

STEP FORWARD

Every step counts. Every move matters.

An eight-week physical activity
campaign
for adults aged 60–80 in Brent,
London

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Your eight-week Step Forward journey

0 Welcome

1
baseline + goals

0 Walking

2
balance basics

0 Strength

3
functional
practice

0 Outdoors

4
green-space
walk

0 Balance

5
falls confidence

0 Together

6
activity buddies

0 Your way

7
personal plan

0 Next

8 steps
review +
evaluation



THREE MEASURABLE CAMPAIGN AIMS

1 Activity: +20% relative • **2 Falls concern: -15% relative** • **3 Social network: +20% relative**

• • • • All targets are proposed for feasibility testing; they are not predicted outcomes.

• • • • Source: Step Forward: proposed intervention design

TASK 1 / Campaign rationale

WHY HERE?

WHY NOW?

WHY THIS GROUP?

UK evidence • National guidance • Social inequality • SMART aims





Physical inactivity is a social epidemiology issue

HEALTH

Lower activity is linked with reduced functional capacity and increased cardiometabolic risk.

PLACE

Transport, poorly maintained routes and access to affordable facilities limit opportunity.

CONNECTION

Loneliness, fear of falling and weaker social networks can reduce confidence to join.

Campaign proposition: address capability, opportunity and motivation together—not blame individuals.

Source: Marmot et al. (2020); WHO (2020)



Who meets the 150-minute threshold?

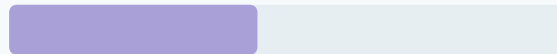
AGES 55–74

64.3%



AGES 75+

44.3%



ALL ADULTS 16+

64.6%



These nationally published groups do not map exactly to the campaign age range of 60–80.



The social gradient is large

HIGHER SOCIOECONOMIC GROUP

73%

NS-SEC 1–2: active 150+ minutes/week

LOWER SOCIOECONOMIC GROUP

54%

NS-SEC 6–8: active 150+ minutes/week

19 percentage-point activity gap

Implication: free sessions alone are insufficient without attention to transport, routes and outreach.

Source: Sport England (2026), Active Lives 2024–25, report p. 7; Marmot et al. (2020)



Why Brent? Local assets plus unmet need

LOCAL EVIDENCE

Brent's historical 2019/20 JSNA reported adult activity below the London average. A current, age-specific Brent baseline still needs sourcing.

CONTINUATION

Brent Healthy Walks offers free, leader-guided group walks and shorter 30-minute options, helping bridge beyond week eight.

TARGETING

Recruit adults 60–80 facing access barriers, isolation or low confidence—not simply residents already regularly active.

Brent is the proposed setting; no council commission, partner agreement or venue booking is implied.



National guidance: movement across later life

AEROBIC MOVEMENT

150

minutes of moderate intensity
each week, building up

FUNCTION

2 DAYS

strength + balance + flexibility
activity weekly

DAILY HABIT

MOVE

regular activity; reduce
prolonged sedentary time

Adults aged 60–64 follow the general adult guidance; tailored falls support depends on individual need.



Short-term barriers can compound long-term risk

NEAR-TERM EFFECTS

Lower confidence to move
Reduced fitness and balance
Social withdrawal
Difficulty with daily routines

LONGER-TERM RISKS

Loss of independent function
Cardiometabolic disease burden
Frailty and possible injurious falls
Wider inequalities in later-life health

Not all risks follow one inevitable sequence; age, health conditions and environment influence outcomes.

Source: WHO (2020); NICE (2025); UK CMOs (2019)



Three measurable aims and the benefits they seek

AIM 1

+20%

MEASURE

Proportion reaching 150 aerobic minutes/week

BENEFIT

More mobility and physical function

AIM 2

-15%

MEASURE

Mean Short FES-I falls-concern score

BENEFIT

More confidence to participate

AIM 3

+20%

MEASURE

Mean LSNS-6 social network score

BENEFIT

Stronger community connection

All targets are provisional relative changes to be tested for feasibility; measure at baseline and week 8.

