returning Home with a Care Package	James is discharged home with domiciliary care visits for washing, dressing, meals and medication support.	He is pleased to return home but quickly realises how difficult everyday tasks have become. The care package initially provides reassurance.	His son feels comforted knowing support is in place and hopes James will regain independence.	• Inadequate care package • Poor communication between providers • Unrealistic expectations	• Reablement focused support • Regular review of care needs • Consistent staffing
7. Inconsistent and Unreliable Care	Different carers attend at varying times, with occasional missed or shortened visits.	James becomes increasingly frustrated. He repeatedly explains routines to unfamiliar carers and begins to lose trust in the service. The lack of consistency leaves him feeling anxious and unsupported.	His son spends increasing amounts of time making complaints and chasing providers.	• Missed medication • Missed meals • Reduced trust • Poor continuity of care	• Stable care teams • Better care coordination • Digital care records shared between staff
8. Loss of Confidence and Growing Dependency	James begins avoiding activities between visits and waits for carers to help him.	Although his knee is physically improving, his confidence deteriorates. Fear of falling causes him to become less active. His independence begins to erode.	His son notices James becoming withdrawn and less willing to leave the flat.	• Deconditioning • Depression • Reduced mobility • Learned dependency	• Falls prevention support • Confidence-building rehabilitation • Community engagement
9. Fall and Emergency Readmission	While attempting to get to the bathroom alone, James falls and is unable to get up. A carer discovers him hours later.	The fall confirms his deepest fears. He becomes frightened of being alone and loses confidence in his ability to live independently.	His son feels guilty and questions whether home is still safe.	• Serious injury • Hospital admission • Loss of confidence • Functional decline	• Rapid response services • Falls technology • Enhanced community support
10. Hospital Dependency and Deconditioning	James is readmitted to hospital. Although his injuries are minor, he requires increasing assistance.	Days become weeks. Staff help with washing, dressing and mobility. James becomes physically weaker and psychologically dependent. He begins to doubt he will ever manage alone again.	His son watches his father's confidence disappear and becomes increasingly concerned.	• Hospital-acquired deconditioning • Institutionalisation • Depression • Longer length of stay	• Intensive rehabilitation • Recovery-focused ward culture • Early discharge planning
11. Best Interest Discussions and Future Planning	The multidisciplinary team reviews James' long-term needs. Returning home is considered increasingly unsafe.	James feels conflicted. He wants to return home but no longer believes he can manage there. He grieves the loss of independence he has worked hard to maintain throughout his life.	His son struggles with the emotional burden of balancing safety with his father's wishes.	• Delayed discharge • Family distress • Loss of autonomy	• Strengths-based conversations • Family-centred planning • Transitional care options
12. Move to Meadows Care Home, Kidbrooke	James moves permanently into Meadows Care Home.	For the first time in months, he experiences consistent support from familiar staff. Although he feels safer and more cared for, he mourns the loss of his home, independence and identity as a self-sufficient man.	His son is reassured by the quality of care but saddened by the circumstances that led to the move.	• Social withdrawal • Loss of identity • Reduced independence • Adjustment difficulties	• Personalised care planning • Maintaining community connections • Emotional and psychological support

MEET MARKAR



Persona Summary

Lives: Markar is 42, originally from Armenia, Markar, his friends call hime Mark is now living in the Borough of Camden, temporary accommodation, sometimes sofa-surfing.

Personal situation: Unemployed, receiving Universal Credit.

Health Status: Chronic kidney disease (likely Stage 3–5) related to chronic alcoholism and substance abuse.

Healthcare Access: Not registered with a GP; relies on A&E for acute issues.

Complex Comorbidities: Mark is dealing with a high-risk combination: chronic kidney disease (CKD), addiction and mental health issues.

Addiction-Driven Renal Issues: A history of alcohol misuse is causing acute chronic kidney damage, directly impacting the kidneys' ability to filter fluids and waste.

Internal Monologue: **"***It's like I have the permanent flu, with bad nerves, like bugs under my skin. Don't trust doctors, they just see the drink, I'll go to A&E in an emergency"*

About Markar

Markar is living from one sofa to the next, on Universal Credit with limited capacity to work. Has digital skills but has no phone or regular access to the internet now. History of substance use alcohol to manage his withdrawal tremors. Stage 3 chronic kidney disease and severe oedema. Not registered with a GP and fears authority.

