Godmanchester Bridge Academy

Safe Touch Policy

2024 - 2026

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Contents:

Introduction:

Children learn who they are and how the world is, by forming relationships with people and things around them. The quality of a child's relationship with significant adults is vital to their healthy development and emotional health and wellbeing. Our policy takes into account the neurobiological research and studies relating to attachment theory and child development that identify that safe touch makes a positive contribution to brain development, mental health and the development of social skills.

In recent years humanity have created societies rightly concerned with safeguarding, but that has created a great anxiety for some people. As a school we endeavour to equip teachers with a toolkit so they feel confident on a daily basis, rather than hope we will all just get it instinctively. This policy gives staff the confidence to incorporate touch into their practice.

We believe that children have the right to independence, choice and inclusion, and we seek to provide opportunities for personal growth and emotional health and wellbeing at Godmanchester Bridge Academy. However, rights also involve responsibilities, such as not harming other people's rights. Pupils unable to control their actions or unable to appreciate danger have a right to be protected; as do other pupils in school, and staff have a duty of care to exercise.

Aims:

This policy aims to:

A. Set out how Godmanchester Bridge Academy uses positive and nurturing touch to promote child development
B. Address sensory processing issues in relation to physical contact
C. Acknowledge different types of safe touch
D. Who can use positive handling techniques, processes and associated record keeping
E. Policy Monitoring arrangements

A. A positive and nurturing approach

Touch is one of the most important senses in our early development. 'As well as being linked with our emotional development, it is also vital for development of the brain in general,' says Anne O'Connor, early years consultant and co-founder of Primed for Life.

Ms O'Connor explains that touch plays an important role in the development of communication; 'Children learn to read our body language as well as understand our words, and touch is important to this. It's also an important way for us to be able to "read" the child and tune into their well-being.'

Above all, touch is a vital part of the process of attachment, building relationships with trusted adults that help a child feel secure and safe, giving them a base for further development.

Dr Manners from Active Matters says; 'It is vital for children that they feel physically comfortable and safe, and being touched, held, cared for, having their noses wiped, all that is critical,' he explains, 'If practitioners and teachers feel they can't do this, a child will pick it up quickly.'

Francis McGlone, professor of neuroscience at Liverpool John Moores University, makes the case that touch is a right, and something that children require for their development. He says, 'Touch is not a nice addition, it is a necessity as much as food.'

At Godmanchester Bridge Academy we believe in the same principles, that safe touch is a right, an essential part of development and about building relationships and connection. For example; hugging releases feel-good hormones in the hugger and 'huggee', which can help soothe stress and forge relationships. This kind of touch can help children develop the ability to regulate their own emotions.

B. Sensory Processing Issues

Sensory processing issues may affect how a child feels about physical contact, being hugged or what kind of reparative touch works best for them. Some children might find a light touch or gentle rub on the back very distressing and much prefer a strong hug or a squeeze. Other children may react in exactly the opposite way and can only cope with light touch. At Godmanchester Bridge Academy we are aware that not all children want to be touched and it important to get to know children well and tune into their individual needs.

Sensory seeking and sensory avoidance may also be evidenced in the way children choose to hug others, and those who need strong 'bear' hugs may find themselves getting into trouble for being

over-enthusiastic when hugging other children. Staff encourage children to gain consent from each other and explicitly teach them to ask first e.g., 'Would you like a hug?'

Children at both ends of the sensory-processing spectrum can be helped to modulate their sensory reactivity over time and with careful tuning into their needs and stage of development. Staff gain consent whenever possible for reparative touch interventions. Some children will have sensory interventions planned into their day which require deep pressure and staff follow guidance from SEND Specialist Team and/or Occupational Therapists in these cases.

