Engaging rural, remote and very remote community members in frailty research

Hearing it from *you*

Australian Frailty Network

phn WESTERN QUEENSLAND
An Australian Government Initiative

Contents

Executive summary	3
Background	4
Methods	6
Key findings	8
Identified research priorities	15
Recommendations	16
Future directions	17
Acknowledgements	17
References	19
Appendices	20

The AFN acknowledges the Traditional Owners and their custodianship of the lands on which the AFN operates. We pay our respects to their Ancestors and their descendants, who continue cultural and spiritual connections to Country. We recognise their valuable contributions to Australian and global society.

First Nations design agency Iscariot Media

Suggested reference:

Chopra S, Dampney P, Dunstan O, Ludlow K, Young A (2026) *Hearing it from you: Engaging rural, remote and very remote community members in frailty research. A report by the Australian Frailty Network for the Western Queensland Primary Health Network.*

Executive summary

Purpose of the report

People living with or caring for frailty in Western Queensland are experts in their own context.

To improve frailty care in rural, remote and very remote settings, Western Queensland PHN commissioned the Australian Frailty Network to collaborate with local partners, care providers, and community members. This report summarises community perspectives on frailty and consumer engagement and identifies local needs, priorities and research engagement barriers for people living in Western Queensland. Engagement occurred through community forums, focus groups, and stakeholder meetings across ten Western Queensland towns.

Alignment with Ageing in the Outback™ Vision

"All older persons in Western Queensland have access to informed, evidence-based healthcare services to support personal decision-making and optimise wellbeing."

This project strengthens the Ageing in the Outback™ strategy by addressing its three ambitions— **redefining engagement, improving navigation,** and **enhancing access to care**— while ensuring that rural, remote and very remote voices shape future research and service design.

Key findings

1. **Engagement and Belonging**

Frailty is more than physical decline; mental health and social isolation are major concerns. Stigma and reluctance to seek help persist, especially among men. Community programs like 60 & Better are valued but need better promotion and inclusivity. Workforce shortages and reliance on volunteers raise sustainability concerns.

2. **Navigation**

Service delivery is fragmented with gaps in aged care beds, screening services, and specialist availability. Mental health support is inconsistent and often reliant on fly-in fly-out models. Household assistance services are not well communicated and are perceived as rigid. Care coordination largely falls on individuals, creating stress and inequity.

3. **Access**

Distance and transport barriers significantly limit access to care, creating financial and emotional strain. This includes lack of affordable local transport within towns. Workforce shortages and high turnover undermine continuity of care. Telehealth helps but is limited by digital literacy and infrastructure gaps. Education for healthcare professionals and communities is urgently needed.

4. **Research Engagement**

Community members expressed a desire to be involved in research that has local impact. Place-based approaches are needed to build trust, get the word out and understand context. Specific strategies are needed to reach those who are very social or geographically isolated.

Background

An overview on frailty

Frailty is a state of vulnerability characterised by a loss of reserve across multiple physiological systems[1]. Put simply, someone who is frail is less able to "bounce back" after a stressor event, be that something minor like a urine infection or a more significant event like a fractured hip. Frailty is an age-related condition, but does not only affect older adults and not all older adults are frail.

Around one in four older Australians are frail[2]. Frailty is a major health problem, especially in older adults and people living with chronic diseases, and can lead to falls, hospitalisation, worsening mobility, functional dependence, and death. Frailty is a dynamic state with possibility for both improvement and deterioration. There are proven interventions to prevent and manage frailty that aim to optimise physical, cognitive and social functioning and manage chronic disease, with exercise, nutrition, social engagement and medication optimisation identified as the pillars for frailty management[3].

The Australian Frailty Network

The Australian Frailty Network (AFN) was established at The University of Queensland in 2023 to deliver a national response to help all Australians age well. The AFN strives to achieve this through knowledge creation and translation, implementation of research findings, and support of training initiatives to improve frailty outcomes for Australians and their caregivers. The AFN vision and statements of purpose and values are outlined in **Figure 1**.

The AFN is driven by the core principle of embedded consumer engagement, with a national Consumer Reference Group who bring valuable perspectives of lived, living and caregiving experiences of ageing and frailty from across all Australian states and territories. The AFN is funded by the Medical Research Future Fund (MRFF) Dementia Ageing and Aged Care Mission (APP2016045) and is led by Professor Ruth Hubbard.

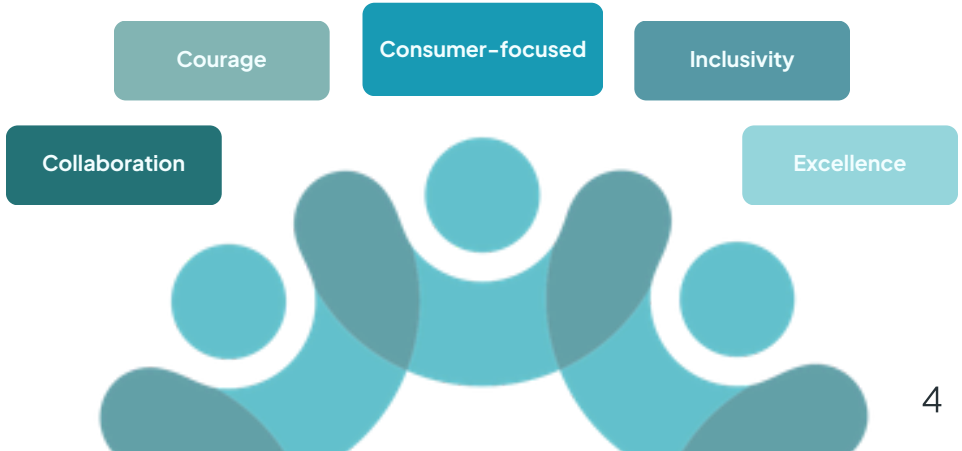
Figure 1. Australian Frailty Network Vision, Statements of Purpose and Values.

Our Vision

To deliver a national response to frailty and help all Australians age well.

Statements of Purpose

- Establish stakeholder priorities for frailty and ageing research.
- Facilitate and conduct high-quality research that generates new knowledge to improve health outcomes.
- Share evidence-based information about frailty and ageing with the public and health professionals.
- Build capacity in multidisciplinary and translational frailty research.
- Enable translation of research into practice and policy through our collaborations and partnerships.



Frailty in rural, remote and very remote areas of Australia

Frailty is increasingly visible across Australian health and social care, yet its impact is not uniformly shared across geographical areas. Research predicts that the rates of frailty in rural, remote and very remote areas of Australia are projected to increase at a more rapid rate than in metropolitan centres[4]. People living in rural, remote and very remote communities experience higher inequalities across most social determinants of health that contribute to poor health[5], including financial stress, limited transport, workforce shortages and long travel distances for specialist care[6]. Despite this, most frailty research, service design and guideline development has been shaped by urban experiences. Rural, remote and very remote voices are often underrepresented in the evidence base that informs investment, models of care and outcome measures.

