Mental Welfare Commission for Scotland

Report on unannounced visit to:

Craiglea Ward, Adult Rehabilitation Ward, Royal Edinburgh Hospital, Edinburgh, EH10 5HF

Date of visit: 11 September 2023

Where we visited

Craiglea is a 15-bedded male adult rehabilitation ward for individuals between the ages of 18 and 65. Referrals are received from many sources, including; inpatient acute services, community services and forensic services. Many of the individuals referred to Craiglea Ward have had contact with mental health services for a prolonged period of time. The objective of Craiglea is to provide intensive rehabilitation to individuals with complex and enduring mental health needs, with the aim of preparing and supporting individuals with discharge into the community.

We last visited this service in August 2019 and made recommendations in relation to low staffing numbers impacting on the activities being offered to patients and developing a more appealing outdoor area for patients.

On the day of this unannounced visit, we wanted to follow up on the previous recommendations, meet with patients, staff and any relatives/carers, as well as look at the care and treatment being provided on the ward.

Who we met with

We met with, and reviewed the care of eight patients, five of whom we met with in person and reviewed their care notes, and a further three where we reviewed the care notes. We also met with one relative.

We spoke with the clinical nurse manager (CNM), the responsible medical officer (RMO), the charge nurse (CN) and other nursing staff. Following the visit we contacted advocacy services and the Royal Edinburgh Hospital Volunteer Hub.

Commission visitors

Kathleen Liddell, social work officer

Claire Lamza, executive director (nursing)

Tracey Ferguson, social work officer

Denise McLellan, nursing officer

What people told us and what we found

During discussion with patients and the staff team, and from reviewing patients' files, it was clear that some of the patients in Craiglea Ward had reached rehabilitation potential. Many of the current patient group in Craiglea have had prolonged periods of inpatient admission. One patient is on the waiting list for hospital based complex clinical care (HBCCC). Three of the patients in Craiglea had been assessed as requiring continuing complex care, had been placed on the delayed discharge list and were awaiting a re-provisioned service. We were told that senior managers have recognised the gap in community service provision for patients with complex care needs and are currently commissioning a new service to meet this need. At the time of the visit, there were no specific details about this service, however we will continue to monitor developments during future visits to rehabilitation services.

Care, treatment, support and participation

Comments from patients

The patients we met on the day of the visit were positive about their care and treatment in Craiglea. The feedback included comments such as "staff are supportive and reliable", "I like the structure I have, it makes me feel worthwhile" and "I attend my ward round and feel involved in decisions about my care".

Most of the patients we met with raised issues about the smoking ban and the 'negative' impact this had on them. This was especially relevant to patients who had limited time out from the ward, which did not allow them sufficient time to leave the grounds to smoke. We asked the CNM what supports were being offered to patients who smoked. We were told that nicotine replacement was offered to patients, the use of vapes was an option as this was permitted on hospital grounds and smoking cessation involvement/support, either individually or in a group setting, was available. We were told that the uptake of smoking cessation support had been low which concurred with the view of most patients we met with, who reported that they did not want to stop smoking.

Patients told us that they had a key nurse whom they met with regularly. Patients also told us that they had regular reviews by their RMO and felt involved in discussions and decisions about their care and treatment. Some patients were unaware they had a nursing care plan and referred to the integrated care plan (ICP) as being their care plan. Some of the patients had an awareness of discharge planning, with others able to identify that they still had some goals to achieve to progress their discharge plans.

The relative we spoke to told us that they were happy with the care and treatment of their relative in Craiglea. They added that they visited the ward regularly and were made to feel welcome by staff.

We were told by the SCN that inpatient rehabilitation services work jointly with community-based carers services to offer a monthly carers group for relatives and carers of patients supported by rehabilitation services.

Nursing care plans

Nursing care plans are a tool which identify detailed plans of nursing care; effective care plans ensure consistency and continuity of care and treatment. They should be regularly reviewed

to provide a record of progress being made. The Commission would expect a rehabilitation service care plan to be based on a whole-systems approach, with a clear focus on recovery.