C. Different approaches

There are six different types of touch and physical contact that may be used at Godmanchester Bridge Academy, these are:

1. **Casual / Informal / Incidental Touch**
   Staff use touch with pupils as part of a normal relationship, for example, comforting a child, wiping a nose, giving reassurance and congratulating. This might also include taking a child by the hand, patting on the back, putting an arm around the shoulders or putting an arm out to discourage an exit from a room; all would be age appropriate. The benefit of this action is usually proactive and can prevent a situation from escalating. Pupils will also have casual / informal and incidental touch between themselves for similar reasons and during shared learning and play activities and would be age appropriate.

2. **General Reparative Touch**
   This is used by staff working with pupils who are having difficulties with their emotions (for many different reasons). Healthy emotional development requires safe touch as a means of calming, soothing and containing distress for a frightened, angry or sad child. Touch used to regulate a child's emotions triggers the release of the calming chemical oxytocin in the body. Reparative touch may include stroking a back, gently squeezing an arm, holding hands, guiding a child to a different/calmer/safe space, rocking gently, cuddling, tickling, sitting on an adult's lap (age appropriate for Reception and into Key Stage 1), or hand or foot massage; all would be at an age appropriate level. Pupils will also use general reparative touch between themselves for similar reasons and would be age appropriate.

3. **Contact Play**
   Contact play is used by staff adopting a role similar to a parent in a healthy child-parent relationship. This will only take place when the child has developed a trusting relationship with the adult and when they feel completely comfortable and at ease with this type of contact. Contact play may include an adult and a child playing a game of building towers with their hands, role play and an adult chasing and catching the child and vice versa; all would be age appropriate. Pupils will also use take part in contact play between themselves for similar reasons and would be age appropriate.

4. **Interactive Play (Rough and Tumble Play -** please see our Play Policy)
   This structured play between pupils follows clear rules and is operated under close supervision of staff. It will only ever take place when all participants are in agreement and

completely understand the rules. This sort of play releases the following chemicals in the brain: ·

- Opiodes - to calm and soothe and give pleasure
- Dopamine - to focus, be alert and concentrate
- BDNF (Brain Derived Neurotropic Factor) - a brain 'fertiliser' that encourages growth.

Interactive play may include: throwing cushions each other, role play of cops and robbers or using foam pool noodles to 'fence' each other; and all would be age appropriate games.

5. Intimate Care

Intimate Care refers to any care that involves toileting, washing, changing, touching or carrying out an invasive procedure to children's intimate personal areas. Procedures and processes comply with our Safeguarding Policy. Intimate care is carried out properly by staff, in line with any agreed plans and ensure:

- The dignity, rights and wellbeing of children are safeguarded
- Pupils who require intimate care are not discriminated against, in line with the Equality Act 2010
- Parents/carers are assured that staff are knowledgeable about intimate care and that the needs of their children are taken into account
- Staff carrying out intimate care work do so within guidelines (i.e. health and safety, manual handling, safeguarding protocols awareness) that protect themselves and the pupils involved

For children who need occasional intimate care (e.g. for toileting or toileting accidents), parents/carers will be asked to sign a consent form.

For children whose needs are more complex or who need particular support outside of what's covered in the permission form (if used), an intimate care plan will be created in discussion with parents/carers. Where there isn't an intimate care plan or parental consent for routine care in place, parental permission will be sought before performing any intimate care procedure.

If the school is unable to get in touch with parents/carers and an intimate care procedure urgently needs to be carried out, the procedure will be carried out to ensure the child is comfortable, and the school will inform parents/carers afterwards. The school will share information with parents/carers as needed to ensure a consistent approach. It will expect parents/carers to also share relevant information regarding any intimate matters as needed.

Creating an intimate care plan

Where an intimate care plan is required, it will be agreed in discussion between the school SLT, parents/carers, the child (when possible) and any relevant health professionals.

The school will work with parents/carers and take their preferences on board to make the process of intimate care as comfortable as possible, dealing with needs sensitively and appropriately. Subject to their age and understanding, the preferences of the child will also be taken into account. If there's doubt whether the child is able to make an informed choice, their parents/carers will be consulted.

The plan will be reviewed twice a year by the Senior Leadership Team (SLT), even if no changes are necessary, and updated regularly, as well as whenever there are changes to a pupil's needs.