The Western Queensland Primary Health Network (PHN) recognises the unique challenges with frailty and ageing in rural, remote and very remote communities. Western Queensland PHN is one of 31 PHNs established and funded by the Australian Government to improve the quality, and accessibility of primary health care within their regions, especially for populations at greater risk of adverse health outcomes. The Western Queensland PHN is responsible for representing and meeting the health needs of a population of about 64,000 people spread across an area of nearly 1 million square kilometres [7] (**Figure 2**).

Figure 2. Geographical area of the Western Queensland Primary Health Network[8].

One of the key priorities of the Western Queensland PHN is to enhance the accessibility and engagement of evidence-based healthcare services for older persons living in the region. In response, they have developed the Ageing in the Outback™ Strategy and Implementation Plan (2024-2026) which aims to achieve the following vision: All older persons in Western Queensland have access to informed, evidence-based healthcare services to support personal decision making and opportunities to optimise wellbeing. The strategy outlines three ambitions: redefining engagement, improved navigation, and enhanced access to care for older adults (**Figure 3**).

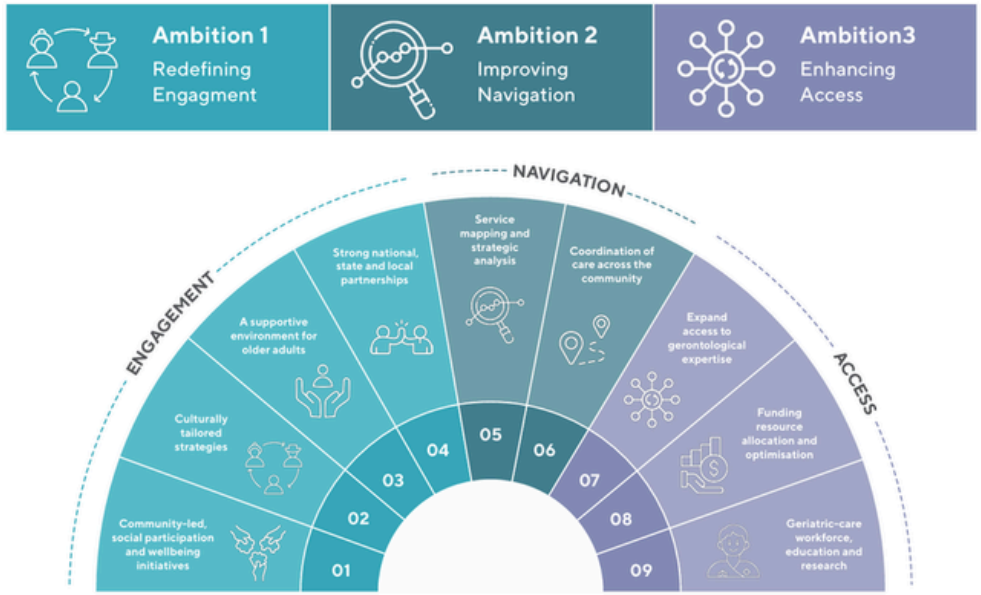


Figure 3. Overview of the Western Queensland PHN's Ageing in the Outback™ strategy.

Rationale and Justification for the Project

The WQPHN has commissioned the AFN to conduct a consumer engagement and research initiative, "Hearing It From You", to deepen community engagement and identify research priorities and methods that reflect the needs, aspirations, and constraints of people living in rural, remote and very remote areas of Western Queensland.

Our aims for this project were to:

- Explore how people living in rural, remote and very remote areas of Western Queensland experience health and aged care services and to identify their local needs, priorities, and preferences.
- Understand how people living in rural, remote and very remote areas of Western Queensland want to be involved in frailty research and how the Australian Frailty Network (AFN) can support their ongoing engagement.

The "Hearing it From You project" directly supports Ageing in the Outback™ ambitions to redefine engagement, improve navigation and enhance access. It also strengthens the AFN's national vision by broadening the Consumer Reference Group and building sustained connections with Western Queensland communities. Importantly, the project does not seek to duplicate existing activity. Instead, it provides a structured way to listen, document, prioritise, and connect local ideas with research capability and funding pathways.

Methods

A team of researchers and community engagement professionals undertook field work in rural, remote and very remote areas of Western Queensland across 10 days:

- **Roma, Charleville, Mitchell, Morvan** (12-16th October 2025)
- **Longreach, Barcaldine, Winton** (27-31st October 2025)

This project involved focus groups and interviews with care workers, consumers and caregivers; meetings with health service representatives; and community forums. Ethics approval was received for the research component of the project (Reference No: 2025/HE000924).

> Our team comprised five women, none of whom had spent substantial time in rural, remote and very remote areas of Australia prior to this project. No team members identified as Aboriginal or Torres Strait Islander; therefore, we did not lead targeted engagement with Aboriginal and Torres Strait Islander community members or undertake visits to Aboriginal communities.

Focus groups and interviews

Eight focus groups **(n = 47)** and **seven** individual interviews (1–1.5 hours) were conducted with community members and health and aged care providers. See **Appendix A** for a breakdown of participants by location. Invitations were disseminated widely through WQPHN contacts, social media and emails; flyers were also placed in small business around the town. All participants provided written informed consent. In line with Qld Consumer remuneration guidelines, consumer and caregiver participants received a $50 gift card to thank them for their time.

The focus groups and interviews were held in community spaces such as health service meeting rooms, libraries, and town halls; three of the focus groups were held online to capture those who were not available during the visit. Discussions explored community needs and priorities; preferences for engagement in frailty research; perceived barriers to, and facilitators of, research engagement; and ideas for improving inclusivity and accessibility. The interview guides are available at **Appendix B and C**.

Mitchell Multipurpose Health Centre

Meetings with service providers

Complementing the formal focus groups and interviews, the project team conducted targeted site visits and consultative meetings with key stakeholders across the region. These engagements included discussions with clinical managers at Multipurpose Health Services and hospitals, residential aged care staff, local councillor, and coordinators of community programs such as the Royal Flying Doctor Service. Visits typically involved facility tours and semi-structured discussions focused on understanding the operational landscape, including service delivery models, infrastructure capabilities, workforce constraints, and local approaches to frailty care.

Community forums

A total of four public community forums were held in key townships, with a focus on engaging people living with frailty, chronic conditions, and their caregivers. These informal sessions created space for local voices to shape discussions around frailty research and service needs. A central aim was to demystify frailty while ensuring that the lived realities of rural, remote and very remote communities meaningfully inform future research priorities.

Key findings

Data from all engagement activities have been synthesised and mapped to the three ambitions of Western Queensland's Ageing in the Outback™ strategy.

