West Midlands Clinical Networks
West Midlands Clinical Senate

Welcome to the West Midlands Perinatal Mental Health Network Stakeholder Meeting

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Perinatal Mental Health Transformation

Perinatal Mental Health
The National Picture
9th September, 2016

Dr Giles Berrisford
Joint Associate National Clinical Director
Perinatal Mental Health
The challenge

- Mental health problems in the perinatal period are very common, affecting up to 20% of women. Half of all cases of perinatal anxiety and depression go undetected. And even when detected they don't receive evidence based treatments.

- Perinatal mental illnesses cost the NHS and social services around **£1.2 billion** for each annual cohort of births*. A significant proportion of this cost relates to adverse impacts on the child.

- Almost a quarter of women who died between six weeks and one year after pregnancy died from mental-health related causes. 1 in 7 women died by suicide.

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* LSE and Centre for Mental Health, The Costs of Perinatal Health Problems (2014)
** MBRRACE-UK, Confidential Enquiries, 2015
Designing a better future

- Perinatal mental health identified as key national priority:
  - Closing the gap: priorities for change in mental health (DH, 2014)
  - Falling through the Gaps: Perinatal Mental Health and General Practice – Mar 2015
  - Prime Minister’s announcement and Life Chances strategy – Jan 16
  - Five Year Forward View for Mental Health – Feb 16
  - Better Births independent report – Feb 16
- Backed up by commitment to new investment
- Using momentum to deliver significant service improvement and improve outcomes for women and their families
In 2015/16 NHS Benchmarking also completed analysis of access to specialist Mother & Baby Units (MBUs) across the country.

- Baseline 15 MBUs with 115 beds.
- Significant gaps in local provision looking at distance travelled for women and babies
- Some women travel over 100km for an MBU
- Significant variation in clinical interventions
Inpatient Mother and Baby Units
The challenge – variation and inequality

- Huge variation at each level
- only 3% of CCGs had maternal mental health strategy.
- fewer than 15% of localities provided specialist services for women with complex or severe conditions at the full level recommended
- more than 40% provided no service at all.

*Map - Maternal Mental Health Alliance, Everyone’s Business campaign 2015*
Good perinatal mental health services

- promote prevention, early detection and diagnosis
- Clinical Networks - GPs, 3rd sector, women and families, full MDT
- Sharing information
- Seamless, integrated pathway giving comprehensive care across organisations and professional boundaries.
- Effective, evidence based treatment
- Training and supervision from specialist teams
Outcomes for women and their families

• All women can access appropriate, high-quality specialist mental health care, closer to home, when they need it during the perinatal period.

• Positive experience of care

• Services joined up around them

• Earlier diagnosis and intervention

• Supported to recover

• Fewer women and their infants suffer avoidable harm.

• There is more awareness, openness and transparency around perinatal mental health.
Policy and funding announcements

- Total investment from 2015/16 to 2020/21 = £365m

- By 2020/21, an additional 30,000 women in all areas of the country should receive access to evidenced-based specialist support, closer to their home, when they need it, including access to psychological therapies and right range of specialist community or inpatient care.

- Enables NHS England to design a **phased, five-year transformation programme** to build capacity and capability in specialist perinatal mental health services, with the aim of enabling women in all areas of England to access NICE-concordant care by 2020/21.
• Levels of funding increase overall across the period.
  ○ 2016/17 to 2018/19 – setting infrastructure, including investment in workforce development, MBU procurement and pump-priming community services. **£15m** in 16/17.
  ○ 2019/20 onwards – new money begins flowing to CCG baselines.
National priorities for 2016/17

- Establish and/or continue to develop effective networks.

- Continue to engage and collaborate with CCGs / GPs and providers to deliver best practice and reduce fragmentation in service provision.

- Identify and assess baseline positions in terms of availability and access to specialist perinatal mental health services (gap analysis in line with NICE guidance)

- Ensure that a broad range of perinatal mental health support is available locally, with clear pathways available for identification and timely access to psychological therapies and specialist perinatal services in line with NICE guidance.

- Establish local workforce strategies.
What will the future look like...?

• Perinatal clinical networks in all regions of the country which provide clinical expertise and leadership for consistent

• High quality and evidence based care for women, babies and their families for the full spectrum of mental health problems.

• Strategic commissioning of perinatal mental health care based on need, with specialised perinatal services organised so that inpatient mother and baby units serve the needs of large populations and are closely integrated with specialised community perinatal mental health teams.