Daily Challenges

- **Trust/Stigma:** Markar has a deep mistrust of health providers, leading to delayed treatment and high-acuity, and resulting in late-stage presentation at hospital.
- **His chaotic Lifestyle:** Markar is incapable of following rigid, long-term medication schedules or attend strict appointment times, so medication compliance is poor
- **No GP Registration:** He is missing out on routine health management, monitoring of kidney function (eGFR), and blood pressure checks.
- **High Mortality Risk:** Markar's precarious housing situation combined with renal failure, significantly increases mortality risk.
- **The Digital Blindspot:** Markar does not have a reliable smartphone, a fixed phone number, or internet access. If say a renal clinic at the Royal Free reschedules a vital appointment, they cannot reach him. If his Camden social worker loses track of which hostel or friend's sofa he is sleeping on, the care loop breaks entirely.

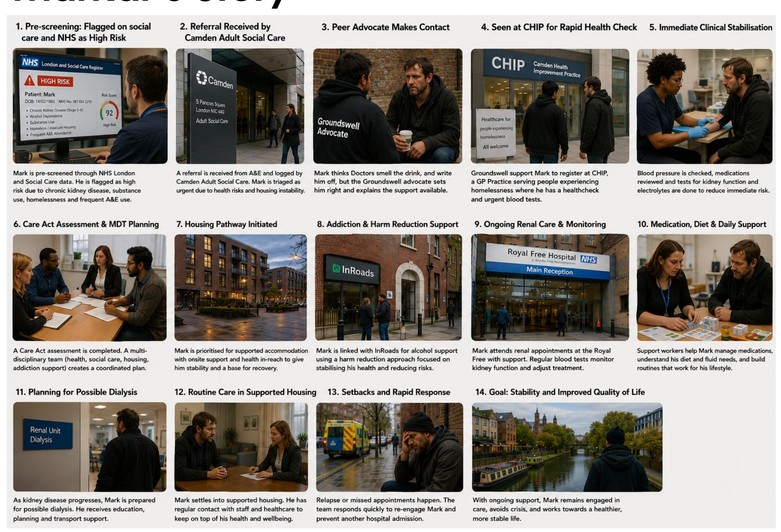
Health and Wellbeing Impact

Mark urgently needs help in the following areas

- **Immediate Action - Accessing Care:** Markar can register with a GP without a permanent address or ID, or access services through local homeless charities or drug/alcohol outreach teams.
- **Specialist Support:** Referral to local substance misuse services (e.g., Change Grow Live), which provide care plans for those not in regular contact with GPs.
- **Benefit Support:** Since he has a long-term, debilitating condition (kidney failure/addiction), he may be eligible for Personal Independence Payment (PIP) to help manage costs.
- **Harm Reduction:** Focus on reducing alcohol intake to prevent acute kidney injury (rhabdomyolysis).

Sadly to address these challenges, Markar will require a multi-disciplinary approach (social services, addiction support, and nephrology) but his current circumstances and condition mean that it will be hard to join up these elements with help to get him into the care pathways available in Camden. Without this he is likely to fall between the cracks and accelerate the downward spiral.

