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1. Introduction

Digital technology has become increasingly embedded within the delivery of health and social care in the United Kingdom. Telehealth, online appointment systems, video consultations, electronic health information and remote monitoring can potentially improve convenience and enable healthcare to be delivered without patients travelling to clinical settings. However, increased reliance on digital healthcare also creates the possibility that people who cannot access or confidently use digital technology will experience greater difficulty obtaining healthcare.

Telehealth can broadly be understood as the provision or facilitation of healthcare at a distance through information and communication technologies. It can include telephone and video consultations, remote monitoring and other digitally supported interactions between patients and healthcare professionals (Kruse *et al.*, 2020). Digital exclusion is broader than simply not owning a computer or smartphone. It can involve inadequate internet connectivity, unaffordable devices or data, limited digital skills, inaccessible technology, lack of confidence, language or literacy barriers, distrust and insufficient social support (NHS England, 2023). Therefore, digital exclusion exists on a continuum rather than representing a simple distinction between people who are online and those who are offline.

This distinction is particularly important for older adults. Although many older people use technology successfully, older age remains associated with increased risk of digital exclusion. Age UK (2025) demonstrates that a substantial minority of older people remain offline or have limited digital skills. Consequently, the movement of healthcare towards digital routes may produce unequal benefits. The risk is particularly important because older adults are also more likely to live with chronic illness, frailty, sensory impairment or multiple health conditions and therefore may have greater need for healthcare.

The rapid transition towards remote healthcare during the COVID-19 pandemic intensified this issue. UK primary care underwent major reorganisation, with telephone and electronic/video consultations increasing substantially while face-to-face consultations declined (Joy *et al.*, 2020). Digital services can offer significant benefits, particularly for people who experience mobility or transport difficulties. Nevertheless, these benefits depend upon an individual's ability to access and use the technology. International evidence has similarly identified technical literacy, cost, privacy, access to equipment and lack of support as barriers to older people's engagement with Telehealth (Kruse *et al.*, 2020; Wilson *et al.*, 2021).

The rationale for this scoping review is therefore that digital transformation cannot be considered successful solely because services are technically available online. Accessibility must also be considered in relation to whether older adults can realistically use those services. This issue is directly relevant to health and social care practice because unequal access can reinforce existing health inequalities.

Review question

How does digital exclusion affect access to Telehealth services among older adults in the UK?

This is unchanged from the C1 proposal.

Objectives

The objectives of this scoping review are:

- To identify the main barriers to Telehealth access for older adults in the UK.
- To examine the impact of digital exclusion on healthcare access, use and outcomes among older adults.
- To explore strategies that may reduce digital inequalities in Telehealth delivery for older people.
- To identify gaps in the current UK evidence base relevant to health and social care practice.

These reproduce the four objectives established in C1.

2. Background

Digital transformation is a significant strategic priority across UK healthcare. The Department of Health and Social Care's *A Plan for Digital Health and Social Care* set out an ambition for a digitally enabled health and social care system and emphasised the development of digital services, infrastructure and personalised care (Department of Health and Social Care, 2022). Importantly, the strategy also recognises the need to mitigate the exclusion of people who are unable or unwilling to use digital services.

The acceleration of remote healthcare during COVID-19 demonstrated both the possibilities and limitations of digital healthcare. Joy *et al.* (2020) examined more than 3.8 million consultations involving UK adults aged 65 years and over during the early pandemic. Telephone and electronic/video consultations increased substantially, while face-to-face consultations and home visits declined. This demonstrated how rapidly healthcare delivery could change. However, rapid implementation also meant that patients had differing levels of preparation for remote access.

Older people should not be treated as a homogeneous population. Some older adults use smartphones, video calls, online banking and health applications confidently, whereas others have little experience of digital technology. Shorthose *et al.* (2024) suggest that age alone is therefore an inadequate explanation of digital exclusion. Frailty, confidence, social support and functional ability can influence whether a person can participate in a video consultation.

