Safe Uncertainty Methodology Toolkit

Children's Social Care | Showcase version for South East Local Authorities

Designed for use in SharePoint, Teams, intranet pages or Learning Management Systems

Purpose of this toolkit

This toolkit turns the safe uncertainty concept and application material into a practical, reusable learning and practice resource. It is intended as a showcase model that local authorities can review, adapt and embed into their own learning management systems, practice hubs, supervision frameworks and leadership development programmes.

Important practice guardrail

Safe uncertainty is not an instruction to tolerate unmanaged risk. It is a disciplined way of holding complexity while remaining evidence-informed, child-focused, relational, reflective and ready to act decisively when risk becomes unmanageable or significant harm is evidenced.

Source basis: developed from the **West Sussex County Council presentation** "**Safe uncertainty - concept and application**", used in SESLIP Workshop 1 and including the Mason four-position framework, Domains of Action, supervision questions, reflexive practice prompts and leadership/culture questions. Participating local authorities may want to refine or update this presentation to align to their own practice.

How to use this showcase toolkit

The toolkit is structured so that an LA can lift the content into the platform it already uses. This document can be used as a demonstration model because it is easy to visualise as pages, templates and databases. The same design can be replicated in Microsoft SharePoint, Teams, Moodle, Google Sites or an internal practice hub.

Audience	Likely use
Assistant Directors / Heads of Service	Leadership framing, culture work, strategic assurance and practice expectations.
Service managers / team managers	Supervision, case reflection, decision challenge, risk discussion and reflective learning.
Principal Social Workers / QA leads	Embedding into practice standards, audit, learning reviews and practice weeks.
Social workers / practitioners	Reflective prompts, case mapping, hypotheses and child/family-centred decision-making.
Learning and development teams	Build as bite-sized modules, reflective tasks, downloadable tools and discussion forums.

Recommended digital build

Platform	How to configure it	Why this works for LAs
Microsoft SharePoint / Teams	Create a practice hub site with document library, MS Forms, Planner actions and Teams channel.	Most LAs already have Microsoft 365; supports permissions and governance.
LMS module	Build 6 modules: 10–15 minute learning objects, reflective questions, knowledge checks and downloadable templates.	Supports tracking, compliance, CPD records and manager sign-off.
Hybrid model	Host the practice hub on SharePoint and add key modules to LMS for mandatory learning.	Best balance: formal learning plus live practice resources.

Toolkit contents

Section	What it contains
1. Learning architecture	Six-module structure for LMS or practice hub build.
2. Practice model	Four positions of safe/unsafe and certainty/uncertainty, with supervision use.
3. Reflective tools	Prompts for production, explanation and aesthetics domains.
4. Live case templates	Supervision record, hypotheses map, decision challenge, action plan and reflective huddle.
5. Leadership and culture tools	Readiness self-assessment, culture prompts and 30/60/90-day implementation plan.
6. Evaluation framework	Measures, learning feedback, audit prompts and LA comment log.

1. Learning architecture for LMS or practice hub

Suggested hub title: Safe Uncertainty in Children's Social Care: Reflective, Relational and Evidence-Informed Decision-Making.

Module	Learning outcome	Core activity	Evidence of completion
1. Setting the context	Explain why children's social care requires a practice approach that can hold complexity without becoming risk-averse or reckless.	Short video/reading plus reflection: "Where do I seek certainty too quickly?"	Reflective note or discussion post.
2. The four positions	Recognise safe certainty, unsafe certainty, unsafe uncertainty and safe uncertainty in casework and leadership.	Drag-and-drop or quadrant case sorting exercise.	Completed quadrant map.
3. Domains of Action	Use production, explanation and aesthetics questions in supervision and decision-making.	Rewrite closed questions into curious, reflexive questions.	Question bank submission.
4. Reflexivity and the role of us	Explore how social worker, manager, LA culture and wider system shape risk perception and intervention.	Reflective case discussion using "role of us" template.	Completed reflexive practice tool.
5. Safe uncertainty versus unmanaged risk	Differentiate between tolerating uncertainty and failing to act when risk is evidenced or escalating.	Decision challenge scenario and escalation boundary exercise.	Decision rationale template.