1. **Engagement and Belonging: Strengthening Communities to Reduce Isolation**

Frailty is more than the physical – social and mental health considerations

Frailty in rural, remote and very remote communities is not limited to physical decline; it encompasses mental health and social dimensions that significantly impact wellbeing. Community members emphasised that **"frailty is not just hips … there's cognitive frailty, mental frailty, and social frailty"**, with stigma and reluctance to seek help remaining major barriers: *"Many reluctant to seek help or admit vulnerability"; "Men ignore it [frailty] more."*

Social isolation is compounded by distance, stigma, and lack of tailored services, particularly for those living alone: *"There is a high percentage of older people in Winton living on their own"; "People get so comfortable and they get in that routine at home … they've got each other, but those on their own really need it."*

Loneliness and practical support challenges were repeatedly raised, alongside a high prevalence of mental health concerns: *"We could have a lot more mental health support because we all get very depressed and down and need somebody to talk to"; "Many of us push it away and don't want to admit it is happening."* These insights underscore the need for holistic approaches that address stigma, strengthen social networks, and integrate mental health support into frailty care. Mental health first aid training was being delivered in Winton during the visit, however reflections from those involved suggest that adaption may be needed for this training to be fit for purpose in the and remote context.

Ageing well in rural, remote and very remote communities requires investment in the community itself

Ageing well in rural, remote and very remote communities depends on strengthening local programs, fostering social connection, and creating sustainable models for community involvement. Initiatives such as **60 & Better** were highly valued and described as *"essential for the ageing community and [they are] run well"*. However, participants noted the need for better promotion and inclusivity, particularly for men and younger seniors. The beauty of these communities lies in their strong social fabric, with many examples of people looking out for each other: *"The community will get together. With my problem on Monday, one lady stopped at my gate and then we ended up with six, seven men who all came in to help."*

Many formal and informal care services are delivered by older people, raising concerns about sustainability: *"Every organisation in town has this problem … a battle to get people to volunteer."* Without engaging younger community members, ageing in place will likely become increasingly difficult in Western Queensland communities.

Communication barriers further limit service delivery, as one participant observed: *"We used to have our own weekly newsletter … That's what this town misses."* Reliance on Facebook excludes

60 & Better is a council-supported initiative offering a mix of activities for older adults. These were operating in Winton, Barcaldine; Similar programs were in operation in other towns (e.g. Healthy Living Program in Charleville).

those without digital access, and spreading information through existing services often reaches only those already engaged. Investment in community infrastructure, inclusive programs, and effective communication strategies is critical to ensure older adults can age well and remain connected.

Engagement and Belonging: Summary

Promoting social connectedness requires an expansion of inclusive, accessible community supports, such as 60 & Better program activities, buddy approaches, link-worker-assisted engagement, newsletter outreach, and targeted programs for older adults who are less engaged.

2. **Navigation: Navigating Fragmented Services towards Person Centred Care**

Services Gaps: Aged Care, Mental Health, Screening, Home Services

The services offered could be categorised as medical care, allied health services and household assistance. Community members appreciated the local health infrastructure including hospitals, nursing homes, public and private clinics and medical centres. Different services were available through government supported programs such as 60 & Better, Home and Community Care Program (HACC), My Aged Care, Royal Flying Doctor Service, allied health services and local council support services.

Despite the existing infrastructure and service support, the limited aged care beds (only six in Winton Hospital) and delays in establishing Jessamine Place (planned since 2011) illustrate gaps in current structural support. Community members also identified gaps in screening services such as breast cancer screening and bone density assessment, which increased the reliance on medical travel to obtain a diagnosis: *"If you have a colonoscopy in Longreach, you might not pay for one night but for three nights."* Dental care and specialist services such as gynaecology and obstetrics, gastroenterology, and eye specialist were delivered by fly-in, fly-out specialists, with some services available only once every two years:

"They will come when they want to come and not when we want them to be there."

Community members echoed the need for a more consistent mental health service delivery operated by local specialists: *"We could have a lot more mental health support because we all get very depressed and down and need somebody to talk to."* and highlighted promotion of programs like 60 & Better to foster social engagement within the community: *"We have all these things - like mark your calendar for this month - for Monday, we play scramble, crochet and chat with a cup of tea, Tuesday is movement, and Wednesday is crafts, and Thursday- morning tea ....."* that could mitigate for lack of consistent professional support.

In addition to healthcare service, gaps in household assistance and support services to support community members to live independently in the homes and communities was commonly addressed. Community members expressed some confusion around availability of household assistance services *"I had two people work for HACC live across me and they have seen me mow the lawn and they have never come to tell me about mowing the lawn even if they have seen me struggle with it."* Community engagement activities: *"Because I am not interested [in playing...*

...cards]. I can't fault them. They are trying the collected 'you' to get connected."

Coordination of Care Across the Community

Care coordination remains fragmented: *"You do the coordination yourself."* Community members are expected to self-coordinate household assist services such as shopping visits: *"They couldn't get them to change time for her [shopping]."* and medical travel for specialist appointments: *"Somebody needs to drive you to Longreach and come back so that is 5 hours."* Community members found this coordinator role distressing and expressed guilt over asking family members for help. On the other hand, healthcare providers have been struggling to support making the services available and more inclusive to the community members due to staff shortages, inadequate training, and work demands.

Incorporating Evidence-Based Geriatric Assessment Tools in Primary Care for Early Identification and Targeted Interventions

Community members across all sites noted rapid transitions from independence to frailty, often triggered by falls, illness, or loss of confidence. However, discussions around the geriatric tools and assessments did not come up in the discussions., which might also explain limited frailty-based interventions across sites.

Navigation: Summary

Strengthening the aged care system requires increased care capacity, establishing reliable frailty screening, integrated mental health and specialist services, and coordinated care navigation.