This is supported by wider evidence. Wilson *et al.* (2021), in a scoping review of older adults' engagement with eHealth, identified barriers operating at individual, technological and wider contextual levels. Kruse *et al.* (2020) similarly identified technical literacy as the most frequently reported Telehealth barrier in their systematic review, alongside lack of desire, cost, privacy concerns, sensory limitations and inadequate technical support.

Socioeconomic circumstances are particularly important. Digital access requires more than possession of a device. Reliable broadband or mobile data, updated equipment and the financial ability to maintain connectivity are also necessary. NHS England (2023) identifies older age, socioeconomic disadvantage, disability, inadequate broadband coverage and limited English proficiency among characteristics associated with greater risk of digital exclusion. The framework consequently identifies access to devices and connectivity, accessibility and usability, skills and capability, beliefs and trust, and leadership and partnerships as areas requiring action.

Digital exclusion is therefore closely connected with wider health inequalities. The Health and Care Act 2022 strengthened duties concerning inequalities in access to and outcomes from health services. Digital transformation that unintentionally makes access more difficult for disadvantaged groups is inconsistent with the principle that services should work to reduce rather than reproduce inequalities.

The issue also has implications for equality and person-centred care. An older patient may simultaneously experience frailty, disability, poverty, limited English proficiency and low digital literacy. These factors can interact rather than operate independently. Ahmed *et al.* (2024), for example, found that older South Asian, Black African and Caribbean adults experienced difficulties related to digital skills and language and often relied upon younger relatives or community organisations. Chadwick *et al.* (2024) similarly found that older age combined with socioeconomic deprivation could intensify difficulties with digital healthcare.

Nevertheless, Telehealth should not be regarded as inherently harmful for older adults. Evidence suggests that it can support chronic disease management, reduce travel and improve convenience when appropriately implemented (Şahin, Yavuz Veizi and Naharci, 2021). The central concern is therefore not whether healthcare should use technology, but how digital services can be implemented without making digital competence an unintended condition of accessing healthcare.

3. Methods

3.1 Review design

A scoping review methodology was selected because the research question is broad and concerns a developing field involving different study designs, populations and forms of digital healthcare. Scoping reviews are particularly useful for mapping the nature and extent of available evidence, identifying recurring concepts and revealing gaps requiring further investigation.

The review was informed by the five-stage framework proposed by Arksey and O'Malley (2005): identifying the research question; identifying relevant studies; selecting studies; charting the data; and collating, summarising and reporting results. This follows the methodology originally proposed in C1. Levac, Colquhoun and O'Brien (2010) argue that scoping reviews benefit from a clear connection between the research question, study selection and synthesis, and these principles were incorporated into the review.

The reporting principles of the PRISMA extension for scoping reviews (PRISMA-ScR) were also considered. PRISMA-ScR promotes transparent reporting of the rationale, eligibility criteria, information sources, selection process and synthesis of scoping reviews (Tricco *et al.*, 2018).

3.2 Search strategy

Searches focused on peer-reviewed academic literature relevant to older adults, digital exclusion and access to digital or remote healthcare in the UK. PubMed and Google Scholar were used to identify potentially relevant literature, alongside searches for peer-reviewed research associated with UK health services.

Search terms were combined using Boolean operators and included combinations of:

(“digital exclusion” OR “digital divide” OR “digital inclusion” OR “digital literacy”) AND (“older adults” OR “older people” OR “elderly”) AND (“Telehealth” OR “telemedicine” OR “remote consultation” OR “video consultation” OR “digital health”) AND (“UK” OR “United Kingdom” OR “England”).

The review primarily prioritised evidence published from 2020 onwards because the COVID-19 pandemic significantly accelerated digital healthcare adoption. Earlier methodological literature was retained where necessary to justify the review methodology.

3.3 Eligibility criteria

Studies were included where they were published in a peer-reviewed academic journal; contained primary or secondary research; examined older adults or included evidence directly relevant to older adults; addressed digital exclusion, digital healthcare, Telehealth or remote healthcare access; were conducted in the UK or contained findings directly applicable to UK practice; and were available in English.

