Learning Uncut Episode 88
VR in Palliative Care – Dallas Pounds and Leon Ancliffe
Hosted by Michelle Ockers

Michelle Ockers:

After listening to my recent conversation with Jeremy Dalton from PwC in episode 85 about case studies in the use of Virtual Reality and Augmented Reality for learning, Leon Ancliffe reached out to me. Leon is the Managing Director of Flix VR. He introduced me to Dallas Pounds who recently moved on from the role of CEO at Royal Trinity Hospice who provide palliative and end of life care for people in London. Together they told me about the extraordinary work they have been doing exploring the use of VR in palliative care. Starting in 2016 with creating bucket list experiences for patients through to VR tours of the hospice facility and then piloting it to expose staff to challenging interpersonal situations as part of supported learning experiences. Leon also discusses projects he has been working on with an eye hospital and a prison service – both of which highlight the power of VR to build empathy and create authentic experiences of situations which are difficult to practice in the real world. They share their experiences and tips for both learning professionals and business leaders to make the most of this rapidly maturing technology.

Michelle Ockers:

Welcome to Learning Uncut, Dallas. It's lovely to have you here.

Dallas Pounds:

Hi, Michelle. It's good to be here. Thank you.

Michelle Ockers:

And Leon, welcome.

Leon Ancliffe:

Lovely. Thank you very much for having us, Michelle.

Michelle Ockers:

It's an absolute pleasure. I think everyone's going to be enthralled with some of the work that the two of you have done together. I know I was when I found out about it. The work you're doing is in a really important sector in the hospice area, the palliative care area. Dallas, as the former CEO of Royal Trinity, would you like to introduce us to who Royal Trinity is and the work that they do?

Dallas Pounds:

Royal Trinity Hospice is an independent charitable hospice based in Clapham Common, so in Central South London. We look after anybody from 18 years and over, who has a life limiting progressive illness. So that's cancers, neurological illness, chronic heart, chronic lung, anything really, which is sadly going to shorten your life. We do that in a 28-bedded inpatient unit in Clapham Common, in London. And also out in the community where anybody calls home, so it can be their own home, a nursing home, residential home, hostel, prison, maybe even a park bench on Clapham Common. So 80% of what we do happens out in the community.

And we're here to provide psychological and emotional support, symptom control, so looking after pain, and breathlessness, and things like that, but also lots of carer support as well. So we're here for the carers of patients, as well as giving terminal care to our patients if they require it, either in the hospice or in their own homes. And it's very much a multidisciplinary approach, Michelle, so it's not a medical lead... We have fantastic doctors, but it's a whole combination of doctors, and nurses, and psychologists, and social workers, and occupational therapists, physiotherapists, so it's a real team approach to getting expert palliative and end-of-life care.

Michelle Ockers:

Just give me some dimension to get my head around, number of patients, and I guess you're supporting carers as well, so I hate to use to word customers, but the number of people you care for or support through the hospice at any point in time.

Dallas Pounds:

Yeah, of course. So every hospice has a catchment area in the UK, and that catchment area's about three quarters of a million people in Central and South-West London. So every year we care for around about two-and-a-half-thousand patients, and for every patient that we see we look after at least one or two of their family members or their friends, so that's unquantifiable, Michelle. Thousands and thousands of people benefit from Trinity's care.

And of course, on top of that, education is a really big part of what we do. So we educate general practitioners, community nurses, specialist doctors, care homes, anybody, really, that gets involved in the care of somebody towards the end of their life. So thousands and thousands of people every year benefit from what Trinity does.

Michelle Ockers:

A really important range of services that you're providing. And roughly what size workforce do you have?

Dallas Pounds:

We also have a large retail element, because of... Obviously, we need to raise lots and lots of funds, so across the charity as a whole we have around 250 staff.

Michelle Ockers:

Okay. And, Dallas, would you like to introduce us to Leon? Tell us a little bit about Leon and how you met Leon.

Dallas Pounds:

So Leon is the managing director of Flix Films, Flix VR. Leon and I met eight years ago when I became chief executive at Royal Trinity Hospice. The hospice was lucky enough that Leon had office space actually at the hospice and had the most fantastic history and relationship with the hospice, doing film making for us, photography for us, and really being integral to everything we did as a charity, a real member of the Trinity family. So that's how we met when I became Chief Executive. Leon did a little introductory film on me in about my 10th day in post, so it got me very used to having a camera in my face quite quickly.