Markar's Story



Journey Map

Journey Stage	What Happens	Markar's Experience	Key Services / Stakeholders	What Might Go Wrong	Impact if Failure Occurs
1. Crisis Point / Referral Trigger	Markar presents at A&E, rough sleeping outreach, police concern, hostel concern, or safeguarding alert. Referral made to Camden Adult Social Care (ASC).	Exhausted, intoxicated, frightened, defensive, physically unwell. Distrustful of authority.	Camden ASC, hospital discharge team, outreach workers, safeguarding team, hostel staff.	Referral information incomplete; Markar leaves before assessment; ASC cannot contact him afterwards.	Missed safeguarding opportunity; repeated emergency admissions; deterioration of CKD.
2. Adult Social Care Intake & Triage	ASC screens urgency under Care Act duties and housing vulnerability criteria. MDT pathway triggered.	May not understand process or engage consistently.	Camden Adult Social Care, Camden Adult Pathway Partnership (CAPP).	Delays in triage; thresholds disputed; no immediate accommodation available.	Markar returns to sofa surfing/street homelessness; health destabilises rapidly.
3. Assignment of Peer Advocate	Groundswell peer advocate assigned to build trust and maintain engagement.	First point where Markar may feel understood and less judged.	Groundswell	Advocate capacity limited; inability to locate Mark; Markar disengages after negative interaction elsewhere.	Loss of trust in entire system; disengagement from treatment.
4. Emergency Stabilisation	Immediate health assessment arranged. Priority GP registration at CHIP. Blood tests and CKD monitoring initiated.	Anxious, overwhelmed, physically unwell. May not perceive kidney disease severity because symptoms are intermittent.	Camden Health Improvement Practice, nephrology clinicians, outreach nurses.	Markar misses appointments; intoxication prevents attendance; no phone/contact details; hyperkalemia or AKI develops unnoticed.	Sudden medical collapse, dialysis requirement, cardiac arrest risk.
5. Housing Assessment & Placement	Housing pathway activated. Temporary supported accommodation sought.	Relief at possibility of stability but may fear institutional settings/rules.	Camden housing teams, supported housing providers, hostel staff.	No suitable placement available; behavioural exclusions; eviction after alcohol-related incident.	Returns to rough sleeping or unsafe environments; medication/storage impossible.
6. Care Act Assessment & MDT Planning	Holistic assessment covering physical health, mental health, addiction, finances, and daily living. Shared care plan created.	Can feel interrogated or overwhelmed by multiple professionals.	Social worker, renal social worker, mental health team, substance misuse services, benefits advisor.	Agencies work in silos; duplicated assessments; Markar disengages due to complexity.	Fragmented care; missed interventions; repeated crises.
7. Addiction & Harm Reduction Support	Referral into alcohol/substance misuse service using harm reduction approach.	Ambivalent about reducing alcohol; fears withdrawal symptoms.	Change Grow Live, InRoads, Camden Safer Streets Team.	Service expectations too rigid; missed sessions trigger discharge; relapse after crisis.	Alcohol binges trigger Acute-on-Chronic Kidney Injury (AKI).
8. Renal Outpatient Monitoring	Ongoing blood monitoring, medication review, blood pressure checks, nephrology appointments.	Struggles with routines, transport, and remembering appointments.	Royal Free London NHS Foundation Trust, University College London Hospitals NHS Foundation Trust	Appointment letters lost; no digital access; transport barriers; clinic stigma.	Kidney function deteriorates unnoticed until emergency dialysis needed.
9. Medication & Dietary Management	Support provided around fluid restriction, medication adherence, nutrition.	Difficult to prioritise diet/medication when homeless or intoxicated.	GP, pharmacists, hostel staff, renal dietitians.	Medicines stolen/lost; inability to refrigerate/store meds; poor nutrition.	Severe electrolyte imbalance, worsening CKD symptoms.
10. Dialysis Preparation (if CKD progresses)	Education and planning for dialysis access and routine attendance.	Fearful, resistant, overwhelmed by commitment required.	Renal unit staff, vascular access teams, social worker.	Markar is unable to tolerate structured dialysis schedule; leaves sessions early; withdrawal symptoms during treatment.	Life-threatening renal failure; repeated emergency admissions.
11. Long-Term Routine Care & Stabilisation	Ideally transitions into stable supported accommodation and coordinated routine care.	Potential gradual trust-building and stabilisation if continuity maintained.	Integrated MDT across housing, health, social care, addiction support.	Staff turnover; funding gaps; relapse; accommodation breakdown.	Cyclical return to crisis/A&E dependency.

MEET ELENA



Persona Summary
Elena is 35, Albanian - Trafficked

Family Status: Single mother to a 4-year-old daughter, born shortly after her arrival in the UK.

Location: Living in a shared house (temporary NRM-funded accommodation

Points of consideration: She has been formally recognised as a victim of modern slavery, and dealing with current challenges of the National **Referral Mechanism** (NRM) and the benefits system. Thai affects her financial, legal, housing and medical support.

Internal Monologue: "*I'm terrified of seeing a doctor, in case I'm deported… anyway I can't even explain "where it hurts*"

About Elena

Elena was promised a job in a hotel in London to support her elderly parents. Passport confiscated, and forced into domestic servitude. Rescued after 2 years, but 5 years later, pregnant and still not formally recognised as a victim of modern day slavery. Gets a weekly "subsistence" payment and cannot legally work. Her English is limited to basic phrases, can't understand the Home Office/DWP/NHS letters.

The Trafficking Experience - Elena was recruited in her home village with the promise of a job in a "luxury hotel" in London to support her elderly parents. Upon arrival, her passport was confiscated to "process her visa," and she was instead forced into domestic servitude and sexual exploitation. She was kept in isolation for nearly two years, told that the UK police would arrest her if she tried to leave because her "documents were illegal."

Daily Challenges

Elena has been formally recognized as a potential victim of modern slavery through the National Referral Mechanism (NRM).