Studies were excluded from the core analysis if they were editorials, commentaries, policy documents, professional guidance or conference proceedings. Government, NHS and third-sector documents were used only to establish background and policy context and were not treated as included research studies.

Five peer-reviewed UK studies were selected for detailed charting because they offered complementary evidence concerning digital access, frailty, socioeconomic disadvantage, ethnicity and cognitive impairment.

3.4 Study selection and data extraction

Potential studies were initially assessed through their titles and abstracts. Full texts of potentially relevant studies were then considered against the eligibility criteria. Information was charted according to author and year, study design, population and setting, main findings and relevance to the review question.

Using several study designs was appropriate because the research question concerns both measurable patterns of exclusion and people's experiences. Quantitative evidence can identify associations between characteristics such as frailty and digital exclusion, whereas qualitative evidence can explain why barriers occur.

3.5 Data analysis

A thematic approach was used to combine findings across the five studies. The principles of thematic analysis described by Braun and Clarke (2006) informed the process. Findings were read and compared, recurring concepts were coded, related concepts were grouped and broader themes were generated.

Four themes were identified: digital skills, confidence and technological access; frailty, health status and dependence on support networks; inequalities, socioeconomic disadvantage and intersectionality; and preference, trust and the importance of human contact.

3.6 Ethical considerations

The review used published research and involved no recruitment, intervention or collection of identifiable participant information. Formal participant consent was therefore not required for this secondary research project. This develops the ethical approach originally established in C1.

Nevertheless, secondary research has ethical responsibilities. Findings were represented accurately and sources acknowledged to avoid plagiarism or misrepresentation. Particular care was taken not to portray older adults as universally technologically incapable. Such assumptions risk reinforcing ageist stereotypes and obscure substantial differences in ability, experience and preference within older populations.

Ethical considerations also extend to equity. If research disproportionately includes people who are already digitally connected, the experiences of the most excluded individuals may remain underrepresented. This limitation was therefore considered when interpreting the evidence.

4. Results

4.1 Characteristics of included studies

Five peer-reviewed UK research studies were selected for detailed analysis.

Study	Design/population	Main findings	Relevance
Tuijt et al. (2021)	Qualitative interviews with 30 people living with dementia and 31 carers	Technological barriers, missed calls and reduced non-verbal interaction complicated remote care	Shows how cognitive impairment can increase remote-care difficulties
Hider et al. (2023)	Cross-sectional UK survey of 639 respondents with inflammatory rheumatic diseases	19.7% reported no internet-enabled device and 14.6% never accessed the internet	Quantitative evidence linking digital exclusion and remote healthcare
Shorthose et al. (2024)	Multicentre cross-sectional study; 255 participants	Complete exclusion was 5.1%; frailty increased exclusion when support was unavailable	Demonstrates importance of frailty and social support
Ahmed et al. (2024)	Four focus groups with 27 older South Asian, Black African and Caribbean adults	Digital skills, language, dependence on others, anxiety and preference for face-to-face care were important	Demonstrates intersection of age, ethnicity and language
Chadwick et al. (2024)	Qualitative interviews with 26	Limited skills, support, finances, poor usability and	Shows interaction between ageing and

	people; 24 aged ≥70	anxiety affected engagement	socioeconomic disadvantage
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4.2 Theme 1: Digital skills, confidence and technological access

The strongest theme across the evidence was that access to Telehealth requires a combination of material access and digital capability.

Hider *et al.* (2023) provide particularly useful quantitative evidence. Among 639 respondents, 126 (19.7%) reported having no access to an internet-enabled device and 93 (14.6%) reported never accessing the internet. People without an internet-enabled device were older than those with access. Importantly, even among internet users, digital literacy was only moderate, demonstrating that ownership of a device does not necessarily equal the ability to navigate digital healthcare successfully.

