

Pilot Project Report

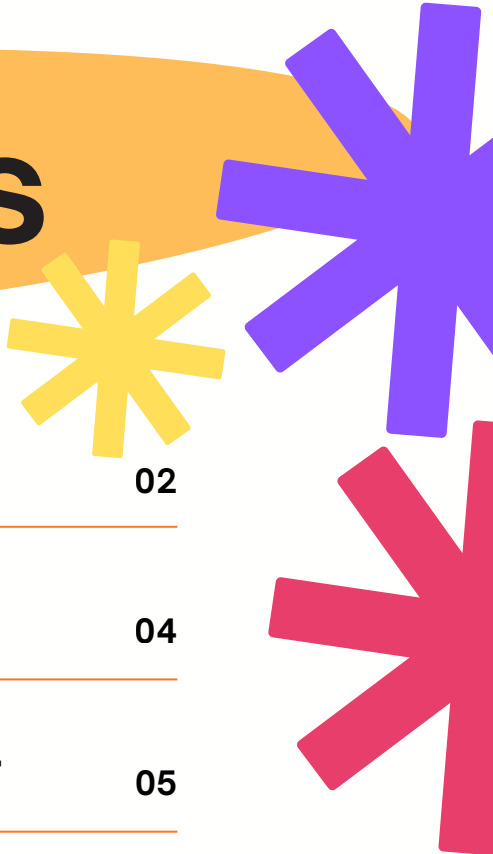
CARE TO DANCE



TAP DANCE *FOR WELLBEING* *WITH LIVE MUSIC*



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Completed by Jess Murray 8th September 2026.

Project Overview

The pilot project explored how Fleet Arts could work with social prescribers, care homes and local health providers to offer fun and creative movement sessions for older people in different healthcare and social settings.

During the pilot stage, Fleet Arts and the Care to Dance creative team collaborated with Strong and Steady (Age UK Derby and Derbyshire) in Ripley and Alfreton, Samuel House Care Home in Heanor, and Belper BCN Social Prescribers. The pilot project was supported by funding from Fleet Arts and Amber Valley CVS.

The aims of the pilot project were to:

- Develop good practice through collaboration and reflexive learning.
- Create a viable model of delivery.
- Explore potential partnerships for a more extensive follow-on project.

Care to Dance brings together tap dance, live music and occupational therapy to offer a participant experience focused upon self-expression, musicality and having fun.



Pilot project activity:

3 sessions at Samuel House Care Home.

2 Sessions with Strong and Steady delivered by Live Stronger for Longer (Age UK Derby and Derbyshire).

3 sessions with individuals connected with Belper PCN Social Prescribers.
Presentation/workshop at Move More Amber Valley Partnership Meeting.

Care to Dance team:

Jess Murray – Tap dance facilitator/ Creative Producer at Fleet Arts

Joe Egan – Music facilitator

Annie Woodhouse – Consultant Occupational Therapist

Phoebe Saunders – Volunteer/ graduate artist

Rebecca Lambley – Shadowing dance artist

Tina Carter – Shadowing dance artist



Sessions were advertised and delivered as 'seated tap dance' but with the option for participants to stand either with or without a balance aid. The sessions were tailored to be accessible and meet a range of different needs, developing ways of working that can support those living with Dementia and their carers, increase strength and balance to reduce risk of falls, and supporting mental health and wellbeing.



The concept of Care to Dance is grounded in previous experiences of the core creative team (Murray, Woodhouse and Egan) working both individually and in previous collaborations including Tap In To (2018-19), Tappin In (including co-delivery with Opus Music) (2025).

About This Report



The Care to Dance Model:

1. Developing session content.
2. Collaborative co-delivery (Dance, Music and Occupational Therapy).
3. Future applications and contexts for the model.

This pilot and evaluation, has highlighted a wide scope for further project development and continued action research. However, we focus here upon three areas of design and implementation of the Care to Dance model that inform our approach to the next phase of the project.

This report combines reflections on strategies and learning that have informed delivery, alongside recommendations for continued development of this model in the future. A detailed occupational therapy report and activity analysis provided by Occupational Therapy consultant Annie Woodhouse are included in the Appendix and quoted to share insights and illustrate examples from this perspective.

1.

Developing Session Content

Key points:

- Influenced by the ‘sit-to-stand’ model used in Strong and Steady sessions.
- Use of differentiation or grading-up and grading-down for a person-centred approach to delivery.
- Creating a social and inclusive environment.

Each Care to Dance session is led by a tap dance facilitator supported by a musician playing live in the session. An Occupational Therapy consultant is present at the majority of the sessions and other health and care professionals such as social prescribers or care home staff also participate and offer support where needed. Chairs are placed in a circle that also accommodates the musician. Participants are able to borrow tap shoes or wear their own if they have them. The group begins seated but some participants are invited to stand as the session continues. Activities move through a progression of warm-up, skills development and creative application including moments of self-expression through guided improvisation.

The facilitators and Occupational Therapist purposefully create an informal, welcoming space, where participants are able to share information about how they are and connect socially with one another both before and after the practical session.



