Digital Inclusion Programme
Final Evaluation Report

June 2025

CONTENTS

Executive summary

Context

Digital inclusion is increasingly recognised as critical to achieving equitable, person-centred health and social care.

Launched in March 2023, the Digital Inclusion Programme (DIP) was developed by the Scottish Government's Digital Health and Care Division and delivered in partnership with SCVO. Designed using the Scottish Approach to Service Design, the Programme built on learning from Connecting Scotland, Digital Lifelines, and digital inclusion work in care homes. It responded to persistent digital exclusion in Scotland, particularly among people using mental health and housing services, and aimed to develop sustainable, person-centred models of digital inclusion across health, care, housing, and community settings.

At the heart of the Programme was a framework based on five digital inclusion pillars: motivation, access to devices, connectivity, skills and confidence, and inclusive service design. These guided both the delivery and evaluation of the Programme.

The Programme brought together five core components:

- knowledge sharing and learning – a Community of Learning and wider stakeholder engagement supported peer exchange and continuous improvement;

- building digital inclusion capability – workforce development, including co-designed Digital Champions training and learning pathways via TURAS and the SSSC Learning Zone;

- designing digital inclusion – co-design of inclusive digital models, tailored to local needs and offering both digital and non-digital options;

- understanding the experience of digital inclusion – stakeholder and lived experience engagement, which helped shape practical tools and service approaches; and

- benefits realisation and evaluation – embedded evaluation, including baseline/follow-up data, costed case studies, and learning synthesis across the programme.

Three interlinked funding strands were designed to test, adapt, and embed digital inclusion practice. Digital Pioneers tested early models in mental health and housing contexts, the Progress Fund deepened and began embedding approaches and Connecting to Care focused on place-based integration with local systems in health and care.

The evaluation adopted a mixed-methods approach to understand the difference this made for individuals, services, and systems, and to capture transferable learning for future policy and practice.

Key findings

The Programme benefitted more than 3,600 people across Scotland, distributed more than 950 devices and over 650 connectivity packages to address digital exclusion. The funded work

demonstrated how tailored, community-based digital support can transform experiences of health and care, improve outcomes for individuals, change service delivery models and influence workforce and culture, while also exposing persistent barriers and system limitations.

Impact on Individuals

Participants reported significant improvements in digital skills, confidence, and wellbeing. Many started from a place of little or no experience with digital tools, and often had complex health, housing or support needs. With sustained, relationship-based support:

- individuals developed confidence using emails, video calling, managing Universal Credit accounts and mobile apps to access housing or employment opportunities;

- many reported reduced social isolation and improved mental wellbeing and self-esteem from being able to reconnect with family or access online support groups; and

- health engagement improved, including reduced missed appointments, accessing online health portals and enhanced capacity to self-manage long-term conditions.

The most effective support was trauma-informed and person-led, delivered by trusted workers who understood the emotional, cognitive, and practical barriers people faced.

The programme provided evidence that digital inclusion improves care access, experience and outcomes. For example:

- projects showed that when digital access was introduced as part of existing care relationships, individuals were more likely to engage with preventative services and self-care;

- digital tools helped improve continuity of care—such as in video consultations, self-referrals, or communication with care and support services; and

- participants described being able to "do more for themselves" and "feel more in control".

In several cases, digital inclusion had a preventative effect helping individuals to avoid crisis or manage independently at home for longer.

Impact on policy and practice

The programme led to demonstrable change in how services understood and responded to digital exclusion:

- organisational cultures shifted, frontline staff became more aware of digital needs, managers began embedding digital inclusion into service planning, and digital confidence became part of standard conversations;

- the Digital Champions model emerged as a particularly effective vehicle for sustainable support – trusted staff embedded in everyday teams helped create a culture of shared responsibility for digital inclusion; and

- several projects influenced local strategies, improved cross-sector collaboration, or initiated joint working with HSCPs, GPs, libraries, or housing services to sustain impact beyond the short-term project period.

The costed case studies revealed strong potential for economic benefits when digital inclusion is embedded in care delivery. The examples demonstrated how even small-scale investments can yield system-wide efficiencies, particularly when aligned with preventative health and social care goals. It highlighted that future projects would benefit from building cost tracking into design from the outset.

Challenges to digital inclusion

Despite positive outcomes, several structural and systemic barriers limited progress.

Engagement with health and social care partners was variable. While some services integrated digital inclusion into care planning or staff development, others saw limited buy-in due to risk concerns, time pressures, or lack of digital capability.

Short-term funding disrupted continuity. Projects struggled to maintain momentum when staff contracts were tied to fixed-term funding, and many were unable to embed learning or build long-term pathways for support.

Those accessing the services often faced persistent individual barriers including, language, literacy, mental health, trauma, unstable home lives and fear of failure. Participants often required long-term, relational support, tailored to their needs to overcome these challenges.

Affordability was another key factor with individuals lacking ongoing access to data, device charging, or replacement equipment and services being limited regarding the additional resources that they could provide.

Success factors

Success was evident when the following were in place:

- relational support from trusted staff, often those already providing care, housing or community-based services;

- flexible, adaptive delivery, focused on what mattered to the individual;

- integration into everyday practice, with digital needs identified during assessments and embedded in care planning;

- investment in Digital Champions, supported by training, reflection, and organisational buy-in;

- co-design and peer learning, both internally (with service users and colleagues) and externally (other organisations) to create relevant and appropriate services and support; and

- strategic alignment, where projects linked to existing local health and social care priorities, infrastructure or digital plans.

These practices created the conditions for sustainable change, reinforcing digital inclusion as a means of delivering better support and care.

Summary and recommendations

The Programme has shown that digital inclusion is a practical and necessary enabler of person-centred, preventative and equitable health and social care. Projects demonstrated that when digital support is embedded within trusted relationships and tailored to individual needs, it leads to improved confidence, increased access to services, and enhanced wellbeing. It also brings wider benefits to services, enabling more proactive, connected, and sustainable models of care. However, these benefits are not guaranteed. Without long-term planning, investment and service integration, progress is at risk of being lost.

Practice level recommendations

Digital inclusion should become a core feature of how services engage with individuals. This starts with recognising digital needs as part of holistic care planning, and normalising conversations about digital access, confidence, and motivation. Frontline staff need the time and support to have these conversations, with clear pathways for action.

Successful delivery models integrated Digital Champions into everyday teams, providing approachable, informed support for both staff and service users. Where Champions were trusted and visible, digital inclusion became a shared responsibility and part of the service culture. The Digital champions training should be rolled out across services, enhanced with training that goes beyond technical skills and incorporates trauma-informed approaches and sector-specific knowledge.

Practical tools developed through the Programme, including the Practice Guide, the Digital Inclusion Toolkit offer accessible ways to plan, deliver and review support; these tools should be promoted and used.

Case studies from the Programme provided early evidence of cost savings linked to digital inclusion through reduced service demand, increased independence, and improved self-management. However, economic benefits are not routinely captured. Future projects should integrate economic monitoring into their design to help build a stronger economic case for long-term investment.

Policy level recommendations

To ensure that digital inclusion is delivered consistently and sustainably, it needs to be embedded in the policy frameworks, standards, and funding mechanisms that shape health and care. This includes integrating digital inclusion into local strategic plans, commissioning processes, and performance frameworks. Services should be supported and expected to demonstrate how they are identifying and addressing digital exclusion.

The Programme highlighted how short-term funding remains a significant barrier to progress. Projects that demonstrated real impact still struggled to secure continuation funding, limiting their ability to retain staff, share learning or embed change. Policy should shift away from short-term pilots and towards multi-year investment in digital infrastructure, workforce capacity and partnership working.

There is also a need to address structural gaps in provision and support individuals facing multiple disadvantages who remain underserved. National policy should give greater visibility and targeted support to these groups.

Actions over the short to medium term should focus on building awareness and using the available digital inclusion tools, building capacity to embed digital inclusion into everyday practice and then, over the long term, actions should focus on system wide integration and sustainability.

1.   Introduction

1.1   In May 2024, SCVO commissioned Blake Stevenson Ltd to evaluate the Digital Inclusion Programme. The evaluation aimed to explore the Programme's effectiveness in enhancing digital inclusion among individuals accessing mental health and housing services, and to produce recommendations for embedding sustainable digital inclusion practices across these sectors. It also aimed to capture transferable learning that can inform wider digital health and care policy, including the development of national frameworks for evaluating digital inclusion.

1.2   The evaluation was structured around the following core objectives:

- to assess the impact of the Programme on individuals, including changes in digital access, digital skills, confidence, engagement with digital health and care services, and broader wellbeing outcomes;

- to evaluate the Programme's contribution to service development and systems change, particularly in how digital inclusion is embedded within housing, mental health, and wider health and social care settings;

- to identify economic outcomes and potential cost benefits, including the impact on demand for health and care services as a result of increased digital engagement;

- to generate practical learning and evidence that can inform sustainable models of digital inclusion and support the future development of policy and practice in this area; and

- to contribute to the development of a shared, cross-sector understanding of digital inclusion, including the conditions and enablers that support or hinder progress.

1.3   This report presents the evaluation findings and includes a range of recommendations which are proposed to inform both policy and practice. These are designed to support the meaningful integration of digital inclusion within health, social care, housing and mental health services and build on this learning so that digital inclusion can become a core element of service provision across Scotland.

Structure of the report

1.4   The remainder of this report is structured as follows:

- Chapter 2: Context and methodology;

- Chapter 3: Key findings;

- Chapter 4: Challenges and successes to embedding digital inclusion; and

- Chapter 5: Summary and recommendations.

2.   Context and methodology

Background and strategic context to the Digital Inclusion Programme

2.1   The Digital Inclusion Programme (DIP) was developed in response to the growing recognition, across policy and practice, that digital inclusion is fundamental to achieving equitable, person–centred care. It aligns with the Digital Health and Care Strategy, Mental Health and Wellbeing Strategy, and Housing to 2040, as well as more recent frameworks, including the Scotland's Population Health Framework and Health and Social Care Service Renewal Framework, all of which highlight digital inclusion as a social justice imperative underpinning service sustainability.

2.2   Audit Scotland's report on Digital Exclusion played a key role in shaping the Programme, noting both the strong digital inclusion response during the pandemic and the subsequent risk of losing momentum. It also praised good practice within digital health and care, where services are increasingly embedding inclusion in a meaningful way.

2.3   The Programme was further informed by the Digital Scotland Service Standard, particularly Criterion 5, which emphasises designing services that everyone can use. This guided efforts to embed a digital inclusion lens into service design and delivery, focusing on access, skills, confidence, and support, rather than assuming that non–digital alternatives are sufficient.

2.4   The DIP complements the Scottish Government's Connecting Scotland initiative and associated work to develop a national framework for evaluating digital inclusion. It contributes to the shared national ambition of creating sustainable and equitable digital service models across sectors. A central tenet of the Programme is the recognition that digital inclusion is a collective responsibility. This reflects the principle that digital access should not be left to chance or individual capacity—it must be actively supported by organisations and systems. In practice, this means embedding digital inclusion in person–centred care, equipping staff and services with the resources and training they need, and ensuring that infrastructure and policy environments promote equitable digital participation.

Digital Inclusion Programme

2.5   Formally launched in March 2023, the Digital Inclusion Programme (DIP) was developed by the Scottish Government's Digital Health and Care Division and is delivered in partnership with the Scottish Council for Voluntary Organisations (SCVO). Designed using the Scottish Approach to Service Design, the programme built on extensive stakeholder engagement and learning from previous initiatives such as Digital Lifelines, designed to improve health outcomes for people who use drugs, and digital support in Care Homes.

2.6   The programme was established in response to persistent digital exclusion across Scotland, with a particular focus on people accessing mental health services and people using housing services, particularly those at greatest risk of health and social inequalities. It

aimed to build a shared understanding of what effective, person-centred digital inclusion looks like across health, care, housing, and community settings, while contributing to the design and delivery of sustainable models for future service delivery.

2.7   The initial paper ([From Pillars to Practice: Developing a framework for embedding digital inclusion in health and social care](#)) set out the model for how digital inclusion was understood in the programme across five different pillars: motivation, device, connectivity, skills/confidence and inclusive design.

2.8   The programme itself was structured around several key components:

Knowledge sharing and learning:

2.9   A central feature of the Programme has been the creation of a Community of Learning, a regular space for funded partners to reflect, share insights, and strengthen their practice. This has been complemented by stakeholder engagement events, lived experience engagement sessions, and collated learning across the programme to support wider dissemination. The Programme also contributed to national learning by publishing resources, case studies, and practice guidance.

Building digital inclusion capability:

2.10   Recognising that the workforce plays a critical role in supporting digital inclusion, the Programme invested in developing the skills, confidence, and capacity of practitioners across sectors. This included co-designing tailored Digital Champions training for staff in housing and mental health contexts in partnership with Mhor Collective and embedding learning pathways in NHS Education Scotland's (NES) TURAS platform and the Scottish Social Services Council (SSSC) Learning Zone. The programme aimed to supported both staff confidence and organisational readiness to embed digital inclusion in service delivery.