Chadwick *et al.* (2024) add qualitative depth to this finding. Participants described limited previous exposure to digital technology, lack of suitable devices or connectivity and difficulty obtaining appropriate assistance. Some older adults had retired before computers became routinely used in their workplaces. This suggests that present-day digital literacy can reflect opportunities accumulated throughout the life course rather than simply willingness to learn in later life.

The design of digital systems was another barrier. Participants described complicated interfaces, passwords, navigation difficulties and systems that did not adequately accommodate physical or cognitive limitations (Chadwick *et al.*, 2024). These findings challenge interpretations of digital exclusion that place responsibility entirely upon older individuals. A service may be technically available while remaining practically inaccessible because of its design.

International evidence supports this interpretation. Kruse *et al.* (2020) found technical literacy to be the most frequently identified Telehealth barrier in their systematic review of 57 studies. Wilson *et al.* (2021) similarly identified digital knowledge, confidence and usability as important influences on older adults' eHealth engagement.

4.3 Theme 2: Frailty, health status and dependence on support networks

The second theme concerns the interaction between digital access, frailty and social support.

Shorthose *et al.* (2024) found that complete digital exclusion from video consultations was relatively uncommon when assistance from a support network was considered. Of 255 participants, 5.1% experienced complete digital exclusion. However, 10.7% of participants living with frailty experienced complete exclusion compared with only one person among

those classified as not frail. Frailty was associated with individual digital exclusion where support from others was unavailable.

This finding is important because it demonstrates that digital access may partly depend upon social resources. An older person unable to operate a video platform independently may still access a consultation if a relative or carer is available. Conversely, an individual with similar health limitations but without such support may be excluded.

However, reliance on relatives should not automatically be interpreted as an adequate solution. It can reduce privacy and independence, particularly where sensitive health information is discussed. It can also transfer responsibility for healthcare access from services to unpaid relatives.

Tuijt *et al.* (2021) demonstrate additional problems for people living with dementia. Their qualitative study involving 30 people with dementia and 31 carers found that remote consultations could be reassuring and useful, but difficulties included remembering concerns without normal environmental and non-verbal prompts, managing new problems remotely, missed or rescheduled calls and ensuring that the person with dementia remained included in the conversation.

Digital exclusion therefore involves more than internet access. Cognitive impairment, sensory difficulties, manual dexterity, multimorbidity and frailty can determine whether a theoretically accessible service is realistically usable.

4.4 Theme 3: Inequalities, socioeconomic disadvantage and intersectionality

Digital exclusion frequently overlaps with existing social inequalities.

Chadwick *et al.* (2024) found that older people living in socially deprived areas could experience particularly significant barriers. Participants described financial insecurity affecting internet access, limited previous opportunities to develop digital skills and insufficient support. Older age and deprivation therefore appeared capable of producing cumulative disadvantage.

Ahmed *et al.* (2024) provide an additional intersectional perspective. Their focus groups with 27 older adults from South Asian, Black African and Caribbean backgrounds identified difficulties involving digital literacy and language, alongside dependence on younger family members or community organisations. Participants also emphasised that digital health services should not operate according to a one-size-fits-all model.

This is significant for UK practice because categorising people only by age may conceal the mechanisms through which exclusion occurs. An older adult who is affluent, digitally experienced and supported by family may experience Telehealth very differently from an older adult affected by poverty, limited English proficiency, disability and social isolation.

The evidence therefore suggests that digital exclusion can amplify pre-existing inequality. This interpretation is consistent with NHS England's (2023) framework, which recognises

that groups at increased risk of digital exclusion frequently overlap with populations already experiencing health inequalities.

4.5 Theme 4: Preference, trust and the importance of human contact

The final theme concerns the assumption that lack of digital engagement always reflects lack of skill. Some older adults actively prefer non-digital healthcare.

Ahmed *et al.* (2024) found a strong preference for face-to-face appointments among participants, who emphasised physical interaction and connection with healthcare professionals. Digitalisation was also associated with stress, fear and anxiety when participants felt that new systems had been imposed without sufficient explanation.