We found the nursing care plans in Craiglea to be of mixed quality. Some of the care plans we reviewed were individualised, goal focussed, person-centred and adopted a strengths-based and holistic approach. These nursing care plans evidenced patient participation, and where appropriate relative/carer involvement. Other care plans we reviewed did not have the same level of information recorded and were mainly didactic, with little evidence of rehabilitation focussed care, patient involvement or clear detail on the purpose of the nursing intervention recorded. We observed that some of the care and treatment goals recorded in the nursing care plans did not link to the care and treatment goals recorded in the ICPs. The lack of clarity between the two documents made it difficult to ascertain what the identified care and treatment goals were and how the MDT would deliver the care and treatment to the patient, in order to support them meet their outcomes.

We saw intermittent reviews of the nursing care plans. We were unable to locate robust reviews that included summative evaluations relating to the efficacy of the intervention, or the individuals' progress. We discussed this with the CNM and CN on the day of the visit and were told that there was a dedicated band 4 nurse in Craiglea responsible for reviewing and updating nursing care plans. We were told that the staff member was on leave and there was no replacement to undertake this role, during this time. We were concerned that there was no system in place to review nursing care plans regularly and consistently. Regular reviews of nursing care plans provide a record of patient progress that has been made and/or highlights areas of the care and treatment plan that the patient may require additional support with.

We would expect a rehabilitation care plan to focus on goals around physical, psychosocial, therapeutic, financial, social, recreational and vocational needs. We saw some evidence of this in nursing care plans however, were pleased to see that ICPs took into account these goals, as well as the needs and strengths of the patient.

We found that there were three monthly reviews of the ICPs. We found comprehensive and detailed information recorded in them. The ICP included psychological formulations for patients with assessed complex care needs. The formulations recorded how the MDT could best support the patient alongside supporting staff to reflect on their expertise and how this could generate new ways of working with patients. We were pleased to find that the ICP meeting was attended by the MDT, the patient and carer, where involved, and reviewed mental health, risk, discharge planning, finances, substance misuse and time off the ward goals.

The Commission's 2020 themed visit report on rehabilitation services highlighted the link between long-term mental health problems and an increase of physical health problems. We heard on the day of the visit that many of the patients in Craiglea have been in hospital for prolonged periods of time. Long hospital admissions are known to be barriers to routine and national health screening initiatives that patients might otherwise have access to while in the community. We were pleased to find that there was a significant focus on physical health care for patients in Craiglea. There was evidence of physical health care needs being addressed and followed up appropriately by the junior doctor.

We saw some evidence of a culture that supported healthy lifestyles in relation to diet, exercise and mental wellbeing. In reviewing the files, we saw that many of the patients were not meeting care and treatment goals in relation to nutrition and exercise. We were pleased to see that the ward offered some initiatives to support healthy lifestyle choices however, we would have liked to see more opportunities for patients to engage in educational opportunities that would further promote engagement and support with diet, nutrition and exercise.

Many of the patients we met with told us that they had addiction issues related to alcohol, tobacco and drugs. For patients who required support with smoking, alcohol and drug addiction, we found evidence of this being offered via smoking cessation and referrals to NHS Lothian addiction services.

We found the risk assessments to be of a high standard and they included an associated safety plan. The risk assessment included detailed pass documentation, recording the purpose of all time out of the ward and also included a failure to return plan.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:
https://www.mwcscot.org.uk/node/1203

Recommendation 1:
Managers should ensure that the care and treatment goals recorded in nursing care plans are linked to Integrated Care Pathway care and treatment goals to ensure consistency and continuity of care and treatment.

Recommendation 2:
Managers should ensure that all nurses are carrying out regular reviews of care plans focusing on individual needs and that care plans have clear goals/outcomes.

Care records

Information on patients care and treatment was held electronically on TrakCare. We found this easy to navigate. The majority of case records were recorded on a pre-populated template with headings relevant to the care and treatment of the patients in Craiglea. It was evident from reviewing the case records that patients in the ward required high levels of care, motivation and support. The patient group could experience high levels of stress and distress, leading to increased clinical risk, due to high levels of verbal and physical aggression. We were pleased to note that the MDT were actively involved in providing the support, care and treatment to patients at these times.

The majority of the case notes we reviewed evidenced person-centred and individualised information, detailing what activities the patient had engaged in that day and what had been positive or challenging. We were pleased to see comprehensive recording from all members of the MDT. In particular, case records from the occupational therapist (OT), art therapist and the mental health support workers who provided activities were of a high standard, recording personalised, outcome and goal focussed information and included forward planning. We saw evidence of one-to-one interventions between nursing staff and patients. This tended to be with the mental health support workers during engagement in activities with patients.

We were pleased to find that the case notes included regular communication with families and relevant professionals.