Designing digital inclusion:

2.11   Using a co-design approach, the Programme supported the development and testing of inclusive digital support models tailored to the needs of people accessing mental health and housing services. The focus was on designing digital services that are accessible, equitable, and person-centred, providing non-digital alternatives and enabling people to confidently choose digital options when these offer better outcomes. Motivation and trust were recognised as crucial enablers of digital engagement.

Understanding the experience of digital inclusion:

2.12   The programme undertook extensive stakeholder engagement and direct engagement with people with lived experience of digital exclusion, including those accessing mental health services and social housing. Insights were gathered through dedicated engagement sessions across the duration of the programme. These activities informed the development of the 'Pillars' Framework, which identifies five pillars: motivation, access, skills and confidence, inclusive services, and system enablers and has shaped both delivery and

evaluation. The Programme also shared progress with the Digital Citizen Panel (facilitated by the Alliance), helping to ensure that national developments reflect real-world needs and priorities.
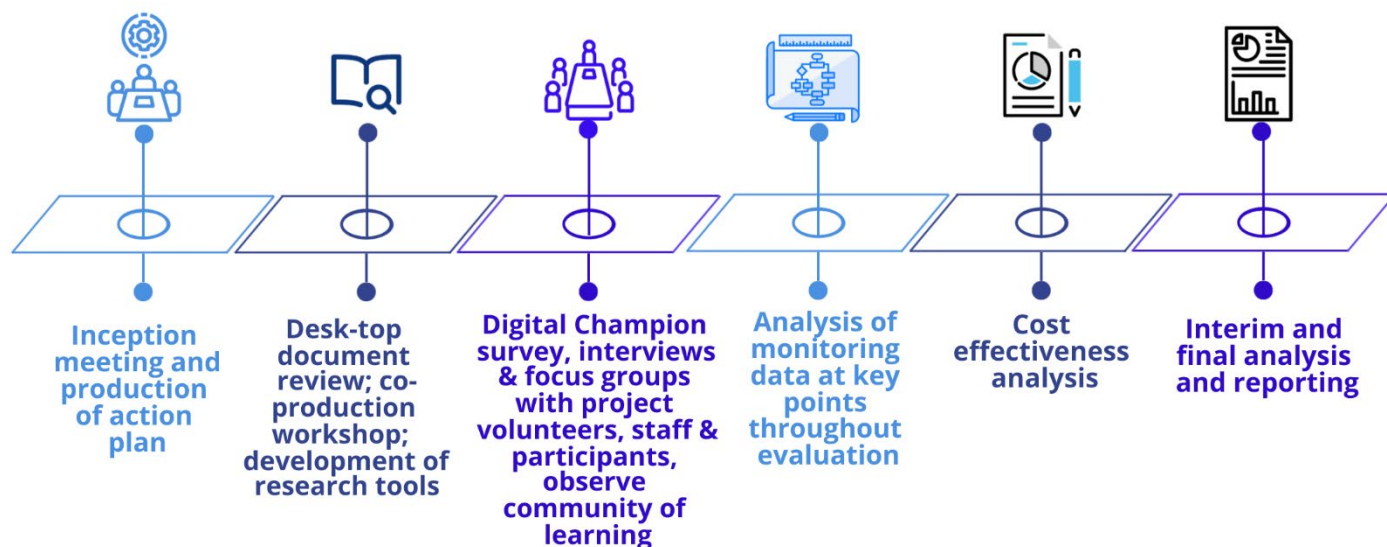
Benefits realisation and evaluation:

2.13   Evaluation was embedded from the start to build an evidence base on the individual, workforce, and system-level benefits of digital inclusion. Funded projects gathered both quantitative and qualitative data, including baseline and follow-up surveys to assess impact on digital skills, confidence, wellbeing, and service access. The independent evaluation was commissioned to bring together learning across the programme, including the development of costed case studies to evidence the economic and service-level value of embedding digital inclusion in health and care.

2.14   The Programme also included three interlinked funding strands, whose design and delivery were guided by the Pillars framework:

- Digital Pioneers: early-stage projects focused on developing models of digital inclusion in mental health and housing settings. Thirteen projects were funded.

- Progress Fund: additional funding for selected Pioneer projects to strengthen partnerships and begin embedding successful models into services. Twelve projects were funded that covered a broad spectrum from community-based digital skills development and mental health recovery support to research-led approaches exploring structural barriers to access.

- Connecting to Care: this funding supported integration of digital inclusion into health, care, and housing systems, particularly through place-based and cross-sector collaboration. Seven projects were funded in this third strand.

2.15   These funding strands were intentionally phased to allow the programme to test, adapt, and embed digital inclusion practice. Learning from each stage informed the next, helping the programme evolve in response to real-world insights and stakeholder feedback.

2.16   More details about the individual projects and the funding they received can be found in Appendix 1.

Evaluation approach

2.17   A mixed-methods approach was used to create a comprehensive understanding of the Programme's implementation and impact. Several data collection methods captured evidence across different activities and stakeholder perspectives. These methods were selected to provide both breadth and depth, combining high-level monitoring insights with qualitative accounts of experience and change, and importantly. to complement rather than duplicate SCVO's comprehensive monitoring and engagement activities. Figure 1 summarises the methodology. Further detail of the key elements is provided in the rest of the section.

Figure 1: Summary of the methodology

| Inception meeting and production of action plan | Desk-top document review; co-production workshop; development of research tools | Digital Champion survey, interviews & focus groups with project volunteers, staff & participants, observe community of learning | Analysis of monitoring data at key points throughout evaluation | Cost effectiveness analysis | Interim and final analysis and reporting |

Monitoring calls and evaluation discussions

2.18   Monitoring calls and evaluation discussions were held with Progress Fund and Connecting to Care funded projects. These discussions captured information about project aims, target groups, delivery models, emerging challenges, and perceived outcomes. They also provided opportunities for reflection and the documentation of learning. Due to the timing of the evaluation the initial funds were looked at retrospectively using monitoring data.

Survey of Digital Champions

2.19   The digital champions training was part of the Building Capability theme of the programme and an online survey of Digital Champions was conducted to capture respondents' motivations, training experiences, confidence levels, perceived impact, and the extent to which digital inclusion had become embedded in their day-to-day practice. Respondents represented a range of roles—including Digital Inclusion Leads, peer facilitators, and support practitioners—and provided insight into the wider capacity-building goals of the Programme. The survey was conducted using Snap Surveys with the link distributed by SCVO. The survey was live for eight weeks and 37 Champions responded from a potential 112, which represented a 33% response rate.

Interviews with project staff, service partners and beneficiaries

2.20   A series of interviews and focus groups were conducted, with beneficiaries including individuals supported through Connecting to Care and Digital Pioneers projects and service partners. This included 11 project staff and volunteers, 21 beneficiaries, and four local stakeholders/referrers from across six projects. These discussions were complemented by the development of in-depth case studies, which brought together perspectives from staff,

partners, and service users. This qualitative fieldwork offered a nuanced understanding of the Programme's impact on digital skills, access to services, confidence, independence, and wellbeing.

Costed case study examples

2.21   As part of the evaluation, a small number of costed case studies were developed to explore the potential financial and service-related benefits of digital inclusion for individuals accessing health and care support. The aim was to go beyond individual stories of impact and begin to build an evidence base that could demonstrate the value of digital inclusion in economic terms—particularly for health and social care providers and commissioners.

Participation in the Community of Learning events

2.22   Members of the evaluation team attended six Community of Learning events to experience the sessions, provide opportunities to meet with the projects and observe peer learning, and how the Programme was shaping shared understanding across sectors.

Analysis and reporting

2.23   As part of the programme design, structured data collection was embedded within delivery to enable meaningful assessment of change at both individual and organisational levels. SCVO, as the delivery partner, led on the development and administration of these data collection processes, ensuring consistency and comparability across projects.

2.24   Each participating organisation was asked to collect baseline and follow-up feedback from individuals they supported using a standardised impact survey. These surveys gathered information on people's digital skills, confidence, access to services, and broader wellbeing. Data was collected at multiple time points throughout the life of the programme, providing an evidence base for assessing change over time. These data were also reviewed as part of our analysis.

2.25   The qualitative data gathered from the discussions with projects and beneficiaries, the Digital Champions survey and the secondary data collected by SCVO through the monitoring reports and impact surveys were analysed in line with the key evaluation aims. This involved a process of coding responses to identify key and recurring themes as well as any differences in viewpoints and experiences across projects.

2.26   An internal team meeting to discuss the key emerging themes was held before producing the report outline. The outline was shared with SCVO and the Scottish Government for comment before the draft report was produced. The results of the analysis are presented in this report.

Challenges and limitations of the approach

2.27   The evaluation was designed to be flexible and responsive to the evolving nature of the programme, and to complement SCVO's own comprehensive monitoring activities. The

phased structure of the programme—starting with the 12-month Digital Pioneers Fund, followed by the 6-month Progress Fund for continuation projects, and concluding with the 12-month Connecting to Care programme—was a deliberate service design choice. This sequential funding model enabled learning to be captured and built upon across each stage. However, the timing of the evaluation, which was commissioned part-way through the initial Pioneers phase, presented some challenges.

2.28   By the time the evaluation team was able to engage with projects, many were already delivering Progress Fund activities. As a result, reflections on the Pioneers phase were limited, with conversations more focused on current delivery. In addition, not all Pioneers projects received continuation funding, and maintaining engagement with these projects beyond the end of their funding period proved difficult. While the evaluation schedule accounted for the staggered nature of the programme, project teams were often in periods of intense delivery or closure when key opportunities for learning and reflection needed to be captured.

2.29   While the costed case studies provided valuable indicative insights, there were several challenges to the approach. For many case studies, it was difficult to attribute observed changes solely to digital inclusion, as individuals were typically receiving multiple forms of support. Projects also had limited access to detailed service use data, which limited the ability to estimate cost savings robustly. The diversity of individual journeys made generalisation difficult, and many potential benefits—such as increased independence or reduced reliance on services—are likely to emerge only in the longer term, beyond the evaluation period.

2.30   Despite these challenges, the evaluation has yielded strong evidence of digital inclusion' impact on individuals and organisations, along with valuable learning to inform future practice and investment.
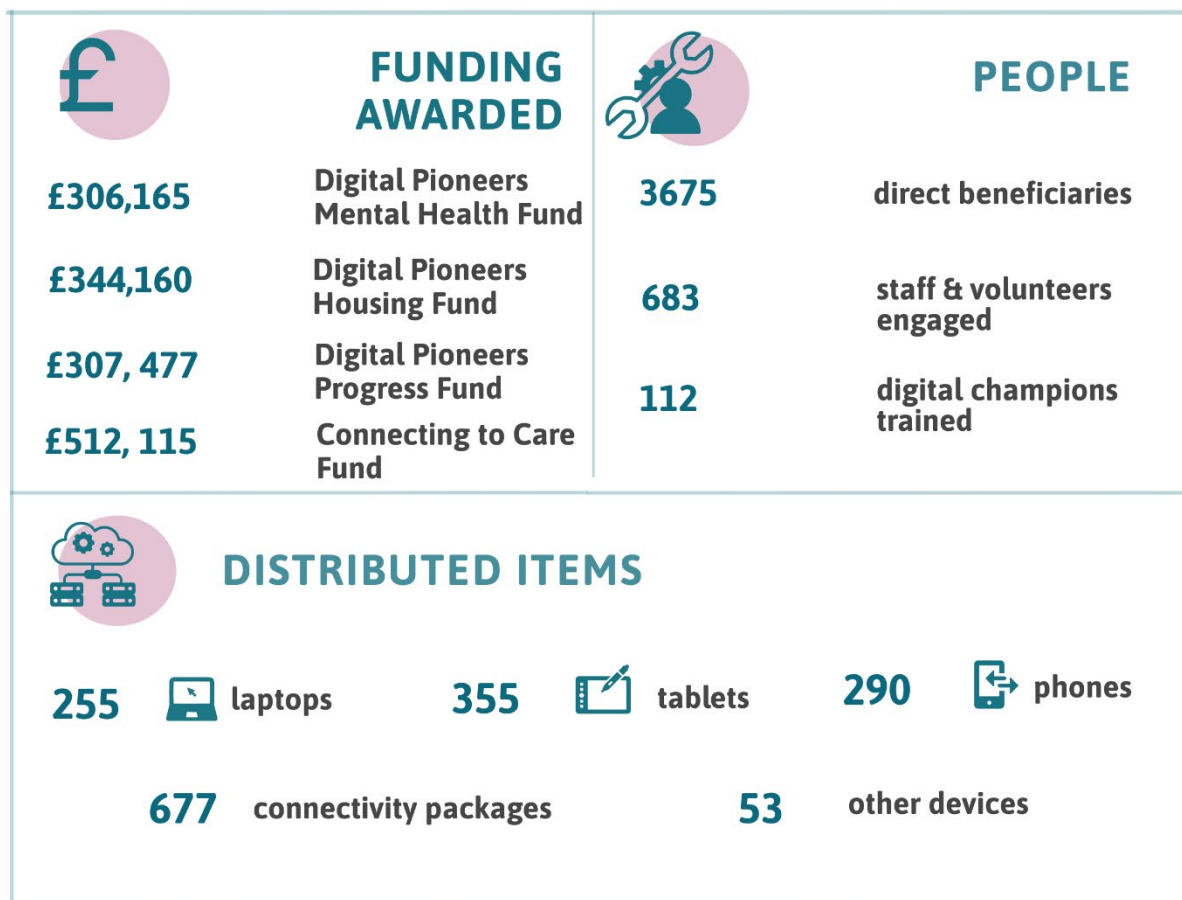
3.   Key findings

3.1   Understanding the difference this programme has made to individuals was a core objective from the outset. SCVO reported on the impact monitoring and so this chapter, includes a summary of that dataset, provided and analysed by SCVO, and complements this with additional qualitative evidence gathered from project reporting, Community of Learning sessions, and engagement with project staff and participants. Together, this evidence builds a rich picture of the impact of digital inclusion support for people accessing health and care services and the organisations delivering them.