- **Financial Support:** She receives a weekly "subsistence" payment (roughly £49.18 per person) while her case is being decided. Since she has a child, she also receives additional support, but she is currently in "limbo," waiting for a Conclusive Grounds decision from the Home Office.
- **Right to Work:** As of 2026, Elena cannot legally work while in the NRM because she does not yet have a "leave to remain" status. This forces her to rely entirely on state support and charity.
- **Language Barrier:** Her English is limited to basic phrases ("yes," "no," "please," "thank you"). This makes it difficult to understand the complex letters she receives from the Department for Work and Pensions (DWP) or the Home Office.
- **The "Limbo" Effect:** Elena feels trapped. She cannot plan for the future because she doesn't know if she will be allowed to stay in the UK or be returned to the country where her traffickers still operate.
- **Parenting in Fear:** Her primary focus is her daughter. She worries that if she is deported, her daughter (who speaks only English) will struggle in a country she has never known.
- **Recovery:** She attends weekly counseling through a specialist charity like Black Country Women's Aid, though the language barrier requires an interpreter, which isn't always available.

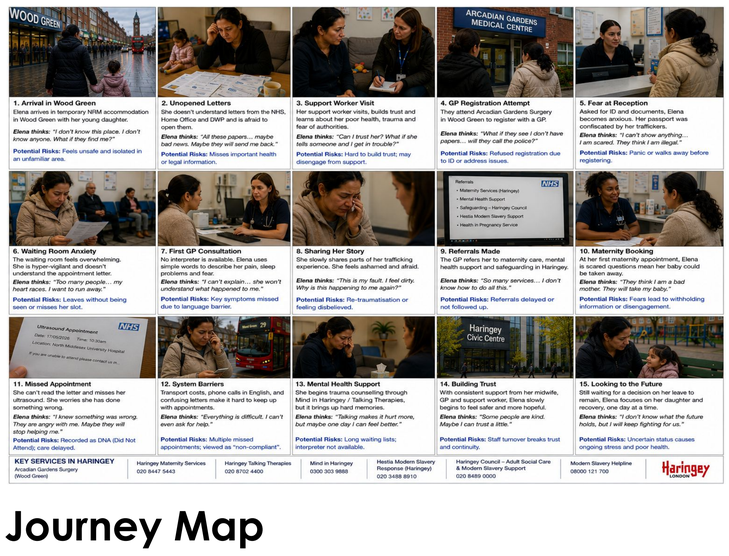
Health and Wellbeing

- Elena doesn't use words like "PTSD" or "depression." Instead, she describes how she feels: "My head is full"
- She feels overwhelmed by intrusive memories and constant worry about the Home Office. She often stays awake to watch over her daughter, fearing someone will come to the door.
- Hyper-vigilance: She describes feeling "jumpy" or panicked in crowded places or when she sees men who look like her traffickers.

In terms of physical Health her body carries the "memory" of her exploitation:

- **Chronic Pain:** She complains of constant back and pelvic pain, often a somatic (physical) manifestation of her past abuse.
- **"Heavy heart":** She describes chest tightness and heart palpitations, which are actually symptoms of high anxiety.
- **Exhaustion:** Between caring for a toddler and the stress of her legal case, she feels "empty" or like she has "no blood" (low energy).