Michelle Ockers:

Nice. And Leon, how did you become associated with Trinity? How did that start?

Leon Ancliffe:

Okay, Michelle. We've been making films in healthcare for the last 15 years, but more in the

traditional sense. So we've been doing fundraising, training films, raising awareness, introductory films to new CEOs which we had the privilege of doing when Dallas arrived. So we're really embedded within healthcare.

But one of the things that we're really interested in is innovation. We've made hundreds and hundreds of films for Trinity over the last 10 years, but we've also worked with many, many other healthcare charities and organizations. But it was Trinity that we're really keen to explore the use of virtual reality with, because we have that really significant connection with them, and the trust was already there with them.

Michelle Ockers:

I'm getting a strong sense of the longstanding partnership that you two organizations have. And, of course, we wanted to talk about VR specifically today. Your work didn't start with training in VR, and I know our audience, our listeners, are predominantly learning and development professionals, and we will head to the learning and development space. But I think the backstory of how you got started with VR at Trinity is really worth telling, because it says something about many things, but one of the things it says is it took to the power of virtual reality, and I think that's important for people to get their heads around. So talk to us about how you got started with VR at Trinity.

Leon Ancliffe:

Okay. So like you said, Michelle, our journey didn't start with Trinity, with regards to virtual reality. We're actually in a privileged position to be creating a training film for the Motor Neuron Disease Association, and it was a traditional, two-dimensional film where we were meeting people who had the condition, and we were learning from them how they were using technology to enhance their lives. Because motor neuron disease is a really difficult condition, because it can be quite rapid for a lot of people. So learning how they can use technology and other services to enhance their lives was really important, and they wanted us to create a film which showcased what was available.

During that time I was meeting different families at different stages of the illness, and I was privileged enough to meet a remarkable woman called Sarah Ezekiel. Sarah was diagnosed with MND, it will be 17 years ago now, and Sarah was an artist and she was a vivacious, healthy lady with one child, and she was pregnant with her second child. And when she was pregnant she started to lose a bit of sensation in her hands, and she went to the doctor's, and it's a long story, but basically they said, "You have MND. You have Motor Neuron Disease." And within nine months, Sarah had lost all her mobility. She lost her speech, she couldn't walk, she lost a lot very, very quickly.

But then the condition stopped, and it didn't take her life. But it had taken everything that meant something to her, and everything that she felt was worth living for. And so one of the questions I asked her during the interview was, "Do you have any regrets?" And she said to me, "Well, when I was younger I always wanted to swim with dolphins, but I never had the chance to do that because my condition took that away from me." At the same time I was doing some research and development with the BBC, British Broadcasting House, and it just so happened that, that week when I was looking through their virtual reality content, that an experience had come up that had been submitted, which was swimming with dolphins. And the nice thing about this particular experience was that it wasn't synthetic, it wasn't like a game, it was real life content.

So I went straight back into the studio, and I started having a look through the content. And I saw it, and I thought, "Oh my God, this is incredible." It was so well filmed, and the quality was exceptional, and the sounds, and... Oh, it was really amazing. So I spoke to Sarah, and I said, "Sarah, I don't know whether this is going to make an impression on you or whether you're interested, but would you like to try out a virtual experience of swimming with dolphins?" And her whole face just lit up, and I really hoped that it was going to add something. And so we spoke to the association, and the association

gave us permission to arrange this experience. And we took Sarah down to the BBC, and we gave Sarah the virtual reality experience of swimming with dolphins.

And at the same time, we were filming it, because we knew it had never been done before and we knew, back in 2015, people weren't using virtual reality in healthcare. And we captured Sarah having this experience, and the minute this experience began, her whole face lit up. And Sarah only had very little mobility in her neck, but as soon as the experience started, she just seemed to come alive. She smiled, and if you go to our website you can actually see that first moment where Sarah had her experience.

Anyway, we took the goggles off, and we asked Sarah, "How was that experience?" And Sarah uses a type of technology to communicate, because she can't speak, and the technology is called Eyegaze technology. So she uses a screen where she looks into the screen, and she typed out her response to my question. And she said for the first time in 16 years she felt able bodied. And everyone in the room... You could feel the hairs on the back of your neck stand up, and we... Actually, it almost brought tears to our eyes, because we knew that, in that one moment, we'd created a connection, and we'd given someone an experience which was beyond the physical, and beyond what she thought she was able to achieve.