“Just being part of it for the first time in a long time”

**Participant, Samuel
House Care Home.**

Early in the pilot project timeline, the lead dance facilitator and Occupational Therapy Consultant took part in a Strong and Steady movement session run by the team at Living Stronger For Longer, Age UK Derby and Derbyshire. This experience informed the structure of the chair-based sessions delivered in the pilot, taking inspiration from the ‘sit to stand’ structure and elaborating on particular techniques through the tap dance and music approach. For example, an exercise where participants work from seated to standing through key postures to aid balance and contact with the floor was adapted as a tap and body percussion exercise –

1. Sound with heel beats on the floor
2. Lean forwards and drum on thighs
3. Begin to stand and shake fingers/hands
4. Stretch or click extending arms upwards

The music echoed this progression with a melodic scale moving up and down in pitch to guide the movement and help participants intuitively know when to elevate (within their range) or be seated.

The Occupational Therapy analysis of physical activity performance components described this as:

“Maintain stable seated/standing posture for duration of the session. Participants choosing to stand require standing balance and tolerance to safely do so. Bending and reaching from a standing or seated position. Abduction and adduction at shoulder and hip joints. Flexion and extension at all arm and leg joints particularly ankles and knees. Bilateral and unilateral movement. Use of both dominant and non-dominant hands. Exploration and development of personal range of movement, strength, stamina. Primarily, gross motor skills used throughout. Motor planning prompted by audio and visual cues provided by dancer, musician and other participants.” (Woodhouse, 2026a)

“Increased strength and stamina, particularly targeting lower body strength and mobility. Dual tasking to train attention. Co-ordination, vestibular and proprioceptive skills/awareness. Increased cardiovascular abilities and reduced fatigue. Graded activity to practice weight changing, turning and static, dynamic and reactive balance.” (Woodhouse, 2026a)



The pilot has been effective in learning how to use established tap dance facilitation methods relating to physical, interactive and creative aspects in the content of seated dance and the falls prevention ‘sit to stand’ model as used by Strong and Steady. During the pilot we delivered a Care to Dance session with the Strong and Steady groups in Ilkeston and Ripley. Feedback was that Care to Dance offered ways to reinforce the content of the regular Strong and Steady sessions in a creative and playful way. Participants commented that they had experienced a work out that used a range of muscle groups, but hadn’t been as conscious of this due to the fun and enjoyment aspects. This is echoed in the Occupational Therapy consultant’s report which observed that:

“Participants often appeared unaware that the session was physical exercise, highlighting positive engagement through occupation rather than exercise as a prescription” (Woodhouse, 2026a).



Workshops were structured through a warm up with stretches followed by skills development leading to a creative, expressive activity or ‘jam’ as the culmination. All skills and techniques needed for the final activity are embedded through previous sections. The content is highly differentiated, offering different ways to approach activities and movements avoiding hierarchical language such as ‘easy’ or ‘difficult’, articulating different ‘options’ that can complement each other within the group. The Consultant Occupational Therapist refers to this as “grading up” (increasing demands) and “grading down” (decreasing demands). Repetition of certain aspects over multiple sessions supported familiarity through recall, measurable improvements over time, and a sense of “mastery” in relation to participant’s personal skill set, experience, values and goals. While different steps or rhythms could be introduced to maintain interest through variety, the length of musical phrases and movement combinations was kept relatively short (two bar or 8 count phrases) to ensure that full participation is not dependent on cognitive ability and those that wouldn’t retain material between sessions can process information in the moment. Half-time versions of rhythms were demonstrated by the facilitator along with low demand versions (cognitive/physical) of movements. Regular reminders were given to rest, adapt movements causing pain or over exertion, and prompts for refreshments. Dynamic risks assessments were carried out by all practitioners throughout.

The shift from ‘skills development’ to ‘creative play’ or ‘jamming’ is gradually phased in. A repeated rhythm is established before participants are invited to make small changes, add extra steps and rhythms, or solo over the foundational rhythm or ‘groove’. This approach allows participants to approach the creative and improvisatory aspects on their own terms and at their own pace, giving agency and reinforcing the relevance of the collective rhythm making of the group. Musical interactions are key in establishing this. ‘Call and response’ and ‘call and copy’ became key components allowing playful interaction between the musician and the participants, and enabling facilitators to notice information about participant’s processing, recall and physical movement range. While session activities such as ‘call and response’, ‘call and copy’ and ‘jamming’ over a groove are by nature different every time they take place, maintaining their presence in a regular session structure over multiple sessions allowed participants to anticipate these elements and gain confidence within them over time.

Some participants commented that improvising was their preferred part of the session because they didn’t feel pressure to remember material, others felt more confident dancing material that was set. Therefore, a key area of learning in this pilot was the need to balance these offers evenly and where possible integrate them as differentiated options within a given activity.



“You think, am I going to be able to do this? And then you can!” Participant – Care Home

“Participants show potential for development in role competence and self-efficacy through repetition and reassurance” (Woodhouse 2026a).

2. Collaborative Co-delivery

Key points:

- The adaptability of the facilitators and their capacity to respond collaboratively.
- Different cost based and time resource options for delivery.
- Benefits of Occupational Therapy approach in identifying existing and new knowledge and strategies.
- Value of Occupational Therapy terminology in evidencing creative health impact and benefits in a healthcare framework.