3. **Access: Enabling Access, not just Availability**

Navigating Care Across Distance

Distance to health services, particularly specialised care, tests, and treatment was identified as a significant barrier to accessing care in rural, remote and very remote communities: **"People don't realise how far we are."** Participants had to either make their own way to care services, often travelling long distances, or they relied on the Royal Flying Doctor Service (RFDS) to access care in other towns or cities. When visiting the RFDS in Charleville, staff members said that frail and older patients made up the majority of their caseload. While participants recognised that the service was essential, it removed patients from their supports and created additional challenges such as needing to find their own way to return home and caregivers being unable to accompany loved ones. One consumer recounted the distress of an emergency transfer: *"They put me on a board... No wallet, no phone, no nothing. Flew me to Toowoomba. Kicked me out of the hospital. And I had to find my own way home."*

Getting Around Town - Need for Local Transport Options

Local transport was also limited in most areas, which made visiting community and health services difficult, particularly for older or frail adults who did not drive. One participant noted the safety risks associated with older adults losing confidence on the road: *"They told me he drives at the highway at 50 or 60 and gives way to other people, but the confidence to drive is not there."* A police officer in Roma noted the limitations for those outside of town: *"You know, you can go into properties that can be an hour's drive and in effect they're stuck there... It's just not feasible."*

In Charleville, a care worker noted there was no public transport, meaning residents needed to rely on family, contact limited ride-sharing services, or connect with a community service which was said to cost $70 each way for a short trip. A Care Navigator highlighted the severity of these financial trade-offs for those on Home Care Packages: *"Make a choice here. Do you want the doctors, or do you want the groceries? What do you want? ... Because their packages don't fit both."* Financial pressures were also raised in terms cost of food (particularly where there was only one grocery store in town) and travel subsidies that do not nearly cover the costs of travelling to major centres, particularly for those without friends or family in the city. Community members acknowledged that distance and travel are part of living in rural, remote and very remote area, and were pragmatic with their expectations for solutions: **"we're probably not after a miracle, just some options."** Other towns, such as Roma and Winton, had access to a shuttle bus which made getting to appointments much easier.

Distance and transport barriers were said to lead to long wait times, inability to access treatment, financial burden, and emotional strain. In one focus group, participants spoke about not knowing the local transport systems in Brisbane and suggested a *"Brisbane Kit"* to educate people living in rural, remote and very remote areas about the logistics of visiting the city, noting: *"Getting on a bus is fine, but getting on which one? Got no idea what's going on."*

Challenges of Maintaining a Stable Health Workforce

Participants reported workforce shortages and high turnover of healthcare workers. Healthcare workers spoke about burnout and the inability to take breaks because there were no staff to replace them. Participants explained that the majority of specialist and allied healthcare was provided by fly-in fly-out professionals, leading to limited continuity of care. In Roma, a healthcare worker noted how this impacts discharge flow: *"We only get allied health info once or twice a week, so maybe they might sit in the hospital waiting until the next Friday just to be seen by the physio."*

Participants advocated for having onsite specialists to reduce delays and costs: *"We need permanent staff here, permanent people here."* In some communities and specialties (e.g. oral health, mental health) workforce shortages were evident, with one provider stating: **"There is no one. No one qualified, no one competent and no one trustworthy enough... [to] do it."**

One community member suggested that a hospital in Western Queensland should act as a hub for surrounding communities: *"Being the hub of the whole [South West] for those people, instead of going to Brisbane first, they can get triage here in the proper hospital."* Additionally, the Federal Government's Pacific Australia Labour Mobility scheme was identified in Longreach as enabling stability in the aged care workforce, and thus quality of care, by funding workers to live in the community for several years.

Telehealth helped to mitigate some challenges, but participants recognised it wasn't always appropriate. The telehealth centre in Longreach was identified as a key enabler to allow community members to use telehealth, without which specialist access would not be possible due to low digital literacy, poor internet connection and/or lack of computers that impede older adults navigating telehealth on their own.

The Need for Frailty-Focused Education and Training

When asked what solutions were needed for frailty-focused care, participants frequently spoke about the importance of education. Participants noted that some care professionals lacked training and were inexperienced, for example, in how to care for patients living with dementia or how to use specific equipment. At the Roma community forum, a community member explained that the nearby hospital had dialysis facilities but lacked trained staff:

“Intensive care and nobody knew how to work the dialysis [machine]. It was so old.”

This meant patients had to learn how to administer their own treatment or travel to Toowoomba or Brisbane.

Community education about frailty was also mentioned as a priority. Limited digital literacy was identified as a barrier to online education, with one provider noting, *“The older ones bring in their phones because they can't turn it on.”* Instead, it was was suggested that existing events and groups could be leveraged to educate the community face-to-face.

Access: Summary

Improving equitable access to care requires enhanced local transport, integrating frailty-focused training for the health workforce, expanding complementary telehealth options, and leveraging community networks for frailty awareness.

4. Engaging Western Queensland communities in research

This project confirmed the need for place-based engagement to effectively design and implement research studies in Western Queensland. Despite significant efforts to communicate with communities about the field trip, there was limited engagement at some events. Many attendees spoke about the *"seagull effect"* when out of town or urban based researchers or clinicians visit towns and take way stories and experiences from people without giving anything back to the community. Other attendees spoke about being overwhelmed with engagement, with so many services, organisations or researchers coming to town. Individuals expressed not always knowing what to attend, what to say or whether their experience would even be useful.

In locations such as Roma, the *"Roma Coma"* was cited as a reason for lower engagement, which was described as a common unwillingness to participate or an assumption that others would attend on their behalf. In other locations barriers such as lack of access to transport, time of day, carer responsibilities and health worker case overload were regularly identified as reasons prospective participants could not attend the scheduled focus groups and community forums. While the AFN Consumer Engagement Coordinator attended interagency meetings for both Maranoa and Longreach Councils and spoke about the planned itinerary in all areas, there was still a lack of commitment from agencies to attend events in person.

During the trip, individuals suggested improved future research engagement could be achieved via the following initiatives:

"Talking is the Best Form of Advertising"

- Walking around the town centre in the days before and introducing yourself to local services, businesses and customers.
- Setting up a table in front of the local IGA or bakery to hand out flyers and introduce yourselves to the community.

Communication Channels and Outreach

- Utilise local media sources such as ABC radio, community radio, local newspapers and community newsletters.
- Promote events via Facebook groups and Community Facebook pages/groups.
- Create a single, comprehensive flyer containing all session information for research outreach and associated events.
- Have a local champion in each area who can promote your events and research interactions by inviting you to meetings online beforehand, reminding others about your upcoming visit and also by printing out your flyers and putting them up on display.