Multidisciplinary team (MDT)

The ward had a broad range of disciplines either based there or accessible to them. In addition to the nursing staff, there was a full-time consultant psychiatrist, junior doctor, psychologist, art therapist and OT.

The multidisciplinary team (MDT) work closely to provide psychological therapies, psycho-education programmes and support individuals to develop meaningful activities and strategies to help them through their recovery journey.

We heard that there were nursing staff vacancies in Craiglea, mainly band 5 nursing staff however, were pleased to hear that newly qualified band 5 nursing staff would be joining the ward in the coming weeks. Bank staff were used regularly to cover staffing shortfalls. We were told that the ward had a core group of bank staff who regularly worked on the ward, and who support the continuity of care delivery. The CNM told us that there had been initiatives to support recruitment, such as modern apprenticeships that offered work experience, development of nursing skills and access to practical learning while studying.

The MDT met weekly in the ward. The patients were split into two groups and each patient group was discussed at the MDT meeting on a fortnightly basis. Patients were invited to attend the ward round. On review of the patient files and from speaking with patients, we saw and heard evidence of patient, and where appropriate, family participation in the MDT meeting. We also heard from one patient that advocacy had attended their MDT meeting discussion, which they found supportive.

The MDT meeting was recorded on TRAKCare. We found detailed recording of the MDT discussion, decisions and personalised care planning for the patients. It was clear that everyone in the MDT was fully involved in the care of patients in Craiglea. We saw that there were discharge planning activities that were progressing, and where the community rehabilitation team (CRT) were involved to support discharge.

Use of mental health and incapacity legislation

On the day of our visit, all patients were detained under the Mental Health (Care and Treatment) (Scotland) Act 2003 (Mental Health Act). We found the detention certificates relating to the Mental Health Act stored electronically on TRAKCare.

Any patient who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a patient had nominated a named person, we found copies of this in the patient's file.

Part 16 (s235-248) of the Mental Health Act sets out conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. Unfortunately not all the correct paperwork was in place and not all paperwork which was in place was accurate.

The ward used the HEPMA (hospital electronic prescribing and medicines administration) system, however, stored all the consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act 2003 on Trakcare.

On reviewing Trakcare and HEPMA simultaneously, we found that the majority of the consent to treatment certificates (T2) and certificates authorising treatment (T3) under the Mental Health Act 2003 which we reviewed were valid. However, we found that the prescribed medication for one patient was not authorised on the appropriate certificate and advised that a review of this patient was required.

We found that navigating both electronic systems, to ensure that the prescribed medication was being dispensed according to the appropriate certificates, was complicated and potentially problematic. We would suggest that a paper copy of all T2 and T3 certificates should be kept in the ward dispensary, so that nursing staff have easy access to, and an opportunity to review, all T2 and T3 certificates.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the Adults with Incapacity (Scotland) Act 2000 (the AWI Act) must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the AWI Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We were told that none of the patients in Craiglea required section 47 certificates.

Rights and restrictions

Craiglea continued to operate a locked door, commensurate with the level of risk identified with the patient group.

The patients we met with during our visit had a good understanding of their rights and detained status under the Mental Health Act. All of the patients we met with were aware of their right to advocacy support and some had legal representation. We were pleased to see information sent to the patient by the RMO, detailing their legal status, their rights in relation to this and contact numbers for advocacy to support patients to exercise their rights. Some of the patients had exercised their right to appeal their detained status with support from advocacy and legal representation. We noted that quarterly ICP review meetings discussed patients' rights. We suggested to the CNM on the day of visit that discussions with patients regarding their rights should take place more regularly. We suggested adding a section to the MDT format to discuss each patient's legal status and associated rights.

We heard there was a community meeting in the ward every week, organised by nursing staff. The meeting was an opportunity for patients to communicate their views on any issues in the ward and discuss these with each other and staff. The community meeting also provided an opportunity for patients to make suggestions regarding activities and/or social events they would like arranged in the ward.

Section 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a patient is a specified person in relation to these sections of the Mental Health Act, and where restrictions are introduced, it is important that the principle of least restriction is applied. We were told by nursing staff that

three patients in Craiglea were specified. This information was taken from the patient information board in the staff duty room. On review of these patients' files, we found that the paperwork in relation to specified persons had expired. We spoke with the patients concerned and they confirmed there were no restrictions placed on them. We raised with the CN on the day of the visit the importance of updating the patient information board to reflect the current care and treatment plan. This information was updated during the Commission visit.