Similarly, Chadwick *et al.* (2024) found that some participants regarded digital healthcare as impersonal and felt that technology threatened to replace traditional healthcare relationships. Participants also reported anxiety about making mistakes and distrust towards some digital systems.

These findings show that digital exclusion includes motivational and relational dimensions. An older adult may possess a device but avoid digital healthcare because they lack trust or believe that it provides inferior communication.

This distinction is important for person-centred care. Refusing digital healthcare should not automatically be interpreted as a deficit requiring correction. Maintaining meaningful choice is therefore central to equitable Telehealth delivery.

5. Discussion

This scoping review asked how digital exclusion affects access to Telehealth services among older adults in the UK. The evidence indicates that digital exclusion can reduce access by creating barriers at several interconnected levels: access to equipment and connectivity; skills and confidence; physical and cognitive capability; socioeconomic resources; social support; language; trust; and service design.

A major finding is that chronological age alone provides an incomplete explanation. Shorthose *et al.* (2024) demonstrate that frailty and support networks can be more informative when examining access to video consultations. Chadwick *et al.* (2024) similarly demonstrate that digital engagement is shaped by previous technological exposure, financial circumstances, health, confidence and social support.

This has implications for health and social care assessment. Asking whether a patient “has internet access” is insufficient. Services need to determine whether the patient has an appropriate device, connectivity, confidence, accessibility support and the ability to use the relevant platform independently. Assessment should also consider whether relying on relatives is acceptable to the patient.

The findings also suggest a relationship between digital exclusion and healthcare experience. Hider *et al.* (2023) found that limited digital or health literacy and lack of internet access were associated with lower confidence and satisfaction with remote consultations. Therefore, inequalities may persist even among patients who technically manage to access remote healthcare.

However, the evidence does not support rejecting Telehealth for older people. Telemedicine can improve convenience and reduce geographical barriers, and systematic-review evidence has demonstrated potential benefits for older populations (Şahin, Yavuz Veizi and Naharci, 2021). The issue is whether digital routes complement or replace accessible alternatives.

A hybrid model appears most consistent with the evidence. NHS England (2023) explicitly states that digital approaches should complement non-digital services and support. Ahmed *et al.* (2024) likewise found that participants favoured retaining offline alternatives. Maintaining telephone and face-to-face routes is therefore not resistance to innovation; it is an equity measure for people unable or unwilling to use particular digital channels.

Digital-skills interventions also require consideration. Providing training may improve confidence, but the findings suggest that training alone cannot eliminate exclusion. A person may be digitally literate yet unable to afford reliable internet access. Another may have adequate connectivity but experience cognitive or sensory impairment. Another may simply prefer face-to-face communication. Effective intervention therefore requires multiple approaches.

Community-based support represents one promising approach. NHS England (2023) recommends collaboration with voluntary, community and social enterprise organisations, libraries and community hubs to support digital participation. Evidence from community-based digital inclusion programmes suggests that trusted local support can help disadvantaged groups overcome barriers involving skills, confidence and access (French *et al.*, 2025). Recent rapid-review evidence similarly indicates that interventions for older adults need to account for the context in which support is delivered rather than assuming that providing technology alone will resolve exclusion (Wale *et al.*, 2025).

There are also important ethical concerns surrounding proxy access. Shorthose *et al.* (2024) demonstrate that support networks can substantially reduce exclusion. However, depending upon family members can create inequalities between older people with and without available relatives. It may also compromise confidentiality or autonomy. Services should therefore provide formal assistance rather than assume that families will act as unpaid digital intermediaries.

The review additionally highlights intersectionality. Ahmed *et al.* (2024) demonstrate that older adults from minoritised ethnic backgrounds may experience digital barriers alongside language and existing healthcare inequalities. Chadwick *et al.* (2024) demonstrate the interaction between older age and deprivation. Digital exclusion should therefore be understood as a potential mechanism through which wider social disadvantage is translated into unequal healthcare access.

This interpretation is consistent with the Health and Care Act 2022, under which NHS bodies have responsibilities concerning inequalities in access and outcomes. It also supports NHS

England's (2023) recommendation that digital inclusion should be embedded into service design rather than treated as an optional additional programme.