Programme reach

3.2   Across the three funding strands, the Digital Inclusion Programme awarded a total of £1,469,917, enabling significant reach and impact across Scotland. In total, 3,675 individuals directly benefited from support, alongside 683 staff and volunteers who were also engaged through training and delivery activities.

3.3   The programme invested in building local capacity by training 112 Digital Champions, equipping them to support others and embed digital inclusion within services. To tackle digital exclusion, projects distributed 255 laptops, 355 tablets, 290 mobile phones, 677 connectivity packages, and 53 other devices.

Figure 2: Summary of Programme reach

FUNDING AWARDED

£306,165   Digital Pioneers Mental Health Fund

£344,160   Digital Pioneers Housing Fund

£307, 477   Digital Pioneers Progress Fund

£512, 115   Connecting to Care Fund

PEOPLE

3675   direct beneficiaries

683   staff & volunteers engaged

112   digital champions trained

DISTRIBUTED ITEMS

255   laptops   355   tablets   290   phones

677   connectivity packages   53   other devices

Impact on Individuals

3.4   From the data collected by the projects across the Digital Inclusion Programme and the evaluation fieldwork, a wide range of participants reported improved digital skills, increased confidence, and better access to health and social care services.

Enhanced digital skills and confidence

3.5   Participants often began with little or no digital literacy. Through patient, well-paced support, they developed essential skills like using email, video calling, online forms, or digital health portals:

- one project noted, "Some individuals who previously had no access to digital are now using WhatsApp and Zoom to stay connected with family or attending medical appointments via Near Me." These new skills not only improved digital literacy but also built self-confidence and independence;

- CENTRED reported that people in supported accommodation who had never previously used the internet were now completing housing and benefit applications independently.; and

- Lead Scotland reflected that their trauma-informed approach helped learners overcome anxiety and fear about technology, especially among people with long-term health conditions and disabilities.

3.6   Participants frequently linked their digital confidence to a broader sense of control over their lives. In one rural project, a participant noted, "I can now look after my own prescriptions, emails, and money online. I don't need someone else to do that for me anymore." Another project noted that the ability to send a birthday card or photo to family members gave people back "a sense of normal life". These small changes enabled by the increased digital confidence, could have a significant impact on participants' everyday lives.

> **Marina**
>
> Marina came into contact with Link Living after experiencing a heart attack in the summer of 2024, which left her feeling depressed and isolated. Her clinical psychologist recommended the service to build confidence and regain some independence while waiting for mental health support. Due to long waiting times for traditional services, she was offered one-to-one digital inclusion support through the Linked-Up project.
>
> Marina had some basic skills using a mobile phone but wanted to improve her ability to manage key tasks online—especially accessing her GP, managing prescriptions, and shopping independently. Over six weekly sessions, she worked with the same Peer Coach, to build confidence and learn how to use essential online services at her own pace.
>
> *"The person I saw was the right person for the job, I felt at ease with him I didn't feel silly, I felt very relaxed".*

Marina was guided through setting up and using apps for her GP surgery and for online shopping with Tesco. She described the experience as "person-led"—driven by her own goals and priorities. Having the same person throughout the sessions helped her feel more comfortable, and she said the relationship felt more like a friendship by the end of the programme.

Now, Marina regularly uses online services she once avoided. She orders prescriptions monthly and shops online weekly, tasks that have become increasingly difficult to manage over the phone. She credits the project not only with building her skills but also with reducing her anxiety about technology.

Reflecting on her experience, Marina appreciated that it was tailored, unrushed, and focused on what mattered to her. While she had never received support like this before, she said it came at exactly the right time in her life—and she's now open to trying other digital tools to help support her health and wellbeing in the future.

3.7   The data from the impact surveys support this qualitative research. Project participants reported improvements in digital skill areas, especially in:

- connecting online (e.g., emailing, messaging or using video calls) with average score increases of 28.2%;

- finding information online (e.g., searching for reliable content), again with a sizeable average score increase of 28.4% in their confidence level to do this; and

- managing money online, accessing services, and using the internet for learning or entertainment all saw improvements, highlighting the breadth of digital tasks participants became more confident in.

Improved health and wellbeing outcomes

3.8   Projects reported benefits in mental wellbeing, linked to reduced isolation and improved access to health and social care. With new digital skills and confidence, beneficiaries could engage with and access more services.

- the ALLIANCE's Digital Links project embedded Community Link Workers within GP surgeries. They provided tailored digital support that enabled people to book appointments online, access prescriptions, and connect to local services. As one participant shared: "They didn't just give me a device—they helped me understand how to use it in a way that mattered to me";

- the Simon Community noted that enabling access to digital mental health support reduced emergency presentations and supported earlier intervention;

- AdvoCard highlighted the impact of digital advocacy in supporting people with mental health challenges to exercise choice and feel heard.

- the Ayrshire Community Trust (TACT) Health and Mind's project in psychiatric settings enabled inpatients to use digital tools for the first time in their care journey, supporting both practical needs and connections to friends and family; and

- CENTRED also highlighted the importance of improved connectivity in tackling isolation. This project supported individuals in Highland communities who faced compounded digital exclusion due to geography and poverty. They reported that the work of the project had improved access to health services and enabled social contact: "For many it was their only link to the outside world during difficult periods."

3.9 For participants accessing the projects, data from the impact surveys captured broader social connectedness outcomes which showed a rise in average scores of 4.4% of feeling connected to others.

3.10 Digital inclusion also reduced the barriers to participation in other forms of support—housing advice, employability, and community activity. There were multiple examples of participants now being able to manage Universal Credit accounts and DWP journals, use online banking, shopping and public transport apps. One project said, "It's not just the tablet—it's the confidence to be in the world again".

3.11 Multiple projects emphasised that these improvements were not just about accessing digital services/resources—they were about dignity, self-worth, and control. As one organisation shared: "We supported a woman who had not left her house for months. Being able to learn how to use an iPad and access a virtual peer group changed everything for her".

Jimmy

Jimmy is waiting for an operation and is on long term sick leave. He'd been given a laptop by another local organisation during Covid but didn't use it much because he was worried about pressing the wrong button and making a mistake.

"Before I was scared to turn the page in case I did something wrong. Now I know, if I make mistakes, just to go back, I ken no to be afraid."

The learning co-ordinator worked with Jimmy to build his confidence and make sure he could use digital resources safely. He now has an email address and uses it to stay in touch with family who work overseas. He also uses email to contact the local hospital with any questions about his operation and his Job Centre work coach about his benefits. This means that he no longer needs to struggle with the journey to the Job Centre to hand in his sick note. He's also been shown how to access benefit information from the Department of Work and Pensions website and learn about pensions on Age UK's website.

Impact on care, wellbeing and access to services

3.12 Digital inclusion has enabled early intervention, supported prevention, and enhanced service access. Several projects reported that by supporting people to access resources online—such as NHS Inform, breathing apps, or community wellbeing groups—they reduced reliance on emergency care or repeated visits to GPs. Individuals learned to self-manage, look up information, and connect to early support. For example:

- Health & Mind demonstrated that digitally equipped participants were more consistent in attending therapy sessions;

- CENTRED observed that service users in Highland communities were less reliant on emergency services after developing digital skills, as they were able to engage with preventative services earlier;

- Lead Scotland's work in rural Aberdeenshire showed that being able to access health information online reduced anxiety and enabled individuals to better self-manage long-term conditions.

> **Elsie**
>
> Elsie had an iPad but wasn't confident going online so had mainly used it to store family photos. Elsie was diagnosed with Type 2 diabetes at the end of 2024 and the learning co-ordinator has shown her how to use NHS Inform and Diabetes UK websites. Elsie has been using the information on these sites to eat more healthily and is now better able to control her blood sugar levels.

3.13 Across the impact surveys, on average, participants reported better ability to use online systems to manage their health and care with an average score increase of 13.3%.

3.14 Participants who had previously avoided health appointments due to anxiety or logistical barriers reported better engagement once they had the digital skills and devices to do so. In rural areas, being able to attend video consultations reduced the need for long travel and meant individuals with mobility or mental health challenges could engage more consistently. One participant in a mental health project noted, "I couldn't face the GP surgery, but now I can speak to them from my own home—I feel more in control."

3.15 Projects identified several mechanisms of impact:

- improved communication: participants contacted services via email or messaging instead of making unnecessary or challenging in-person journeys;

- greater service efficiency: booking and cancelling appointments online reduced missed appointments and admin time;

- earlier intervention: individuals were more likely to seek support when the barriers to access were reduced; and

- increased autonomy: participants reported being able to manage prescriptions, benefits, and housing without relying on others.

3.16   A consistent theme was the compounding benefit of digital access: individuals who became confident digitally were more likely to explore and take up wider supports, to volunteer, contribute to group activity, and explore other learning or work options. This shows the potential for digital inclusion to be a catalyst for broader engagement, prevention, and wellbeing. A project noted: "People didn't just become digitally included—they became included in life again."

> **Craig**
>
> Craig was looking for work but didn't have the digital skills needed to complete online job applications. He felt like local agencies were pressurising him to find a job and felt overwhelmed by fast-paced employability courses.
>
> The project worked at his pace and helped Craig to better use a phone and laptop. Craig is now able to use his devices independently and became confident using them as part of his job searches. He is now in employment.

3.17   The holistic approach to providing digital support was important. Many projects developed hybrid or wraparound models of delivery, combining drop-ins, home visits, group work and digital peer learning. These helped to embed digital access as a routine part of broader support, normalising digital inclusion as a tool for health and care, not just a stand-alone technical intervention. This approach aligns with the Pillars to Practice Framework – motivation, devices, connectivity, skills/confidence, and inclusive design.

Impact on organisation policy and practice

Changes in organisational culture

3.18   One of the most significant shifts observed across the funded projects was the gradual but meaningful change in organisational culture around digital inclusion. At the outset, many organisations viewed digital access as a specialist function—something delivered by specific roles like IT staff or digital leads, rather than an integral part of frontline service delivery. Over time, however, this perception began to change. In organisations like Lead Scotland, this shift was supported by embedding digital inclusion into all project planning and delivery. Staff who were not previously involved in digital support began recognising opportunities to integrate it into their work. As projects embedded digital tools into everyday practice, and as staff gained confidence through practical experience, a broader cultural realignment began to take shape.

3.19   This cultural shift was mirrored in other settings. At Health and Mind, project leads worked across departments to navigate information governance, recruitment and training of volunteers, and to create policies for shared device use in psychiatric wards—ensuring digital tools were accessible and safe for service users. Staff who had initially felt uncertain or unqualified to discuss digital tools began to see these conversations as part of their core role—just as important as housing advice, emotional support, or benefits navigation. As one project described, "Staff didn't initially see themselves as 'digital people.' But once they

saw the difference digital could make in confidence, ownership and outcomes—that changed." These operational changes signalled a broader commitment to inclusion.

3.20   Organisations also reported changes in how digital inclusion was viewed at leadership level. In several projects, what began as a small-scale or pilot initiative sparked wider conversations about sustainability, infrastructure, and digital equity. For example, Aberdeen Foyer and The ALLIANCE described how their digital inclusion work influenced internal policies and triggered new collaborations with health and care partners.

3.21   The Pillars for Digital Inclusion framework reinforces this need for systemic change by positioning digital inclusion as a collective responsibility of organisations, not just individual users. It argues that the current model, which frames inclusion as an individual's responsibility to develop skills, is insufficient. Instead, organisations should proactively build inclusive systems—through strategy, training, procurement, and leadership— recognising that a digitally inclusive society benefits all.

Effectiveness of the Digital Champions

The Digital Champions training was provided by MHOR Collective and the Digital Champion model emerged as an effective mechanism for delivering person-centred, context-sensitive digital support. Champions provided one-to-one practical help and encouragement, often building on their own experiences of digital learning. Data from the Digital Champions Survey shows that 41% of respondents had their role embedded in core delivery, and another 32% were part-funded to deliver it alongside other responsibilities. Importantly, many Champions came from the communities they were working with, and their lived experience enhanced their credibility and understanding of the needs of those they supported.