Module	Learning outcome	Core activity	Evidence of completion
6. Leading and embedding the approach	Plan how the LA will use safe uncertainty in supervision, QA, panels, learning reviews and culture work.	Team action planning and 30/60/90-day implementation plan.	Manager sign-off and action plan.

Design principle for L&D teams

Do not make this a passive e-learning module only. Safe uncertainty is a practice stance. It needs discussion, supervision, live case reflection and leadership modelling.

2. Core practice model: the four positions

The presentation uses Barry Mason's safe/unsafe and certainty/uncertainty frame. In practice, the value of the model is that it helps workers and leaders notice the stance they are taking, not simply the process they are following.

Position	Typical stance	What it can look like in CSC	Helpful supervisory move
Safe certainty	Confident, structured and purposeful.	Clear evidence, proportionate plan, agreed contingency and known statutory threshold.	Maintain clarity while asking: "What might we be missing?"
Unsafe certainty	Fixed, defensive or fear-driven certainty.	Single story dominates; risk view hardens; intervention escalates without testing alternative hypotheses.	Slow the thinking: "What would happen if this hypothesis was wrong?"
Unsafe uncertainty	Overwhelmed, unclear or paralysed by complexity.	Drift, lack of oversight, unclear decision rationale, missed visits or unmanaged escalation.	Create structure: "What is known, evidenced and urgent today?"
Safe uncertainty	Curious, reflective and open, while still acting responsibly.	Multiple hypotheses, family/network voice, risk mitigation, collaborative planning and clear review points.	Hold the balance: "What uncertainty can we safely hold, and what must be resolved?"

Quadrant case mapping template

Question	Notes
What is the current presenting worry or decision point?	
Which quadrant are we most likely operating from today? What evidence supports that view?	

Question	Notes
What is known and evidenced?	
What is assumed, feared or inferred?	
What hypotheses have we tested with the child, family and network?	
What would be the risk of acting too quickly from certainty?	
What would be the risk of holding uncertainty too long?	
What is the next safe, proportionate step?	

3. Domains of Action: supervision and decision conversations

The presentation references Lang, Little and Cronen's Domains of Action: production, explanation and aesthetics. The toolkit translates these into supervision practice so that managers can move between action, meaning-making and ethical/relational reflection.

Domain	Purpose	Use when...	Example questions
Production	Clarify facts, immediate worries, thresholds, actions and risk management.	A child may be at immediate risk; the plan is unclear; statutory action may be needed.	What are we worried about? What has happened so far to manage risk? Do we need to act now?
Explanation	Explore meaning, multiple truths, hypotheses, child/family/network perspectives and practitioner assumptions.	The case is complex; the narrative has become fixed; progress feels stuck.	How do we understand the child's life? What sense do we make of the family's response? What else could explain this?
Aesthetics	Consider ethics, values, relational impact and what the work feels like to those involved.	The manager or worker feels uneasy; relationships are central; intervention may cause harm as well as safety.	What sits well with this approach? What leaves us uneasy? What does the relationship tell us?

Supervision prompt bank

Purpose	Prompts
Ground risk	Where is the evidence of direct significant harm or likely significant harm? What is known today, and what remains uncertain?

Purpose	Prompts
Check discomfort versus danger	Has risk become unmanageable, or have we/the network become uncomfortable with holding it?
Challenge process drift	What would we do if this process or framework did not exist? What is the purpose of moving into a different process now?
Open multiple hypotheses	What are the different stories we are holding? Whose story is most dominant? Whose voice is missing?
Include the child	What does the child tell us about life where they are living? How might the child experience our involvement?
Explore practitioner position	What experiences, values or anxieties of our own might be shaping how we see this situation?
Plan safely	What uncertainty do we need to hold onto, what must we resolve, and what is the next safe step?

4. Reflexive practice: the role of us

A key message from the source presentation is that relationships are at the heart of creating change, and that professional systems should examine their own role in maintaining or shifting patterns. This section supports practitioners and leaders to consider the relationship between family, social worker, manager, local authority and wider system.