The pilot revealed the advantages of working with a team of creative facilitators through co-delivery which differs greatly to the common experience of freelance community arts facilitators that are usually tasked to deliver sessions as the sole facilitator. The presence of an Occupational Therapist in sessions enabled the dance and music facilitators to focus more exclusively upon the creative content and delivery with confidence that any specific or subtle needs, barriers or goals beyond those experienced by facilitators in the moment, could be observed and shared later between the leadership team and ongoing plans created. The level of detail that the Occupational Therapist could observe, measure and share with the dance and music facilitators through recommendations was a great benefit. Examples of changes made to delivery in direct response to this were:

- Ensuring that certain activities could be demonstrated within certain participant's field of vision by moving toward them in the space.
- Considering seating plans to balance the volume of the music versus the dance facilitators verbal instruction for participants that were hard of hearing. Managing the music volume in these moments whilst not stopping the music in order to continue the 'flow of the session'.
- Adding exercises that include foot articulation to aid participants in cognitively processing aspects of walking and balance.

Live music is a core component of the Care to Dance model offering a range of benefits to participants and facilitating engagement. Session leaders commented that the live music was effective in encouraging some participants to move more than usual.

“Music and rhythm provided accessible entry points for participants with differing cognitive, physical, or sensory abilities. Observable outcomes included enhanced mood, increased concentration, laughter, and motivation” (Woodhouse 2026).

The capacity of the music to be responsive to the shifting dynamics in the session is a key enabler of participant engagement. The music and dance facilitator manage this collaboratively, each being able to initiate shifts in tempo, musical feel to encourage a certain type of response whether to build the energy, encourage a particular movement such as a stretch or percussive sound, or to encourage participants to rest between activities without stopping entirely.

Being able to incorporate music requests on the spot, or preparing them for future sessions became a key strategy. In the care home setting we worked in, Singing in the Rain and La Bamba were established favourites. Playing familiar and preferred tunes inspired greater physical participation and even for one participant to whistle an entire tune in performance for the rest of the group! Music offers another route of access to participation and we have found that particularly for those with less experience of dance, live music provides permission to engage, an alternative way to identify with the activity and a means of legitimizing participation if dance is an activity they are less comfortable with.



Being able to draw upon multiple perspectives across different specialisms (occupational therapy, dance, and music) to develop new ideas for activity or shift approaches to delivery, or offer support offered many benefits. However, this approach also represents a challenge to logistical planning and financial viability of the model on account of requiring 3 facilitators for each session. A recommendation moving forward is to adapt the role of Technical Instructor as found in Occupational Therapy as a way to manage the interaction between the Occupational Therapist and lead facilitator (whether dance or music). Using this approach, the Occupational Therapist would undertake an initial assessment with participants and attend some sessions, giving key feedback and guidance to facilitators to agree strategies for them to apply going forward.

3.

Future Applications

Key points:

- The role of place-based connections and local partners.
- Using the model to support and manage personalized goal setting for falls prevention, mental health and wellbeing.
- Potential settings including care homes, community spaces, at home.
- Integrating opportunities for continued professional development through training.
- Potential to combat professional burnout in healthcare.

This pilot project and the conversations that have happened around it have shed light on how the Care to Dance model might sit within the wider landscape of public and creative health. This pilot project has created opportunity to build relationships with health providers and other creative wellbeing organisations in the Derbyshire region such as Age UK Derby and Derbyshire, Move More Amber Valley and Active Derbyshire. Adopting a person-centred approach to delivery and using tap dance and music to achieve personalized goals relating to occupation has emerged as key aspects of the Care to Dance model. These relate to two main areas; falls prevention, and physical and mental wellbeing.

Community Healthcare Settings

Care to Dance could be developed for:

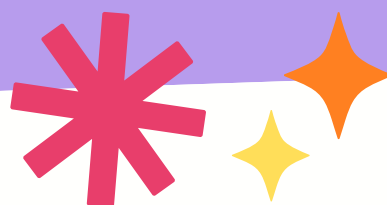
- Care homes
- Community venues
- Social prescribing pathways
- Dementia support programmes
- Carer and family sessions

The pilot has enabled us to trial partnership working with social prescribers which has been effective and led to participants being signposted to regular sessions, sometimes with social prescribers joining them. However, Social Prescribers or health practitioners are not able to share information about participants directly, making an initial consultation with the Care to Dance Occupational Therapy consultant important to ascertain how individuals needs and goals might be met through the session activities. Going forward, we recommend that the Care to Dance Occupational Therapy consultant could carry out this assessment over the phone prior to attending. Alternatively, they would create a short, structured questionnaire that the facilitators could use to gather information from participants in person where appropriate. The Occupational Therapy consultant would then review individual's progress at a mid-way point (assuming a 6-12 week block of sessions) to make recommendations to facilitators and participants. An evaluation with participants at the end of the process would focus upon identifying what has been achieved in relationship to initial goals set.

Conversations with Strong and Steady participants and facilitators suggests that Care to Dance session could offer a follow-on activity to the Strong and Steady provision which is for a limited period of 24 weeks. Upon exiting the program, participants are encouraged to continue physical activity that will help with strengthening and falls prevention such as a walking group, gym sessions or other chair-based exercise groups for example. Care to Dance would like to continue and further develop the relationship with Strong and Steady (Age UK Derby and Derbyshire) to explore ways to offer a follow-on provision.