3.22   Champions identified varied motivations for taking on the role: a desire to support people during recovery, lived experience of digital exclusion, or simply a passion for helping others. Many described the satisfaction of witnessing someone move from digital fear to confidence. The Digital Champions training was broadly seen as effective, but the Champions called for more contextual training from their own organisations in areas such as mental health, trauma, neurodiversity, and peer support. One champion noted, "We are increasingly finding people that require digital support have other complex needs so training around mental health and neurodiversity would be good to support this."

3.23   Support structures also influenced the impact of the Digital Champion role. Those who received protected time, regular supervision, and opportunities to share learning reported better outcomes with others identifying a lack of time and organisational understanding as barriers to embedding their support.

3.24   While initially designed to provide practical, one-to-one digital support, the role of Digital Champions evolved into something more strategic and influential within some organisations.

3.25   Rather than being viewed solely as technical support workers, Digital Champions became catalysts helping to embed digital inclusion into everyday practice and shifting how teams thought about their role in enabling digital access. They did this by:

- normalising digital conversations across teams: Digital Champions helped move digital inclusion from a niche topic to something that could be confidently discussed by any staff member, in any setting. Their presence helped demystify technology and make digital support part of routine service delivery;

- mentoring and upskilling colleagues: in several projects (e.g. SAMH, Cyrenians, Prospect Community Housing), Champions worked alongside care workers, tenancy support officers, and link workers to build their confidence and embed digital into their core responsibilities; and

- influencing organisational practice: In some projects, Digital Champions also began to influence how services were structured: For example, in Moray Wellbeing Hub, Champions were central to aligning digital inclusion efforts with wider health, justice, and housing strategies. Some Champions were involved in designing referral pathways, creating accessible resources, and shaping training materials for future use.

> **Tom**
>
> I began volunteering with TACT when the Health and Mind Project launched in April 2024. Since then, I've been actively involved in several areas, including supporting in-patients and community drop-ins. One of the most rewarding aspects of my role has been providing digital support at home to those people who couldn't attend the drop-ins. Helping individuals who face challenges accessing services has deepened my understanding of the power of technology to improve lives.
>
> During my time with the project, I've completed various training programs that have helped shape my role and my skills. I have completed TACT's internal training, NHS training, and MHOR Collective Digital Champions training. These experiences have not only enhanced my technical knowledge but have also given me a broader understanding of mental health and digital inclusion. As the project has developed, so too has my confidence, and I've enjoyed seeing how my contributions have made a real difference in people's lives.
>
> In December 2024, I was fortunate to receive a 12-week work placement with TACT, thanks to a funded opportunity from North Ayrshire Council. This placement allowed me to continue applying my digital skills while taking on more responsibility. As the lead Digital Champion in the group, I took the initiative to establish a Digital Support Group within the TACT office. This group has become a space where service users can receive hands-on assistance in setting up their devices and building their confidence with technology.

> It's been incredibly rewarding to see individuals grow more comfortable with their devices and technology, knowing that I've played a role in that development. It has been very rewarding to help people manage their mental health and wellbeing by providing the tools and support they need. By giving them the resources to handle challenges on their own, we've reduced their need to rely on external services. This has helped them feel more in control, independent, and confident. Watching people become more self-sufficient in managing their mental health has been a truly fulfilling part of the work.

Use of the Practice Guide for Digital Inclusion

3.26   Drawing on learning generated across the Digital Inclusion Programme, particularly insights from the Community of Learning sessions and co-production activities with a range of stakeholders, the guide was developed to provide a practical learning resource for frontline practitioners. The Practice Guide was published on 30 January 2025 and is hosted on the NHS Education (NES) Scotland learning and development platform, TURAS and the Scottish Social Services Council (SSSC) learning zone.

3.27   The resource offers practical tools, conversation starters, and best practice examples grounded in the experiences of funded projects to help them embed digital inclusion into their practice.

3.28   Usage statistics for the first six months are limited because awareness of the guide is still developing but initial data shows that there have been over 500 views and more than 330 active users.

Impact of the Community of Learning

3.29   Throughout the Digital Inclusion programme, participating projects were brought together monthly through a series of in-person and virtual Community of Learning sessions, facilitated by SCVO. These sessions provided structured opportunities for organisations to share progress, reflect on practice, and support one another in embedding digital inclusion within their services. They encouraged a deeper understanding of how digital tools, practices, and pressures intersect with organisational culture and staff wellbeing.

3.30   The Community of Learning sessions blended peer learning, reflective practice, and thematic discussions. For example, the February 2025 session focused on Digital Wellbeing, exploring what this concept means in practice for staff and organisations.

3.31   After each session, relevant resources were shared, not only from SCVO to all participants, but sometimes between individual projects who had a shared experience or who were passing on their learning and knowledge.

3.32   These sessions were structured to prioritise peer learning, offering time for presentations, informal discussions over lunch (when in person), and joint reflection. This design helped to consolidate learning and created space for celebrating achievements across the cohort.

3.33 The Community of Learning sessions had a significant impact across multiple levels:

- peer support and shared practice: participants valued hearing from others facing similar challenges, which reduced the sense of working in isolation and sparked new ideas for delivery and problem-solving. For example, staff from several housing associations used peer discussions to compare device lending schemes and consider support models;

- increased confidence: the space to present, reflect, and hear feedback helped staff grow in confidence about their own digital inclusion work and its impact. "Networking with others from other areas in the care sector has been great. Hearing others share their success stories and challenges has been invaluable.";

- actionable learning: the sessions led directly to changes in practice, such as introducing internal wellbeing check-ins, applying trauma-informed design principles in digital tools; and

- strategic planning: the final sessions for the projects were used as reflection and a springboard to consider long-term sustainability, identifying what would be needed to keep digital inclusion embedded once funding ended.

3.34 The evaluation discussions with projects highlighted the role that the Community of Learning sessions served in providing a vital support structure for projects, not only by providing knowledge and tools, but also by nurturing a reflective and collaborative community of practice.

Integration into service delivery

3.35 Projects across the programme were embedding digital inclusion into their core service delivery where possible. In some organisations, for example, staff in housing, care, and mental health roles began assessing digital needs alongside other support planning. For some this was within their own organisations, at Scottish Action for Mental Health (SAMH) digital inclusion became part of the fabric of its mental health support services. By equipping service users with tablets and introducing digital wellbeing tools such as Sleepio, Daylight, and STOPP into co-produced care plans they helped participants manage anxiety, track mood, and regulate emotional responses as part of their recovery.

3.36 For others embedding digital inclusion involved partners. Prospect Community Housing and Whale Arts integrated digital inclusion into their tenancy support model by working closely with the local GP practice and Community Link Workers. They delivered drop-in and one-to-one digital sessions in housing offices and local wellbeing hubs focusing on tasks like using eConsult, booking appointments, and managing online prescriptions. There were also examples where better digital inclusion was also happening within core health and care services. For example, Queens Cross Housing Association partnered with Won Connect, local pharmacies, and health centres to deliver digital support directly within healthcare settings. This included training for health centre staff to increase their awareness

and ability to signpost patients to digital inclusion resources. This integration moved inclusion beyond a "project" into routine service provision.

3.37   The Digital Pillars framework provides a structured way to understand and support this integration. The five pillars—motivation, devices, connectivity, skills and confidence, and inclusive design—reflect the real-world enablers and barriers identified by projects. Motivation was seen as the first critical step: if people did not see the relevance of digital tools, they were unlikely to engage. Champions frequently used "hooks" (music, video calling, games) to build that initial interest. Working at the pace of participants was also important here: projects described how they would begin by identifying the digital skills that would make a difference to participants' lives before introducing digital health tools.

Economic impact

3.38   As part of the evaluation, a small number of costed case studies were developed to explore the potential financial and service-related benefits of digital inclusion for individuals accessing health and care support. The aim was to go beyond individual stories of impact and begin to build an evidence base that could demonstrate the value of digital inclusion in economic terms—particularly for health and social care providers and commissioners.

3.39   The case studies sought to map the journey of specific individuals before and after receiving digital inclusion support, identifying key outcomes such as improved access to services, reduced demand on frontline staff, or greater independence in managing health. Using this information, we attempted to estimate potential cost savings or avoided costs for public services, drawing on published cost data and practitioner insight.

3.40   In the first example, this project was the only one that had a health and wellbeing assessment tool, LifeCurve™, which has associated public service costs built into the framework. This allowed for a relatively robust estimation of savings linked to improved functional ability.

Gladys

Gladys is a woman in her early 80s living in a sheltered housing complex in Glenrothes. She was referred to the LifeCurve Digital Inclusion and Wellbeing project, following concerns about reduced mobility and increasing difficulty managing day-to-day tasks due to osteoarthritis and hip pain. At the point of her first LifeCurve assessment, Gladys' functional position was recorded as "Using Steps", which falls within the mid-stage of the LifeCurve and is associated with an estimated health and care cost of £1,950 per year.

Gladys was not taking part in any exercise, had low digital confidence, and was uncertain about how to manage tasks such as online form-filling. She had also not yet accessed available support for home adaptations or mobility aids. Over the course of the project, Gladys received coordinated and practical support including:
- an initial LifeCurve assessment to establish her position and identify areas for support;

- help to develop digital skills and confidence, including assistance with a Blue Badge application and use of the Elevate brain training app;
- signposting to and encouragement to attend seated fitness classes;
- discussion around appropriate mobility aids — resulting in the use of a rollator;
- arrangement and installation of a wet floor shower by housing staff; and
- ongoing check-ins from project staff before and after her hip surgery.

This support was tailored to Gladys' needs and focused on small, manageable changes that supported her independence.

Following her engagement in the LifeCurve project and successful surgery, Gladys' functional ability improved significantly. Six weeks after her hip operation, her LifeCurve position had improved by four levels — from "Using Steps" to "Getting Up from the Floor" and she was no longer on the LifeCurve. She had resumed attending activity sessions, was walking short distances outdoors, and reported increased digital confidence. She described the support as helpful and said that having someone available to assist with digital tasks gave her "peace of mind." She also confirmed that the programme had contributed positively to her recovery and ability to live independently.

Based on information from health and social care cost modelling for the LifeCurve, and assumptions drawn from local service cost benchmarks, we estimate the following savings associated with Gladys' improvement:

- health and care cost savings: each stage on the LifeCurve is associated with an estimated annual NHS cost increase of £650. Moving from "Using Steps" (costed at £1,950/year) to "Getting Up from the Floor" (costed at £650/year) reflects **a saving of £1,300 per year** in expected NHS service use; and
- reduced post-surgery rehabilitation input: Gladys' quicker recovery reduced the likely need for structured rehabilitation input, such as community physiotherapy. A reduction of even one home physio visit per week over a 6-week period represents **a saving of £246**[1].

Total estimated savings £1,546

If similar savings achieved for Gladys were experienced by 46 other people supported by the project, the savings would exceed funding provided to the project.

3.41   Other case studies, while less structured in terms of linked cost frameworks, provide valuable insights into how tailored digital inclusion support can reduce unnecessary service use and empower individuals to manage their health more effectively.

Graham

Graham's physical and mental health conditions meant that he was housebound and making inappropriate calls to emergency and support services. His GP surgery referred to him to TACT for support in December 2024 and the project lead and volunteer began

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[1] PSSRU 2023/24.

visiting him at home soon after. They initially met weekly, but this decreased to fortnightly as his confidence improved.

Project staff described how the apps installed on Graham's phone were all set up to send notifications and the constant 'pings' were overwhelming. In trying to respond to them, Graham would often press the wrong button and not know what to do next. In his frustration, he'd reach out to different services for help and was reported to phone NHS 111 or emergency services several times a day.

The cost of an NHS 111 call has been estimated at £11.401[2] (which is the cost of the call only – not any callbacks or emergency support provided) meaning that **Graham was incurring costs to the NHS of at least £4,000 a year** and potentially several times that from unnecessary 111 calls.

If similar savings achieved for Graham were experienced by 12 other people supported by the project, the savings would exceed funding provided to the project.

After identifying his phone as a source of stress and a trigger for his contact with services, a key first step was removing unused apps and notifications. A volunteer also prepared some simple instruction booklets to help Graham use the apps on his phone.

Other support included showing Graham how to access NHS Inform and the different apps and techniques that could be used to better manage frustrations and anxieties. Graham now uses online breathing exercises and self-help journalling techniques instead of calling services every time he needs help. While Graham still makes phone calls, project staff estimate that these have reduced from several times a day to weekly (and are often necessary to enable him to manage his physical health condition).

Showing Graham how to make it easier to access online information has also been important and he now uses voice searches so that he doesn't need to worry about finding the correct spelling to do a text search. Before accessing Health and Mind, Graham rarely left the house but was planning to join one of the drop-in sessions towards the end of the project.

"*The difference between now and Christmas is huge. He's now talking about engaging back in the community, talking about going to our digital class.*" (project staff)

3.42   In other cases, digital inclusion support helped not just the primary individual but also those in a caring role, creating a multiplier effect in terms of both wellbeing and potential savings.

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[2] Turner J, Knowles E, Simpson R, et al. Impact of NHS 111 Online on the NHS 111 telephone service and urgent care system: a mixed–methods study. Southampton (UK): NIHR Journals Library; 2021 Nov. (Health Services and Delivery Research, No. 9.21.) Chapter 9, Cost–consequences of introducing NHS 111 Online.