Building Trust

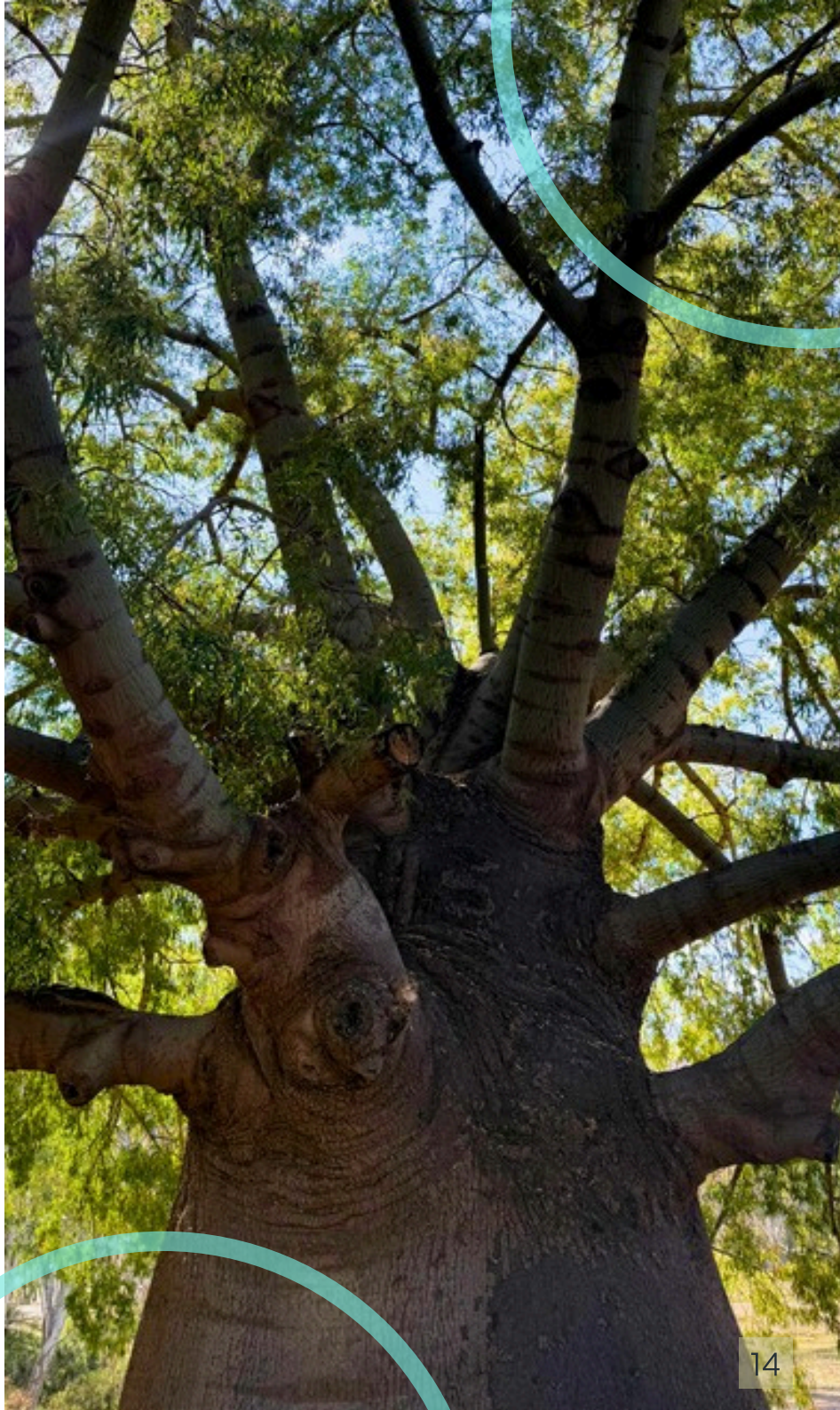
- Providing a short personal letter to participants with action points explaining what you are going to do and what the outcomes are to simplify all the paperwork.
- Being honest about what you can deliver and admitting "sometimes it's just watch this space".

Carer Involvement

- Understanding that the perspectives of carers is just as important as the perspective of the health consumers themselves: “It’s the carers that need to know as well, not just the older person.”
- Carers often also experience their own health problems and also are able to offer a different perspective of the health consumer’s experience.
- Health consumers may feel more comfortable with a carer or a support person present to help manage their emotions and also access different venue environments. Some individuals experiencing fatigue, cognitive impairment or communication difficulties may appreciate knowing a support person can assist them to participate.

Leveraging Existing Networks

- Consider timing your visits and engagement to coincide with local events such as festivals, fairs, Country Women’s events, rodeo events, cattle sales and arts events.
- Rather than expecting people to come to you, go to them. Find out when monthly meetings with groups like Healthy Ageing, 60 & Better, Council Interagency Meetings and other Allied Health groups and services are and ask to be invited to join the meeting.



Identified Research Priorities

Engagement

- Evaluate community-based programs (e.g., 60 & Better, Healthy Ageing, Men's Shed, Tai Chi) for reducing loneliness and improving mental health.
- Research stigma reduction strategies and ways to encourage help-seeking among older adults, especially men.
- Explore social connection models that sustain participation and foster intergenerational involvement.
- Trials of social prescribing in rural, remote and very remote contexts comparing different workforce models.
- Develop education and interventions for emotional wellbeing, mental frailty and mental health support that fit with the rural, remote and very remote context. Examples include adaptions to the Older Persons Mental Health First Aid program.
- Establish a 'Researcher in Residence' scheme where researchers and/or clinicians reside in a community for a period of at least 2 weeks. This would allow researchers/clinicians to develop greater relationships with health services, health providers and community members as well as to observe patterns and trends unique to each community.

Navigation

- Investigate navigation support models for rural, remote and very remote patients (e.g., link-worker roles, care coordinators).
- Explore experiences navigating aged care and NDIS access processes and eligibility criteria to inform improvements to simplify and streamline.
- Determine current and future need for aged care beds across rural, remote and very remote townships to inform advocacy for funding and investment to enable ageing in local communities; this includes need for beds in dementia secure units.
- Evaluate advocacy approaches to empower rural, remote and very remote voices in interactions with metropolitan health systems.
- Co-design integrated care models that reduce siloed operations and improve continuity across health and community services.

Access

- Co-design and evaluate cost-effectiveness of transport solutions for rural, remote and very remote areas (e.g., community transport co-ops, low-cost rideshare models).
- Economic modelling of innovative travel models for specialist appointments and hospital visits.
- Test incentives (housing, debt forgiveness, placements) for attracting and retaining staff.
- Assess impact of workforce shortages and strategies for retention, continuity, and training in aged care and health services.
- Evaluate telehealth models for specialist care and mental health support in rural, remote and very remote communities.
- Ageing and dying in place: Explore infrastructure and service models that enable end-of-life care at home.

Recommendations for Health and Aged Care Services in Western Queensland

Engagement and Belonging

- Ensure sustainability of community programs (e.g., 60 & Better, Men's Shed, walking groups) and expand these to new communities where possible.
- Formalise "buddy" systems for newcomers or those living alone.
- Embed brief mood and loneliness screening in routine health checks with referral pathways to tele-mental health or local counselling.
- Revive local non-digital communication channels such as newsletters, and use radio, posters, and mailbox drops to share events and services with people who do not use social media or email.
- Implement social prescribing and link worker roles in primary care practices to prescribe social activities, transport, and mental health supports for those at risk or affected by frailty.
- Review and reframe community service offerings to attract men (e.g., practical, informal sessions (BBQs, men shed chats)) and people who don't identify as older or frail (e.g., re-brand services as "staying strong" or avoiding specific ages).
- Small, rapid grants for new clubs particularly those targeting men and other less engaged groups (e.g., walking groups, card clubs, book circles, music afternoons).
- Create community transport co-ops with fuel vouchers and driver rosters for health visits and social events.
- Explore strategies to attract and retain younger volunteers to support community services that benefit older adults (e.g., micro-incentives such as fuel cards, recognition).
- Partner community groups and aged care providers with schools and training institutions to foster intergenerational engagement (e.g., tech-help afternoons, yard clean-ups, and oral-history projects).