• Standardised data and outcome measures for all perinatal mental health services (including maternal and infant outcomes), to measure and monitor improvement activity and service provision.
Specialist Perinatal Community Care

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>COLOUR</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Green</td>
<td>Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 <a href="http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%20Edition.pdf">Link</a></td>
</tr>
<tr>
<td>4</td>
<td>Yellow</td>
<td>Specialised perinatal community team that meets Joint Commissioning Panel criteria <a href="http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf">Link</a></td>
</tr>
<tr>
<td>3</td>
<td>Orange</td>
<td>Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours</td>
</tr>
<tr>
<td>2</td>
<td>Red</td>
<td>Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time</td>
</tr>
<tr>
<td>1</td>
<td>Red</td>
<td>Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only</td>
</tr>
<tr>
<td>0</td>
<td>Red</td>
<td>No provision</td>
</tr>
</tbody>
</table>

Disclaimer: Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact info@everyoneinbusiness.org.uk if you suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area listed here.
The opportunities...

• Opportunity to develop robust pathways to ensure all women receive adequate care
• The GP perinatal mental health toolkit will support
• Need to be involved with the commissioning process to ensure needs of local population are met
• Need to be part of the Maternal mental health networks to ensure full pathway is developed
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Perinatal Mental Health Scoping of Services

Liz Moore

Quality Improvement Officer - Maternity
Purpose

Scope PMH provision across West Midlands

Dedicated PMH services

Access
Demand
Workforce
Training
Discharge
Network
Who contributed to the scoping?

2gether NHS Foundation Trust
Dudley and Walsall Mental Health Trust
Worcestershire Health and Care Trust
Birmingham and Solihull Mental Health Trust
Shropshire and South Staffordshire Foundation Trust
Birmingham Children’s Hospital
Coventry and Warwickshire Partnership Trust
Black Country Partnership Trust
Do you have a dedicated PMH service?

Yes - 4/8

Shropshire and South Staffordshire (MBU)
Birmingham and Solihull (MBU)
Coventry and Warwickshire
Worcestershire
Access into the system

No Service – Referral to
Adult Mental Health Team

Service – Direct referral to PMH team from
GP
Obstetrician
Midwife
Health Visitor
Adult Mental Health Team
## Demand

<table>
<thead>
<tr>
<th>Trust</th>
<th>BSMHT</th>
<th>SSSFT</th>
<th>Worcester</th>
<th>Cov &amp; Warw</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of births in catchment area per annum</td>
<td>22500</td>
<td>8670</td>
<td>(Stiffs)</td>
<td>6200</td>
</tr>
<tr>
<td>No. of PNMH referrals received per annum</td>
<td>1321</td>
<td>591</td>
<td>480</td>
<td>450</td>
</tr>
<tr>
<td>Average Referral time to 1&lt;sup&gt;st&lt;/sup&gt; appointment</td>
<td>5 weeks</td>
<td>21 days</td>
<td>2-6 weeks</td>
<td>3 weeks</td>
</tr>
<tr>
<td>Average time from 1&lt;sup&gt;st&lt;/sup&gt; appointment to follow-up</td>
<td>4 weeks</td>
<td>26 days</td>
<td>3-4 weeks</td>
<td></td>
</tr>
<tr>
<td>Average length of time patient remains in the service</td>
<td>7 months</td>
<td>58 days</td>
<td>18 months</td>
<td>Up to 12 months</td>
</tr>
<tr>
<td>Average No. of in-patient admissions per annum</td>
<td>44</td>
<td>42</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Average Length of stay (Mother and Baby Units only)</td>
<td>10 weeks</td>
<td>37 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average occupancy rate (Mother and Baby Units only)</td>
<td>98%</td>
<td>53.16%</td>
<td></td>
<td></td>
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</table>
# Workforce

<table>
<thead>
<tr>
<th>Trust</th>
<th>BSMHT</th>
<th>SSSFT</th>
<th>Worcester</th>
<th>Cov &amp; Warw</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Psychiatrist</td>
<td>2.2</td>
<td>1.0</td>
<td>0.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Psychology</td>
<td>1.0</td>
<td></td>
<td></td>
<td>2.1</td>
</tr>
<tr>
<td>Psychotherapist</td>
<td></td>
<td>0.1</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Community Psychiatric Nurses</td>
<td>3.0</td>
<td>2.7</td>
<td>3.3</td>
<td>5.0</td>
</tr>
<tr>
<td>Junior Doctor/ SAS Dr</td>
<td>1.6</td>
<td>0.25</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1.0</td>
<td>0.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Specialist Nursery Nurse</td>
<td>5.0</td>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Midwife</td>
<td>2.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Health Visitor</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant Mental Health Therapist</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service/Team Manager</td>
<td>2.0</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>Administrative Support</td>
<td>4.0</td>
<td>1.4</td>
<td>0.5</td>
<td>1.6</td>
</tr>
</tbody>
</table>
Training