Mary and Kate

Mary has COPD and was recently diagnosed with Type 2 diabetes. Her daughter Kate is her carer. Mary first heard about Lead Scotland's digital support offer from a friend in December 2024 and a learning co-ordinator went on to visit her weekly at home.

Because Mary didn't know how to use her iPad, the learning co-ordinator began by developing her basic digital skills. This included how to stay safe online and access different digital apps and resources. They also went through the Learn My Way website together to identify the topics that would be most useful. Mary is now using online banking and monitoring digital security cameras via her iPad.

Once Mary was more confident going online, the learning co-ordinator introduced her to digital tools that could help her better manage her health conditions. For example, she booked a home eye test through the Outside Clinic website and Mary now has the right prescription for her glasses. She's also been shown how to find sitting exercises for COPD on the NHS Inform website.

The learning co-ordinator has also been supporting Kate, who is dyslexic and finds it difficult to read information online. Kate has been shown how to use screen readers so that she can access the information she needs to care for her mum. Kate has learned about Type 2 diabetes and the importance of healthy eating on the NHS Inform website. She's using recipes from NHS Inform to cook for her mum. Mary's bloods were described as now being better controlled and 'coming down.' **The costs of a hypoglycaemic event can cost the NHS up to £1478[3]** with complications from poorly controlled diabetes costing the NHS in the UK over £7 billion a year[4]. Better control of Mary's diabetes could therefore generate substantial savings to health services. **Avoiding just 53 hypoglycaemic events across all people supported by the project would cover funding provided to the project.**

Before Lead Scotland started supporting Mary and Kate, Kate would ask for advice from a family member or their GP surgery each month. But now that she can access information online, Kate doesn't feel she needs to phone the surgery anymore. **The cost of a 10-minute GP appointment has been estimated at £45[5]**, suggesting that the support from Lead Scotland that has led to **Kate being less reliant on GP services has saved the NHS £540 a year.**

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[3] smith MD, Ridyard C, Botan V, Brewster A, Dunmore S, James J, Khunti K, Laparidou D, Law G, Mountain P, Roberts L, Rowan E, Spaight R, Spurr K, Siriwardena AN. Model-based economic evaluation of the effectiveness of "'Hypos' can strike twice", a leaflet-based ambulance clinician referral intervention to prevent recurrent hypoglycaemia. PLoS One. 2023 Mar 16;18(3)

[4] Hex, N., R. MacDonald, J. Pocock, et al. 2024. "Estimation of the Direct Health and Indirect Societal Costs of Diabetes in the UK Using a Cost of Illness Model." Diabetic Medicine 41

[5] PSSRU Unit Costs of Health and Social Care 2024

3.43   A final example illustrates how digital inclusion can enable individuals with complex needs to transition from intensive clinical support to community-led activity and self-management.

Emma

Emma is a woman in her late seventies with a long-standing history of complex mental health needs, including psychotic depression and hoarding behaviours. She had received intensive support from adult mental health services for most of her life and transitioned to older adult services after turning 65. Until recently, she required weekly input from NHS Fife's community mental health team.

Emma was referred into Link Living's Linked-Up Peer Digital Inclusion Service by her clinical psychologist in older adult community services. She had limited digital skills and was initially unsure of her ability to go online. However, with tailored support from a peer digital coach, Emma received help building confidence, learning how to use a digital device, and accessing therapeutic and community resources online.

Over a series of sessions, Emma became more confident using her device and began to explore opportunities for online engagement. With increased digital access and support, she founded a holistic therapies group for older people in her community. She now independently coordinates group meetings, accesses third sector resources, and engages with peers online — actions that mark a significant transformation in her mental health journey and social inclusion.

Emma's psychologist described this change as a "huge blossoming," emphasising that she is now making meaningful contributions to her community and is no longer reliant on weekly mental health appointments. Since engaging with the project, the client has established a holistic therapies group for older adults: organising meetings and meeting spaces, accessing third-sector services, and facilitating peer engagement. This is a remarkable shift for someone who previously required regular weekly support from community mental health teams. Community mental health visits have been estimated[6] to cost £280, suggesting that over £1,000 a month or **£14,500** a year of cost burden has been alleviated by the digital inclusion service.

If similar savings achieved for Emma were experienced by five other people supported by the project, the savings would exceed funding provided to the project.

3.44   These case studies demonstrate that digital inclusion can have a meaningful economic impact, particularly when support is personalised and sustained. Estimated savings ranged from several hundred pounds to over £14,000 per person per year, with reductions in health service use, improved self-management, and decreased reliance on professional

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[6] NHS Cost Collection 2023/24

care. Across the case studies, the savings realised to offset the project funding varied from five people to 46 people.

3.45   However, there are limitations to this approach. The attribution of change solely to digital inclusion is challenging, as individuals often receive multiple forms of support. Few projects had access to comprehensive service use data, making precise financial modelling difficult. Additionally, the benefits of digital inclusion—especially in relation to independence, confidence, and prevention—are often long-term and not fully realised within the evaluation period.

3.46   Nonetheless, these examples provide compelling illustrations of how small, tailored interventions can yield both personal and system-level benefits, supporting the case for continued investment in embedded digital inclusion within health and care services.

Conclusions

3.47   Understanding the difference this programme has made to individuals has been central to the evaluation. Drawing on a rich mix of monitoring data, impact surveys, project reports, and direct testimonies, this chapter demonstrates the wide-ranging and often transformative effects of digital inclusion support. People gained practical skills, but also confidence, independence, and improved wellbeing. The data shows that these changes led to greater engagement with health and social care, reduced isolation, and in some cases, significant reductions in service demand.

3.48   The evaluation also found that when digital inclusion was delivered through trusted relationships, tailored support, and integrated service models, the benefits extended beyond individuals to carers, families, and frontline staff. Although there are limitations to quantifying these impacts economically, the case studies provide powerful illustrations of potential system-wide savings and improved outcomes. The evidence clearly shows that digital inclusion, when embedded in everyday practice, is not just a technical solution—it is a catalyst for more person-led, accessible, and effective care.

4. Challenges and successes to embedding digital inclusion in health and care

4.1 While the evidence from funded projects clearly demonstrates the positive impact of digital inclusion—enabling individuals to access health and care services more effectively, develop confidence, and reduce social isolation—it also raised a range of persistent and structural challenges. This chapter presents a view of both the barriers and the success factors experienced by projects. It explores the complexities of working across sectors, the realities of delivering digital support in under-resourced contexts, and the lived experiences of people facing multiple layers of exclusion. Alongside these challenges, it highlights the creative, compassionate, and relational approaches that helped projects to succeed—building trust, embedding digital tools into everyday care, and creating inclusive, person-led models that others can learn from.

Challenges to digital inclusion

4.2 These challenges have been categorised as engagement with health and care partners, short term funding impacts, persistent barriers and sustainability and they are discussed in more detail in this section.

Engaging health and social care partners

4.3 Engagement from statutory health and social care partners varied across the funded projects. Where it worked well—such as in projects where digital inclusion was visibly championed by local leads or embedded within wider reform efforts—momentum built quickly. However, many of the projects who were third sector organisations reported difficulty in securing buy-in from health and care teams who were facing workforce pressures and competing priorities. In some areas, digital inclusion was seen as peripheral rather than core to health and care delivery. This limited integration opportunities, made co-delivery more difficult, and often restricted the flow of referrals and uptake of support.

Figure 3: Challenges to digital inclusion – engaging health & social care partners

4.4   Mixed engagement: several projects described fragile or fragmented digital infrastructure within health and care settings. The projects reported that even where digital inclusion was prioritised, there was limited ability to provide reliable connectivity or devices for staff and participants. For example, staff in community care roles often used personal phones or unsecured networks to support clients digitally; teams in outreach settings lacked portable devices or Wi-Fi, making it difficult to demonstrate or support using digital tools with service users.

4.5   Staff confidence and capability: staff capability was both a barrier and opportunity—for health and care partners. Staff were often motivated but lacked confidence, especially in explaining health-related technologies (e.g. accessing test results online, using video consultations, or navigating NHS apps) or lacked knowledge of how to integrate digital support into appointments or self-management advice. This meant that some health professionals avoided digital discussions entirely, worried they would "open up issues they couldn't solve." Contextualised workforce training with practical scenarios would support and reassure staff to develop the appropriate skills.

4.6   Organisational culture and prioritisation: A consistent theme was the absence of an organisational culture that supported digital inclusion. Issues here included:

- lack of clarity on who was responsible for digital support within multidisciplinary teams.

- no expectation or time allowance in job plans to discuss digital access with patients or clients.

- minimal integration of digital access questions into care planning, assessments, or supervision.

4.7   Projects that succeeded in engaging health and care teams often had a named advocate within the Health and Social Care Partnership (HSCP) or Integration Joint Board (IJB) who championed the work. Where this was absent, projects adopted a more scattergun approach to engagement and success here was dependent on more opportunistic connections being made. Others relied heavily on leadership within their own third sector organisations with limited reciprocation from statutory services.

4.8   Systems integration (or lack of): system integration was a persistent challenge—both in terms of data and collaboration. Services supporting digital health often could not access or share key information with clinical partners (e.g. about someone's preferences for video consultations, or digital readiness). Care records and referral systems rarely included prompts to assess or record digital access or confidence. Many projects worked in isolation due to lack of interoperable systems, siloed funding, or rigid governance procedures.
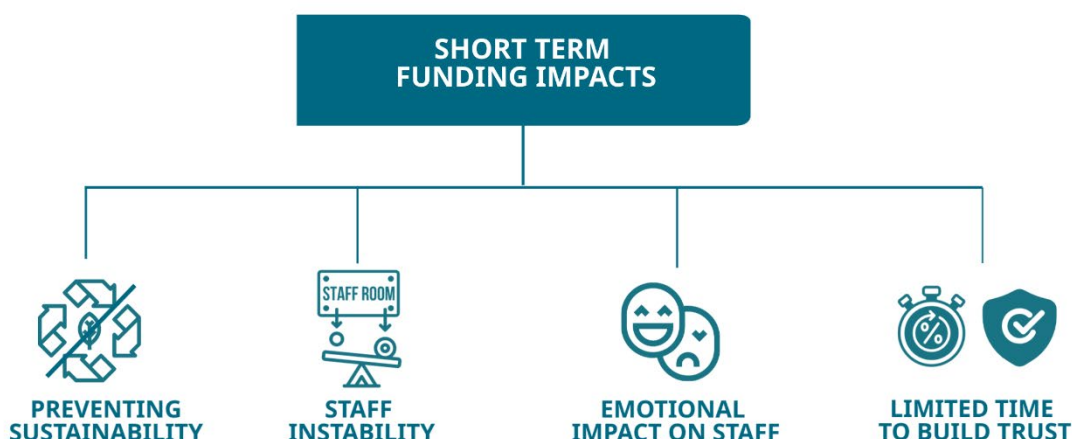
Short-term funding impacts

4.9   Projects consistently cited the short-term nature of funding as a major barrier to both planning and continuity. This had several consequences: staff contracts were often

insecure, which limited the ability to build capacity; digital champions could not be retained or embedded within teams; and successful pilot approaches could not be scaled or mainstreamed. An organisation noted that the time it took to build trust with service users and partners meant that their most impactful work happened just as funding ended. Others found themselves "reinventing the wheel" for each round of funding, rather than iterating on learning and building infrastructure.

Figure 4: Challenges to digital inclusion – short term funding impacts

4.10   Preventing sustainability: across nearly all funded projects, short-term funding was described not only as a logistical challenge but as a structural barrier to meaningful and sustained digital inclusion. Projects faced repeated difficulties in maintaining momentum, retaining skilled staff, embedding approaches into wider systems, and making a strategic case for longer-term impact—all due to the constraints of time-limited funding.

4.11   Staffing instability: projects frequently reported difficulties recruiting and retaining staff with the right mix experience, interpersonal and digital skills within a limited funding window. Even where recruitment was successful, contracts were short term, and then Digital Champions or project workers left for more secure roles just as they were building trust with participants or gaining traction in health and care settings.

4.12   One project reflected: "We spent the first half of the project recruiting and training, and the second half preparing to wind down. There was barely time to deliver, let alone embed."

4.13   Others expressed frustration that they had developed effective models but were unable to retain the staff needed to carry them forward, leaving a sense of "starting from scratch" in future funding rounds.

4.14   Emotional impact on staff within projects: there was also a less visible, but equally important emotional toll. Discussions with project staff and monitoring reports highlighted the negative effect on staff morale when promising work was not continued. One frontline worker explained "We had participants come every week, build confidence, share progress… then it stopped. We couldn't give them an answer about what would happen next."

4.15   This loss of service risked reinforcing mistrust and exclusion for people already marginalised and this presented ethical discomfort for some projects in starting work they could not guarantee to finish.

4.16   Limited time to build trust: overall, the short-term nature of the funding created a mismatch between the time needed to build trust, embed digital inclusion and influence system change, and the expectations placed on projects to evidence results. This was particularly acute in health and care partnerships, where commissioning cycles, operational pressures, and governance processes moved slowly.