Navigation

- Expand aged care capacity by increasing the number of beds and accelerating development of facilities like Jessamine Place.
- Establish regular schedules for essential screenings (e.g., X-rays, breast cancer, bone density) and ensure consistent specialist availability through stable workforce models.
- Invest in locally based mental health services and integrate mental health support into primary care.
- Promote and expand social engagement programs such as 60 & Better to strengthen community connection and wellbeing within the community.
- Introduce dedicated care coordination roles (e.g., care navigators or link workers) to reduce the burden on community members for self-coordination of health and household services.
- Embed frailty screening in routine primary care using simple, evidence-based geriatric assessment tools for early identification and intervention.

Access

- Invest in local and affordable transport options for accessing care services, such as a community shuttle bus.
- Develop a local hub for Western Queensland services to reduce travel and emotional strain. Ensure the Patient Travel Subsidy Scheme applies to this model to reduce out of pocket costs for patients and families.
- Explore patient driven models of care that allow patients to coordinate their care to see multiple specialists in one visit, and at times that appropriately allow for travel to appointments.
- Create a consumer information package about the logistics of visiting and accesses services in Brisbane and other major centres.
- Advocate for expansion of funding, incentives and supports for healthcare professionals to live and work in rural, remote and very remote communities.
- Continue to invest in services to support access to telehealth where appropriate as a complementary approach, rather than replacement for face-to-face care.
- Develop and/or implement frailty-focussed education programs for healthcare professionals and consumers.
- Leverage existing community groups and events to communicate frailty information.
- Develop frailty-focused education programs for healthcare professionals and provide community education on prevention strategies to slow transitions from independence to frailty.

Future Directions

- Expand AFN Consumer Reference Group to include interested community members so they can be involved in shaping future research initiatives.
- Seek funding to expand current AFN research initiatives to the rural, remote and very remote setting. Examples include:
  - **EMPOWER:** design and implement a frailty response framework to reduce avoidable presentations to emergency and acute care services.
  - **Primary Care:** adapt frailty pathways and integrate within frailty screening initiative being implemented in the Alliance for Healthy Ageing (AHA) project.
  - **FITTEST:** adapt and test this model of frailty prevention in rural, remote and very remote setting.
- Collaboration on future initiatives by identifying appropriate funding schemes to design research studies to address identified research priorities.
- Explore opportunities for "Researcher in Residence" programs to allow frailty researchers to spend extended periods working in rural, remote and very remote settings.
- Partnership with Queensland Health's Dementia and Frailty Clinical Network (QDAF) to better support hospital to community transitions for people living in rural, remote and very remote communities.
- Explore the specific needs of priority populations in Western Queensland. This current field trip involved limited engagement with Aboriginal and Torres Strait Islander community members, those from Culturally and Linguistically Diverse Backgrounds and those who are geographically isolated (e.g., living in very remote areas or homebound), which could be a focus of future engagement.

Acknowledgements

We are thankful to each individual who took the time to speak with us. Your humour, wit, resilience, kindness and strength of character touched us all so deeply. We saw and heard that "there are places beyond Toowoomba", and throughout our conversations, we came to see just how differently each person, town and community experiences living with and/or caring for others with frailty.

We would like to express our utmost gratitude to the Western Queensland PHN and their staff for funding this trip and hosting us within your communities. In particular we thank Sally Fraser (Specialist Advisor) for her advocacy, encouragement and support of our trip, and Leisa Fraser (Acting Executive Head of Strategy, Planning and Performance) for her administrative support and making time to meet with us in Winton. Additionally, we thank Sheridan Hammet (Coordinator Aged Care) and Rachel Bock (Project Manager, Integrated Care and Commissioning) who took the time to meet with us on the ground and provided so much support before we even landed.

At the Australian Frailty Network, we would like to thank our Director Professor Ruth Hubbard for her support of this endeavour. We would also like to thank Ms. Janice Porter (Knowledge Translation Officer) for her contribution to the design of our advertising materials, the trip's online event promotion and registration as well as social media content produced during both trips. Our gratitude also goes to Ms. Sarah Martin (Research Assistant) who assisted with our research ethics application and initial resource development, and to Ms. Donna Reidlinger (Senior Operations Manager) for her administrative and logistical support through the whole project.

As the authors of this report, we are deeply grateful for the opportunity to take this trip together, that bonded us as a research team and as honorary members of the Western Queensland community, if only for a short time and with a view to return one day soon.

Authors

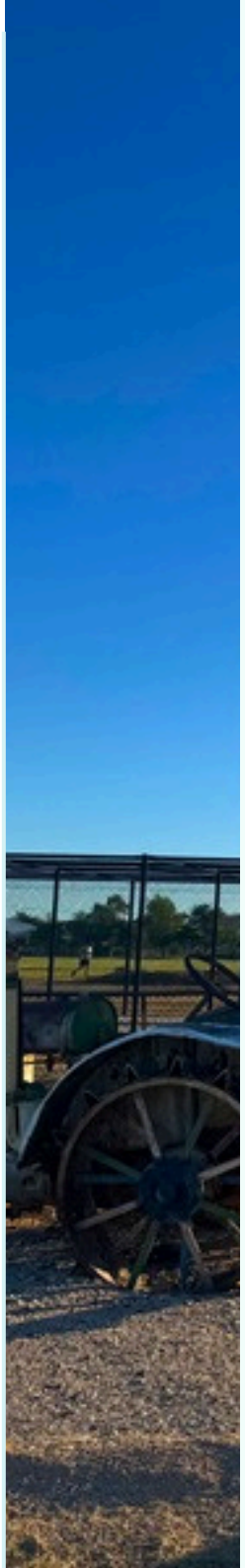
Dr. Sakshi Chopra
Mrs. Peta Dampney
Ms. Olivia Dunstan
Dr. Kristiana Ludlow
Dr. Adrienne Young

Enquiries

afn@uq.edu.au

We would like to thank the following **individuals, groups and services who contributed to this project and report:**