Psychiatrists and Psychologists 😊
Community Psychiatric Nurses 😐
Social Workers and Nursery Nurses 😞

Specialist Midwives and Health Visitors 😞
Discharge

Between Community PMH team and MBU 😊

Between Community MH team and MBU 😞

Lack of specialist knowledge
What can a PMH Network do for you?

Support to develop services
Sharing of best practice and quality standards
Training
Peer Support

Improved pathways
Enhanced workforce
Enhanced working relationships and networking
Research
Access to patient voice
Strengthen voice to commissioners
Liz Moore
liz.moore4@nhs.net
West Midlands Clinical Networks
West Midlands Clinical Senate

Wifi: parkinn_guest

Twitter: @WMSCN

Web: www.wmscnsenate.nhs.uk
No specialist perinatal mental health team

Dr Helen Sullivan
Consultant Obstetrician
The Royal Wolverhampton Hospitals NHS Trust
Content

• Woman with pre existing mental health disorder
• New concerns in current pregnancy
• Postnatal depression
• Postpartum psychosis
Pre existing mental health disorder

• Shavay
• 39 year old lady both of whose other children have been removed from her care.
• Three admissions of several months under mental health section in last ten years for a psychotic disorder
Pre existing mental health disorder

- Communication
- Key worker
- Psychiatrist
- Other agencies
- GP
Pre existing mental health disorder

- Medication
- SSRIs and SNRIs
- Atypical antipsychotics
- Depot preparations
Pre existing mental health disorder

- Safeguarding
- Family
- Support network
- Contraception
Pre existing mental health disorder

Healthcare professionals working in universal services and those caring for women in mental health services should:

- Assess the level of contact and support needed by women with a mental health problem (current or past) and those at risk of developing one

- Agree the level of contact and support with each woman, including those who are not having treatment for a mental health problem

- Monitor regularly for symptoms throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth.

- Discuss and plan how symptoms will be monitored (for example, by using validated self-report questionnaires).

NICE 2014
Pre existing mental health disorder

- Claire is booking for AN care
- 29 year old who was taking sertraline for 18 months four years ago. She was diagnosed with depression after the death of her mother. She also had work related stress. She is currently well.
Pre existing mental health disorder

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• Agree the level of contact and support with each woman, including those who are not having treatment for a mental health problem

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• Discuss and plan how symptoms will be monitored (for example, by using validated self-report questionnaires).

NICE 2014
New Concerns

All women asked twice:
• During the last month have you often been bothered by:
• Feeling down, depressed or hopeless?
• Having little interest or pleasure in doing things
• Is this something you need or want help with?

• Over the last two weeks:
• How often have you been bothered by feeling nervous, anxious or on edge?
• How often have you been bothered by not being able to stop or control worrying?
New Concerns

• Sonia has been to see her midwife for a routine check up at 26 weeks of pregnancy.
• She is weepy and tells her midwife she feels low all the time and has trouble sleeping and is not eating well. She feels lonely and has not been getting on well with her partner. She says she wishes she had not got pregnant.
New Concerns

Assessment should include:

- History of any mental health problem, including in pregnancy or the postnatal period
- Physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem
- Alcohol and drug misuse
- The woman's attitude towards the pregnancy, including denial of pregnancy
- The woman's experience of pregnancy and any problems experienced by her, the fetus or the baby
- The mother–baby relationship
- Any past or present treatment for a mental health problem, and response to any treatment
- Social networks and quality of interpersonal relationships
- Living conditions and social isolation
- Family history (first-degree relative) of mental health problems
- Domestic violence and abuse, sexual abuse, trauma or childhood maltreatment
- Housing, employment, economic and immigration status
- Responsibilities as a carer for other children and young people or other adults.