In facilitating guided improvisation, the Care to Dance model removes barriers to participation that those with a Dementia diagnosis might face by offering a failure free approach, allowing responsiveness to individuals in the moment, and a tool for physical and social engagement that does not require recall. Rhythm and music have proven effective in accessing different areas of cognition and routes to specific short-term and long-term memories, sense of identity and meaning. The occupational therapy consultant observed that:

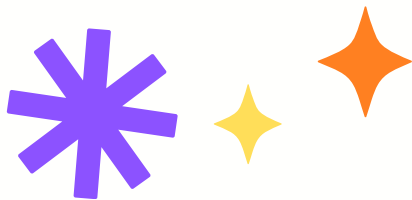
“Step imitation, call-and-response, and following musical cues stimulate attention and working memory”, and also that “many participants relate to past occupational roles linked to dance, theatre, or music” (Woodhouse 2026a).



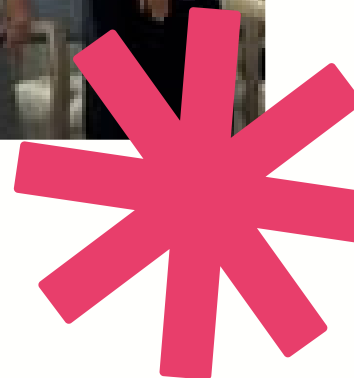
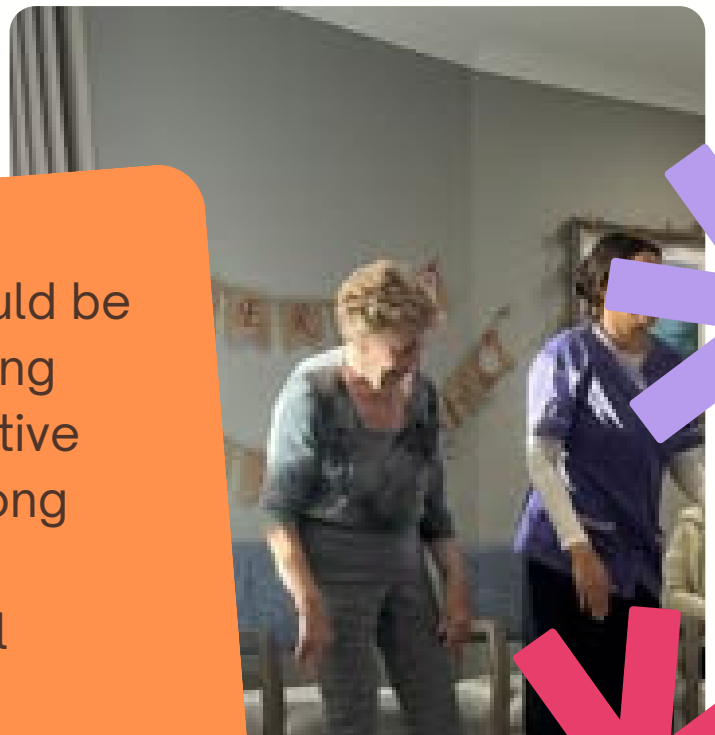
Enjoyment of the activity and peer support were key motivators in enabling participants with Dementia to engage, leading to physical, cognitive and mental health benefits. The occupational therapy consultant used Arts Obs” scores (Fancourt, 2015) both pre-, during, and post-session which “consistently showed an increase in positive mood and engagement across participants” (Woodhouse 2026). Woodhouse observed that:

“Activities target leisure occupations (music, rhythm, communal participation) but also indirectly promote functional movement skills, balance, and endurance relevant to self-care and mobility” (2026a).

The group dynamic and peer motivation were evident, demonstrating that “participation fosters peer support and productivity, as motivated residents often encourage and model participation for others” (Woodhouse 2026a).



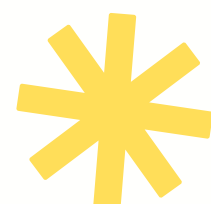
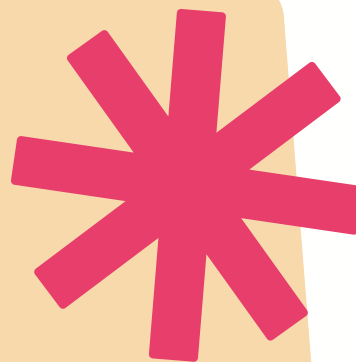
A potential area of growth could be to offer sessions for those living with Dementia and Mild Cognitive Impairment (MCI) to attend along with their carers and families, supporting creative and social interaction in the context of a shared activity and creating respite opportunity for carers to mitigate carer burnout.



Home-Based Delivery

There is potential to develop:

- Online sessions
- Pre-recorded content
- Home-based programmes for housebound individuals
- Links with initiatives such as Couch to 5X



Initial discussions have identified potential for Care to Dance to build an offer linked to Couch to 5X

“A programme designed and created by GOGA Amber Valley and active Partners Trust to help people make beneficial changes to bring more movement into their lives” (<https://makingourmove.org.uk/resource-and-links/couch-to-5x/>, accessed 10/08/2026).

This program works with individuals to choose what each ‘X’ might be for them, therefore aligning with the person-centred goal setting approach of Care to Dance. Using a personalized approach to building strength and mobility through the ‘sit to stand’ and seated tap dance approach is suited to those with long-term health conditions. Pre-recorded or online sessions could be accessed by currently housebound individuals, or as a pre-cursor encouraging participants to attend an in-person session with others after a period of remote engagement.

