BN: So, if you don’t mind if we just start, if you explain your organisation and your role within it.

NA5: Yeah, so my name’s (name) and I’m the (name of role) for the trust working in the newly established (name of) team. I say team loosely because it’s only two of us. So, it’s a consultant in public health and myself and I’ve just been in post just over a year now. So, and it’s a new team within the organisation so I think we’re still trying to navigate our way around how we fit in within the organisation as well because I think a lot of people find, feel as if it’s some of the stuff that we do is just nice to do stuff so we’re trying to [00.57 although] we’ve had probablies a prevention agenda within the trust for a good few years now, a lot of that was mainly around the smoking and alcohol so we’re just trying to embed the wider population health work within the organisation, especially around health inequalities.

BN: Right.

NA5: So, and we’ve sort of got a legacy strategy which is coming to an end at the end of this year, a health and wellbeing strategy, which has got prevention and health inequalities and everything in there. So, we’re busy transitioning and writing a new strategy for the organisation, which is going through the internal channels at the moment, and we’re hoping that we’ll be able to get MECC included in that new strategy. But obviously that needs sign off from the exec team.

BN: Right.

NA5: But we’re very keen to use that at the organisation and I suppose I don’t know whether I’m going into a bit too much at the moment.

BN: No, no.

NA5: But I think like for us, l think we probablies could have implemented MECC maybes six months ago but what we wanted to do, we wanted to get it right because I know this big conversations across the region that, you know, people have done the training but it’s actually getting then the capacity and/or the manager to be able to release people to do, to deliver the training.

BN: Yeah.

NA5: So, we wanted to make sure that we got it. It’s built into the strategy so then the exec team are on board then that will filter down throughout the organisation that how we then implement that strategy, that strand of the strategy so that staff have got the time allocated to be able to deliver the training. So, we were I think that was our approach that we wanted to do it that way really. So, we haven’t implemented although I think there’s a couple of people who’ve probablies done the train the trainer. I think one of the Macmillan nurses might have done it, but actually as a trust we haven’t implemented MECC as yet.

BN: Right. Yeah, OK. Yeah, I suppose we’ll go further into that in a bit, but I just kind of wanted to touch upon when you said people view you as the kind of extra nice bits. Can you expand on sort of what you mean by that?

NA5: Yeah. So, I think especially around health inequalities or maybes prevention, you know, I think although we do a lot of prevention work in the trust, I think some people see it as that’s probably something that say the public health teams do at the local authorities, and actually, you know, how can they influence, you know. In an acute setting it’s very much like you’re treating people, you know, once they arrive. But actually, it’s changing people’s mindset to think that actually how can we prevent them even turning up at our front door in the first place.

BN: Yeah.

NA5: And there’s things and conversations that we can have with people to try and change that and influence the behaviours and stuff. So, I think that’s where we would like to get to. And then around health inequalities as well, trying to make staff more aware about health inequalities and even the social determinants, you know, the wider social determinants that we as an acute trust can actually help support that as well.

NA5: Yeah. Oh, excellent.

BN: You know, so things around health inequalities, looking at our…looking at the things that we do, you know, i.e., our waiting lists, you know, looking at them a little bit differently and maybes looking at them by the different characteristics and age profile and deprivation and stuff like that. So, that’s all it’s a big an agenda but it's all quite new, and a new way of doing things which can be quite challenging at times because people think that oh no, well we [05.14 unclear] this way but it’s trying to get that awareness of actually there is other ways that we can do it to actually get longer term benefits.

BN: Yeah.

NA5: Especially from the winter time when the pressure’s on and operationally, you know, you’ve got ambulance backed up at the front door, people think well I just need to focus on the here and now but it’s actually trying to get people to see the bigger picture that actually if we do things slightly different then that might actually help in the long run.

BN: Yeah, definitely. So, what motivated you to work within your sort of population health role?

NA5: Well, I started out my NHS career working with the public health team when it was PCTs, primary care trusts. And that was about (number) years ago I think, and I worked part time in the public health team and the health promotion, and I loved it. It was great but then obviously the changing landscape and PCTs no longer existed and then we moved into the community side of the organisation and stuff and public health moved to local authorities. Then I moved job roles and stuff like that, but I went and done my degree when I was still working in health promotion, and it was around the public health and health and wellbeing so I’ve always had an interest in that.

BN: Right.

NA5: But then I started, I moved into the acute setting doing service improvement and then some of my projects over the last probablies three years has been around the prevention work and patient engagement and stuff like that. And then when our consultant in public health started, obviously I was doing some projects with him and it’s just expanded since then and then this, and then they created this job.

BN: OK.

NA5: So, it’s like it’s my ideal job. When I saw it, I just thought oh that’s what I want to do. It’s just yeah, it’s so rewarding.

BN: Yeah.

NA5: It’s really good. Yeah.

BN: Oh, that’s great. And so, can you tell us a little bit about how you first became aware of MECC, became interested in it?

NA5: Yeah, well we tried, because I think we, myself and (name), the public health consultant, we worked quite closely, especially buy in with the public health teams in (name of location) and (name of location). And especially in (name of location) they’ve got a couple of people who do the training, who do train the trainer, and then so they forward us on if they’ve got any slots free and they want people to go on. So, we heard about it that way and also as well, (name), he obviously goes into the meetings with the regional, so (name).

BN: Yeah.

NA5: Yeah, so he has these public health consultant meetings and obviously they talk about it there. So, (name)’s quite familiar with the MECC stuff and I think the organisation, they did look at it a couple of years ago, but I think just down to capacity and other commitments within the organisation it didn’t really go anywhere. But I think we’re quite keen to get I suppose some awareness training for staff around what is population health and what is the prevention agenda and things like that, and we didn’t, we weren’t first thinking about should we design our own training, in house training around that, which we probablies could have done, and we had a public health registrar with us on a rotation and she was looking at maybes developing some population health training and prevention training but and then she moved on and it just sort of stalled. And so, we did, we had that as one of our indicators in our current health and wellbeing strategy about some staff prevention training, but that’s one area that we’ve never, we haven’t just been able to crack and I think a lot of it is just down to capacity, that it’s just myself and (name) and the team at the moment.

BN: Yeah.

NA5: So, we just want to make sure that that’s built into the next strategy, because we’re quite passionate that we need to do that to get staff on board and start having those conversations with them. Because, you know, there’s like a million outpatient appointments every year within the trust that even if we can just change the behaviours of a couple of people or support, having conversations with them, with even half of those patients can only be a good thing, isn’t it?

BN: Yeah.

NA5: So, yeah, so I think it’s our plan.

BN: Yeah. OK excellent. So, and where do you think kind of MECC training fits with that in house training that you were considering developing? Is it kind of instead of or could it be complementary to?

NA5: No, well we were thinking about having our own but then when…and then I had a conversation, I had a meeting with (name of regional MECC at scale coordinator) from the regional team, and what we didn’t want to do because we knew there was lots of organisations already doing the MECC training, what we didn’t want to do is do something that was different. So, we thought well actually, we need to do, if that training’s already there, why don’t we just why don’t we do that, that would be the best thing. So, we can draw on our regional colleagues, you know. If we’re coming across barriers, and I know there’s lot of, you know, the training’s already developed and they’ve got – I know (name of regional MECC at scale coordinator) had sent me like what they call it, like an action plan, an implementation plan of how we would go about it. So, we thought, you know, all of that, why reinvent the wheel when there’s all that stuff already there.

BN: Right.

NA5: And make sure that it’s the same message that’s going out right across the region as well really.

BN: Yeah.

NA5: So, I think we were quite keen to keep everything the same, right across the region really.

BN: Yeah. That makes sense. And so, can you remember kind of what your initial attitude was like towards MECC and whether your opinions around MECC have changed over time at all?

NA5: I think it is, I think it’s really good from the, as I say, I haven’t done the training or anything yet, but having the conversations with (name of regional MECC at scale coordinator) and the wider team and I went to a session through (name of location), they’d done an event, I think it was in June sometime, went there and heard about how other organisations had embedded it within their areas. It was really good to see that actually. The foundation, you know, once you get the foundations right can be really good and it’s not just healthcare as well. I mean there was like the fire service there as well and the local authority, so it was like there’s so many people that interact with our population, our communities, that even like housing officers and stuff like that, there’s so many people that can have conversations. I think people think that it’s very much it’s all about when the clinicians are speaking to patients and stuff like that, that’s what probablies internally in the trust I would…I thought at first, it’s when actually it could be anybody couldn’t it? It could be when our porters are taking the patients from the wards down to have an x-ray or something like that, just having those brief conversations with people. So, I think it really, having the conversations with (name of regional MECC at scale coordinator) really opened up my eyes to actually this is not just about our nursing staff and our consultants and doctors. It’s about the whole workforce.

BN: Yeah. That’s great. And what—

NA5: And plus as well, our – well what I was going to say as well is that our staff, I mean we’ve got eight and a half thousand staff and our staff, majority of them come from our local community, so our staff are on our communities as well, so it’s also about internally within the organisation as well is our HR colleagues and stuff, you know, [14.46 unclear] those and looking just beyond the day to day activity that we do with our outpatients, all people in our A&E departments and stuff looking at the wider workforce as well and what interactions they have, and in people from those different areas I think that was one thing that I thought that this is not…it can be for non-clinical staff as well.

BN: Right. Yeah. And what about kind of the attitude of your leadership and management within the trust towards MECC? Do you kind of know their reactions yet I suppose?

NA5: I don’t not yet. I mean, I do know, I’m aware that’s probablies more (name) has been having those conversations, but I know our, we’ve just, it’s about 18 months ago now, we launched our new vision and our new strategy, our five year strategy, and within that we talk about leadership and leading in our work and doing things a little bit differently, and we’ve talked about supporting patients to improve their own health and wellbeing, and it’s about how do we do that, what actions are we going to do around that, and we also talk about in our strategies about we want to take action to reduce the gaps in ill health within our local population, so I think the MECC stuff just all fits in with that, so I think myself and (name), that’s the way that we’re trying to steer the conversation about that yes we’ve got that as our strategy and those are our objectives, but what about so how are we going to reach that. So, we’re trying to influence that and say, you know, well one way we can do that is through the MECC training. And I believe, you know, I think the organisation is signed up to that. I think it seems very positive, but I think we just need to work through that a little bit more because it’s still in the early stages. It’s still in very much a draft form, our new strategy at the moment.

BN: Right.

NA5: But we’re hoping to make sure that we influence those conversations, so as I say, rather than creating, you know, we just haven’t got capacity within our small team to be doing a bespoke internal training package and why would you when we’ve got a regional one.

BN: Yeah.

NA5: And so, I think that’s the way that we want to influence the exec team and I believe, I think they are on board and they know that from the vision that we’ve got that’s one of the things that we want to do.

BN: Yeah. Oh, that’s great. And so, what would kind of be the plan to sort of roll out MECC training and does the train the trainer come into that? Have you kind of considered would you go to the train the trainer or how would it work do you think?

NA5: Yeah. I mean, again still in very early stages at the moment, but I think what we were thinking of is that we would have an initial core group of staff and we would make sure we would probablies get some people, because we’ve already got two or three people that are really keen to do it, and what we’re saying to them is just hang fire, let’s get the strategy and get the buy in from our exec team to make sure that this is definitely the way that we’re going to go as an organisation and then we can start planning that. But we have got a couple of teams that are quite keen to do it so I think initially, I think, our thoughts would be that we probablies getting some champions across the organisation, you know, people who are already keen to do it. And working within our health and wellbeing strategy at the moment we’ve got some key people that we can, that we know that they would be more than keen to actually undertake the training.

BN: Right.

NA5: I think the challenge is going to be, is about the capacity, and I think that’s one of the challenges across the region isn’t it, is that when people have been and done the training, the train the trainer, for them to be then released from their day job, certain time even if it’s just once or twice a month to then deliver the training back end for the other staff to be released to be able to undertake that training. I think that is the challenge because, you know, operationally you do seem to be always, it’s the fire fighting, especially come the wintertime, isn’t it? So, I think that’s really going to be the challenge. But I think initially I think we would be looking at some of the champions and the people are doing an initial cohort and probablies break it down, and I think we would like to build it in to our training and development programme that’s already established so people can go, so it would get advertised through that route and we would actually get some of our organisational development colleagues, get some of them trained as well so then the onus is not on us, our team, but it’s going through actually the training department and the organisational development team as well, that they would then will be able to deliver training because obviously that’s part of their day to day job is delivering training development sessions.

BN: Right.

NA5: So, then them to do it as well, so we’re hoping that we can get some people in key areas and like as in our occ health department we’ve got a health and wellbeing team. Try and get one or two of those trained so then they can then do training across their areas. But I suppose we haven’t gone right down to that nitty gritty at the moment, we’re still busy writing the strategy.

BN: Yeah. Yeah.

NA5: So yeah.

BN: And so, what would kind of your motivations be like to become a MECC trainer, would you say? So, you yourself.

NA5: I would be, yeah, I would be more than keen to do it as well. I think I would probablies have a little bit more capacity than probablies what (name) would but I suppose we would probably both be trained because I think for us to be promoting it I’m one of those people that I like to know what I’m talking about, so I’d want to have done the programme, and even if I’m not delivering as many of the sessions as some of the others, at least I’ve been trained and I can deliver the session so I know what it’s about so I can then when we’re having interactions and conversations with other teams and departments across the organisation I can sort of, you know, show people what it is and describe what it is and try and get more people signed up to do train the trainer sessions.

BN: Yeah.

NA5: Like a snowball effect really. And also as well, and I think as well that there’s a bit of a backup as well that last minute if we’ve got ten members of staff booked on, so the course and then somebody drops out at least I could always step in.

BN: Yeah.

NA5: So yeah.

BN: That makes sense. And how would you feel about becoming a MECC trainer and delivering training, is that something, have you done training in the past?

NA5: I have yeah. I mean, as I say, I used to do…I worked in the service improvement, quality improvement team, so we used the Lean methodology and so I used to deliver training for that.

BN: Right.

NA5: I wouldn’t say it’s not, you know, I don’t know many people who like standing up and delivering training but actually when you get into the swing of it, and if you’re passionate about what it is that you’re talking about, which this I am, especially around the health inequalities. Even just showing people, like even in the divide between the north and south and the health inequalities in that, and the life expectancy between north and south, but then also within our region and within our local areas, just showing people because when you describe that to people some people are like oh my God, like even within (name of location), you know, from living in (name of location) compared to living in (name of location), you know, the difference in life expectancy or living your life in longer ill health compared to other areas, I think I’m really passionate about that and trying to close that gap. So, I think although it’s not a natural thing for me, I don’t mind. I don’t mind doing it.

BN: Yeah. So, that would be an OK sort of part of it. It’s not the unknown, I suppose.

NA5: Yeah. No, that’s it, yeah.

BN: Yeah. And—

NA5: I would say, I mean I’m not a qualified trainer or anything like that. I’ve got no formal qualifications, but in the areas of work that I’ve been in, I have delivered training and awareness sessions.

BN: Yeah. Right. Yeah. That’s good. And what would you say your knowledge is like around MECC and what kind of would you want to learn more about on the…what would you need to know more about on the training to become a MECC trainer?

NA5: I think for me, I think I probablies know most of it. Well, a good chunk of it, you know, about the background really about the context and the narrative. But it will just be I think just more about making sure that I’m think around the health and equality stuff, how I know that. But I think it’s just more about making sure that I get the right pitch because obviously I think you’re going to get all different members of staff, aren’t you? So, I think it would probablies be some of it will be maybes about the wider determinants of health. But as I say, I know roughly what that is, but I think most of it, I think that’s probablies OK. I think it’s just making sure that I get the training beforehand. I think I should be fine with it really.

BN: Yeah. Yeah. Great. And what kind of way do you think would be kind of approach to the training do you think would be best in terms of the way you learn, and to help you become a MECC trainer?

NA5: I think I’m very visual and I think to be honest I prefer it being face to face so you can have those conversations. And I think it just give a different dimension to when it’s online, and I know there is a place for that, but I think especially when I would be doing the train the trainer session, I prefer that to be face to face so you can just have those informal classroom discussions. But I think, and I think it’s just having the…I think for me it’s more about the capacity for me being able, making sure that I’ve got the capacity to be able to deliver it because what I wouldn’t want to do is take up the time and get trained and everything and then think I can’t even deliver it, I’m just so busy.

BN: Yeah.

NA5: So, yeah, so I think I’ve probablies got a lot of the background knowledge and the skills of being able to deliver training sessions. I think it’s just hearing first hand from the MECC trainers about, you know, what works well and what doesn’t work well. And learning from them really.

BN: Yeah. Yeah, definitely. And so obviously you mentioned time as probably the biggest barrier for you in terms of to give the training and the people to receive the training, is there anything that you can think of that would help with that in the trust?

NA5: I suppose some of it would be if doing a mixture. And I know some staff the same as me would prefer it face to face, but I think these days as well that’s a struggle even getting rooms as well these days. You know, getting the space to be able to deliver that, that I think we’d probablies need to have just a different mixture of how we do that, maybes one face to face a month and then maybes a couple of Teams because I think nursing staff from here it will be easier for them rather than coming away from the ward, if they could do it via Teams.

BN: Yeah.

NA5: But I appreciate as well that some of the nurses on the ward haven’t got all of the kit and everything like that, so I think there’s probably some work that we need to do as an organisation as well is that if we’re going to be asking people to do this, you know, even if we’re talking about training porters and stuff like that, you know, some of them haven’t got easy access to a PC and stuff like that, so how can we support them I being able to actually get access that they can even join in the Teams one.

BN: Yeah.

NA5: The Teams session. But we’re hoping that if it’s in the new strategy then obviously our strategy now and our appraisal documentation and stuff, you know, it filters down so we’ve got our strategy and then we’ve got our action plan for the following year for the trust, and that will then filter down into the division and directorate action plans which then filters down into staff appraisals and setting their objectives. So, we’re hoping that by putting that strand through all of it that a way that teams and departments can support the organisation to reach objectives is we can say put your staff, allow the staff to go on the staff awareness or do the train the trainer, so we’re hoping that we’re going to be able to do it that way, which will allow staff to be able to actually do that so and then if it’s on the appraisal it’s more likely they get done.

BN: Yeah.

NA5: And we’re actually making managers aware that that’s an option that they can help the organisation to reach their objectives.

BN: Yeah.

NA5: Because I think sometimes people struggle with well what am I going to put against that, but at the end of the year if [31.15 unclear] if they can say well actually I’ve allowed ten of my staff to go and actually, or allowed two of my staff to be train the trainers and I’ve had twenty of who’ve then gone through that, then it’s quite measurable, isn’t it?

BN: Yeah. Yeah, definitely. And I suppose you might not have got around, got to it yet, but on that kind of action plan and strategy, have you kind of thought about is there anything about how to help cascade the training after the train the trainer session, or have you got any thoughts around that?

NA5: No, I haven’t really had any thoughts, and we haven’t got down to that level as yet, and I think that’s probablies where we would want to be having discussions with (name of regional MECC at scale coordinator) and his team for them to share any learning of what other organisations have done, because I’m sure they’ve all come across the same challenges as what we will, but actually if they’ve got things that we’ve probablies not thought about then we can test them out as well within the organisation.

BN: Yeah.

NA5: And I think we’re probablies going to have to have a couple of approaches because we’ve got out two acute hospitals but then and we’ve also got a big chunk of our staff that work out in the community as well. So, it’s about how do we make sure that we’re reaching out into the community as well, our staff within the community and they were delivering services not just focusing on the trust as in like the acute setting, making sure that we’re very much involved in the community teams as well.

BN: Yeah.

NA5: Which, you know, that’s going to…that then brings another challenge, you know, because some of them, you know, the different shifts that they work and the rotations and things, it’s probablies it is a challenge and I sometimes worry because I think oh my gosh, so who is going to manage this. If there’s only two of us within our team then even just the admin side of things of being able to quantify how many people, and I know that there’s like an [33.40 unclear] thing now isn’t there, from the training that they can go through that training portal or something. But even just the administration, the whole of that is like both me and (name), we wouldn’t be able to keep on top of that. But I suppose it’s got to be somebody’s job but then it’s agreeing who in the organisation is job is that, and that’s why we were quite keen that it goes through our organisational development team because they’ve already got that experience of how they do that and we had the MECC training set up within ESR and people going back on and it's all linked to staff’s profiles and stuff like that, then we can easily rather than it being very much an admin somebody sitting with a spreadsheet and got names on and stuff like that, so it’s all of those practical things that we’re going to have to work through, but I suppose we need to be facilitating those conversations because then I think some staff will think oh it’s just another job for us to do.

BN: Yeah.

NA5: So, but I suppose that’s the conversation that we’ll have to agree with the exec team.

BN: Yeah.

NA5: About how we do it and it’s an organisation.

BN: Yeah. It sounds like a big task. Big undertaking.

NA5: Yes, I know. Yeah. The more I talk about it I think oh [35.04 unclear].

BN: So, have you been to the MECC forums or any of those sort of peer support groups yet, or is that something you might consider in the future as well when you’ve been to the train the trainer?

NA5: Yeah. I did go listen in to one of the sessions, I think. I think (name of regional MECC at scale coordinator) sent me a link and I did listen in to one of them. But I think it definitely would be that once we know that we’re definitely doing it and we’ve got a plan then it would be something that we would definitely we would join.

BN: Yeah.

NA5: Even if it’s just for, you know, peer support really more than anything and to listen in to, because I suppose the different organisations are in different parts of the journey, aren’t they? So, just be interesting to hear other people’s stories and journeys and how they’re trying to overcome some of their, you know, because there’ll be the typical values, isn’t it, which I know one of them is getting staff released to be able to go to the training is a big thing.

BN: Yeah. Definitely. And another one that’s going to come up in previous literature on train the trainer is some refresher training. I suppose it might be harder for you to think about whether that would be helpful, but in your mind at the minute do you think that would help with cascading training at all?

NA5: I think so, yeah. Because I think things change all the time, don’t they, so I think the refresher training, I think, is a good thing because there might be new literature that comes out and I think it’s good for people just to be kept up to date with all of that, so I think a refresher would definitely be good.

BN: Yeah. OK. Excellent. Well, that was everything I had to ask you.

NA5: Oh right, lovely.

BN: Is there anything you want to add, do you feel like we haven’t gone over was in your mind before the interview?

NA5: No. I think that’s about it really. I hope that’s been helpful because as I say, we’re still right at the beginning of our journey but yeah, I think the only thing is I get a bit confused about because I know the local authority do the train the trainer programmes, and about so they’re saying oh well we can do it on your behalf but I just don’t know how that all fits in and I think our organisation, you know, our thoughts were actually we need to get – we could do that, we could send staff now and tick some of the places within the local authority which would be good to build relationships and stuff, but also it’s for us we were thinking we need to have that exec buy in, you know, right from the top, so that if we are coming across those barriers, if we’re saying that we’re going to deliver x amount of sessions over the next year or something then if we’re not reaching that we need to be going back to exec to say why we can’t.

BN: Yeah.

NA5: And then for them to help us unblock those challenges, unblock the barriers. But so, but I think I do sometimes get a bit confused about the different lines, you know. So, can our staff go to the local authority ones and vice versa and stuff like that. I’m not quite sure. I’m assuming they can, but that was only thing that I was a bit like oh, because somebody had sent me an email saying is it OK if I go on this. I know we’ve talked about it but is it OK if I go on. But I think it is fine, but then we’ve probablies not, I don’t know whether so are they capturing, if they’re doing interventions and stuff, is it being captured for the local authority and I don’t know how that would work so.

BN: Yeah. So, a bit more clarity on how cross sectors it is, I suppose.

NA5: Yeah. Uh-huh.

BN: Yeah.

NA5: So, because then if they’ve had training from the local authority and then they start delivering some training themselves, then if they’re recording it and is the recording then going to the local authority and it wouldn’t come up on our training, I don’t know. So, just little things like that really that we probablies need to work through as time goes on. But I just wasn’t quite sure because people were asking me and I was like well I’m surmising that if they’re putting the offer out there that they’ve got a few places and people can go on then, yeah, you can go on, but I wasn’t quite sure whether they could or not.

BN: Yeah, I’m not sure to be honest. I think you can, but yeah, it is where those numbers would be recorded, I suppose. I don’t know the answer to that.

NA5: Yeah. No.

BN: So yeah. No, that makes sense so that will be a concern. Yeah.

NA5: With as long as the people are getting trained and I mean to me I particularly wouldn’t be that bothered because then they did, we’re getting a message out there to, you know, and if they’re having those conversation with our patients and our communities then that’s all great at the end of the day isn’t it, because somebody who might have had a conversation with the housing officer could well be our patient as well so they just [40.41 unclear]. If they’re both having that conversation with the person then that’s great, isn’t it?

BN: Yeah.

NA5: Rather than none of them having the conversation. So.

BN: Yeah.

NA5: That’s the main thing, isn’t it?

BN: Yeah. Yeah, definitely. Well, thank you so much NA5). I really appreciate it.

NA5: Yes. No worries.

BN: Thank you. I’ll stop the recording.

[End of recording]