Persistent barriers

4.17   Digital exclusion was rarely just about lacking devices or skills. Many participants faced multiple, overlapping barriers including low literacy, limited English language skills, previous trauma, and mental and physical health conditions. Some had had negative experiences of online systems that created fear or mistrust. Others were living in temporary accommodation or insecure housing where charging, connectivity, and storage were real challenges. These layered set of barriers shaped people's ability—and willingness—to engage digitally.

4.18   Effective projects understood that digital inclusion was relational, not transactional. They used trauma-informed approaches, moved at the person's pace, and began with motivation—supporting people to build trust in both the technology and the support worker. The importance of accessible language, flexible delivery formats (e.g., in-person, drop-in or group support), and providing devices or connectivity without means-testing was frequently emphasised.

Figure 5: Challenges to digital inclusion – persistent barriers
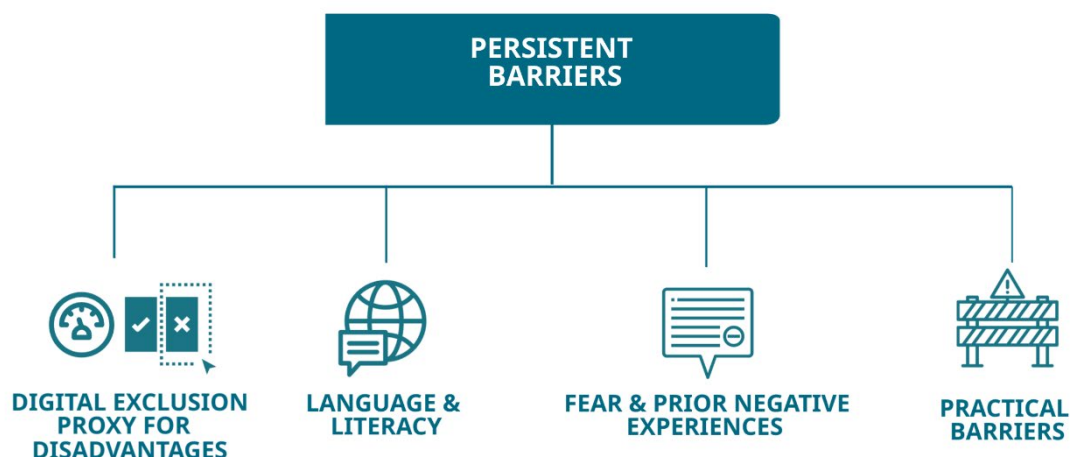
4.19   Digital exclusion as a proxy for other disadvantages: Participants who were most digitally excluded were often those already experiencing multiple forms of disadvantage. Project leads reported working with people who were:

- living in insecure housing or experiencing homelessness;

- managing long-term physical or mental health conditions;

- affected by addiction, violence, or trauma; and

- carers, people with learning disabilities, or those with limited English language skills.

4.20 For these individuals, digital exclusion was rarely the starting point. It was a symptom—reflecting a wider pattern of exclusion from services, decision-making, and opportunities. In these contexts, digital support had to be introduced carefully, often starting with basic needs, relationship-building, and motivational hooks. One project noted: "the assumption that people just need a device or some training really misses the point. For some, we're the first service they've trusted in years. We don't start with 'do you want to get online?' We start with 'how are you doing?'"

4.21 Language and literacy: projects reported that standard digital inclusion tools often failed to account for the range of literacy, language and cognitive needs people face. For example:

- forms, apps and online health systems frequently used jargon or inaccessible language;

- video consultation platforms assumed a level of familiarity and cognitive ability that many did not have; and

- there were limited resources available in community languages or for those with learning disabilities.

4.22 Staff also found that many people struggled with functional digital skills, such as remembering passwords, recognising scams, or knowing which websites to trust. These are not purely technical deficits—they reflect anxiety, lack of confidence, and in many cases, limited prior exposure to supportive digital environments.

4.23 Fear and previous negative experiences: another barrier was emotional: some participants associated digital tools with feelings of fear or inadequacy. Some had previously failed to navigate online systems like Universal Credit or NHS services and viewed that failure as a personal deficit. Others had experienced trauma related to surveillance or data misuse, which made digital engagement feel risky or threatening.

4.24 A Digital Champion reflected: "We had someone in supported accommodation who panicked every time we mentioned the phone. Turns out their abuser had used location tracking on them. No amount of skills training would have helped if we hadn't understood that first."

4.25 A frontline worker observed: "We supported someone with memory difficulties who had been scammed online. Understandably, they didn't want to go near anything digital again. Our job wasn't just to show them how to use tech—it was to rebuild trust in the system."

4.26 Practical barriers: Even where people were motivated and supported, practical barriers remained. These included:

- limited or no access to data or Wi-Fi at home;

- devices that were shared, broken, or too old for apps and video platforms;

- no safe or private place to charge or use devices; and

- competing priorities (e.g. food insecurity, housing instability, or caring responsibilities) that made digital learning feel secondary.

4.27 Several projects addressed these barriers creatively—providing data packages, loan devices, and flexible drop-in support—but few had resources to do so consistently.

Sustainability

4.28 For many participants, digital access was not a one-time fix. Devices needed charging and replacing; connectivity had ongoing costs; and confidence needed to be maintained. Projects voiced concern that without continued support—particularly for those with fluctuating needs or low income—initial gains could quickly be lost. Some services continued to subsidise data or devices from other budgets but acknowledged this was unsustainable.

Figure 6: Challenges to digital inclusion – sustainability

SUSTAINABILITY

MAINTENANCE OF DIGITAL INCLUSION

AFFORDABILITY

EMBEDDING DIGITAL INCLUSION
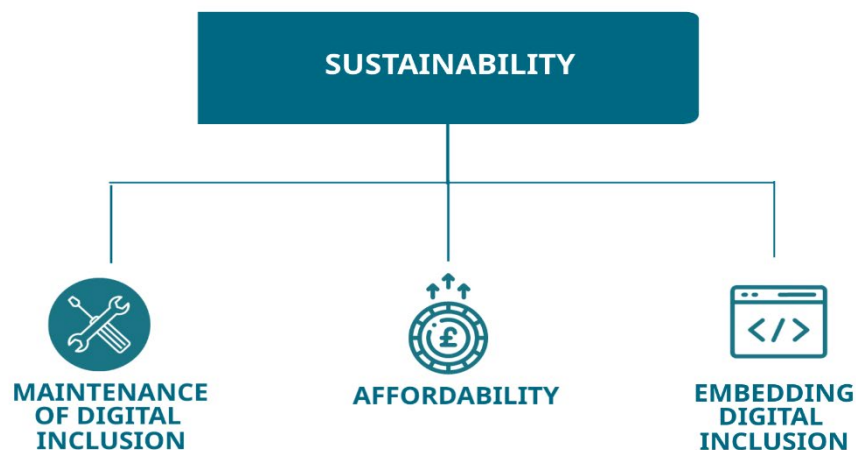
4.29 Maintenance of digital inclusion: many participants required consistent, repeated support to sustain their digital engagement. One-off interventions—such as a device handover or short-term training—were valuable starting points but insufficient in the long-term. Projects described how some participants made initial progress—accessing apps, video calling family, or booking appointments online—but struggled to sustain confidence. Life events, changing health, or even a forgotten password could set them back. Projects explained that participants often needed ongoing encouragement and reassurance as well as time, safe spaces, and the ability to revisit content multiple times, without feeling judged.

4.30 Another project lead explained: "We saw real transformation with some individuals, but by the end of the programme, they needed help again—logging into their GP app, remembering how to access Zoom." A project described "It's not a ladder. It's a spiral. People move in and out of confidence depending on what else is happening in their life."

4.31 Affordability: even when skills and confidence were built, cost barriers frequently halted or reversed progress. Projects described individuals who:

- could not afford replacement devices when their phones or tablets broke;

- lost access to mobile data after the initial SIM support ended;

- could not afford to charge their devices regularly due to energy costs; and

- prioritised other essentials (e.g., food, transport, debt repayments) over digital services.

4.32 One project noted "We had participants relying on public Wi-Fi or rationing their data just to stay in touch with health services. They were choosing between connectivity and dinner."

4.33 These affordability issues were especially acute for people on low incomes, those in temporary accommodation, and individuals with fluctuating health or care needs. Many had already been provided with devices or training through other programmes, but without affordable, ongoing connectivity, the benefit was lost.

4.34 Embedding digital inclusion: the projects showed that, with the right support, people previously excluded from digital tools can engage successfully. However, projects consistently highlighted that sustaining this engagement is not guaranteed. Even the most impactful interventions struggled to continue without long-term infrastructure, investment, and embedded support systems—leaving many gains temporary or fragile. Several projects were unable to embed learning into mainstream provision, and some noted missed opportunities for integration. One project shared: "We had great engagement from the local care team, but because we couldn't guarantee continuation, they were reluctant to build us into care planning processes." Sustainability challenges were often organisational, not just individual. Many delivery partners relied on temporary staff and short-term funding, with digital inclusion rarely part of core service planning or commissioning. As one organisation reflected: "We built a brilliant model with huge take-up, but there's no route to continue it. We're constantly reinventing the wheel because the system doesn't invest in digital inclusion as a core service.

Success factors

4.35 Despite facing multiple barriers, the Digital Inclusion programme funded projects that delivered a wealth of effective, creative, and context-sensitive practice. Projects across Scotland found ways to overcome complexity, embed digital support into care relationships, and create genuinely empowering experiences for people who had previously been excluded.

Figure 7: Digital inclusion success factors
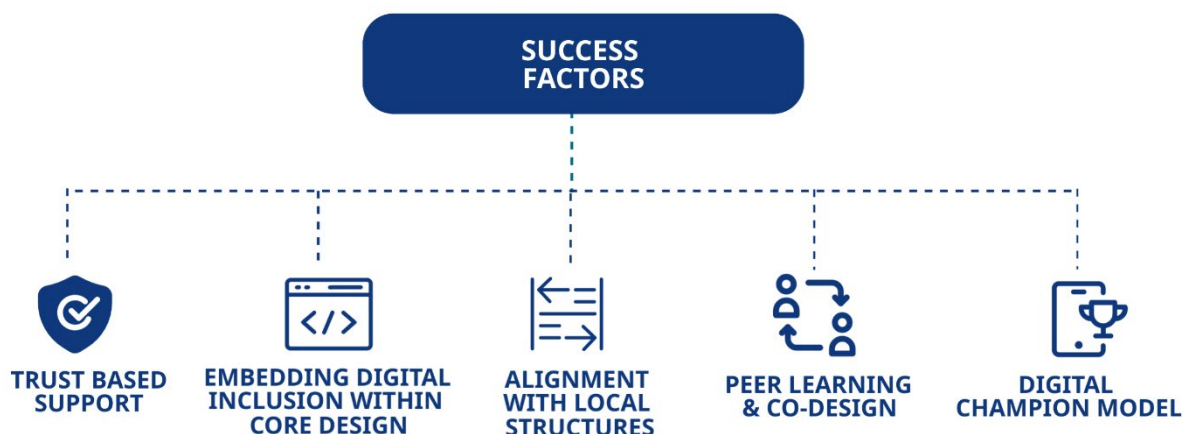
Trust-based and relationship-driven support

4.36   One of the most consistent success factors across all projects was the central role of trust. Digital inclusion was rarely achieved through transactional or one-off interventions. Instead, projects showed that it emerged from consistent, person-centred support provided by someone the participant already knew—or grew to trust.

4.37   Digital Champions, support workers, and peer mentors were most effective when they were embedded in wider care teams, day centres, or housing support services. Their presence allowed participants to explore digital tools gradually, at their own pace. As one participant put it: "I wouldn't have done this with anyone else. I trusted her—and she didn't rush me."

4.38   Projects stressed that digital engagement came only after weeks or months of relationship-building.

4.39   Flexibility in delivery and content was a further critical enabler of success—in how support was delivered, where it was offered, and what content was prioritised. Services that adapted to individuals' lives and learning styles were able to sustain involvement over time.

4.40   Successful projects:

- delivered support in homes, cafés, community centres, and care settings—not just in formal environments;

- offered one-to-one and group formats, based on participant preference;

- supported 'real life' uses of technology—e.g., attending a virtual GP appointment using video consultations, connecting with family, managing energy bills;

- encouraged self-directed exploration, rather than focusing solely on functional skills.

4.41   Flexibility was also vital when working with individuals experiencing crises, poor health, or fluctuating capacity. Staff frequently paused digital support to address immediate

emotional or practical needs, returning to it only when the person was ready. One project explained "Sometimes we had to put the tablet away and just talk. But they knew we'd come back to it."

Embedding digital inclusion within core service delivery

4.42   A key learning across the programme was that digital inclusion was most sustainable and impactful when integrated into core service delivery. Rather than establishing separate digital projects, the most effective projects made digital confidence part of everyday conversations—during assessments, care planning, and ongoing support. This integration had several benefits:

- it normalised digital discussions across the whole team—not just with designated champions;

- it ensured digital needs were recorded, tracked, and acted upon alongside other health and care needs; and

- it avoided treating digital exclusion as a deficit.