Source: UK CMOs (2019); Kempen et al. (2008); Lubben et al. (2006)



TASK 2 / Intervention and evaluation

**EIGHT WEEKS.
PRACTICAL SUPPORT.
HONEST EVALUATION.**

Activities • Poster • Partners • Resources •
Measures





Weeks 1–2 | Building trust and confidence

WEEK 1 · FIRST STEPS

Welcome + consent; activity and falls-history discussion; baseline minutes, Short FES-I and LSNS-6; small personal goal.

WEEK 2 · FINDING FEET

Accessible walking route, supported balance exercises and discussion of what makes movement easier or harder.

Every week: adapted intensity, peer interaction, attendance register and optional home practice.

Source: Step Forward: proposed session protocol; NICE (2025)

Weeks 3–4 | Strength and outdoor access



WEEK 3 · STRONGER

Sit-to-stand, wall-supported movements and graded resistance-band work with suitable seated alternatives.



WEEK 4 · STEPPING OUT

Short and longer supervised green-space routes; route/accessibility review and an indoor bad-weather alternative.



Weeks 5–6 | Falls concern and social support

WEEK 5 · BALANCE

A trained professional leads graded exercises; participants discuss worry about falling; midpoint Short FES-I.

WEEK 6 · MOVING TOGETHER

Group activity, optional buddy matching and peer support; midpoint LSNS-6 and acceptability feedback.

Important: identify falls history at intake and refer eligible people for clinical falls assessment.

Source: NICE (2025); Deci and Ryan (2000); Kempen et al. (2008)



Weeks 7–8 | Independence and handover

WEEK 7 · YOUR ACTIVITY

Participants choose walking, strength or balance options; agree a personal ongoing routine and review barriers.

WEEK 8 · KEEP GOING

Repeat baseline outcomes; celebrate engagement; gather feedback; signpost to existing local led walks and groups.

Sustained activity beyond the pilot is a longer-term objective, not something week-eight data can prove.

Source: Brent Council (2026); Skivington et al. (2021)

Promotional poster | Step Forward

STEP FORWARD

*Every step counts.
Every move matters.*

AGES 60–80 | 8 WEEKS

**WALK • STRENGTH • BALANCE •
CONNECT**

Feel stronger • Build confidence • Meet
friends



Venue, dates and joining details: TO BE CONFIRMED | Illustrative academic campaign proposal.



Implementation: make participation possible

SAFE

Qualified instructors; exercise adaptations and rests; ask about previous falls; referral plan for higher-risk participants.

ACCESSIBLE

Step-free venue, accessible toilets, large print, language support and safe transport/route planning.

RESPECTFUL

Informed consent, data protection, participant choice, cultural sensitivity and voluntary buddy matching.

Delivery prerequisites, not claims that the council has approved or funded the programme.

Source: NICE (2025), NG249; WHO (2020)



Evaluation is embedded from week one

WEEK 1

EVALUATOR

Consent; activity baseline; Short FES-I; LSNS-6

WEEKS 2–7

FACILITATOR

Attendance; fidelity; adapted activities; home practice

WEEKS 5–6

EVALUATOR

Short FES-I and LSNS-6 midpoint review

WEEK 8

EVALUATOR

Repeat outcomes; feedback; retention + missing data

Process evaluation = was the programme delivered and used? Outcome evaluation = what changed?

Source: Skivington et al. (2021); Kempen et al. (2008); Lubben et al. (2006)



How do we know each aim was achieved?

AIM 1 Activity Weekly moderate-intensity minutes from the same diary at weeks 1 and 8; proportion reaching ≥ 150 minutes.

AIM 2 Falls concern Short FES-I: 7–28, lower = less concern; compare mean paired scores at weeks 1 and 8.

AIM 3 Social network LSNS-6: 0–30, higher = stronger network ties; compare paired mean scores at weeks 1 and 8.

No fictional baseline values or results shown. Activity diary covers the aerobic aim, not the full strength/balance guideline.