Lens	Reflective question	What to capture
Child	How does the child experience daily life, risk, relationships and professional involvement?	Child's words, presentation, relationships, wishes, lived experience.
Family and network	What strengths, stressors, histories and meanings shape the family response?	Protective factors, patterns, support, barriers, network capacity.
Practitioner	What am I noticing in myself when I think about this family?	Anxiety, frustration, hope, judgement, rescue, avoidance, identification.
Manager	What am I encouraging, closing down or amplifying in supervision?	Balance of challenge/support, focus on evidence, curiosity and action.
Organisation	How are thresholds, performance, media pressure, workload or culture shaping the decision?	Pressures, spoken/unspoken norms, assurance requirements, defensiveness.
Wider system	How are partners, courts, schools, health, police or community context influencing	Network narratives, power, collaboration, constraints and opportunities.

Lens	Reflective question	What to capture
	what seems possible?	

Reflective huddle template

Huddle step	Prompt	Time
1. Name the dilemma	What decision or tension are we holding?	5 mins
2. Evidence and uncertainty	What is known, what is assumed, and what is not yet known?	10 mins
3. Multiple perspectives	What might the child, family, network and professionals each say?	10 mins
4. Role of us	How might our actions, language, processes or anxieties be shaping the situation?	10 mins
5. Safe next step	What action increases safety while preserving curiosity and relationship?	10 mins
6. Review point	When will we know whether this has helped?	5 mins

5. Safe uncertainty versus unmanaged risk

Non-negotiable distinction

Safe uncertainty must include clear thinking about immediate danger, evidence of significant harm, proportionate action, management oversight, contingency planning and review. Without these, uncertainty may become unmanaged risk.

Safe uncertainty includes...	Unmanaged risk may include...
Known risks are evidenced and reviewed.	Unclear or outdated risk picture.
Multiple hypotheses are held and tested.	Single story, false optimism or no clear hypothesis.
Child's lived experience is actively sought.	Adult narratives dominate; child voice is weak or absent.
There is a proportionate plan with contingencies.	No clear action, drift, missed visits or lack of escalation.
Manager oversight helps regulate anxiety and decision-making.	Managerial oversight is absent, reactive or only process-driven.
The professional network shares responsibility and challenge.	Partners are unclear, disengaged or reinforcing untested assumptions.
The rationale for holding risk is recorded clearly.	Decision rationale is vague, defensive or undocumented.

Decision challenge record

Decision challenge question	Response / evidence
What decision are we considering and why now?	
What is the evidence of current or likely significant harm?	
What risks are immediate and what risks are longer-term?	
What protective factors and mitigating actions are present?	
What would the child say matters most today?	
What alternative explanations have been considered?	
What are we trying to manage: risk, the narrative, organisational pressure or our own discomfort?	
What is the least intrusive action that can increase safety?	
What is the escalation threshold and contingency plan?	
Who will review this decision, and when?	

6. Leadership and organisational culture

Embedding safe uncertainty requires leadership conditions that enable reflective, brave and proportionate practice. The presentation asks leaders to consider culture, climate, dominant values, unspoken norms and political context. The following tools translate that into a practical LA self-assessment.

Component	Reflective question	Evidence to look for	RAG
Context	What situational pressures or histories are influencing how practice develops?	Inspection history, serious incidents, media/political pressure, thresholds, demand.	R / A / G
Confidence	How comfortable are leaders and managers with not having all the answers?	Supervision quality, use of hypotheses, leadership messages, tolerance of complexity.	R / A / G

Component	Reflective question	Evidence to look for	RAG
Control	What are we trying to control: risk, narrative or discomfort?	Decision records, escalation patterns, panel behaviour, language in QA.	R / A / G
Curiosity	What would happen if we stayed curious a little longer?	Family/network involvement, reflective prompts, challenge spaces, learning reviews.	R / A / G
Safety	How do we ensure curiosity does not become drift?	Contingencies, review points, oversight, thresholds, audit, escalation routes.	R / A / G

Culture diagnostic prompts

- ☐ What are the spoken and unspoken rules about risk in this organisation?
- ☐ When practice is under pressure, do we default to process, escalation, closure, drift or curiosity?
- ☐ How are staff treated when they make brave but defensible decisions?
- ☐ What do performance dashboards encourage managers to notice or ignore?
- ☐ Where do we create time for reflective practice, and where do we squeeze it out?
- ☐ What language do leaders use about families: blaming, rescuing, relational, curious, deficit-based or strengths-based?
- ☐ How do QA, audit and panels reward evidence-informed uncertainty rather than simplistic certainty?