Staff responsible to intimate care:
Any roles which may require carrying out intimate care will have this set out in their job description. No other staff members can be required to provide intimate care. All staff at the school who carry out intimate care will have been subject to an enhanced Disclosure and Barring Service (DBS) with a barred list check before appointment, as well as other checks on their employment history.

How staff will be trained:
Staff will receive:

- Training in the specific types of intimate care they undertake
- Regular safeguarding training
- If necessary, manual handling training that enables them to remain safe and for the pupil to have as much participation as possible

They will be familiar with:

- The control measures set out in risk assessments carried out by the school
- Hygiene and health and safety procedures
- They will also be encouraged to seek further advice as needed.

How procedures will happen:
Wherever possible, procedures are carried out within the toilet areas adjoining classrooms. For example, most children needing 'nappy' changes are ready for pull-ups and can be supported to change in the upright position in an open cubicle within the toilet areas adjoining classrooms. For any child who requires full nappy changes, the school would work closely with the family to promote toilet training and reduce the impact of 2:1 nappy changes having an impact on the educational provision for other children as quickly as possible. It is fine for male members of staff to change female pupils, as long as they have an enhanced DBS with a barred list check.

Other intimate care procedures will be carried out in an agreed suitable location bearing in mind that the school does not have a hygiene room.

When carrying out procedures, the school will provide staff with:

- Protective gloves, cleaning supplies, changing mats and bins.

For pupils needing routine intimate care, the school expects parents/carers to provide:

- A good stock (at least a week's worth in advance) of necessary resources, such as nappies, underwear and/or a spare set of clothing.
- Any soiled clothing will be contained securely, clearly labelled, and discreetly returned to parents/carers at the end of the day.

Concerns about safeguarding
If a member of staff carrying out intimate care has concerns about physical changes in a child's appearance (e.g. marks, bruises, soreness), they will report this using the school's safeguarding procedures.

If a child is hurt accidentally or there is an issue when carrying out the procedure, the staff member will report the incident immediately to the Senior Leadership Team.

If a child makes an allegation against a member of staff, the responsibility for intimate care of that child will be given to another member of staff as quickly as possible and the allegation will be investigated according to the school's safeguarding procedures.

6. Positive Handling (Calming and assisting a Dysregulating Child)

Staff are trained to support dysregulated pupils verbally if they can and only physically if they absolutely must. Staff are to support pupils to reach calm with us, through many strategies, before the last resort of positive handling. Trained staff may use positive handling as a last resort when a pupil is:

- May cause harm to themselves or others or damage to property
- Unacceptably threatening, dangerous, aggressive or out of control behaviour
- Persistently disrupting the education of others

And:

- To avoid an offence being committed

This should be reasonable, proportionate and necessary in order protect the child who is in distress, protect other children from a distressed child and to protect oneself and other staff/colleagues.

Examples include:

I. Children who are very distressed, frustrated or heightened sometimes take active behaviours which could harm a member of staff who is present e.g., lashing out, striking, pushing, pinching, kicking or throwing an object.

II. Children who are very distressed, frustrated or heightened sometimes take active behaviours which could harm another child who is present. e.g., a fight which breaks out between children by mutual consent, or a child who targets another child for assault.

III. Children who are very distressed, frustrated or heightened sometimes take active behaviours which could harm themselves. e.g., a child hitting themselves, striking parts of their body against an object (wall, door or furniture) or by biting themselves.

IV. Children who are very distressed, frustrated or heightened sometimes attempt to run away from their classroom, their school building or leave the school premises entirely.

V. Children sometimes resist the reasonable requests of staff to collaborate, cooperate or comply with expectations in the learning environment. Where a child resists those requests, it can sometimes result in seriously disruptive behaviour which interferes with the learning activities. In these circumstances, some intervention may be required in order to allow the learning to proceed for those children who are engaged in the learning environment.

VI. Children sometimes make choices which are not related to distress, resistance or frustration but which are assessed by staff as 'risky behaviour' which is unacceptable because of its risk of injury. e.g., using some implements in the environment or engaging in behaviour which could result in an injury to themselves or others.