- NICE 2014
New concern

If there is a risk of self-harm or suicide:

• Assess whether the woman has adequate social support and is aware of sources of help

• **Arrange help appropriate to the level of risk**

• Inform all relevant healthcare professionals (including the GP and those identified in the care plan)

• Advise the woman, and her partner, family or carer, to seek further help if the situation deteriorates

• NICE 2014
Postnatal Depression

• Women asked at all post natal contacts about how they are feeling and emotional wellbeing.
• Follow up questions as for antenatal period
• If any concerns; referred to GP or keyworker
• Formal risk assessment for PND is the role of the health visitor

• How many times does a community midwife see a post natal woman?
Education

• Annual in service training about perinatal mental health for 9 years
• Core part of both obstetric and midwifery training
• Excellent external resources
Incidence

• 12% experience depression during pregnancy
• 13% experience anxiety during pregnancy
• 15-20% experience depression in the first year
• 1 – 2 in 1000 experience postpartum psychosis
Incidence

- 4500 birth per year

- 274 women referred to my service with concerns about their mental health at booking in one year.
Key message

• Without a perinatal mental health service we struggle to identify those women suffering from moderate mental health disorders.
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Developing a Community Perinatal Mental Health Service – the Coventry/Warks model

Dr Kirstie McKenzie-McHarg
Consultant Clinical Psychologist
South Warwickshire NHS Foundation Trust
Cov/Warks context

- 60 miles north to south
- Population of 878,500
- Birth population of approximately 11,500pa
- One large teaching hospital (UHCW)
- Two smaller general hospitals (Warwick and George Eliot, Nuneaton)
- County-wide mental health service (CWPT)
In the beginning...

- Clinician-led service established, jointly chaired by a clinical psychologist and a psychotherapist
- Involved psychiatry, psychology, CPN, psychotherapy, IAPT rep, obstetrician, midwife, health visitor
- ‘Best practice’ perinatal mental health pathway for Cov/Warks developed
- Contact from Arden & GEM CSU
Process of Change

• CRCCG commissioned Arden & GEM Commissioning Support Unit (AGCSU) to audit its perinatal mental health services. AGCSU expanded this to include Coventry & Warks
  – Consultation with provider and commissioner organisations included 4 locations, 3 CCGs, 3 acute hospital Trusts and 1 mental health Trust
• Close working between Chair of the clinician-led group and Arden liaison
Identified service issues

• Inequity of services across the region
• Inconsistent care pathways
• Insufficient resources
• Unclear demand
• Complex needs a potential high risk
Inequitable Services

- **Coventry (births approx 6,000):**
  - 0.6wte consultant psychiatrist
  - 1.4wte CPNs

- **Rugby (births at Coventry)**
  - No service

- **North Warwickshire (births approx 2,500):**
  - 0.4wte clinical psychologist

- **South Warwickshire (births approx 3,000):**
  - 0.2wte consultant clinical psychologist
  - 0.6wte clinical psychologist
Inconsistent care pathways

- **Coventry:** Access generally via a designated Single Point of Entry
- **Rugby:** No service available
- **North:** Referrals only accepted via midwifery at George Eliot Hospital
- **South:** Referrals accepted by maternity services at Warwick Hospital and GPs
Insufficient Resources

• **Coventry:** No clinical psychology, only catering to most severe range due to insufficient CPN resource

• **Rugby:** No service at all

• **North:** No psychiatry. No CPN. Insufficient psychology resource

• **South:** No psychiatry. No CPN. Insufficient psychology resource.
Unclear Demand

- Insufficient data regarding the number of women requiring a perinatal service meant that the three involved CCGs had a limited ability to provide appropriate services, or to be compliant with national guidelines.
Complex Needs and Risk

- Suicide is the leading indirect cause of maternal death in the UK
- Medication is less acceptable to pregnant and breastfeeding women
- Specialist knowledge and MDT working is essential
- There was no perinatal psychiatry available in Warwickshire
Collaboration

• Involved clinicians were invited to a key stakeholder group which included NHS England, service users, local authorities, CCG representatives, provider organisations

• Past and present service users were also involved via maternity liaison groups and individual clinicians
Moving Forward

• With the information gathered via consultation, all three CCGs actively requested full business cases for a new perinatal mental health service for each of the three areas for which they commissioned

• The clinician-led group Chair worked closely with AGCSU to update and complete full business cases for each CCG and AGCSU led on presenting these to the CCGs
Options Analysis in each bid

- Do nothing
- Commission an entirely new, stand-alone service for the whole county
- Utilise existing resources and ‘plug gaps’ as necessary across the county
Do Nothing

• Inequity of services across the region
• Inconsistent care pathways
• Insufficient resources
• Unclear demand
• Complex needs a potential high risk
Completely new service

• Attractive for a number of reasons
  – Could design a gold standard service ‘from scratch’
  – All staff could be employed via one Trust
  – Services would be new and hence equitable