7. Templates for LA adoption

A. Safe uncertainty supervision template

Section	Prompt
Case context	Child, family, current plan, legal/status framework, key decision point.
Known evidence	What is evidenced and from which sources?
Uncertainty	What do we not know yet? What assumptions might we be making?
Quadrant check	Which position are we working from: safe certainty, unsafe certainty, unsafe uncertainty or safe uncertainty?
Domains of Action	Which questions are needed today: production, explanation, aesthetics?
Role of us	How are worker, manager, organisation and network shaping the situation?
Child/family voice	What has the child/family told us directly? What might they experience from our involvement?

Section	Prompt
Decision	What is the next safe, proportionate and relational step?
Contingency	What would trigger escalation, change of plan or urgent action?
Review	Who will do what, by when, and how will we know it has helped?

B. Safe uncertainty action plan

Action	Owner	By when	What safety will this increase?	How will we review?

C. LA implementation roadmap

Phase	Actions	Outputs
First 30 days: prepare	Agree sponsor; identify practice lead; choose platform; adapt language to local model; select pilot teams; agree evaluation baseline.	Named sponsor, pilot plan, draft hub/LMS shell, baseline confidence survey.
Days 31-60: pilot	Run manager briefing; launch modules 1-3; test supervision template in live teams; hold reflective huddles; gather comments.	Pilot feedback, amended tools, examples of anonymised learning.
Days 61-90: embed	Launch full module set; add to supervision policy/practice standards; align QA/audit prompts; create community of practice.	Final toolkit, manager guidance, QA link, learning report.
Ongoing	Review use in supervision, panels, learning reviews, audit moderation and leadership development.	Quarterly dashboard and practice learning summary.

8. SharePoint showcase structure

The following page structure can be copied into or replicated in Microsoft 365. Each page should contain a short explanation, a reflective task, downloadable template and comment box.

Page / area	Content blocks	Database or template
Home: Safe	Welcome; why it matters; practice guardrail;	Progress tracker.

Page / area	Content blocks	Database or template
Uncertainty Practice Hub	start here pathway.	
Learning modules	Six module pages with video/slide summary, reflection, activity and knowledge check.	Module completion database.
Supervision tools	Prompt bank, supervision template, decision challenge record, action plan.	Template gallery.
Case reflection library	Anonymised scenarios, quadrant maps and team huddle notes.	Case reflection database with tags.
Leadership and culture	Readiness self-assessment, culture prompts, implementation roadmap.	RAG self-assessment tracker.
LA comment area	Feedback questions for LAs reviewing the showcase.	Comments database: theme, suggestion, owner, response.
Evidence and evaluation	Feedback forms, confidence measures, audit prompts, learning outcomes.	Evaluation dashboard.

Suggested SharePoint database properties

Database	Properties
Module tracker	Name; module; role; status; confidence before; confidence after; action committed; date completed.
Case reflection log	Case type; quadrant; domain used; key learning; safety action; review date; anonymised learning theme.
LA comment log	Local authority; role; page/tool; feedback theme; suggested change; priority; response; decision.
Implementation plan	Action; owner; team/service; target date; status; dependencies; evidence of embedding.

9. Launch workshop options

Option	Length	Best for	Outline
Manager briefing	60 minutes	Team managers and service managers before pilot launch.	Context; four positions; supervision prompt bank; pilot expectations; evaluation.
Practice learning session	90 minutes	Mixed practitioners and managers.	Case scenario; quadrant mapping; Domains of Action; safe next step; reflective learning.
Half-day leadership	3.5 hours	Heads of Service, PSW,	Culture diagnostic; safe

Option	Length	Best for	Outline
workshop		QA, L&D and operational managers.	uncertainty vs unmanaged risk; leadership conditions; implementation plan.
Community of practice	Monthly 60 minutes	Pilot teams and practice champions.	Live learning, dilemmas, template testing, barriers and adaptations.