And because of that, we thought, "Wouldn't it be great if we were able to give patients who are coming to the end of their lives the opportunity to have a bucket list experience, and try out other experiences, and see whether they have as much fulfilment as Sarah did?" And that's when we went back to Trinity, I showed Dallas the video of Sarah having her experience, and straight away I could see Dallas's mind just exploding with ideas on how we might be able to use this amazing technology.

Michelle Ockers:

So, Dallas, tell us a little more about where you took that at Trinity, when Leon showed you that experience that Sarah had had.

Dallas Pounds:

Yeah. So when Leon appeared at my office door with a pair of goggles in his hand, I've got to say it was the first time I had ever come across virtual reality. I'm not a gamer, and I've never actually had goggles on. And having heard the story of Sarah, I was absolutely fascinated to see how that felt. So in the comfort of my own office, I went on a world tour for about five or six minutes, courtesy of virtual reality, and I really was hooked after that. And as Leon says, I immediately realized that we could do some very special things for our patients who were no longer (able to) go off and live their dreams anymore, or revisit places that meant a lot to them.

So my first, initial thought was, "Wow, we can give some good bucket list experiences," for want of a better term. "We can get people back to places they love. We can get them experiences of things like swimming with dolphins, throwing themselves out of a perfectly good airplane, going on a balloon ride, seeing lions in the wild." So, immediately, I could see the benefits for bucket lists. And then as we sat, chatting, we got quite carried away, thinking about, "Well, we could do a virtual reality tour of the hospice, we could do some training, we could so some research." And I think we could see the art of the possible straight away, but did decide to start with bucket lists, because we understood that there were going to be some challenges in doing virtual reality in the hospice, which I'm sure Leon can tell you a bit more about than I can.

Leon Ancliffe:

So we're talking nearly seven years ago, now, when we were introducing virtual reality into the hospice. And yeah, there were some significant challenges. Obviously, being a hospice, security, network availability, and strength of WIFI was... We didn't want to compromise it,

and we also wanted to ensure that the patients that were the experience was having the very best experience we could achieve for them. So we wanted to make sure that they weren't inhibited. We were huge advocates to using virtual reality without using a computer. So if you're giving someone who's got very limited mobility a virtual reality experience, why would you tether them to something that reduces their mobility further?

But ironically, like Dallas was saying, I envisaged that maybe a palliative care patient would want a very relaxed experience at the end of their lives, on a beach or in a forest. And actually, the ironic thing is that when you ask someone coming to the end of their lives what sort of experience they want, nine times out of 10 they'll tell you, an experience which makes them feel alive, and that will be an extreme experience. That will be an experience that really reminds them about what was possible when they had the ability to do more physically. Because at the end of someone's life, it doesn't necessarily mean that cognitively they're not able to go beyond what they physically can.

And when you actually give someone an experience who's coming to the end of their lives, an experience which they felt was beyond them, it's amazing. It's like giving them a gift, and that's the response we were getting from the hospice. All those patients we gave experience to, it was like giving them a bucket list experience, it really was. It was quite remarkable.

Michelle Ockers:

It sounds remarkable. I think I would even be brave enough to jump out of an aircraft in VR.

So that was 2015, you started with the bucket list experience. At what point did you start exploring the use of VR to support your workforce, and in particular, moving towards what we would call training or learning experiences? When did you make that transition and how did you start? And I don't mind which of you picks that up.

Dallas Pounds:

Yeah. I'll start with that. We didn't have a plan to transition, Michelle. This was all really quite organic. It grew as we became more confident, but also as more people became interested and aware of what we were doing. And I think, what I realized quite early on, was that virtual reality could become an extra thing in the clinician's tool bag for them, so alongside the medicines, alongside the therapies that we were used to, virtual reality could actually add another dimension, and not only bring about these incredibly emotional responses in patients, but also some fun and something different to the day, to take them away, out of that hospice day, out of that day where they were contemplating the end of their life. So I saw it very much as a piece of tool, a tool bag for our clinical staff.

I think the first thing that we realized was that if we did a virtual reality tour of the hospice, and brought the hospice to life, and took somebody around the hospice in a virtual way, guided by real people in the hospice, that might help my staff out in the community to show people what the hospice was like, that it's not a scary place, that we're all smiling, that it's not dark and dingy. So I think we just organically changed into doing a virtual reality tour for the hospice, which was the first one ever, I think, for a hospice.