When we are reviewing patients' files we look for copies of advance statements. The term 'advance statement' refers to written statements made under sections 274 and 276 of the Mental Health Act, and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. On the day of the visit, one patient we reviewed had an advance statement in their file. We discussed the low uptake of advance statements with the CN who told us that nursing staff do have discussions with patients regarding the benefit of advance statements. These discussions were evident during ICP meetings. It was evident during our review of the patient files and in discussion with some of the patients that they were not at a point in their recovery to be able to make decisions regarding their care and treatment.

Advocacy services were available in the ward and provided by the local mental health advocacy service, Avocard. We were told that advocacy attended the ward on request and provided a good service to patients who wished to engage with them. We were pleased that most of the patients we met with on the day of the visit had advocacy support.

The Royal Edinburgh Hospital had a patient council group that offered collective advocacy and drop-in sessions that some of the patients in Craiglea attended.

We were pleased to hear that the patient council had delivered human rights-based training to patients and staff, promoting rights-based care to patients.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

We heard about and found evidence in the care files of a broad range of activities that were available for patients in Craiglea. The activity and occupation in the ward was provided by mental health support workers, OTs and an art therapist. The patients we met with spoke very positively about this part of the service, and were complimentary about the activities offered in the ward, and especially out in the community.

There was an activities board on the wall of one of the corridors of the ward that recorded activities on offer. The activities available included cooking, creative writing, spiritual care, art therapy, smoothie group and football. We were pleased to see that patients could also access activities out with the ward, some of these being provided by third sector providers. These activities included attending 'The Hive', where patients could engage in activities and socialise with other patients in the hospital. Some patients attend the Glasshouses for gardening activities with support provided by the Cyrennians and Artlink.

We heard that many of the patients in Craiglea were involved with the REH volunteer hub. We made contact with the volunteer hub and were told that that ten of the patients in Craiglea engaged regularly in activities provided by staff at the volunteer hub and public volunteers. Activities offered included odd jobs, computer-based admin support, sociology, chemistry and astrology study, litter picking, plant care and poetry sessions. There were plans for the volunteer hub to offer therapet and 'build your own bike' to patients in the near future. We were pleased to see that these activities supported rehabilitation goals and promoted skills-based and educational opportunities for patients.

We saw and heard that patients were offered activities to promote daily living skills. Patients were supported to 'deep clean' their room regularly with the support of the housekeeper and their key nurse. This care goal had proved difficult to achieve for some patients, due to low levels of motivation and at times, a decline in mental health.

Patients had set days for laundry and were supported with this activity. For some patients, it was part of their care plan to cook their own meals in the kitchen with the support of staff. For patients who engaged in the cooking programme, a weekly food budget was provided by the ward to purchase food.

We were concerned to hear from patients and mental health support workers that due to staff shortages in other areas of NHS Lothian, planned individual and group activities could be cancelled at short notice. Staff we spoke with told us that cancelling planned activities had an impact on the therapeutic relationships they had with patients, as well as an effect on staff morale. We were told that the mental health support workers who provided the activity and occupation in the ward were supernumerary to staffing numbers. On the day of the visit, the mental health support worker was counted in staffing numbers due to staff shortages, so was therefore unable to offer the planned activities.

The issue of staff shortages that had an impact on patient activity and occupation was raised in the previous report. Whilst we acknowledge the challenges of staff shortages, we were concerned that continued staff shortages compromises continuity of care and is likely to negatively impact on each patient's rehabilitation goals. We raised this with the CNM on the day of the visit, who shared our concerns over staff shortages and the impact on patients and staff. The CNM advised us that these concerns continued to be raised with senior managers.

Recommendation 3:
Managers should ensure that rehabilitation services and staffing numbers are adequate to allow for planned activities.

The physical environment

Craiglea was located on the second floor of the original part of the Royal Edinburgh Hospital. The layout of the ward consisted of single rooms and double rooms. There were shared toilets, showers and one bathroom. The double rooms had a partition in place, in between bed spaces, which supported a degree of privacy and dignity for patients. We were able to view a single and double room. Both were personalised. There remained an issue with storage on the ward. Many of the patients had a considerable amount of belongings, given they have been in hospital for long periods of time and there was inadequate space to store their belongings.