VII. Children in Reception years (and sometimes other year groups) sometimes arrive at school and refuse to leave their parent or carer at the threshold of the school premises, or the classroom or other area. Parents and carers often ask staff to assist them to physically separate the child from them in order for the child to enter the learning space, or for the parent/carer to disengage from the child.

D. Who Can Use Positive Handling?

The staff at Godmanchester Bridge Academy using positive handling will have been fully trained in positive handling techniques. There are some situations where those without training have the right (Use of reasonable force, July 2013. DfE advice template (publishing.service.gov.uk)) to use a reasonable degree of force, namely:

- Everyone has the right to defend themselves against an attack provided they do not use a disproportionate degree of force to do so.
- In an emergency, for example, if a child was in immediate risk of injury or on the point of inflicting in- jury on someone else, any member of staff would be entitled to intervene.

Any use of positive handling should be **reasonable, proportionate and necessary.**

Procedures Staff will, where possible, initiate always:
Employ de-escalation strategies and calming measures before positive handling intervention is used. De-escalation strategies and calming measures may include the following:

- Conversation, distraction, coaxing skills, gentle persuasion or redirection to other activities (e.g. touching the child's arm and leading him / her away from danger, gently stroking the child's shoulder, holding hands to support co-regulation, rubbing / stroking a child's back)
- Encourage the child to help him/herself feel more secure by wrapping a blanket tightly around him/herself or holding on tightly to a large cushion or stuffed toy
- Put distance between the child and others - move others to a safer place
- Calmly remove anything that could be used as a weapon, including hot drinks, objects, furniture
- To prevent a child continuing to pose harm in a dangerous situation, advise others to leave, but remain with the child yourself
- Use containment only if necessary for a short period while waiting for help, preferably where a member of staff can observe the child
- Keep talking calmly to the child, explain what is happening and why, how it can stop, and what will happen next
- Use first aid procedures in the event of injury or physical distress when safe to do so.

If it is decided that positive handling restraint is necessary as a last resort then staff will:

- Issue a verbal warning of an intention to intervene physically.
- Try to summon additional support before intervening. Such support may simply be present as an observer, or may be ready to give additional physical support as necessary.
- Lower the child's level of anxiety during the restraint by continually offering verbal reassurance and avoiding generating fear.
- Aim for side by side contact with the child. Avoid positioning themselves in front (to reduce the risk of being kicked) or behind (to reduce the risk of allegations of sexual misconduct).
- Aim for no gap between the adult's and child's body, where they are side by side. This minimises the risk of impact and damage.
- Aim to keep the adult's back as straight as possible.
- Beware in particular of head positioning, to avoid head butts from the child.

- Hold children by “long” bones, i.e. avoid grasping at joints where pain and damage are most likely.
- Cause **minimum level of restriction of movement** of limbs consistent with the danger of injury (so, for example, adults will not restrict the movement of the child’s legs unless in an enclosed space where flailing legs are likely to be injured).
- **Ensure that there is no restriction to the child’s ability to breathe.** In particular, this means avoiding holding a child around the chest cavity or stomach.
- Avoid lifting children up from the floor, or from under furniture or from height.
- Keep talking to the child to reassure them unless it is judged that continuing communication is likely to make the situation worse.
- Don’t expect the child to apologise or show remorse as many young children do not understand the difference between accidental and deliberate hurt.
- **Use as little restrictive force as is necessary** in order to maintain safety and for as short a period of time as possible.
- In very extreme circumstances two or members of staff might be necessary to ensure the safety of all involved.

Any use of positive handling should be **reasonable, proportionate and necessary.**

Recording and Reporting

A detailed written statement recording an occurrence of positive handling intervention will be made as soon as possible after the incident on the child’s individual Arbor record and in the blue incident book and must include:

- What took place, to and by whom, its severity and how long it lasted
- What effects there were and to whom
- Circumstances leading up to the incident (who was involved, time of day and where it occurred, what activities were taking place etc).
- Actions that were taken by staff to avoid positive handling
- Details of other children or staff who were present at the time. This should be done as soon as possible and within 24 hours of the incident. According to the nature of the incident, it may be noted in other records such as the accident book. Parents will be informed as soon as possible.

Planning and Risk Assessment

After an emergency positive handing intervention, the situation is reviewed and plans for an appropriate future response are made. This will be based on a risk assessment which considers:

- the risks presented by the child’s behaviour
- the potential targets of such risks
- preventative/adaptive and responsive strategies to manage these. It may be deemed necessary as a result of the risk assessment to write an ~~individual behaviour plan~~ Risk Reduction Plan that is developed to support a child. If a ~~behaviour~~ the plan includes positive handling intervention it will be just one part of a whole approach to supporting a child’s behaviour.

The Risk Reduction Plan should outline:

- An understanding of what the child is trying to achieve or communicate through their behaviour
- How the environment can be adapted to better meet the child's needs
- How the child can be encouraged to use new, more appropriate behaviours
- How the child can be rewarded when he or she makes progress
- How staff respond when the child's behaviour is challenging (responsive strategies). There are a range of approaches such as humour, distraction, relocation, and offering choices which are direct alternatives to using physical intervention.

Staff who work with the child, and any involved visiting support staff, will draw up a plan with the child's parents/carers. The plan will be reviewed regularly.

Supporting and Reviewing:
It can be distressing to be involved in a positive handling intervention, whether as the person carrying out the intervention, the child or someone observing or hearing about what has happened. After a positive handling intervention, support is given to the child in an age appropriate way so that they can understand why they were managed in this way, through our restorative conversations approach (see Behaviour Policy). A record is kept about how the child felt about this where this is possible.

Where appropriate, staff may have the same sort of conversations with other children who observed what happened.

In all cases, staff should wait until the child has calmed down enough to be able to talk productively and understand this conversation. Support will also be given to the adults who were involved, either actively or as observers. The adults will be given the chance to talk through what has happened with the most appropriate person from the staff team.

Monitoring:
All reports of positive handling intervention will be reviewed by the Senior Leadership Team and where appropriate the Governing Body on a termly basis. Monitoring the use of positive handling intervention helps identify trends and therefore helps develop our school's ability to better meet the needs of all of our children.

E. Complaints:

The use of physical intervention can lead to allegations of inappropriate or excessive use. Where anyone (child, carer, staff member or visitor) has a concern, this should be dealt with through the school's usual complaints procedure.

F. Policy Monitoring arrangements

This policy will be reviewed by the Senior Leadership Team bi-annually. At every review, the policy will be approved by the Governing Body and the Headteacher.

Links with other GBA policies:
This policy links to the following policies and procedures:

- Play Policy

- Accessibility plan
- Child protection and safeguarding
- Health and safety
- SEND
- Supporting pupils with medical conditions
- Behaviour Policy

G. References

Home | p4life (primedforlife.co.uk)

Activematters - Dedicated to children's early years physical development and activity

www.thriveapproach.com

DfE advice template (publishing.service.gov.uk) on reasonable force

Positive Handling Training for Schools with De-Escalation and Restraint (dynamis.training)

Headteacher: Claire Pirrie **Date:** October 2024

Safeguarding Link Governos: Mathew Kelly **Date:** November 2024

Appendix 1: template parent/carer consent form

PERMISSION FOR SCHOOL TO PROVIDE INTIMATE CARE	
Name of child	
Date of birth	
Name of parent/carer	
Address	
I give permission for the school to provide appropriate intimate care to my child (e.g. changing soiled clothing, washing and toileting)	☐
I will advise the school of anything that may affect my child's personal care (e.g. if medication changes or if my child has an infection)	☐
I understand the procedures that will be carried out and will contact the school immediately if I have any concerns	☐
I **do not** give consent for my child to be given intimate care (e.g. to be washed and changed if they have a toileting accident). Instead, the school will contact me or my emergency contact and I will organise for my child to be given intimate care (e.g. be washed and changed). I understand that if the school cannot reach me or my emergency contact, if my child needs urgent intimate care, staff will need to provide this for my child, following the school's intimate care policy, to make them comfortable and remove barriers to learning.	☐
Parent/carer signature	
Name of parent/carer	
Relationship to child	
Date	