Example 90-minute session plan

Time	Activity	Facilitator notes
0-10	Welcome and purpose	Emphasise that this is not a replacement for thresholds, statutory duties or safeguarding action.
10-25	Safe uncertainty overview	Introduce the four positions and ask participants where they tend to go under pressure.
25-45	Case scenario: quadrant mapping	Small groups map what is known, assumed and uncertain.
45-60	Domains of Action	Groups generate production, explanation and aesthetics questions.
60-75	Decision challenge	Groups identify safe next step, contingency and review point.
75-90	Commitment to practice	Each participant records one supervision question they will use this week.

10. Anonymised practice scenarios for learning

How to use these scenarios

These are deliberately brief and generic. LAs should replace them with locally agreed anonymised case material and ensure all learning material follows internal information governance requirements.

Scenario 1: adolescent risk and family conflict

A 15-year-old is regularly missing overnight. Parents are exhausted and asking for the child to be accommodated. The young person says home is “too controlling” and refuses some professional contact. School reports reduced attendance. Police intelligence suggests association with older peers, but direct evidence of exploitation is limited.

Discussion question	Notes
Where might the network move into unsafe certainty?	

Discussion question	Notes
What would unsafe uncertainty look like here?	
What evidence is needed urgently?	
How might the young person experience professional involvement?	
What is the next safe relational step?	

Scenario 2: long-term neglect and child protection drift

A child has been subject to a child protection plan for 11 months. There has been some improvement in home conditions and school attendance, but change is inconsistent. Professionals disagree about whether the plan should escalate, continue or step down. The parents attend meetings but do not always follow through on agreed actions.

Discussion question	Notes
Are we seeking certainty because the plan has reached a time marker?	
What is the evidence of direct harm, likely harm and protective change?	
What might disguised compliance, overwhelm, poverty or professional relationship patterns each explain?	
What role have we played in enabling or limiting change?	
What would a brave but defensible decision look like?	

11. Evaluation and assurance framework

Measure	Method	Frequency	What good looks like
Learner confidence	Before/after module survey.	Each module / quarterly.	Increased confidence in holding uncertainty and using supervision prompts.
Use in supervision	Supervision audit or manager self-report.	Monthly during pilot.	Evidence of hypotheses, child voice, risk rationale and contingency.
Decision quality	Audit of decision records and panels.	Quarterly.	Clear rationale differentiating evidenced risk, uncertainty and professional discomfort.

Measure	Method	Frequency	What good looks like
Culture shift	Pulse survey and reflective forums.	Quarterly.	Staff report that curiosity, challenge and brave defensible decisions are supported.
Practice impact	Learning reviews, QA findings, feedback from families/practitioners.	6-monthly.	More relational, proportionate and evidence-informed practice; reduced drift and defensive escalation.

LA comment questions for showcase review

- ☐ Would this toolkit fit within your current LMS or practice hub?
- ☐ Which parts would need adapting to your local practice model, thresholds or supervision framework?
- ☐ What would make this safer, clearer or more useful for managers?
- ☐ What examples, case studies or local language should be added?
- ☐ How could this support leadership culture, not just practitioner learning?
- ☐ What evidence would you want to see after a 90-day pilot?

12. Quick-start build checklist

- ☐ Agree senior sponsor and practice owner.
- ☐ Choose platform: Notion showcase, SharePoint hub, LMS module or hybrid model.
- ☐ Create six module pages and upload the core tools.
- ☐ Add supervision template to local supervision guidance or practice standards.
- ☐ Pilot with two to three teams and one leadership group.
- ☐ Use anonymised case reflection to test the approach in practice.
- ☐ Collect LA comments using the comment log.
- ☐ Review after 30, 60 and 90 days and decide what to embed permanently.

Suggested closing message for the hub

Safe uncertainty asks us to remain curious without becoming passive, to act without pretending we know everything, and to make brave, defensible decisions with children and families rather than about them.