• Prohibitively expensive

• Unnecessarily disruptive

• May lose some key individuals and hence expertise
Utilise existing services

• Maintain existing resources
• Utilise existing knowledge, skills and experience
• Far more cost-effective
• Promotes good inter-Trust working
• Capitalises on pre-existing positive working relationships
‘Fill the Gaps’ funded across region

<table>
<thead>
<tr>
<th>Location</th>
<th>Original Service</th>
<th>New Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry</td>
<td>0.6wte Consultant Psychiatrist, 1.6wte CPNs</td>
<td>0.8wte Consultant Psychiatrist, 3.4wte CPNs</td>
</tr>
<tr>
<td>Rugby</td>
<td>None</td>
<td>2.1wte Clinical Psychologists</td>
</tr>
<tr>
<td>North Warwickshire</td>
<td>0.4wte Clinical Psychologist</td>
<td>0.25wte Consultant Psychiatrist, 1wte CPN, 0.8wte Clinical Psychologist</td>
</tr>
<tr>
<td>South Warwickshire</td>
<td>0.2wte Consultant Clin Psych, 0.6wte Clinical Psychologist</td>
<td>0.35wte Consultant Psychiatrist, 1.5wte CPNs, 0.6wte Consultant Clin Psych, 1wte Clinical Psychologist</td>
</tr>
</tbody>
</table>
Personnel

- 7 CPNs (including the Team Leader): 5.9wte
- 2 Consultant Psychiatrists: 1.4wte
- 1 Consultant Psychologist: 0.6wte
- 6 Clinical Psychologists: 3.9wte

On placement:
- 1 Trainee Psychologist (not funded)
- 1 Junior Doctor (not funded)
Who uses the service?

• Women who are planning pregnancy (with a severe mental illness), pregnant, or up to six months postnatal (at the time the referral is received)

• Women are seen with referrals from any clinical professional (eg GP, psychiatrist, obstetrician, midwife, health visitor)

• The presenting problem must be perinatal in nature – eg birth trauma, pregnant with bipolar disorder, stillbirth, perinatal onset anxiety or depression
The process of leadership

• Invitation to clinician-led group Chair to take on the role of clinical lead
  – tensions amongst disciplines
  – difficulties re supervision and line management
  – difficulties as a result of cross-Trust employees
  – did not want a ‘top down’ approach

• Implementation of a clinical leadership group (CLG) involving psychiatry, psychology, CPN, health visitor and midwife

• Each individual represents their discipline
Goals of the CLG

• Existing resources should be maintained
• The service should be as cost-effective as possible while maintaining and improving clinical quality
• Services must be equitable for all women across Coventry & Warwickshire
• Any change to existing services should be viewed by all as improvements
• All involved disciplines must be valued equally
• The CLG must provide a pathway for all team members to feed in ideas and comments with shared ownership
Ongoing role of the CLG

• Ensuring views of all team members are heard
• Strategic development
  – Perinatal accreditation
  – Development of unique referral forms
  – Oversight of teaching and training to midwives, health visitors, IAPT, GPs, etc
  – Service user led forum for challenge and support of the service
Innovative leadership

• Shared, collaborative, clinical leadership
• Incorporates five main disciplines
• Cross-Trust working
• Outstanding positive working relationships
• Shared ownership of the service, ideas and development
• Constantly updating knowledge and skills
• Improved communication between disciplines
Patient Experience Network
National Awards 2015

The Healthcare Transformation AWARDS
hosted by NHSCC and Health + Care

FINALISTS ANNOUNCEMENT FOR:

COMMISSIONING FOR OUTCOMES AND REDUCING VARIATION
INNOVATION IN SERVICE REDESIGN
CLINICAL COMMISSIONING LEADERSHIP

NHS Clinical Commissioners
The independent collective voice of clinical commissioning groups
Next Steps / Priorities

• **For the service:**
  – include midwifery and health visiting as part of the funded team
  – work towards accreditation with the Quality Network for Perinatal Mental Health Services

• **More broadly:**
  – Support the implementation of perinatal mental health networks locally and across the country
  – See collaborative CLGs running perinatal MH services across the country
  – see the inclusion of parent-infant mental health services within the perinatal setting
  – work closely with developing perinatal services such as new perinatal mental health teams, and perinatal IAPT
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Table top discussion

- WHAT and WHEN needs to happen locally?
- WHO locally needs to be involved to make this happen and who will take overall responsibility?
- HOW can the Network help?