Source: UK CMOs (2019); Kempen et al. (2008); Lubben et al. (2006)



What this evaluation can—and cannot—establish

STRENGTH

Same instruments at entry and week 8; process data on reach, attendance and intervention fidelity.

LIMITATION

No control group; self-report and social desirability bias; short follow-up and possible dropout bias.

IMPROVEMENT

Report missing data and baseline comparability; seek an objective measure and 3–6-month follow-up.

Observed improvement would not by itself demonstrate that Step Forward caused the change.

Source: Skivington et al. (2021); Craig et al. (2003)



Potential local and national partners



BRENT COUNCIL

Local: free healthy walks; refer participants into existing routes.

Aim: Free inclusive activity



AGE UK HHB

Local: trusted outreach and older-adult social activity.

Aim: Improve later life



SPORT ENGLAND

National: reduce physical-activity inequalities; campaign resources.

Aim: Uniting the Movement



RAMBLERS

National: accessible led wellbeing walks, routes and leaders.

Aim: Walking for wellbeing



Use resources from existing campaigns responsibly

BRENT HEALTHY WALKS

Purpose: Free, sociable local walking

Adapt: Routes, walk leader practice, 30-minute options

WE ARE UNDEFEATABLE

Purpose: Move more with health conditions

Adapt: Accessible messaging, activity ideas and downloadable campaign materials

RAMBLERS WELLBEING WALKS

Purpose: Lower the barrier to joining a walk

Adapt: Welcoming walk format, route planning and volunteer-leading ideas

Replicate ideas where appropriate; check reuse permissions before copying imagery, handouts or branded materials.

Source: Brent Council (2026); We Are Undefeatable (n.d.); Ramblers (n.d.)

TASK 3 / Benefits and behaviour change

**BENEFITS.
BARRIERS.
THEORIES.
SOLUTIONS.**



Benefits extend beyond physical fitness

PHYSIOLOGICAL

Functional strength and balance; improved daily mobility; potential cardiometabolic benefits.

PSYCHOLOGICAL

Confidence, wellbeing and reduced worry about falling; personal mastery of safe activity.

SOCIOLOGICAL

Peer support, belonging and participation in local spaces; potential longer-term connectedness.



Potential benefits—not guaranteed individual outcomes.

Source: WHO (2020); Sherrington et al. (2019); Deci and Ryan (2000)

COM-B: what must change for behaviour to change?



Critical limitation: the model does not itself remove deprivation, unsafe streets or transport poverty.