Professional Development and Workforce Support

- Training placement opportunity for occupational therapy and physical therapy students
- Professional development programme for artists and therapists
- Creative wellbeing intervention to support healthcare professionals and reduce burnout

The Care to Dance pilot project has embedded opportunities for peer professional development, offering two paid positions for dance artists to shadow sessions, and accommodating a recent Masters graduate as a volunteer to gain experience of community arts facilitation. Feedback from these members of the Care to Dance team, alongside conversations with representatives of other professional bodies have demonstrated the potential to use the model in a variety of professional contexts. In taking these ideas forward, occupational therapy frameworks would be used as a point of intersection between creative wellbeing and public health, by providing practical training for occupational therapy students, continued professional development (occupational therapists, dance and music facilitators) and as an activity to mitigate burnout for healthcare professionals (Edwards and Dirette, 2010) by offering “opportunities for employed OTs to engage in work that fits with core OT values” (Woodhouse 2026a).

One area of potential development would be to broker partnerships with universities to accommodate occupational therapy students undergoing work placements as a part of their accredited studies which would also address the financial implications of working with therapists.

The occupational therapy consultant on this project is also an experienced community dance facilitator, and has identified areas of academic or professional development that Care to Dance could engage with as a case study in the future.

Work could be undertaken with Occupational Therapy, Dance for Wellbeing, Physiotherapy students to consider:

- Research evidence base, such as that for falls prevention or dual tasking.
- Research outcome measures and assessment approaches use by both qualified and non-qualified staff.
- Explore the use of the Technical Instructor Role and any appropriate training for dancers and musicians to act as such.
- Explore Goal setting methods such as EKOS and COPM to facilitate the TI role.

Conclusion

The Care to Dance pilot demonstrated that combining tap dance, live music and occupational therapy can create an engaging, inclusive and person-centred approach to supporting older adults' physical, cognitive and emotional wellbeing. The project successfully fostered social connection, increased confidence, supported falls prevention, and showed particular promise for people living with Dementia and age related cognitive decline. The pilot has established a strong foundation for future growth, partnership development and wider application within creative health and community care settings.

Further Recommendations

1. Continue developing partnerships with social prescribers, Age UK Derby and Derbyshire, care homes and health providers.
2. Introduce structured assessment and goal-setting processes with participants led by occupational therapy input.
3. Develop a more financially sustainable delivery model, potentially using Occupational Therapy Technical Instructor approaches.
4. Expand provision for people living with dementia, carers and families.
5. Pilot home-based and digital programmes to reach housebound participants.
6. Develop training and placement opportunities for students and practitioners.
7. Undertake further research and evaluation to strengthen the evidence base around falls prevention, wellbeing outcomes and creative health interventions.

Bibliography

Woodhouse, A. (2025a) Occupational Therapy Activity Analysis Report. Phase 1 (Pilot). Care to Dance Project – Fleet Arts.

Department of Health and Social Care (2025) Fit for the future: 10 year health plan for England. CP 1350. London: HM Government. Available at: <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future> (Accessed: 10 April 2026).

Edwards, H. and Dirette, D. (2010) 'The relationship between professional identity and burnout among occupational therapists', *Occupational Therapy in Health Care*, 24(2), pp. 119–129. Available at: doi.org.

Skelton, D.A. and Dinan, S.M. (2005) 'Tailored group exercise (Falls Management Exercise - FaME) reduces falls in community-dwelling older frequent fallers (an RCT)', *Age and Ageing*, 34(6), pp. 636-639.

Sport for Confidence (no date) Our Blueprint. Available at: https://www.sportforconfidence.com/_webedit/uploadedfiles/All%20Files/SFC_Blueprint_v11.pdf (Accessed: 10 April 2026)

Appendix

1. Care to Dance Pilot Project: Executive Summary
2. Woodhouse, A. (2025a) Occupational Therapy Activity Analysis Report. Phase 1 (Pilot). Care to Dance Project – Fleet Arts.
3. Woodhouse, A (2025b) Care to Dance Occupational Therapy Report Social Prescribing.
4. WoodHouse, A (2025c) Care to Dance OccupationalTherapy Report Samuel House Care Home.

Appendix 1.

Executive Summary

The Care to Dance pilot project explored how Fleet Arts could work collaboratively with social prescribers, care homes, community health providers, and occupational therapists to deliver creative, inclusive movement sessions for older adults. Combining seated tap dance, live music, and occupational therapy principles, the project aimed to improve physical health, prevent falls, support people living with dementia, reduce social isolation, and enhance mental wellbeing through enjoyable and accessible activities.

Pilot Activity

The project delivered:

- 3 sessions at Samuel House Care Home (Heanor)
- 2 sessions with Strong and Steady (Age UK Derby and Derbyshire)
- 3 sessions with participants referred through Belper PCN Social Prescribers
- A presentation/workshop at the Move More Amber Valley Partnership Meeting

The pilot involved a multidisciplinary team of dance, music and occupational therapy professionals, supported by community partners including Age UK, social prescribers and care home staff.

Key Findings

1. Effective Session Design and Delivery

The project successfully adapted elements of the Strong and Steady falls prevention model into creative dance sessions. Participants engaged in exercises that improved:

- Strength and mobility
- Balance and coordination
- Cardiovascular fitness
- Confidence and self-efficacy
- Cognitive processing and attention

Importantly, participants often viewed the sessions as enjoyable creative activities rather than exercise, increasing engagement and motivation.

The model's success was supported by:

- A clear structure (warm-up, skills development, creative play/jamming)
- Differentiated activities offering multiple participation levels
- Repetition balanced with variety to support learning and confidence
- Inclusive approaches suitable for people with varying physical and cognitive abilities, including those living with dementia

Participants reported increased confidence, enjoyment, and a sense of achievement, while occupational therapy observations highlighted improvements in physical and cognitive functioning.