4.43   These simple shifts could help to sustain focus beyond the life of the funded project.

Implementing the Digital Champion model

4.44   The Digital Champion model was one of the programme's most consistently effective features. Champions acted as bridge figures—trusted, knowledgeable and embedded—able to demystify technology and provide hands-on, tailored support. What made the model work well was not just technical skill, but the ability to build rapport, offer encouragement, and adapt to individuals' health, literacy, or cognitive needs. Champions created psychologically safe environments, where participants could fail, try again, and ask "silly" questions without shame. Projects that invested in their Champions through training, supervision, and reflective learning were also able to influence culture, helping shift perceptions of digital from "optional extra" to "core enabler."

Peer learning and co-design

4.45   Projects benefited greatly from peer learning and shared reflection—both internally and across the wider programme. The Community of Learning sessions offered space to test ideas and draw inspiration from others. This was particularly helpful in a context where many staff were working in isolation or with limited prior experience. Within projects, co-design could be a powerful tool with some involving participants in shaping content, pace, and delivery which helped with engagement and even retention. Whether through informal conversations or structured feedback loops, many adapted their offer based on lived experience—creating more relevant, person-led support. One project said: "Participants helped us design the sessions. They told us what they needed, and what wasn't working. That changed everything."

Alignment with local infrastructure

4.46   Success was more likely where digital inclusion efforts aligned with wider local strategies—such as delayed discharge reduction, self-management support, or workforce wellbeing. In these contexts, projects were better able to access shared infrastructure (devices, Wi-Fi, clinical pathways), leverage referrals from health and care teams, and build partnerships that could extend beyond the life of the programme.

4.47   Several projects have begun influencing practice beyond their immediate scope. CENTRED Scotland, for example, began shaping digital access strategies across wider Highland partnerships. Health and Mind brought together the third sector, NHS Boards and IJBs to develop and test a solution that would provide sustainable device access and shared infrastructure for mental health service users.

4.48   Some areas had designated leads within HSCPs or third sector interfaces, which helped to maintain momentum and keep digital inclusion on local agendas. Others worked closely with wider services – libraries, housing associations, or link workers to build a more cohesive support ecosystem.

Conclusions

4.49   The insights gathered through this programme reveal that embedding digital inclusion within health and care is both essential and achievable—but not without difficulty. Projects faced significant challenges, from structural issues like short-term funding and fragmented infrastructure, to deep-rooted barriers linked to trauma, poverty, and exclusion. Yet they also demonstrated that with the right approaches—flexible delivery, trust-based relationships, and integration into core service delivery—digital inclusion can flourish.

4.50   Critically, the chapter shows that success did not come from technology alone, but from the human relationships that made digital engagement safe, relevant, and empowering. Effective projects moved at the pace of the individual, adapted to real-life contexts, and treated digital inclusion as relational rather than transactional. The most impactful work came from projects that were embedded in communities, aligned with wider local strategies, and supported by strong partnerships. These efforts laid the groundwork for longer-term change—demonstrating that when digital inclusion is prioritised, invested in, and integrated into core service models, it can become a lasting driver of equity in health and care.

5.   Summary and recommendations

5.1   The Digital Inclusion Programme has demonstrated the wide-ranging benefits that can be achieved if digital support is embedded into health and social care. Across the funded projects, there is evidence that digital inclusion is both an enabler of person-led care and a lever for broader system change. Participants experienced improved confidence, reduced isolation, and enhanced access to health and care services. Services, in turn, benefited from more engaged clients, increased efficiency, and in some cases, cost benefits to the wider health and social care system.

5.2   What is clear from the evaluation is that digital inclusion cannot be a standalone intervention—it must be embedded within trusted relationships, wider service delivery, and supported by ongoing organisational commitment and leadership. Effective practice was rooted in community-led, trauma-informed, and rights-based approaches. While outcomes varied depending on local context, the overarching narrative is one of empowerment and progress towards better health and wellbeing outcomes.

5.3   With the learning from this, and other digital inclusion programmes, and the range of resources that have been produced from this programme, there is now a strong foundation of knowledge, tools and examples to guide next steps. The task now is to build on these successes, address the systemic barriers, and ensure that digital inclusion is not a temporary intervention, but a sustained and supported part of Scotland's health and social care future. With continued investment, cross-sector collaboration, and policy alignment, Scotland's key decision makers are well positioned to lead and embed digital inclusion as a core component of health and care delivery.

Recommendations for practice

5.4   Digital inclusion should be fully integrated into how services operate, not seen as a standalone project. Organisations should build digital access and confidence into their everyday approaches to care, starting with the basics—ensuring individuals have the motivation, tools, and support to connect. This means that conversations about digital confidence during assessment and care planning, and embedding simple, accessible digital solutions into how services are delivered become everyday activities.

5.5   Several projects highlighted the importance of using place-based tools and co-design approaches to shape inclusive models of support. The Digital Inclusion toolkit provides templates and practical methods to support this work—helping services assess readiness, map local needs, and design with, rather than for, their communities. Organisations that applied these principles, whether formally or informally, were more likely to integrate digital inclusion successfully and sustain it beyond the life of the funding.

5.6   Digital Champions emerged as a particularly effective mechanism for embedding support. Their presence helped to normalise digital support within teams, provided trusted and approachable help to participants, and created a culture where digital inclusion was everyone's responsibility. This proven model could be woven into core

workforce planning and development. The digital inclusion training should go beyond technical skills to include trauma-informed and health-context-specific content so that Champions are equipped to provide the appropriate support to those they are working with.

5.7   Where engagement with digital remains low, services need to recognise and respond to the complexity of barriers people face. Projects repeatedly highlighted that motivation is only one piece in the jigsaw—confidence, fear, past trauma, literacy, and life circumstances all shaped people's ability to engage. The most successful projects took a holistic approach that recognised how and why people were excluded and then used flexible and patient/paced approaches, building trust before offering digital help. There will always be people who cannot or choose not to digitally engage, so maintaining non-digital alternatives is also essential for equity.

Economic recommendations

5.8   The economic case for digital inclusion is becoming clearer. Case studies from this programme show how relatively modest interventions—such as providing skills support or helping someone to use a health app—have the potential to reduce pressure on upstream services and support people to live more independently. However, capturing this impact requires better monitoring tools and more consistent approaches. A stronger evidence base of economic impact is needed to inform commissioners' future decision making.

5.9   Future projects should build economic monitoring into their design, using simple practical indicators such as changes in service use, evidence of increased self-management and confidence using tools, instances of avoided crisis interventions. The Digital Inclusion Check-Up and associated planning templates can support services to identify where they can add measurable value.

5.10   There is also potential in supporting projects to use Social Return on Investment (SROI) methods, especially for capturing wider impacts such as improved mental health, reduced loneliness, or increased employability. Strengthening this element would allow funders and policymakers to recognise the broader societal return of investing in digital inclusion.

5.11   In summary, to embed digital inclusion in service delivery will require:

- leadership and strategic recognition of the benefits and impacts that digital inclusion can bring;

- services treating digital inclusion as a routine and essential part of care planning;

- use of tools (e.g. those in the Digital Inclusion Toolkit) to map current services and opportunities to integrate support;

- routinely assessing and recording digital access and confidence as part of assessment and review processes;
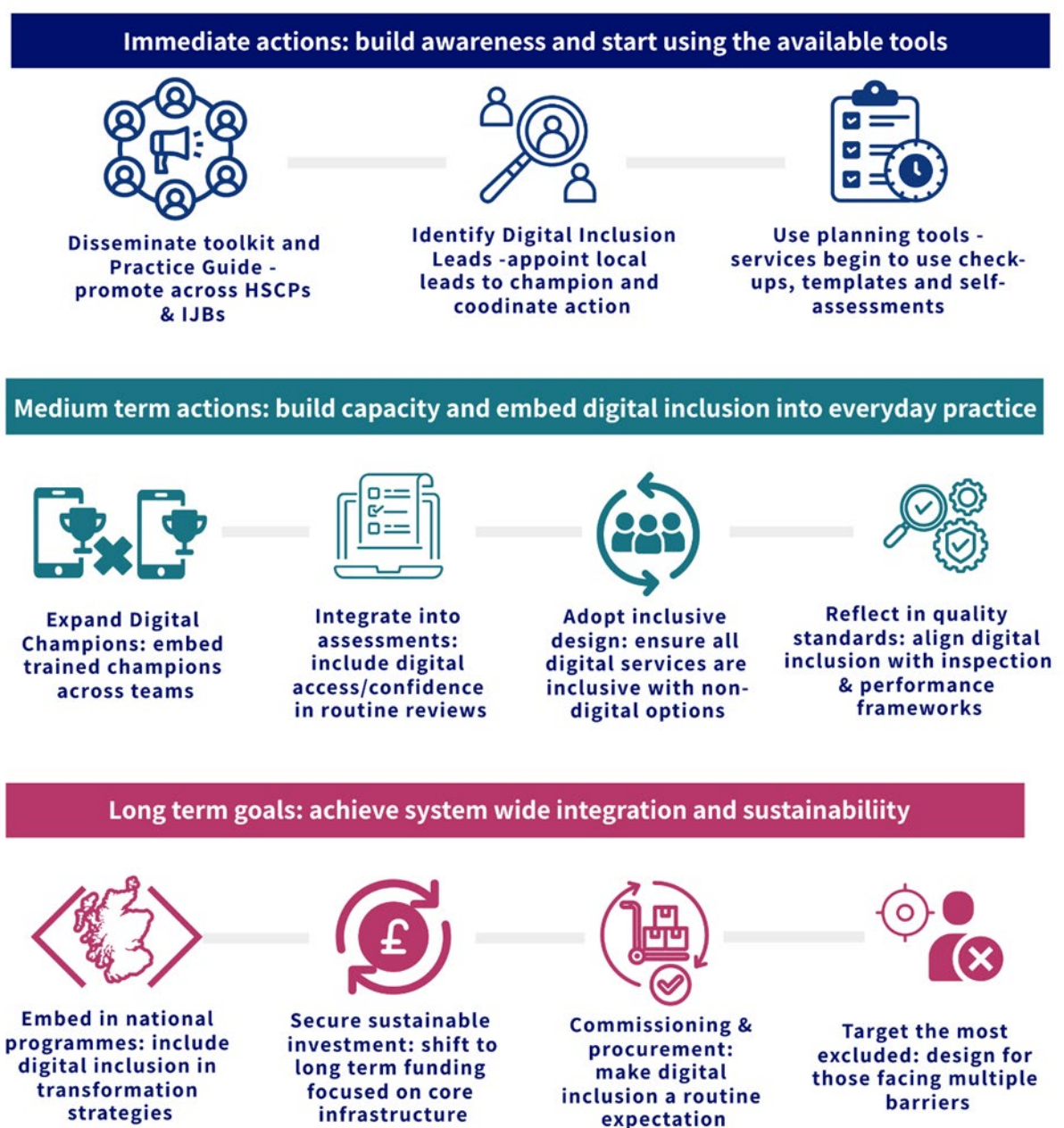
- scale and spread of the Digital Champion model so that Champions with trauma-informed and health-specific training are embedded across service teams, including admin, reception and clinical roles;

- embedding inclusive design in all digital service and support offers and ensuring non-digital alternatives are maintained; and

- use of economic tracking tools in future funded projects to document cost effectiveness.

Recommendations for policy

5.12   To ensure digital inclusion becomes a systematic and sustainable feature of health and care, national and local strategies must continue to reflect its central importance. Digital inclusion is already embedded in the Digital Health and Care Strategy and is now recognised as a core action in the Population Health Framework 2025-2035 and the Health and Social Care Renewal Framework. It is also a key commitment in Care in the Digital Age: Delivery Plan 2024-25, which reinforces the need to ensure equitable digital access and participation. Embedding digital inclusion into these strategic frameworks—alongside locality planning processes and social care reform—will help to drive consistency and accountability. It should also be integrated into the commissioning cycle, so that services are routinely asked to demonstrate how they support people to connect and participate digitally as part of mainstream service delivery.

5.13   It is important to embed digital inclusion into strategic frameworks—such as the Digital Health and Care Strategy, social care reform programmes, and locality planning processes. It is also valuable to include digital inclusion in the commissioning cycle, so that services are asked to demonstrate how they support people to connect.

5.14   Policy also has an invaluable role in creating the conditions for success. Short-term funding cycles were identified as a major barrier to sustainability, undermining the potential for longer-term planning and integration. Future investment should focus on building core infrastructure—people, devices, connectivity, and systems—rather than the ongoing focus on short-term outputs.

5.15   Importantly, policy needs to address the gaps in provision for groups who face multiple layers of disadvantage. This includes people with learning disabilities, those in supported accommodation, people where English is an additional language, and people with multiple health conditions, and those at the margins of health and care systems. These groups often experience the highest levels of digital exclusion—and yet have the most to gain when support is well designed.