Strengths and limitations

An important strength of this review is the inclusion of both quantitative and qualitative evidence. Hider *et al.* (2023) and Shorthose *et al.* (2024) provide measurable evidence of digital exclusion, while Ahmed *et al.* (2024), Chadwick *et al.* (2024) and Tuijt *et al.* (2021) provide detailed explanations of how barriers are experienced.

However, several limitations should be recognised. First, the evidence base remains relatively small and heterogeneous. Telehealth encompasses different technologies, making direct comparison difficult. Telephone consultation, video consultation, patient portals and remote monitoring place different demands upon patients.

Second, some included studies concern specific clinical populations such as inflammatory rheumatic disease, chronic kidney disease or dementia. Their findings cannot automatically be generalised to every older adult.

Third, digitally excluded people are intrinsically difficult to recruit into digital-health research. Studies using electronic recruitment or online participation may systematically underrepresent those experiencing the greatest exclusion. This creates the paradox that people experiencing the most severe digital exclusion may be among those least visible within research concerning digital exclusion.

Fourth, much recent research was shaped by the COVID-19 pandemic. Emergency implementation of remote healthcare may not represent how carefully designed Telehealth operates under normal circumstances. Nevertheless, the pandemic exposed inequalities that remain relevant as digital healthcare becomes embedded in routine practice.

Finally, the UK evidence base remains limited regarding whether digital exclusion directly causes poorer long-term clinical outcomes. Existing research provides stronger evidence concerning access, confidence, experience and engagement than downstream outcomes such as morbidity, hospitalisation or mortality. This represents an important area for future research.

6. Conclusion

This scoping review concludes that digital exclusion can significantly influence older adults' ability to access and benefit from Telehealth in the UK. The evidence demonstrates that exclusion is multidimensional and cannot be explained simply by chronological age or internet ownership.

Digital skills and confidence are important, but so are device and connectivity access, affordability, frailty, cognitive and physical capability, socioeconomic circumstances, language, trust, service design and social support. These factors frequently interact.

Consequently, the older adults most likely to require healthcare may also face some of the greatest barriers to accessing increasingly digital services.

The evidence also demonstrates that Telehealth itself is not inherently inequitable. When accessible and appropriately supported, it can offer convenience and improve access. Inequality arises when digital routes become the default without adequate consideration of people who cannot use them.

A digitally transformed NHS should therefore pursue digital inclusion rather than digital substitution. Digital healthcare should expand the routes through which people obtain care rather than remove established routes required by excluded groups.

7. Recommendations

First, NHS organisations should maintain **hybrid access**, including appropriate telephone and face-to-face options alongside digital services. Patients should not experience poorer access because they cannot use an application or online portal.

Second, digital inclusion should be incorporated into **routine assessment**. Healthcare professionals should consider device ownership, connectivity, digital literacy, accessibility needs, language, confidence and preferred communication method rather than using age alone as a proxy for digital capability.

Third, services should provide **practical digital support**. This could include digital-health champions, one-to-one assistance, community-based training and partnerships with libraries and voluntary organisations. Support should be ongoing rather than limited to a single training session.

Fourth, Telehealth systems should be **co-designed with diverse older adults**, including people living with frailty, disability, socioeconomic disadvantage, cognitive impairment and limited English proficiency. Accessibility should be considered during development rather than retrospectively.

Fifth, support networks should be considered when arranging video consultations, but family assistance should not become an expectation. Patients without relatives must have equitable access to formal support, while confidentiality and consent should be protected where proxy assistance is used.

Finally, further UK research should investigate the relationship between digital exclusion and **long-term healthcare outcomes**, rather than concentrating primarily on technology adoption. Longitudinal research is needed to determine whether digital exclusion contributes to delayed diagnosis, missed treatment, avoidable hospitalisation or poorer management of chronic illness. Future studies should also deliberately recruit people who are completely offline so that those experiencing the greatest exclusion are represented.

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