There was a lounge area and a separate dining area for the patients. Patients tended to use the dining space more than the lounge area. We asked some patients why they did not use the lounge area. Patients told us that they would prefer it if the lounge had a pool table and tea and coffee making facilities to help make it a more sociable area. The CN told us that the use of the lounge area was being reviewed by the clinical team, with input from patients.

There was a spacious kitchen on the ground floor of the hospital that patients used to cook. The kitchen had adjustable appliances for patients with mobility issues. The patients could opt into the ward cooking programme as part of their care plan. The cooking programme supported patients to purchase and cook their own food and they were provided with a food budget.

The ward environment required significant areas of improvement and repair. On the day of the visit we observed that that a toilet was blocked, emergency lights were flickering, some of the privacy curtains in the shared bedrooms were not properly attached to the track, some areas of the ceilings were marked and paint on the walls peeling. We were told that the ward was last decorated three years ago and was on the waiting list to be painted again. Given the poor condition of the environment, we would suggest that the decoration and repair work in Craiglea is made priority. This would also support creating a more therapeutic and homely environment for patients.

On the day of the visit, the cleanliness of the environment was a concern. There was debris on the floor and most of the patients' bed spaces were untidy and cluttered with unclean washing, empty mugs and food. We were told that a deep clean of the ward had taken place three weeks prior to the unannounced visit and the ward had daily domestic support. We were told that as part of each patient's daily care goals, they were expected to ensure their bed space was clean and tidy however, as reported above, this could be a challenge due to a lack of motivation and at times a decline in mental health. We raised this with the CNM and CN, and suggested that a review of the care and treatment plans for patients who were unable to complete these tasks was necessary, to inform the team as to what interventions and support the patient required to achieve this care goal, and ensure their bed space was of an appropriate standard of cleanliness.

There was a recommendation in the previous report in relation to provision of outdoor space and garden areas for patients in Craiglea. We were disappointed to see that there had been no progress on implementing this recommendation. Although we recognised the location of Craiglea makes it difficult to provide outdoor space, the lack of access to outdoor space continues to concern us. We consider that it is important for patients to have access to outdoor safe space, especially patients who are experiencing stress and distress.

Although the patients did not raise any issues regarding the environment, there were noticeable disadvantages to patients who required rehabilitation services, specifically patients in Craiglea and Myreside, in comparison to patients in the new part of the hospital building. We are concerned that the individuals' right to privacy and dignity, which is protected by Article 8 of the European Convention on Human Rights, are being compromised due to the current environmental factors. We are aware that plans for a new build as part of the Royal

Edinburgh Hospital redevelopment project were in place however, this work is some years away and has been further delayed by Covid-19.

Recommendation 4:
Managers should urgently address the outstanding environmental issues in relation to decoration, cleanliness and maintenance issues to make the environment more homely and therapeutic.

Recommendation 5:
Managers should review the provision of outside space and garden area in order to develop a more appealing, pleasant and accessible outdoor area for patients and visitors.

Any other comments

Staff managed the unannounced visit well, especially in the absence of the senior charge nurse. We heard that there had been changes and vacancies in the ward leadership team which had been difficult for staff. Staff were transparent about current challenges in the ward setting and areas that required improvement. We heard from staff that opportunities for regular supervision, staff meetings and training have been negatively impacted by absences and vacancies in the ward management and staff team. We were pleased to see that a new charge nurse had been appointed, which would complete the management team and hopefully promote and support regular staff meetings, supervision and review staff training opportunities.

The staff we met with told us that they worked in a very supportive team and there was ongoing commitment from staff to provide high quality care to the patients in Craiglea. This was evident from discussions with patients who praised the staff for their caring and supportive approach.

We were also encouraged to hear about the commitment to development of Craiglea and the other rehabilitation services in the Royal Edinburgh Hospital. We were pleased to hear from the CNM that every service involved in rehabilitation care and treatment met on a monthly basis to discuss service gaps, highlight required areas of improvement and assess what was working well. The CNM had been making links with rehabilitation services in other health boards to discuss new practice ideas, view different environments and consider any new care and treatment that would be beneficial to the patient experience in Craiglea.

Summary of recommendations

Recommendation 1:
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Recommendation 2:
Managers should ensure that all nurses are carrying out regular reviews of care plans focusing on individual needs and that care plans have clear goals/outcomes.

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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

Contact details

The Mental Welfare Commission for Scotland
Thistle House
91 Haymarket Terrace
Edinburgh
EH12 5HE

Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk