Table 2. Practical examples of using the 3 personalised care roles to reduce health inequalities in specific cohorts

Health Inequality/ inclusion group/ SDOH	Social Prescribing Link Worker	Care Coordinator	Health and Well-Being Coach
General role activities	Support with accessing practical support, advice services, emotional support within communities and the voluntary sector, support with housing and financial entitlements Advocacy	Identifying missed screening/reviews Booking/ assisting with completing care plans Call/recall especially with patients/ cohorts not engaging	Goal setting Behaviour change Address lifestyle factors that are key determinants of health inequalities
Cancer	General role activities Linking with community and other support groups for patients with cancer or for carers	Identifying missed screening, booking cancer care reviews, support with navigating health services, running cancer safety reports, two week wait safety netting, Cancer diagnosis follow up support, understanding condition, creating space to reflect on choices	Goal setting after diagnosis and/or treatment, building confidence and self-esteem
Maternity and women's health	Health justice partnerships, linking with community and other support groups, support with accessing housing, income and healthcare entitlements Specialist link workers providing wrap around community led social prescribing addressing perinatal mental health and attachment and bonding needs and providing regular social gathering opportunity in a community hub Community Parent model to support the best start in life for children of vulnerable parents; assistance with preparing for birth, building support network, navigating maternity services, encouraging breastfeeding	Cervical screening call and recall Support with engaging with/accessing/navigating maternity services Postnatal review	Supporting women going through menopause- e.g. group consultations Lifestyle health and wellbeing coaching in pregnancy

Hypertension/ cardiovascular disease	General role activities Community wellbeing activities (e.g. arts, gardening, exercise groups)	Proactive case finding Screening call and recall of health checks New registration health checks Follow up on outstanding reviews and care plans including arranging blood tests Following up on BP at home readings	Prevention- exercise, diet, weight management Increase activation and engagement in supported self-management, prepare referral to specialist support, reviewing progress, exploring resource options/networks Support with care planning
Respiratory disease	General role activities Support with housing/relocation where poor housing contributing to respiratory illness	Call/ recall of annual review of asthma/COPD Flu and other vaccination call/recall Coordinating Long Covid clinics	Increase activation and engagement in supported self-management, prepare referral to specialist support, reviewing progress, exploring resource options/networks Support with care planning Joint virtual group clinics for Long Covid with GP
Mental illness	Community wellbeing activities (e.g. arts, gardening, exercise groups) Psychological interventions- anxiety management, mindfulness, counselling Wider information and advice e.g. helplines, support groups Services to resolve socio-economic needs e.g. benefits, advice housing Linking with other health services e.g. dentistry Specialist link workers with training to support more complex patients with emotional and practical support and address social determinants contributing to poor mental health	Follow up on outstanding reviews and supporting with mental health care plans including arranging blood tests/ annual physical health review	Supporting patients with mild/moderate depression/anxiety, low mood, feeling 'stuck', overwhelmed, underlying perceived barriers to progression, low motivation, isolation, insomnia Supporting patients with bereavement and loss Substance misuse- willingness to address non-depend use, preparation for referral to external specialist support, smoking cessation Running coaching sessions for CCs and SPLWs to improve confidence speaking to patients with complex MH conditions Support with care planning

Children and young people	General role activities Specialist link workers for children and young people being piloted	Setting and coordinating paediatric MDT meetings Safeguarding project to improve safeguarding referral process across agencies Childhood immunisation call/recall	Possible role for specialist HWbCs to support with emotional health, weight management, healthy lifestyle
Diabetes	General role activities Community wellbeing activities (e.g. arts, gardening, exercise groups)	Identify patients at risk of diabetes and arrange review Follow up on outstanding reviews and care plans including arranging blood tests	Increase activation and engagement in supported self management, prepare referral to specialist support, reviewing progress, exploring resource options/networks, lifestyle and behaviour change Support with care planning
At risk of LTCs	General role activities Community wellbeing activities (e.g. arts, gardening, exercise groups)	Proactive case finding- identifying patients/cohorts at risk of LTCs and arranging review/ referring to HWBCs for early intervention	Behaviour change- weight, diet, exercise, , supporting small steps and preparing for specialist referrals to maximise effectiveness and review progress
Prevention/wellbeing	General role activities Community wellbeing activities (e.g. arts, gardening, exercise groups)	Proactive case finding- identifying patients/cohorts and arranging review/ referring to HWBCs for early intervention	General role activities Address isolation, routine, sleep/life balance, barriers to progression Support participation in community activities Recovery and rehabilitation
Musculoskeletal	Linking with community and peer support groups Recognise wellbeing and mental impact and linking in with relevant activities and services such as IAPT Support with employment, finance and housing	Proactive case finding- identifying patients with chronic musculoskeletal conditions who may benefit from referral to SPLW and/or HWBC	General role activities especially goal setting Increase participation in exercise programmes Supporting patients with chronic pain and related conditions e.g. fibromyalgia Functional and procedural skills development Personalised care planning Group coaching sessions

Multiple LTCs	General role activities Community wellbeing activities (e.g. arts, gardening, exercise groups)	General role activities Coordinating multiple appointments and reviews Assisting pharmacists with high risk drug monitoring Organising/chasing investigations/referrals	Increase activation and engagement in supported self-management, prepare referral to specialist support, reviewing progress, exploring resource options/networks Support with care planning
Elderly/frailty	Support with accessing practical support (e.g. carer support, day centres), advice services, emotional support within communities and the voluntary sector, support with finance	Setting up and coordinating MDTs Liaising with social services and community support groups Running a dedicated telephone line Support with care planning Coordinating care across health and social care Referral for community support Referring housebound patients to nursing team for vaccination Acting as first point of contact for care homes Support with managing multiple appointments	Patients with general forgetfulness- overcoming difficulties, exploring options to self-manage, encouragement with specialist resources Supporting patients experiencing social isolation and loneliness Supporting virtual wards- prevent admission, maintain independence Medicine adherence post discharge Procedural and functional skill development Working with carers
Disabilities	General role activities Support with housing and financial entitlements and accessing local support groups Accessing support for patients, families, children and young people e.g. for neurodivergent/behavioural disorders Support with accessing equipment working with rehab team	Arranging LD reviews and care planning	Physical disability- self management and resilience, exploring options, resources, sources of support Pain management- non clinical coping strategies Support with care planning

Vulnerable patients and families	Support with accessing practical support, advice services, emotional support within communities and the voluntary sector, support with housing and financial entitlements Support with complex social needs and linking with multi-agency partners Supporting community integration of inclusion health groups through wrap around community led social prescribing Specialist link workers for gang violence and knife crime reduction using a cross-sectoral public health approach	Support health navigation and connecting to services, GP registration, appointment assistance, advocacy Welfare check for patients not engaging/attending appointments Setting up innovative care models to connect multiple agencies and community organisations and support groups Creating peer advocacy programme in collaboration with local VCSE organisations Digital champions programme to tackle digital exclusion Specialist homeless health CC specifically for people who are homeless or at risk of homelessness Specialist care coordinator o support palliative care provision to homeless patients	General role activities Support with confidence, self-esteem, goal setting Coordinating community response team meetings Supporting patients experiencing social isolation and loneliness Supporting patients with mild/moderate mental health disorders, feeling 'stuck', overwhelmed, underlying perceived barriers to progression, low motivation, isolation, insomnia Substance misuse- willingness to address non-dependant use, preparation for referral to external specialist support, smoking cessation Supporting return to work