2. Benefits of Collaborative Co-delivery

A major strength of the pilot was the combination of:

- Dance facilitation
- Live music
- Occupational therapy expertise

The occupational therapist provided specialist assessment, observation, and recommendations that enabled facilitators to adapt sessions to individual needs.

Live music proved especially valuable by:

- Encouraging participation from people who might not engage with dance alone
- Supporting rhythm, movement, memory and recall
- Creating opportunities for spontaneous interaction and enjoyment
- Allowing facilitators to adapt energy levels and pacing in real time

The collaborative model enhanced participant outcomes but also highlighted challenges relating to staffing costs and long-term sustainability.

3. Positive Impact on Health and Wellbeing

The pilot demonstrated potential benefits across several areas:

Falls Prevention

Participants improved:

- Lower-body strength
- Balance
- Weight shifting
- Functional movement patterns relevant to daily living

Care to Dance also offers a possible progression route for people completing the Strong and Steady programme.

Dementia Support

The approach proved particularly effective for individuals living with dementia because:

- Improvisation creates a "failure-free" environment
- Participation does not depend heavily on memory recall
- Music and rhythm stimulate memory, attention and engagement
- Group activities encourage social interaction and peer support

Occupational therapy observations recorded consistent improvements in mood and engagement before, during and after sessions.

Mental Health and Social Connection

Participants experienced:

- Improved mood
- Reduced isolation
- Greater confidence
- A sense of belonging
- Opportunities for self-expression and enjoyment

Social aspects of the sessions were identified as equally important as the physical activity itself.

Future Opportunities

The pilot identified significant potential for expansion.

Community and Healthcare Settings

Care to Dance could be developed for:

- Care homes
- Community venues
- Social prescribing pathways
- Dementia support programmes
- Carer and family sessions

Home-Based Delivery

There is potential to develop:

- Online sessions
- Pre-recorded content
- Home-based programmes for housebound individuals
- Links with initiatives such as Couch to 5X

Professional Development and Workforce Support

The project has strong potential as a:

- Training placement opportunity for occupational therapy students
- Professional development programme for artists and therapists
- Creative wellbeing intervention to support healthcare professionals and reduce burnout

Recommendations

- 1.Continue developing partnerships with social prescribers, Age UK Derby and Derbyshire, care homes and health providers.
- 2.Introduce structured assessment and goal-setting processes led by occupational therapy input.
- 3.Develop a more financially sustainable delivery model, potentially using Occupational Therapy Technical Instructor approaches.
- 4.Expand provision for people living with dementia, carers and families.
- 5.Pilot home-based and digital programmes to reach housebound participants.
- 6.Develop training and placement opportunities for students and practitioners.
- 7.Undertake further research and evaluation to strengthen the evidence base around falls prevention, wellbeing outcomes and creative health interventions.

Conclusion

The Care to Dance pilot demonstrated that combining tap dance, live music and occupational therapy can create an engaging, inclusive and person-centred approach to supporting older adults' physical, cognitive and emotional wellbeing. The project successfully fostered social connection, increased confidence, supported falls prevention, and showed particular promise for people living with dementia. The pilot has established a strong foundation for future growth, partnership development and wider application within creative health and community care settings.

Appendix 2.

Occupational Therapy Activity Analysis Report.

Phase 1 (Pilot). Care to Dance Project – *Fleet Arts*.

Description:

A seated or standing tap dance and music session where participants can watch, follow and create movement and sound responses to those demonstrated by session leader, live acoustic guitar and other group participants. The focus is on rhythmic movement, auditory feedback, self-expression and social engagement with the aim of facilitating motor control, motivation and cognitive function in order to positively impact engagement in meaningful activity, mood and overall wellbeing.

Participants are lead with fluidity through structured and unstructured movement and music tasks and interactions. The person-centred approach provides a failure free environment with individualised challenges for each participant to work towards a sense of mastery whilst supporting motivation and confidence through the development of new skills in a group setting.

Varying physical, affective and cognitive abilities and needs are assessed, supported and facilitated by collaborative group leadership team including Occupational Therapist ("OT"), Dance facilitator, Musician, Arts Volunteer and additional group support, provided by community-based professionals such as care home staff and social prescribers. The sessions are inclusive and adapted to meet the needs of all participants.

The group setting provides an opportunity to explore and develop role competence of participants who may be experiencing disruption or deprivation of valued occupations and roles due to barriers presented by physical, cognitive and environmental changes, often associated with aging. These changes could be as loss of valued social networks, changes to mobility or a move to a supported environment. Barriers such as physical or cognitive impairments and facilitators such as experience, motivation or skills, are assessed and identified through ongoing subjective and objective assessment in order to maximise the fit of the occupation (the tap dance and music session) to the person within the environment, allowing the individual to develop a sense of purpose, meaning and mastery through to the activity.

Leadership team:

Jess Murray – Tap dancer

Joe Egan – Musician

Phoebe – Arts Volunteer

Annie Woodhouse – Consultant Occupational Therapist

Settings:

1. Samuel House.

Participants residing in Care home setting for either short or long-term residential care.

2. Strong and Steady Falls Prevention Group.

Participants referred by GP to strong and steady sessions due to falls risks.

3. Social Prescribing:

Participants connected to social prescribing networks through GP referrals.

Demands of the Activity***Space considerations:***

Sessions take place in a large space, able to safely accommodate a circle of chairs for the anticipated participant group and professionals present. Hard floor suitable for the use of tap shoes and free of trip hazards required. All spaces fully accessible with access to toilets and refreshments. Chairs required for all participants. Good lighting and an absence of visual or auditory distractions where possible. Barres and mirrors are beneficial. If no barres available, chair backs can be used to provide balance support where appropriate.

Time considerations:

Sessions for this phase of the project have taken place in the morning in order to accommodate needs of participants. For example, to maximise energy levels for those experiencing fatigue or to occur in line with other groups accessed by participants, such as the social prescriber-led coffee morning. These steps aim to reduce barriers to attendance and maximise potential benefits of the activity. Sessions require time for meet and greet, OT engagement, main session, and post session chat/OT intervention. OT intervention could additionally be allocated time outside of the session and take place online/over the telephone for example.

Other practical requirements:

Comfortable temperature to allow for any raised heart rates and body temperature due to physical activity, whilst ensuring muscles are warm enough to safely support the activity. Adequate ventilation.

Sufficient staffing necessary to support toilet or refreshment trips out of the space or accompany participants needing to take time out in a separate area if necessary.

Tap shoes, pull on tap shoes, musical instruments. Occupational Therapy assessment tools including assessment documents, pens, laptop and printed forms for manual completion.

Activity Performance Components:

Physical:

Maintain stable seated/standing posture for duration of the session. Participants choosing to stand require standing balance and tolerance to safely do so.

Bending and reaching from a standing or seated position. Abduction and adduction at shoulder and hip joints. Flexion and extension at all arm and leg joints particularly ankles and knees. Bilateral and unilateral movement. Use of both dominant and non-dominant hands.

Exploration and development of personal range of movement, strength, stamina.

Primarily, gross motor skills used throughout. Motor planning prompted by audio and visual cues provided by dancer, musician and other participants.

Cognitive:

Initiation and termination skills used to identify the beginning and end of simple phrases and rhythms, and in turn taking.

Performance of short movement phrases, or in collections to create longer phrases. Use of long-term memory; familiar music/dance and associations and short-term memory; retention and recall of new material.

Call and response activities offer options to respond with the same or a different rhythm and the same or a different tap steps, facilitating complex executive function which are dynamically self-selected by the individual in order to fit the challenge of the activity with ability and preference. Examples of skills used include cognitive switching (stopping one rhythm to begin another or responding to unexpected cues), chunking (breaking down complex rhythmic units into smaller, manageable chunks for easier recall) and predictive processing (anticipating the next beat to ensure a smooth flow).

The activity facilitates/practices, sustaining attention, use of working memory and inhibition control (initiation and termination of movements/rhythms).

Sensory:

Vestibular and proprioceptive systems to maintain balance and positioning using varying degrees of pressure, force, speed and momentum to execute weight changes, turning, twisting, bending and reaching from a standing or seated position.

Touch between participant and session leaders used where appropriate to provide alternative (sensory) modes of communication.

Hearing to identify and manipulate rhythm and respond to sounds made by others.

Vision to observe prompts, engage in social interactions and assess for risk.

Affective:

Motivation required to attend sessions, impacted by potential barriers such as transport, mental health condition, social circumstances, finances.

Intrapersonal and interpersonal capacities utilised. Social demands of the group provide an opportunity to build confidence in a supportive environment. Sharing of cultural experiences through expression such as learned rhythms specific to individual's experience.

Therapeutic Value:

- Falls prevention:

Increased strength and stamina, particularly targeting lower body strength and mobility. Dual tasking to train attention.

Co-ordination, vestibular and proprioceptive skills/awareness. Increased cardiovascular abilities and reduced fatigue.

Graded activity to practice weight changing, turning and static, dynamic and reactive balance.

- Dementia/cognitive impairment:

Improvisation and expression offer a failure-free environment.

A variety of modes of communication provide a sense of connection appropriate to retained abilities (approaches can be shared with family).

Thinking and doing (dual tasking) activity to promote attention and reduce falls risk.

Promote self-actualisation by facilitating valued roles and skills which link to established identities through preserved abilities.

- Mood/Motivation/Mental Health:

Reducing loneliness.

Enhancing mood and cognitive stimulation.

Encouraging physical activity in a joyful, meaningful way.

Reaffirming identity through creativity and reminiscence.

Building confidence, routine, and community connection.

Grading:

- Grading up (increasing demands):

Move from seated to standing, reduce amount of physical support when confidence gained.

Add sections of movement together, two steps, two sounds, two phrases (use of “chunking”, increasing demands on working and procedural memory).

Work through levels of resistance, including body weight exercise and low impact steps and hops to positively impact bone density.

Increase social demands by working in pairs, taking turns, sharing own ideas, allocating group roles to meet the skills, interests and experience of individuals such as meet and greet – offer tea and coffee, handing out tap shoes, demonstrating and offering reassurance to peers or singing a familiar song.

- Grading down (decreasing demands):

Increase physical support such as ballet barre or carry out movement from a seated position.

Encourage participants to dip in and out of the activity as needed.

Improvisation where reduced memory/executive function skills present. Responses echoed by peers/session leaders offer a sense of agency and validation in the group setting.

Provision of tasks to follow if reduced confidence or communication/expression abilities.