Appendix 2: template parent/carer consent form

PARENTS/CARERS	
Name of child	
Type of intimate care needed	
How often care will be given	
What training staff will be given	
Where care will take place	
What resources and equipment will be used, and who will provide them	
How procedures will differ if taking place on a trip or outing	
Name of senior member of staff responsible for ensuring care is carried out according to the intimate care plan	
Name of parent or carer	
Relationship to child	
Signature of parent or carer	
Date	
CHILD	
How many members of staff would you like to help?	
Do you mind having a chat when you are being changed or washed?	
Signature of child	
Date	

Next review date:

To be reviewed by:

This plan will be reviewed twice a year.

Appendix 3: template risk calculator

Godmanchester Bridge Academy

Risk Calculator

Name	B
Date of birth	00/01/1900
Date of assessment	

Harm / Behaviour	Opinion or Evidenced **O / E**	Seriousness of harm (A) **1/2/3/4**	Probablility of harm (B) **1/2/3/4**	Severity Risk Score **A x B**
Harm to self				
Harm to peers				
Harm to staff				
Damage to property				
Harm from disruption				
Criminal Offence				
Harm from absconding				

Risks which score ***6*** *or more (probability x seriousness) should have strategies listed on the plan*

Seriousness	
1	Evidence of upset or disruption
2	Evidence of needing support internally from our school resources e.g. first aid, nurture, budget allocation
3	Evidence of needing intervention from external agencies outside of school resources e.g. hospital, professional counselling or group work, insurance claim
4	Evidence of harm that cannot be resolved e.g. disability, sectioned mental health, loss through arson
Probability	
1	Incidents were more than a year ago with no identified triggers remaining. There is evidence of historical risk and no evidence of current risk.
2	Incidents occur approximately on a monthly basis. The risk remains relevant.
3	Incidents occur approximately on a weekly basis. The risk is likely to occur again.
4	Incidents are daily or constant. The risk is persistent.

Appendix 4: template risk reduction plan

Godmanchester Bridge Academy

Therapeutic Plan

Student Name: **B**
School / Setting:
Year Group:

Plan Co-ordinator:
Date of Plan:
Review Date:

Risk reduction measures and differentiation (to respond to triggers) What are the differentiated experiences we give this child to help lower anxiety and create helpful feelings and valued behaviours?	How are these measures used? (Times & durations, planned scripts, planned activities, who is doing what, when are they doing it, where, which adults are involved, which peers are involved, contingency arrangements)
Valued behaviour What does it look like when they are stable and displaying valued behaviours?	**Strategies to respond** What do you want staff to do or say when they observe each of the valued behaviours?
DIFFICULT detrimental behaviours These should be the first signs the individual's behaviour is becoming detrimental. The individual no longer displays the valued behaviour. The behaviour is difficult but there is no imminent risk of harm to self of others or risk of damage to property.	**Strategies to respond** What do you want staff to do or say when they observe each of the listed anxiety, detrimental or difficult behaviours?
DANGEROUS detrimental behaviours This box can be left empty if there are no dangerous behaviours. A dangerous behaviour is one which will imminently result in injury to self or others, damage to property or behaviour that would be considered criminal if the child was the age of criminal responsibility.	**Strategies to respond** What do you want staff to do or say when they observe each of the listed crisis, detrimental dangerous behaviours?
Post-incident recovery and debrief measures What are the structured conversations that are needed, and who is best placed to have these? How long after the incident will they occur?	

Signature of Plan Co-Ordinator: ---------- Date: ----------

---------- ----------

Signature of Parent / Carer: ---------- Date: ----------

Signature of Young Person: ---------- Date: ----------