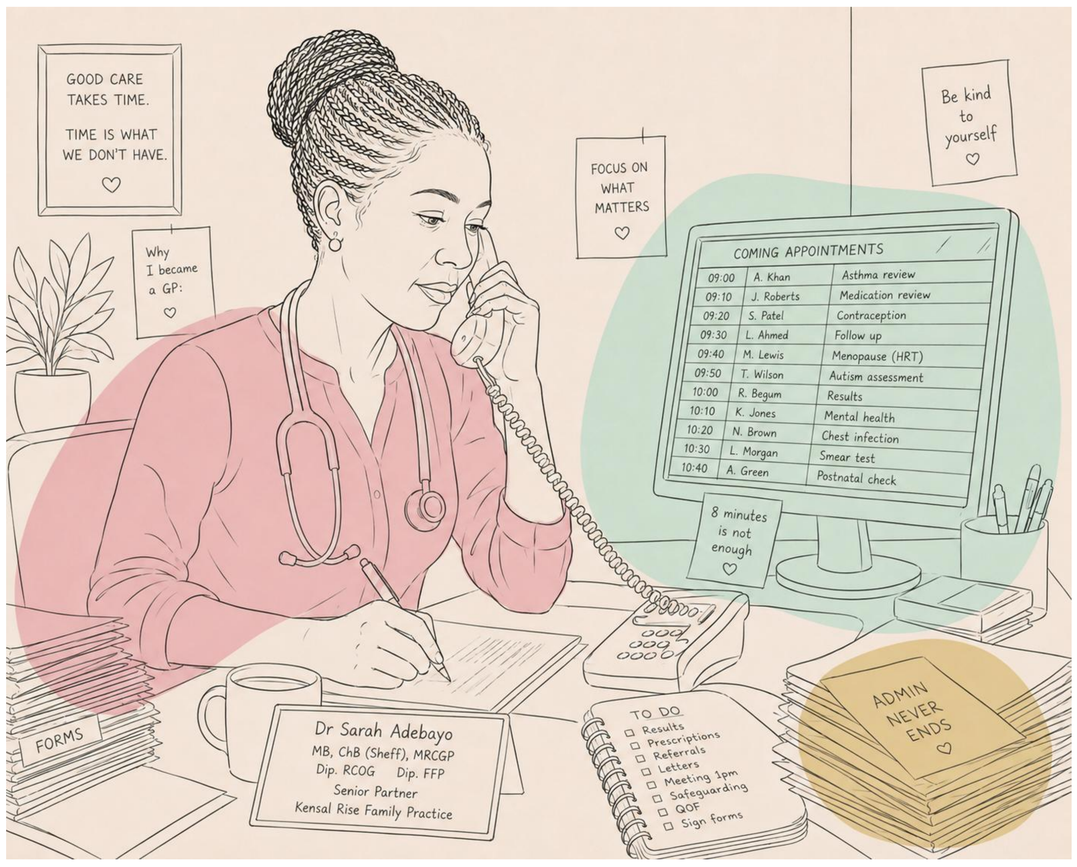
Elena's Story



Journey Map

Journey Stage	What Happens	Mark's Experience	Key Services / Stakeholders	What Might Go Wrong	Impact if Failure Occurs
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4. Emergency Stabilisation	Immediate health assessment arranged. Priority GP registration at CHIP. Blood tests and CKD monitoring initiated.	Anxious, overwhelmed, physically unwell. May not perceive kidney disease severity because symptoms are intermittent.	Camden Health Improvement Practice, nephrology clinicians, outreach nurses.	Mark misses appointments; intoxication prevents attendance; no phone/contact details; hyperkalemia or AKI develops unnoticed.	Sudden medical collapse, dialysis requirement, cardiac arrest risk.
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MEET SARAH: PRACTITIONER



About Sarah

Sarah Adebayo, 48 is a senior partner working at a practice in Kensal Rise. Women's health is her vocation and she has an MB, ChB(Sheff), MRCGP, Diploma Royal College of Obstetrics & Gynaecology, Diploma Faculty of Family Planning. She qualified at Sheffield 2001 and completed her GP training in Brighton before moving to Maida Vale to eventually become a partner at the Practice in Kensal Rise in 2010.

Her professional interests are in in gynaecology, contraception and sexual health, and also has a special interest in HRT and autism. She is now a Senior Partner and finds the challenge of running the practice conflicts with the time she needs to devote to her teenage children doing GCSE and A Levels. Sarah is coping with two teenage girls on her own. She is constantly torn between caring for her patients, supporting her colleagues, quietly absorbing and controlling her emotions at work, and being able to be as controlled and empathetic with the emotional rollercoaster of the teenage years. And that leaves no time for her own personal reflection, and with no-one beside her to give her the care, affection and support she needs.

Exhausted, and frustrated, she craves a sabbatical but knows this is impossible right now. She must cope with the life she has created for herself, even if the aspiration and the reality are so far apart. One 8 minute appointment after the next, never time to read notes as carefully as she would like to, never time to reconsider the choices she's made before the next appointment begins, and she puts on her welcoming smile.

She is frustrated that the 8 minutes per patient means she can't properly address their needs, and that the administrative burden falling upon her personally is getting more and more burdensome. Too many reorganisation in the NHS have weakened morale, and services like adult social care, the housing problems in the borough, growing substance abuse, are making her question her career in the health service. The gap between the aspirational vision and the reality of delivering care, in constrained times, is jarring. And so once again, she puts on her smile to encourage her colleagues, support their morale, before returning home and prepare for th next day.