5.16   In summary, to integrate digital inclusion within policy-making will require:

- embedding digital inclusion into national and local health and social care strategies and reform programmes;

- consideration of digital inclusion in commissioning and procurement and service redesign;

- a move away from short-term project funding toward longer-term, outcome-based investment;

- supporting core infrastructure for digital inclusion delivery, including devices, connectivity and staffing; and

- provision for groups with multiple and intersecting barriers and who experience the greatest exclusion.

Figure 8: Action roadmap

Immediate actions: build awareness and start using the available tools

Disseminate toolkit and Practice Guide - promote across HSCPs & IJBs

Identify Digital Inclusion Leads -appoint local leads to champion and coodinate action

Use planning tools - services begin to use check-ups, templates and self-assessments

Medium term actions: build capacity and embed digital inclusion into everyday practice

Expand Digital Champions: embed trained champions across teams

Integrate into assessments: include digital access/confidence in routine reviews

Adopt inclusive design: ensure all digital services are inclusive with non-digital options

Reflect in quality standards: align digital inclusion with inspection & performance frameworks

Long term goals: achieve system wide integration and sustainabiliity

Embed in national programmes: include digital inclusion in transformation strategies

Secure sustainable investment: shift to long term funding focused on core infrastructure

Commissioning & procurement: make digital inclusion a routine expectation

Target the most excluded: design for those facing multiple barriers

5.17   As Figure 8 summarises, there are clear actions that would turn the learning to date about digital inclusion into lasting change.

5.18   In the immediate term, knowledge and tools from this programme, in particular the Digital Inclusion Toolkit and Practice Guide should be promoted widely across Scotland. HSCPs, IJBs and wider services in the public sector organisations should identify leads for digital inclusion and begin using the resources that have been developed.

5.19   In the medium term, the roll out of the Digital Champions training across health and care teams would create Champions that become embedded and help normalise digital inclusion as part of everyday support. Digital inclusion questions should be integrated into standard assessments and review processes, so that digital needs are identified and supported early. Over time, inspection and performance frameworks should begin to reflect this expectation. This will help ensure digital access and confidence are recognised as integral to quality care.

5.20   In the longer term, the ambition should be to ensure that digital inclusion is a core part of how Scotland delivers health and social care. This includes ensuring digital inclusion is embedded in national transformation programmes such as the Digital Front Door, ensuring that everyone—regardless of their age, income, health or background—can access the benefits of digital health and care.

APPENDIX 1: FUNDED PROJECTS

Digital Pioneers Mental Health Fund

Organisation Name	Project Summary	Amount Awarded
Carr Gomm	Carr Gomm's Connected Lives project builds on the learning from their previous Digital Inclusion Research Project (DIRP). Funding allowed them to expand their digital inclusion support across Glasgow's Integrated Services and enhance support through establishing a safe, online peer network to facilitate improved wellbeing through meaningful community connections. The project supported 53 people, 40 staff and volunteers and trained 9 digital champions.	£54,667
Saheliya	Saheliya Digital Pioneers project works with marginalised New Scots women in Edinburgh and Glasgow to increase their digital skills and confidence. Funding allowed them to continue to deliver digital inclusion and language sessions to improve skills and confidence to access further supports and services to improve mental health and wellbeing. The project supported 54 people, 5 staff and volunteers and trained 5 digital champions.	£54,773
Moray Wellbeing Hub CIC	Moray Wellbeing Hub's Digital Mental Health Capacity Building project established a digital mental health hub to improve digital skills and access to services in Moray. Funding allowed them to build on current work with Health and Social Care Partnership Moray to offer online and in person digital support to improve digital skills and confidence and social connections. The project supported 729 people, 26 staff and volunteers and trained 31 digital champions.	£54,982
Scottish Action For Mental Health	The Scottish Action for Mental Health's Enduring Digital Accessibility project works with people in supported living settings to enhance their digital skills and confidence. Funding allowed them to expand and formalise their existing digital inclusion activities in Edinburgh, Perth and Glasgow and increase access to online supports and services. The project also enhanced staff and participants' access to their care management system to improve peoples' engagement within their individual care plans. The	£51,270

	project supported 22 people, 30 staff and volunteers and trained 7 digital champions.	
Cyrenians	Cyrenians Digital Inclusion project works with people facing long term unemployment, transitioning from hospital care and living in residential care. Funding allowed them to expand their current digital inclusion activities and provide a digital hub at their Farm, one to one support and in-depth digital skills support in Edinburgh and West Lothian. The project supported 34 people and 7 staff and volunteers.	£36,244
Just Bee Productions	Just Bee's Just Breath project works with people to reduce mental health inequalities, assessments and waiting times to access services. Funding allowed them to deliver a variety of digital inclusion activities with people in crisis to improve their digital skills and confidence to access services and supports to support their Mental Health. The project supported 93 people, 4 staff and volunteers and trained 1 digital champion.	£54,229

Digital Pioneers Housing Fund

Organisation Name	Project Summary	Amount Awarded
Aberdeen Foyer	Aberdeen Foyers Housing Digital Support project work with young people in Aberdeenshire at risk of experiencing homelessness. Funding allowed them to expand their current services to provide devices, connectivity and digital inclusion support to improve access to supports and services and to reduce isolation. The project supported 43 people, 5 staff and volunteers and trained 1 digital champion.	£54,867
Blackwood Homes and Care	Blackwood's Digital Buddies project worked with older people in supported living accommodation, in rural areas in Scotland. Funding allowed them to expand their current digital inclusion model across newly acquired supported living accommodation. The project supported 45 people and 30 staff and volunteers and trained 5 digital champions.	£55,000
Simon Community Scotland	Simon Community Scotland's Get Connected Housing project works with people experiencing homelessness. Funding allowed them to embed their	£54,982

	existing digital inclusion approach within their Housing First & Housing Support Services within Edinburgh. The project provided devices, connectivity and one to one digital support to work with people transitioning from homelessness and temporary accommodation to sustained tenancies. The project supported 132 people, 19 staff and volunteers and trained 8 digital champions.	
Prospect Community Housing Limited	Prospect Community Housing's Link Up project works with people with a disability or long-term health condition in Wester Hailes. Funding allowed them to continue to work in partnership with WHALE arts to deliver digital drop-ins and one to one support to improve digital skills and confidence. The project supported 43 people 5 staff and volunteers and trained 1 digital champion.	£31,310
Shettleston Housing Association Limited	Shettleston Housing Association's Shettleston Does Digital project works with older adults who are not in work or are retired. Funding allowed them to expand their existing digital inclusion work in partnership with Fuse Youth Cafe to deliver digital drop-ins and digital skills training to improve digital confidence and increase access to services and support. The project supported 157 people, 10 staff and volunteers and trained 9 digital champions.	£54,980
Link Living	Link Living's Digital support service supports young people and people with moderate to severe mental health conditions across Edinburgh to improve digital skills. Funding allowed them to continue delivery of their Digital Support Service providing connectivity, devices and one to one support to improve digital skills and confidence. The project supported 72 people and 1 member of staff.	£50,268
Queens Cross Housing Association Limited	Queens Cross Housing Association's Digital Spaces in Community Places works with multiple digitally excluded groups across communities in Glasgow. Funding allowed them to continue delivering digital sessions including coding for young people, digital cafes for older people and structured course content across 4 community facilities in Glasgow. The project supported 149 people, 40 staff and volunteers and trained 15 digital champions.	£42,753

Digital Pioneers Progress Fund

Organisation Name	Project Summary	Amount Awarded
Moray Wellbeing Hub	Moray Wellbeing Hub's Digital Inclusion Pathways to Health and Social Care project provided devices and digital support to those affected by ill health, carers, people experiencing homelessness, and victims of crime and abuse in Moray. Partnering with Health and Social Care Moray, See Me, and SACRO, the project offered digital training for staff, peer-led support, and signposting to digital health services. The project supported 604 people and 31 staff and volunteers.	£27,462
Prospect Community Housing	Prospect Community Housing's Link Up project supported tenants and residents in Wester Hailes living with disabilities or long-term health conditions by partnering with the local GP practice, the Health Agency, and Community Link workers. The project offered digital inclusion activities through one-to-one and drop-in sessions at local venues, aiming to boost digital skills and confidence. This improved access to self-management tools, eConsult, and other digital health resources. The project also expanded referral pathways and leveraged partnerships within the Living Well Wester Hailes network to explore additional referral routes. The project supported 33 people and 26 staff and volunteers.	£19,354
Queens Cross Housing Association	Queens Cross Housing Association's Digital Spaces in Community Places project partnered with Won Connect to expand digital inclusion activities. The project offered training and support to improve access to online health services and resources for digitally excluded people in Glasgow. Collaborating with local health centres and pharmacies, the project improved access to digital health tools, provided digital inclusion training for health service staff, and enhanced referral pathways for digital inclusion support. The project supported 50 people and 30 staff and volunteers.	£25,298
Saheliya	Saheliya's Mind the Gap project collaborated with female refugees and asylum seekers impacted by trauma to address digital inclusion barriers. The project gathered evidence on challenges in accessing	£27,387

	health services digitally, explored best practices, and enhanced referral pathways and available digital inclusion support for marginalized women. The project improved mainstream understanding, highlighting community-specific needs, and provided digital skills training for staff supporting women to enhance uptake and access to appropriate health and care services, supports, and resources. The project supported 17 people and 11 staff and volunteers.	
Scottish Action for Mental Health	Scottish Action for Mental Health Digital Mental Health Self-Care project supported the development of digital self-care plans for people living with severe and enduring mental health conditions. The project allowed staff to explore plans with service users which included mood tracking, resource libraries, and self-assessment tools, promoting digital self-care and community support awareness. The project aimed to continue to improve digital inclusion support, track user engagement, and link technology-enabled care to proactive mental health support and care plans. The project supported 311 people and 92 staff and volunteers.	£27,387
Shettleston Housing Association	Shettleston Housing Association and Fuse Youth Café's "Shettleston Does Digital" project offered digital inclusion support to tenants and residents at risk of exclusion. Building on their existing programme, the project developed activities to provide essential digital skills for self-management of health conditions, access to online health information, and use of digital health tools. The project improved routes to health and care services digitally by developing new connections with local health services. The project supported 88 people and 10 staff and volunteers.	£26,940
Simon Community Scotland	Simon Community Scotland's Get Connected Health Project supported street-focused individuals experiencing homelessness in accessing health and care services. Partnering with The Access Place Edinburgh, the project enhanced their digital inclusion model to address the unique needs and challenges faced by this population. A digital link worker collaborated across services to provide both in-person and digital health and care support. The	£26,897

	project supported support 20 people and 4 staff and volunteers.	

Connecting to Care Fund

Organisation Name	Project Summary	Amount Awarded
Advocard	Avocard's Digital Advocacy project provides support for people living with mental health conditions to access digital health services in Edinburgh. The project provides one-to-one digital support and advocacy for people who are unable to engage effectively with digital health services. The project has supported 19 people and 9 staff and volunteers.	£80,000
Centred	Centred's Digital project works in partnership with Mhor Collective and NHS Community Link and Health Improvement Services to develop and implement a digital inclusion programme for people experiencing mental health challenges in Highland. The project works to establish defined and implemented referral pathways with NHS practitioners to offer digital support to improve access to digital health services and supports. The project has supported 6 people and 17 staff and volunteers.	£67,440
Fife Council	Fife Council Housing Plus Team in partnership with Connect Fife provide support and access to digital health and wellbeing tools for older people living in Fife. The project provides digital inclusion support as well as access and use of the Life Curve online tool to encourage self-management of health and care needs for independent living. The project has supported 34 people and 34 staff and volunteers.	£72,566
Lead Scotland	Lead Scotland's Digital Skills for Health and Wellbeing project provides digital inclusion learning activities and support for people living with disabilities. The project promotes access to digital health supports and explores and informs the challenges and learning around accessibility within health and care services for people living with disabilities, and their carers in Aberdeen city and South Aberdeenshire. The project has supported 41 people and 12 staff and volunteers.	£79,025

Link Living	Link Living working in partnership with NHS Fife Digital Therapies Team supports individuals living in Fife with mental health conditions to improve access to digital therapies and reduce treatment waiting times. The project aims to embed digital inclusion within the NHS service and supports people to develop the skills and confidence necessary to access online digital therapies. The project has supported 20 people and 2 staff and volunteers.	£79,907
The Ayrshire Community Trust	The Ayrshire Community Trust in partnership with NHS Ayrshire & Arran, North Ayrshire HSCP develops digital inclusion support and resources for in-patients and outpatients receiving treatment in an integrated mental health facility and community hospital covering South, East and North Ayrshire. The project develops resources and support people to access relevant digital health and care tools and services to help with self-management of mental health conditions. The project has supported 3 patients and 29 staff and volunteers.	£53,444
The Health and Social Care Alliance Scotland (the ALLIANCE)	Health and Social Care Alliance Scotland's Digital Links Project supports people referred via the Community Link Workers Programme in Glasgow to increase their knowledge and access to digital health and social care tools. The project provides digital inclusion support, training, and updates to their Local Information System ALISS with relevant health and care resources to support people in improving and self-managing their mental health and well-being. The project has supported 11 people and 11 staff and volunteers.	£79,733

APPENDIX 2: CASE STUDIES (SEPARATE DOCUMENT)