Demonstrate half time versions of rhythms – support with second session leader delivering low demand (cognitive or physical) version of movements and rhythms.

Environmental adaptations:

Use of chair or ballet barre for balance.

Volunteer/OT to engage 1-1 in spontaneous interactions to support cognition/motivation/confidence.

Reduced sensory abilities (sight/hearing) supported by facilitators providing repeated or echoed information provided by performers in an accessible range.

Provide roles and responsibilities appropriate to participants strengths, values and experience.

Consider transport opportunities, including buddy system and community transport to support access.

Consider sensory needs and challenges i.e. lighting options and reduced distractions.

Safety/precautions/risk:

Leadership team carrying out ongoing dynamic risk assessments to enable and support positive risk taking whilst ensuring safety.

Participants advised at the beginning of each session to select activities appropriate to them and rest when necessary.

Initial assessments and interactions with other professionals involved in care (ie. Social Prescribers, Activity Co-ordinators, Health Care Assistants) support these assessments and awareness of risks specific to individuals.

Occupational Therapy Assessments provide information regarding individual risks where indicated in competencies/scope of practice. EG. Osteoporosis, balance issues.

Refreshments provided, regular reminders to drink water.

Reminders to rest or halt any movements that cause pain provided regularly.

Recommendations to improve occupational engagement and performance:

Discover and use familiar melodies and rhythms of participants, discuss memories and associations with those pieces of music.

Support role competence by highlighting participant strengths such as supporting others, singing a familiar song for the group to dance to or preparing the space prior to the session.

Suggest participants swap sides of the body (verbally, through demonstration or touch) in order to address habitual movement patterns which could neglect some physical abilities. Use activities transferring weight from one side of the body to the other, these can be seated, standing with support, standing without support. Copying or mirroring another participant could facilitate the use of both sides of the body as when facing one another and using a dominant side (ie. Right) that will be mirrored on partners left.

Use of chairs/barres when standing to grade balance/strength and confidence with stability.

Simple hops beginning in a seated position and possibly using the barre available in the dance studio could provide resistance. Flaps, heel drops and toe drops can also provide impact with reduced risk and to build strength.

Themed and weighted props could also provide resistance for upper body, for example, an umbrella for a singing in the rain theme. Use of props to strengthen upper body and develop stability.

Experiment with facing towards/away from/standing beside participants when demonstrating. Assistant volunteer and session lead might demonstrate from different angles at the same time. This could be particularly relevant for participants with sight/hearing loss on one side or for participants who have experienced a stroke and associated spatial neglect.

Recommendations for future work:

The implication of this work would be to support healthy, meaningful occupations in the community through meaningful, holistic engagement, supporting the prevention of ill health and the need to access health care services as per the NHS 10-Year Health Plan for England (Department of Health and Social Care, 2025).

Use of digital technologies to improve access/reach of the work via telephone/online sessions which could be 1-1 or group and occur as stand-alone sessions, part of a series or as a “warm up” prior to attending face to face sessions for those whose mental health impacts their ability to access social groups.

Consider how the accessible nature of the sessions can be communicated to participants in order to manage their sense of expectations and reduce the impact of perceived barriers to engagement.

Future partnerships with occupational Therapists could support the application and evidence for the impact of the work on wider function of participants in their daily life such as in activities of daily living barriers to engagement present.

Consider potential for early career placements to broaden newly qualified therapist's understanding of potential areas for emerging OT roles, including through independent practice.

Occupational Therapist to explore partnerships with Occupational Therapy professional body *The Royal College of Occupational Therapy*, to promote the approach, and connect with other OT-led creative activity and share best practice where possible.

Explore connections with universities (commenced) to provide student placements, addressing financial implications of ongoing work with therapists and to offer opportunities for employed OTs to engage in work that fits with core OT values, reducing potential for burn out (Edwards and Dirette, 2010).

Explore the potential to engage other Allied Health Professionals in addressing therapeutic impact of the work, including physiotherapists and speech and Language therapists.

Work with Occupational Therapy/Dance for Wellbeing/Physiotherapy students could consider:

- Research evidence base, such as that for falls prevention or dual tasking.
- Research outcome measures and assessment approaches use by both qualified and non-qualified staff.
- Explore the use of the Technical Instructor Role and any appropriate training for dancers and musicians to act as such.
- Explore Goal setting methods such as EKOS and COPM to facilitate TI role.

Explore agencies delivering work which aligns with ethos of the Care to Dance project such as The Falls Management Exercise (FaME) programme (Skelton and Dinan, 2005) and Sport for Confidence.

Consider how this work can be shared to promote and support other community arts programmes/artists to harness the work of the Allied Health Professionals workforce to develop confidence in delivering and articulating the health-related goals embedded in their work.

Consider research implications/opportunities for the work.

References:

Department of Health and Social Care (2025) *Fit for the future: 10 year health plan for England*. CP 1350. London: HM Government. Available at: <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future> (Accessed: 10 April 2026).

Edwards, H. and Dirette, D. (2010) 'The relationship between professional identity and burnout among occupational therapists', *Occupational Therapy in Health Care*, 24(2), pp. 119–129. Available at: doi.org

Skelton, D.A. and Dinan, S.M. (2005) 'Tailored group exercise (Falls Management Exercise - FaME) reduces falls in community-dwelling older frequent fallers (an RCT)', *Age and Ageing*, 34(6), pp. 636-639.