Persona Summary
Sarah Adebayo, a Senior Partner at her GP Surgery in Kensal Rise

Family Status: Single mother with two daughters, a 15-year-old and 17-year old

Location: Lives in Maida Vale, close to her surgery in Kensal Rise, in a mansion block flat

Frustrations: Lack of joined up services, from housing to adult social care. Women's health is her passion but feels bogged in bureaucracy and bridging the gap where services should be joined up.

Internal Monologue: *"I'm not doing the job that needs to be done for my patients, nor for my children who don't even get 8 dedicated minutes with me"*

Sarah's Day

Stage	What's Happening	What She Experiences	Who She Interacts With	What Might Go Wrong	Possible Mitigation
Home, pre-dawn	Clearing overnight results/messages on her own laptop before the household wakes	Already "at work" mentally before leaving home; blurred home/clinic boundary	No one directly — the clinical system, remotely	Reviewing results half-alert risks a missed detail; family prep time lost	A practice policy of no clinical system access before a set hour; a duty team that triages overnight results, so nothing needs her personal attention pre-shift
Arrival, inbox triage	Working through ~34 messages, two safeguarding alerts, a DNACPR to countersign, before her first patient	Rising anxiety; already behind before seeing anyone	Admin staff, district nurse, on-call colleague	Safeguarding alert reviewed too fast under time pressure, countersigning without full context	Protected, paid admin time before clinic; trained triage support (nurse/pharmacist) to pre-sort so only genuine GP-level items reach her
Patient — isolated 82-year-old	Booked for a UTI; real issue is loneliness, a failing hip, unreturned social care calls	Helplessness; frustration at treating the symptom, not the cause	Patient; (absent) social services	Decline goes undetected until a crisis or fall	Longer slots for flagged complex/isolated patients; direct social-prescribing referral with a named link worker and follow-up
Patient — 16-year-old, disclosure	Contraception consult turns into a Gillick assessment and disclosure of a controlling relationship	Heightened vigilance, emotional weight, clock anxiety	Patient (mother waiting outside); safeguarding lead	Rushed handling; incomplete documentation; knock-on delay to next patient	Flexible safeguarding-designated slots; real-time note-taking support; built-in debrief time afterwards
Patient — perimenopause & autism	Specialist HRT review, drawing on her extra qualifications	Rare professional satisfaction — the work she trained for	Patient	Running over eats into the next patient's time; expertise given for free	Recognised, funded specialist clinic sessions with appointment length that matches complexity
Corridor — practice management	Intercepted with a locum cancellation, a resignation, a CQC query	Role conflict; pulled out of clinical mode without warning	Practice manager; agency locums; CQC	Hasty decisions under pressure; contributes to burnout	Delegated authority to practice manager for routine calls; scheduled (not ad hoc) management time blocks
Patient — escalating benzodiazepine use	Has to decline a repeat prescription with almost nowhere fast to refer him instead	Moral distress; gatekeeping fatigue	Patient; community substance misuse service (waitlisted)	Patient disengages, escalates, or self-manages withdrawal unsafely	Fast-track pathway agreement with local addiction services; in-house link worker; clear safety-netting plan
Patient — damp housing, recurring illness	Writes her fourth housing support letter this month	Powerlessness; moral injury	Family; council housing team (opaque)	Letter goes nowhere; child's health keeps deteriorating	Formal joint referral process with tracked status and an escalation route for high-risk cases
"Lunch"	Results, letters, an overrunning safeguarding meeting	Fatigue; no real recovery time	Safeguarding team; MDT colleagues	Cumulative fatigue affects afternoon judgement	Genuinely protected lunch with admin cover; meetings capped and scheduled outside the break
Afternoon surgery	Mixed-complexity patients — coil fitting, cancer referral, no-interpreter video call — same slot length for all	Constant catch-up; no time to process serious news before the next patient	Multiple patients, some without booked interpreters	Errors from time pressure; patients rushed through serious diagnoses; consent compromised without interpretation	Dynamic slot lengths matched to flagged complexity; buffer slots in the template; mandatory interpreter-booking checks
End of clinical day	40+ results to code, three letters, unread PCN agenda	Guilt about leaving vs staying; exhaustion	The record system, alone	Tired coding introduces errors; unresolved items roll into tomorrow	Scribe or admin support; AI-assisted note drafting; a firm stop time with a clear handover protocol
Home, then the news	Missed dinner, short exchange with her daughter, another NHS reorganisation announced	Guilt, exhaustion, disillusionment	Her children	Strained family relationships; risk of burnout or leaving the profession	Protected, enforced family time (no laptop after a set hour); peer support/mentoring; collective advocacy through the LMC/BMA on workload