- Maranoa Regional Council
- Maricris Bracamonte (Community Support Officer – Regional Economic and Community Development at Maranoa Regional Council)
- Pinaroo Roma Aged Care Facility and staff
- Anna Cross – Director of Nursing at the Mitchell Multipurpose Health Centre
- The staff and patients of the Mitchell Multipurpose Health Centre
- Victoria Nancarrow from the Royal Flying Doctor Service (Community Engagement Coordinator)
- The staff at the Royal Flying Doctor Service at Charleville
- Sandra Gurney (Community Service Coordinator – Shire of Murweh)
- Emily Cole (Project Officer – Healthy Ageing Charleville)
- Staff and Participants at Charleville Healthy Ageing
- Staff and Participants at Morven Healthy Ageing
- The staff at Great Artesian Spa at Mitchell
- Tyler Hunt (Business Support Officer – Longreach Regional Council)
- Longreach Community Library and Staff
- Rhonda Jackson (Administration Manager at Pioneers Residential Aged Care)
- Staff and Residents at Pioneers Residential Aged Care
- Tony Rayner – Mayor of Longreach
- Gillian O'Brien - NDIS Community Care Services Officer – Barcaldine Regional Council
- The residents of the Barcaldine Beech Street Aged Care Facility
- The staff of Barcaldine Multipurpose Health Centre
- Jean Williams (60 and Better Program Coordinator – Barcaldine Regional Council)
- The staff at Winton Neighbourhood Centre
- The members and staff of Winton's 60 and Better Program
- The staff at Winton Multipurpose Health Centre
- The Facebook page group admins for Roma, Charleville, Longreach, Barcaldine and Winton
- Attendees at the Maranoa Council Interagency meeting and Longreach Shire Council



References

1. Kim DH, Rockwood K. Frailty in Older Adults. N Engl J Med. Aug 8 2024;391(6):538-548. doi:10.1056/NEJMra2301292
2. Thompson MQ, Theou O, Karnon J, Adams RJ, Visvanathan R. Frailty prevalence in Australia: Findings from four pooled Australian cohort studies. Australas J Ageing. Jun 2018;37(2):155-158. doi:10.1111/ajag.12483
3. Dent E, Lien C, Lim WS, et al. The Asia-Pacific Clinical Practice Guidelines for the Management of Frailty. Journal of the American Medical Directors Association. 2017;18(7):564-575. doi:10.1016/j.jamda.2017.04.018
4. Taylor D, Barrie H, Lange J, Thompson MQ, Theou O, Visvanathan R. Geospatial modelling of the prevalence and changing distribution of frailty in Australia – 2011 to 2027. Experimental Gerontology. 2019/08/01/ 2019;123:57-65. doi:https://doi.org/10.1016/j.exger.2019.05.010
5. Flavel J, Kedzior SGE, Isaac V, Cameron D, Baum F. Regional health inequalities in Australia and social determinants of health: Analysis of trends and distribution by remoteness. Journal Article. Rural and Remote Health. 2024;24(1):1-11. doi:10.22605/RRH7726
6. Parsons K, Gaudine A, Swab M. Experiences of older adults accessing specialized health care services in rural and remote areas: a qualitative systematic review. JBI Evidence Synthesis. 2021;19(6)
7. WQPHN. WQPHN About Us. 2026. https://www.wqphn.com.au/our-phn/about-wqphn
8. WQPHN. Western Queensland Primary Health Network (PHN) map – topographic. Australian Government Department of Health, Disability and Ageing. 2026. https://www.health.gov.au/resources/publications/western-queensland-primary-health-network-phn-map-topographic?language=en

Appendices

Appendix A: List of participants by location

Location	Number of participants
Roma	**11**
Charleville	**9**
Morven	**8**
Mitchell	**2**
Longreach	**5**
Barcaldine	**7**
Winton	**10**
Blackall	**1**
Tambo	**1**

Appendix B: Care provider focus group/interview guide

Note: This guide will be adapted slightly to accommodate individuals who would prefer or require an individual one-on-one interview with the research team. The guide may also be iteratively adapted in response to participant feedback and engagement to enhance participation.

Resources Needed:

- Recording devices
- Butcher paper, pens and markers
- Whiteboard markers
- Post it notes
- Mental health services flyers
- AFN Consumer Engagement Flyers

Housekeeping points:

- Hello, welcome and facilitators introduce themselves to attendees

Acknowledgement of Country – *"We would like to acknowledge the traditional custodians of the lands (insert local custodian group here) upon which we have all come together to meet, share and connect today. We would also like to acknowledge that you may have come from lands of different traditional custodians today and we invite you to share that as we go through our conversations today. We would also like to acknowledge any first nation peoples with us here today and thank them for their contributions to this area".*

Acknowledgement of Lived/Living Experience: *"At the Australian Frailty Network, the lived and living experiences of those impacted by frailty and their caregivers is central to the work that we do. While we realise that you are attending today as care providers it is important to recognise that you at times may have been impacted by frailty yourself or taken on the role as a caregiver to someone impacted by frailty. These are also lived and living experiences of frailty. So, thank you for coming today to share your experiences and expertise and wish to reassure you that what you share today will influence the work that we do at the AFN. Talking about these types of experiences can be upsetting at the time or even afterwards so I'd like to remind you that please take one of these flyers afterwards or feel free to chat with one of us after the session today".*

"Today's session will go for 60-90 minutes. We want to hear from you about what it is like to care for and work with those impacted by frailty as well as their caregivers. So, we will be asking you all some questions and doing some activities together. Please be sure to ask us any questions as we go through the session".

Question 1. What is frailty? (creating a shared understand)

"In order to gain a shared understanding of frailty, so we are all on the same page, I'd like to hear what frailty means to you, and then I'll share the definition we use to see how our views of frailty are similar or differ".

Facilitators encourage each attendee to share their own definitions of frailty.

"We'd now like to share with you how the Australian Frailty Network and most clinicians/researchers define frailty - Frailty is characterised by a decline of physical and cognitive capacity that leads to increased vulnerability. Frailty may also be influenced by social, emotional and mental health factors. People who are frail often have reduced physical functioning, for example, reduced strength and endurance. Frailty results in a higher risk of poor health outcomes such as falls, hospitalisations, disability and poor quality of life. While frailty is associated with ageing, they are not the same thing. younger people can also be frail, and not all older adults are frail."

Questions 2. What services or supports are most needed in your area to assist those living with frailty or those caring for someone living with frailty?

"*I'd like you to discuss together and write down how you would change or improve services or supports in your community as well as what new services or supports might be needed that have not previously existed. You might like to think of a time or experience when you have been caring for a patient impacted by frailty and you thought "I really wish that kind of service or support existed in this community for them" or "this would really help my patient's caregivers to support their loved one or even themselves better".*

Provide attendees time and encouragement to complete this task and allow for a few minutes if needed.

"*As we finish up this discussion, I'd like you to choose 3-5 services or supports that you have chatted through and believe are the most essential to support the needs of those living with frailty or caring for those living with frailty in your community*".

Provide time (1-3 minutes) for group to choose most important services/supports.

"*Ok, let's chat those 3 – 5 more through now together and as we talk these through, I'd like you to really focus on why these supports or services are important in relation to the area in which you work, treat patients and live as a resident of this area yourself*".