And then, that started the juices flowing for training experience, to actually put our staff behind the goggles, rather than our service users, our patients, behind the goggles. Both to encourage them to explore how it felt to be in situations they hadn't been in before, so maybe conflict, maybe being alongside a very distressed patient towards the end of their life, but also to put themselves in the shoes of the patients as well, to experience how it felt to be a patient lying in the bed, being talked over, and being ignored.

So I think we realized that actually, what we were doing with virtual reality was, as I say, building this arsenal, building this tool bag for our clinical staff, so they could give fun bucket lists, or they could give a real reality tour of the hospice which was encouraging people to be admitted who might have been scared otherwise, but also to use it as a training tool as well. And we did lots of engagement things, and Leon can tell you much more about that process than I can. But I think we just saw it very much as a new piece of kit, a new thing in the tool bag for our clinical staff.

Michelle Ockers:

So what sort of needs did you start exploring in terms of the workforce? Where did you start with your experimentation, and why did you start there?

Dallas Pounds:

We started, really, by thinking about, what were the needs of our staff? What sort of training were our staff getting, and how could we enhance that training using virtual reality?

So actually, Leon lead some focus groups, and some workshops with the staff, and me too, to say, "What sort of things are difficult for you? What sort of things are difficult to teach in the classroom? What sort of experiences are difficult to recreate through role play, and in the classroom, and on flat pieces of paper because you're reading a case study?" And I think from that, Leon, we started to develop the package, didn't we, the sorts of things that you were then able to make for us, for us to try.

Leon Ancliffe:

Yeah. So we've been creating traditional training films for the last 15 years, so we know what goes into the pot to create a good training film. It's interesting, because when you're creating a virtual reality training film, the beginning process, the preparation, the pre-production is very, very similar to traditional film research and development.

So the first thing we did was we went to the members of Dallas's team, and Dallas, and asked them about some of the most challenging situations that their staff find themselves in, and they ranged from conflict to bereavement. For example, a family member arrives at the hospice... Not that this would happen at Trinity, but occasionally it can do, where a family member arrives at a hospice and they've not been told that their loved one has already died. So that can create a huge trauma for that individual, and they express that to the first people they see, and that might be a healthcare professional. If you've got a healthcare professional who's had 20 years' experience, they'd have come across that before, but if you've got a new healthcare professional who's never been in a conflict situation, that can be a really traumatic experience.

So what we wanted to do was, we wanted to create that experience, a virtual experience. So then, almost like from aptitude training, as soon as you bring people in, you train them, and you give them those experiences. And they're only passive experiences, so they put on the goggles, and they get to experience what it's like to be a healthcare professional that's being shouted at and being blamed for the death of their loved one. So they can't respond, they can't react, but they take that in, they take off the headset, and then they speak with a trainer, and they talk about how they felt, almost like an aptitude scenario.

But one of the most powerful scenarios we created was based on a patient coming to the end of their life, and the patient asks the healthcare professional to help them die. And apparently, that can be quite a common affair. Is that right, Dallas?

Dallas Pounds:

Yeah, yeah. It's more common than you would think, yes.

Leon Ancliffe:

Yeah. And so that's a really complex scenario for us to create. So the only way we could create it was to actually go and speak with the patients at the hospice and learn from them how they felt. The best way we can create a training film is by learning from the people who's gone through those experiences. And, so once we've actually gathered all the information, we then develop a draft script, and then we cast our actors. We don't always work with actors. When possible, we'll work with professionals as well. We'll guide them through the process. And then, once we've got our actors in place, we'll rehearse the scene, and then we'll introduce the actors, when possible, to the healthcare professionals, and to the patients that's inspired that script, and that scenario.

And what's really important for us, is that we don't restrict our actors. We do not say, "You've got to do the script word for word," because we're human beings. We need flexibility, and actors will have taken something from those meetings with patients that I cannot direct, and we can't script. It has to be natural. So the patient who was dying in the hospice bed, on the day we were filming the actor who was recreating the scenario, it just so happened that a patient who was in the hospice was really interested in what we were doing and was asking us questions. And we tried to explain. We'd not met this patient before, and we were saying, "We're trying to achieve this scenario," and she said, "Would you mind if I went in and spoke with your actor?" And we created a private environment for her to go in and speak with our actor who was in the patient bed. And then the patient left, and we filmed that scenario, and it was unbelievable. We got it in one take, because my actor had learned exactly what it is that made that scenario work.

And actually, that scenario was a pilot scenario, but a lot of the work we've had since then... So now, we're doing work with Moorfields Eye Hospital, we've done work with the prison service. That scenario is one of our benchmark pieces, because it absolutely connects with the viewer, and makes them think about those conversations on a human level.

But virtual reality is not like film. When you're filming it, it's more like theatre. And so it's all about rehearsing, rehearsing, rehearsing, and then capturing the scenario after that.

Michelle Ockers:

Okay. And the work you do, are the scenarios static or is the person who's going through the virtual reality experience... Do they have choices they can make that can affect where the scene goes next? How does that work?

Leon Ancliffe:

Absolutely. So we've created both.

The pilot scenarios we created with Royal Trinity Hospice were passive scenarios, aptitude, where you watch the scenario, you take off the goggles, and you reflect on that. We did them from two perspectives. So one of the scenarios was based on a patient who was in a hospice bed, and we created the scenario where you have the patient who's in the hospice bed, they've got a loved one. The patient can't communicate, which is quite often the case when you've got a palliative-care patient, and then the healthcare professional comes into the hospice, into the room, and they don't give you eye contact, they don't introduce themselves. They do not do any of the things that are really important when you first meet a patient. So we filmed that scenario and showed what negative practice would be like. And then we filmed it in a positive light. So then, the person who was having the experience can see what it feels like to be a patient who doesn't have that intimacy, and that interaction with a clinician. And then we showed how it should be done.

So they're passive scenarios, but we've worked with other organizations where they're interactive. So we did a project with the Metro Charity, which was on HIV disclosure for young people. So we spent a long time with young people who have HIV, and we learned about some of the scenarios that they're in, that they go through, whether it's in a school environment, whether it's at home, and we created those scenarios. And you can interact with those scenarios, so you can... It's almost like a sliding doors experience where you get to a significant point within the scenario where you get to choose whether you go left or you go right, and then as you go down that path, at the end of that scenario, then you get to go back to where that significant turning point was, and then you get to try it a different way.

The only thing is, with regards to the interactivity, I think it works best with still images. I think video, as soon as you start to add the interactivity you've got to reduce the quality of the video, because a lot of devices are not able to process it as quick, and the platforms are quite expensive. So there is an offset, but I think that's the exciting thing about VR now, is things are starting... Processing power's increasing, and it's just a really exciting time to come to VR now.

Michelle Ockers:

I was going to say, that will shift as the technology's evolving very rapidly. Dallas, I'm curious about a couple of aspects of the work that Leon's described with some of the early pilot work that you did, which obviously has evolved. The debriefing process, so you've got staff who are going into these situations, and whilst it's a training situation, not the real situation, virtual reality can be very immersive. And as Leon was describing, at the end of going through the VR experience, someone's taking the headset off, and there needs to be some sort of reflective process, some sort of debriefing. How was that handled? And was it your staff who were doing that, or how did you set that up to really bring home the learning experience, and also support the staff who had been through the VR experience.

Dallas Pounds:

You're quite right, Michelle. Good virtual reality training is completely immersive. You totally, totally believe in that situation, and you get all the emotional, and physical responses that you would get if you were in that situation. So it's incredibly important that you don't just send somebody off to have the experience and leave them to it.

So what we did at Trinity, because... These were pilot scenarios, so it was important, still, to have Leon involved throughout the whole process. So we had a facilitator, an experienced clinician in the room with the people taking the virtual reality experience so that when they did take the goggles off, all of that emotive response, all of that, "What if? What only? Oh my gosh, I hope that never happens to me," all of that could be discussed, either in an individual basis, depending on who the person was that took the experience...

Or actually, we did some group sessions as well, and we did those because it was a pilot, to prove the concept. We did them with very experienced clinical staff, but we also did them with student nurses, and very junior doctors as well. And the difference in those responses was very, very powerful. For the more junior members of staff, they were quite literally taking the goggles off in tears because they'd never experienced that amount of conflict, they'd never experienced being alongside a patient in that amount of distress. So that was good, so they could talk through it, talk about, "Well, what do you think you might do in this situation? How did that make you feel? How do you think the patient might have felt there? How do you think the family member felt when they were shouting at you, and they were very angry?" So it's important to have a facilitator.

And then, when we gave more experienced clinical staff, including me, the experiences, it was more, "Oh my gosh, yes, I remember an experience almost completely the same as that. I remember how I felt, what I got right, what I didn't get quite right, what I did better the next time." So I think, because we were proving the concept of VR in training, we were very, very careful to give close supervision, to have an experienced person in the room to help the people taking the experience work through those emotions, work through those questions.

We also had some learning outcomes, just very broad learning outcomes for each scenario. So we were able to work through those with the participants as well. "Do you feel that that gave you a better experience, a better learning outcome, than if you'd just been told about it in a classroom or someone had just describe that to you? Did that make it feel more real for you, and how do you think you might progress?"

So I think the pilot training scenarios that Flix and Trinity did were incredibly powerful, and I think they have, as Leon alluded to, set a benchmark for training going forward. So, very proud of them, but equally, you have to be incredibly careful to make sure they're authentic, which Flix do brilliantly, but also to make sure you're going to support the people who are going through that experience as much as you would if they were doing it in real life.

Michelle Ockers:

Yes. And so you've talked about a couple of key points in terms of what you learned out of the pilots. Was there anything else significant you learned out of that pilot process?

Dallas Pounds:

Yeah. Let's be honest, virtual reality is not for everyone, and some clinical staff, they're not great at embracing technology, let's put it that way. They're quite reticent about trying the virtual reality, and we didn't... Because it was pilot, because we were trying it out, we obviously didn't strong-arm anybody into trying the virtual reality. I think we only had one member of staff who found it quite disorientating, and a little bit nausea evoking, but yeah, it's...

I think we just have to accept it's not for everybody. You have to have reasonable head control, and neck strength to wear the goggles and be able to turn your head and get best out of the situation. Even the training scenarios are still better if you can just move your head around in a natural way to take in your entire environment.

So I think there are a few learning points. I don't know from a content point of view. Leon, was there learning from a content point of view too?

Leon Ancliffe:

Well, we recognize the importance of spacialized audio really early on. That was so significant. The visuals were one thing, but the spacialized audio was so important, particular in the training capacity. And it-

Michelle Ockers:

So I think I have an idea what spacialized audio might mean. Did you want to unpack that a little bit, explain what that term means, Leon?

Leon Ancliffe:

Yeah, absolutely. So spacialized audio is, I'm going to try put this in layman's terms, but it's basically the same sort of audio that we experience natural, where you actually hear if... Say you have someone shouting your name to the left of you, you will hear them shouting it first in your left ear, and secondly in your right ear, but predominantly you'll hear it in your left ear first. And as soon as you start adding these elements... And that was really important as well, with the bucket list experiences. When we're giving virtual reality experiences to patients, we needed to make sure that... Because they only had limited movement in their neck... But the audio sounded like it was coming in front of them and not behind them, because if there's any audio that sounds like it's coming from behind them or even flat, it can make them feel quite anxious, so spacialized audio plays such a significant role.

When I learned to be a film maker, someone always said to me, "Audio is 50% of your film. You've got to respect it." And actually, with VR, the audio can be even more significant, because it actually leads the person's viewpoint. And with regards to training, that is so, so important that we're able to do that.

But we are only scratching the surface with regards to interactivity. As soon as we're able to give someone a virtual reality experience that they can interact with, and we can retain the metadata, and understand what their experience is, I think that will change the future of training, potentially.

And also, with regards to what Dallas was saying about the people who experience nausea, we need to do more research and development, and learning development, to find out how we can make sure that VR is suitable for everyone. I know with the early VR that we were giving out, it was just put on the headset, and the person has the experience. But now you have virtual reality with 6 degrees of freedom, or stereoscopic VR, which is a virtual reality environment which you are able to move in, and I'm finding, just in these early stages, that actually, 6 degrees of freedom reduces nausea. Because again, the person having the experience feels that they're in the environment, in that moment, and that...

There's so much we can learn from VR, and it's just a really exciting time to do it.

Michelle Ockers:

I think, Leon, you may have come across Learning Uncut though an episode I did recently with Jeremy Dalton, episode 85, which I'll put a link in the show notes, when he talked about some of the developments. And of course he's with PwC who've got the budget to play around with some of the leading-edge technology, developments. PwC is certainly convinced that VR and AR are coming of age very quickly, and the work you've been doing

is showing the way with some of that as well. So things like the nausea, that you get the fidelity high enough, and the nausea challenge goes away for most people. And he talked about examples of highly interactive scenarios where a lot of data can be generated and used in debriefing as well.

Leon Ancliffe:

Exactly, yeah.

Michelle Ockers:

So there's a lot more coming our way, I think, with VR. How long ago did you do the pilot work at Trinity? When was that, roughly?

Leon Ancliffe:

That was about three years ago. Dallas?

Dallas Pounds:

Four, I think. Yeah. I think time flies. I think it's probably more like four years ago, 2017.

Michelle Ockers:

So you're very fresh.

Dallas Pounds:

From 2016 to 2017.

Leon Ancliffe:

Yeah. Unfortunately, with COVID, everything had to... It stopped for 18 months. Because VR is such an intimate thing, it was more important for us to secure, obviously, the staff, and make sure that patients, and what not was safe.

Michelle Ockers:

Of course. Did you move beyond the pilot stage before COVID hit?

Leon Ancliffe:

Yeah. Since doing the pilot with Trinity, we've gone on, and we've done another pilot with the prison service where we've been developing them virtual reality scenarios based on their prison officer experience, on intimidation. So the prison officer will be able to put on the VR headset. And this is mandatory training that will be rolled out across the prison service. And there, the people who are having those experiences will get to experience what it's like to be in the prison, and be on the prison wing, and experience the type of intimidation that they would experience. And again, we had to spend many, many months interviewing staff, prisoners, and learning from them what it is, the techniques that they use to, one, combat intimidation, and work through it, and also the techniques that the prisoners use to intimidate their prison officers.

The thing with virtual reality, it's really difficult to explain it. It's such a visual medium that I really want to show you it, and that's the best way for you to experience it. As soon as we give someone a virtual reality experience with one of the resources we've created, straight away, their imaginations start going. And nine times out of ten we actually end up doing work with them.

So all these new techniques have only come big filming techniques... Also, we're using stereoscopic VR. A lot of people might not know what stereoscopic VR is, but traditionally VR's been filmed as a 360 flat image, but stereoscopic VR is 3D virtual reality. And that, again, adds to the immersion, and resolution, increasing the resolution, and the spacialized audio. Now, all these different things that are coming out way, it's a really exciting time to get involved with VR at the moment. I implore people to do it.

Michelle Ockers:

So, obviously, you're continuing to hone your craft.

Dallas, and I know you've only recently moved on from Royal Trinity. As the CEO, how do you determine the value, and impact of VR? Because it's obviously an investment of time, and energy required. So how did you gauge, as you've moved through the pilot, and then look at, "Well, what next?" What impact was it having? What was the value in continuing with it?

Dallas Pounds:

I think it's a really valid question, Michelle, because no-one should underestimate the time and the energy that it does take to produce a really good quality virtual reality training resource. I think the most powerful feedback, to be honest with you, was subjective, and we're used to that in palliative care. We get a lot of qualitative data, and subjective data in palliative care, and it was just the reactions and the feedback of the staff that were undertaking the training. Both the experienced staff who were telling us, "Oh my goodness, that's spot on. I've absolutely been in that situation," and the new staff saying, "Oh my goodness, I'm glad I just did that in virtual reality for the first time, and not in real life for the first time." So there's quite a lot of subjective feedback for us.

But I think, equally, what we've realized with patients... We saw the emotional responses, we saw the qualitative responses, and that lead us to think, "Well, actually," to a hypothesis that maybe virtual reality could reduce symptom burden, would reduce symptom load, and that lead us to do a very small, but again, ground-breaking piece of research to see whether virtual reality experience could actually reduce things like pain, and emotional anxiety. We have completed a very small research study, which is being published. So there is some, now, quantitative data as well, to show that virtual reality actually can reduce symptom load.

But I think, from a training point of view, which is what I know that you listeners are most interested in, I think take the subjective and the qualitative. But potentially, what I would do if I were continuing to use VR in a training space, I would be looking to do proper pre-and-post-assessment questionnaires with staff to see if they felt more confident in that situation, to actually get feedback from the trainers as well to see whether the learning outcomes that we'd set for those scenarios had been met, and how well they'd been met. And I would probably bring someone back to that situation six months or maybe six weeks later, depending on the timescale, to make them relive that experience, and see what have they learned from it, what would they do differently this time, having had six months out in the palliative-care space?

So I think there are lots of different ways that you can demonstrate the value of virtual reality, but I think you do have to accept that some of that is qualitative and subjective, and it's about how it makes you feel more than being able to say you've produced 65 widgets in a day.

Michelle Ockers:

And it's interesting that one of the things that VR allows us to do is to put people into situations that are really difficult to replicate in real life, for a whole range of reasons.

Dallas Pounds:

Absolutely.

Michelle Ockers:

You never know when the value of that is going to be returned. I think you've highlighted some of the characteristics of really strong use cases. So I think, like anything in terms of technology for supporting learning experiences, don't be beguiled by the technology for its own sake, but be really clear on what you're trying to achieve, and then select the right technology for the job.