Source: Michie, van Stralen and West (2011); adapted to proposed campaign



Self-Determination Theory: sustaining motivation

AUTONOMY

SUPPORTED BY

Choose activities; set own goals

BARRIER

No choice or imposed routines

COMPETENCE

SUPPORTED BY

Build ability with graded success

BARRIER

Fear of failure or inaccessible tasks

RELATEDNESS

SUPPORTED BY

Buddies, shared activity and belonging

BARRIER

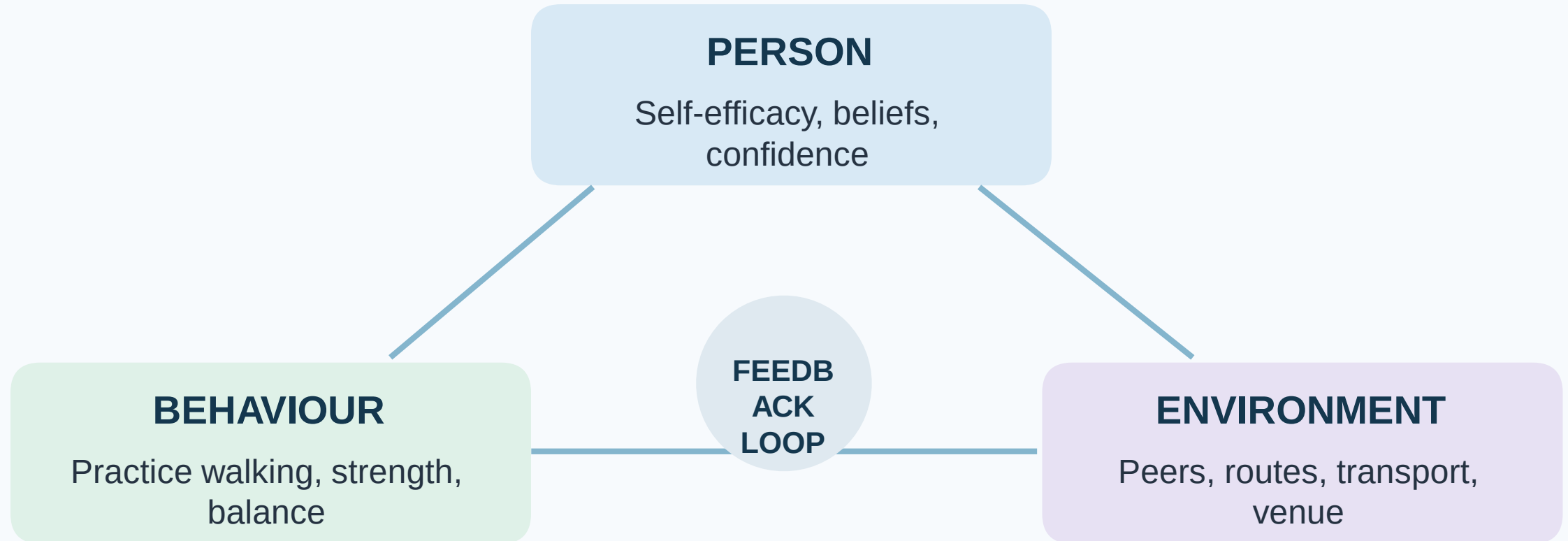
Loneliness and limited support

MORE SELF-DIRECTED ENGAGEMENT

Source: Deci and Ryan (2000); adapted to proposed campaign



Social Cognitive Theory: person × context × action



Peer modelling builds confidence, but confidence alone cannot overcome inaccessible infrastructure.

Source: Bandura (1997); proposed campaign application



Match each barrier to a realistic campaign response

FEAR OF FALLING

COM-B · motivation / capability

→ Trained, graded balance practice + appropriate clinical referral (W5)

TRANSPORT / COST

COM-B · physical opportunity

→ Local, free, step-free venue; route and access support (all weeks)

LONELINESS

COM-B + SDT relatedness

→ Group contact and optional activity buddy (W6)

LOW CONFIDENCE

SDT competence + SCT

→ Small goals, peer modelling and visible progress (W1–7)

Each response is a design proposal and needs testing with participants—not a proven effect yet.

Source: Michie et al. (2011); Deci and Ryan (2000); NICE (2025)



Critically appraise the falls-prevention evidence

WHAT SUPPORTS IT

Structured strength and balance exercise can reduce falls in community-dwelling older adults.

WHAT LIMITS OUR CLAIM

A general eight-week activity pilot cannot assume a reduction in actual falls, particularly without sufficient dose or follow-up.

Measure activity and falls concern; do not promise fewer falls after eight weeks.

Source: Sherrington et al. (2019); NICE (2025), NG249



Health equity requires more than free sessions

REACH

Proactive recruitment through trusted organisations; avoid only attracting already-active participants.

REMOVE OBSTACLES

Support language, mobility, access, hearing, public transport and culturally appropriate communication.

SUSTAIN

Connection to existing Brent Healthy Walks and similar accessible provision; evaluate maintenance later.

Key distinction: inequalities in opportunity are not solved simply by increasing knowledge or motivation.

Source: Marmot et al. (2020); Sport England (2026)



Recommendations and realistic next steps

- Agree a specific Brent neighbourhood, accessible venue and proposed partner roles.
- Pilot the eight sessions with qualified delivery and documented safeguarding.
- Report paired outcomes and recruitment, including missing data and possible bias.
- Plan a 3–6-month follow-up to assess whether benefits persist.

DESIGN FOR PEOPLE • CHANGE THE OPPORTUNITY

Source: NICE (2025); Skivington et al. (2021); Brent Council (2026)



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