Facilitator to encourage and lead chat through those 3-5 services and supports.

Questions 3. How do those with a lived and living experience in Western QLD (RRR) want to be involved in frailty research?

"*The reason we are out travelling and speaking to you all is we want to ensure that the lived and living experiences of frailty from a Western QLD, (RRR) perspective is brought more into focus when designing, developing and undertaking research into frailty. We have had the opportunity to speak with and learn from consumers/patients in this community but what we'd like to hear from you all now together is how do you think research institutes or hubs like us can engage your perspectives as a care providers into frailty research and how we can involve you more in the research that we are doing?"*

Facilitators encourage each attendee to share their own thoughts about this question.

Question 4. How can we also better engage with and involve your patients and their caregivers in what we are doing as well?

"*How do you think we can also better engage with and involve your patients and their caregivers in frailty research? Is there anything that might act as a barrier to their engagement and how could we address these barriers?*"

Question 5. What research areas in frailty research should be most focused on?

"*Reflecting on what we have spoken about today, what are the most important topics that you think frailty research should focus on in the future?*"

Closing

"*That brings our session to a close and we would just really like to thank you for your time today. We have really appreciated learning from you all. We also have some information about joining the Consumer Reference Group at the AFN if that is something that you might like to promote to your patients/consumers, family, colleagues or friends. We will be sticking around for a little bit if you have any questions or would like to go over anything and as mentioned we have those flyers if you would like to know of some local supports. Before you leave today, there are some post it notes here and we would love you to jot down some thoughts or learnings that you will take from today as a way to close things. Thank you so much and lovely to have met you all today*".

Facilitators take time packing up and ensuring any questions or support provided if and as needed.

Appendix C: Consumer group focus group/interview guide

Note: This guide will be adapted slightly to accommodate individuals who would prefer or require an individual one-on-one interview with the research team. The guide may also be iteratively adapted in response to participant feedback and engagement to enhance participation.

Resources Needed:

- Recording devices
- Butcher paper, pens and markers
- Western Qld PHN Flyers
- Gift cards
- Post it notes
- Mental health services flyers
- Australian Frailty Network Consumer Engagement Flyers

Housekeeping points:

- Hello, welcome and facilitators introduce themselves to attendees
- General reminder of exits, location of toilets etc.
- Check lighting is okay, sound is okay etc.

Acknowledgement of Country – *"We would like to acknowledge the traditional custodians of the lands (insert local custodian group here) upon which we have all come together to meet, share and connect today. We would also like to acknowledge that you may have come from lands of different traditional custodians today and we invite you to share that as we go through our conversations today. We would also like to acknowledge any First Nation peoples with us here today and thank them for their contributions to this area".*

Acknowledgement of Lived/Living Experience: *"At the Australian Frailty Network, the lived and living experiences of those impacted by frailty and their caregivers is central to the work that we do. We thank you for coming today to share your experiences and expertise and wish to reassure you that what you share today will influence the work that we do at the AFN. Talking about these types of experiences can be upsetting at the time or even afterwards so I'd like to remind you that please take one of these flyers afterwards or feel free to chat with one of us after the session today".*

"Today's session will go for 60-90 minutes. We want to hear from you about what it is like to be impacted by frailty or care for those impacted by frailty in this area so we will be asking you all some questions and doing some activities together. Please be sure to ask us any questions as we go through the session".

Question 1. What is frailty? (creating a shared understand)

"So firstly, you'll notice that we've been using the word frailty a lot and we can share with you in a bit the definition that clinicians and researchers use to define frailty but what we are really interested in today is how you define frailty or how you would explain it to someone else. So, if we could take turns sharing how you would define frailty in your own words"

Facilitators encourage each attendee to share their own definitions of frailty.

"We'd now like to share with you how the Australian Frailty Network and most clinicians/researchers define frailty - Frailty is characterised by a decline of physical and cognitive capacity that leads to increased vulnerability. Frailty may also be influenced by social, emotional and mental health factors. People who are frail often have reduced physical functioning, for example, reduced strength and endurance. Frailty results in a higher risk of poor health outcomes such as falls, hospitalisations, disability and poor quality of life. While frailty is associated with ageing, they are not the same thing. younger people can also be frail, and not all older adults are frail."

"I'm now going to pass over the talking stick to you all. I'm going to give you some butcher paper and markers so that you can record some points on the paper as you discuss together some thoughts regarding these next questions. We'll then talk through everything together after you have all had some time to chat over these things and work out together what some of the most important points are for us to most focus on".

Question 2. What services or supports are most needed in your area to assist those living with frailty or those caring for someone living with frailty? (service gaps)

"As a group I'd like you to discuss and write down how you would change or improve services or supports in your community as well as what new services or supports that you might create that have not previously existed".

Provide attendees time and encouragement to complete this task and allow for 5-10 minutes if needed.

"As we finish up this discussion, I'd like you to choose 3-5 services or supports that you believe are the most essential to support the needs of those living with frailty or caring for those living with frailty in your community".

Provide time (5 minutes) for group to choose most important services/supports.

"Ok, let's chat those 3 – 5 more through now together and as we talk these through, I'd like you to really focus on why these supports or services are important in relation to the area in which you live and/or access health supports here in the community".

Facilitator to encourage and lead chat through those 3-5 services and supports.

Question 3. How do those with a lived and living experience in Western QLD (RRR) want to be involved in frailty research? (research participation, consumer engagement)

"The reason we are out travelling and speaking to you all is we want to ensure that the lived and living experiences of frailty from a Western QLD, (RRR) perspective is brought more into focus when designing, developing and undertaking research into frailty. What I'd like to hear from you all now together is how do you think research institutes or hubs like us can engage your perspectives into research and how we can involve you more in the research that we are doing? What are all your thoughts on this?"

Questions 4. What are the barriers to engaging in frailty research and what supports are needed? (research participation, consumer engagement)

"What might do you think are the barriers to people living in Western Qld engaging in frailty research, and what supports could we put in place to overcome these barriers?"

Question 5. What should be the focus of frailty research in the future? (research priorities)

"Reflecting on what we have spoken about today, what are the most important topics that you think frailty research should focus on in the future?"

Closing: *"That brings our session to a close and we would just really like to thank you for your time today. We have really appreciated learning from you all. We have gift cards for you as a way to thank you for your time and contributions. We also have some information about joining the Consumer Reference Group at the AFN if that is something that you might be interested in after today. We will be sticking around for a little bit if you have any questions or would like to go over anything and as mentioned we have those flyers if you would like to know of some local supports. Before you leave today, there are some post it notes here and we would love you to jot down some thoughts or learnings that you will take from today as a way to close things. Thank you so much and lovely to have met you all today".*

Facilitators take time packing up and ensuring any questions or support provided if and as needed.

Australian
Frailty
Network