Dallas Pounds:

Absolutely. And don't be scared of technology, and using it, and adding it to your tool bag. If we can do it in palliative and end-of-life care, I think you can pretty much use it anywhere. It's a very, very sensitive field of healthcare, so if we can do it, if we can make use of it, I am absolutely sure everybody else can too.

Michelle Ockers:

And you've had a good partner to do that with, as well, Dallas, right?

Dallas Pounds:

We did. We had the most amazing partnership with Leon and with Flix VR. We were very, very blessed to have that partnership. It was a two-way collaboration. I was excited about the potential. Trinity is a very forward-thinking, innovative hospice, so actually, this came together and worked well. But moving forward, if you are an organization looking to make virtual reality training, do use a partner who you can relate to, who you can trust, and who gets what you do. It's really, really important that your VR partner takes the time to understand what you do, and the values behind what you do. Because, otherwise, the scenarios they make for you will not be authentic.

Michelle Ockers:

So, in terms of creating scenarios, situations which are authentic, Leon, you obviously go to an incredible level of effort to achieve that. And you've talked about some of the research you did, going out and talking to people in different roles, and getting the actors, where you're using actors to speak to people in the situation. You have to develop, really, an understanding. So what other tips do you have around the use cases and how best to achieve the authenticity that matches the good quality use cases for VR?

Leon Ancliffe:

Well, the first thing I'd say, as a production team is obviously spend a lot of time with the organization. And when possible, ask if you are able to actually go and film the real-life experiences. Because if you're able to capture them, more like in a documentary form as opposed to a dramatic form, if you capture a documentary scenario which is real life... You should not ever fake VR scenarios. They have to be as real as you possibly can make them. Because if you do, all that time and all that effort is wasted. There has to be complete commitment to making it real.

So once you filmed the real experience, as crudely as you might need to do it if you haven't got the budget, then go away, and sit with your actors, once you've cast them, and watch it over, and over, and over again, so you're actually able to identify the crux of what makes that scenario real. And then, once you've got the actual framework of your scenario, and you've got your key learning objectives... Because it's great creating a lovely piece of VR, but if you do not cover the learning objectives, again, it's a waste of time. They have to be in there, as subtly as you can make them, but they have to be there. So once you've got those learning objectives, then have the confidence in your actors to actually improvise and use their own skillset to actually add a layer of authenticity to your scenario. Because if you've worked very closely with the actors, they'll have seen what you've captured in real life.

So it's a really intimate thing when you're creating a really authentic virtual reality scenario. And that's one of the reasons we haven't gone forward and started looking at AR and other forms, because we really want to focus on creating authentic virtual reality scenarios before we actually move forward and start looking at other forms of virtual reality.

But another thing that's really exciting is, the technology's catching up. Five years ago, we were inhibited by the technology, and now the technology has evolved. The headsets are lighter, the resolution's improved, spacialized audio is there, it doesn't need to be tethered. And some of the bigger organizations like Facebook, Oculus, they're doing a remarkable job with the technology, but I really hope they don't forget about healthcare. Because five years ago, no-one thought about using virtual reality in healthcare. And actually, to this day, I think it can make the biggest impact in healthcare across all sectors.

Michelle Ockers:

I think you've already demonstrated the impact that it can make in healthcare. And for those learning and development people who are listening, and haven't taken the step to experimenting with VR, what would you say to them, in terms of getting started, Leon? What tips would you have for them?

Leon Ancliffe:

So if they're interested in creating virtual reality content, I'd say go and buy a consumer product, a VR product, and start getting creative with it, innovate. One of the most amazing things we ever did was we live streamed a virtual reality experience to a patient in a hospice bed. We'd never known that had been done before, and the connection was amazing. The only reason we've been able to evolve to where we are now, and experiment, is because of the organization. Royal Trinity Hospice had the confidence to support us on this. But don't think that there aren't organizations out there that won't want to get on board and champion what you do. People buy people, and if you're enthusiastic and you want to make a difference, then people will get behind you and they want to join you on that journey. And I just feel so privileged that we had an organization like Royal Trinity Hospice that wanted to come on this journey with us.

But like I said, it's so exciting. Now is the time. Virtual reality will evolve very similar to the phone. The phone used to be a tethered device, so did the headset. Look at the phone now. The phone is an essential tool in our kit, as human beings. And in the future, I think the virtual reality headset will supersede the phone. We won't have a phone, we'll have a device

that we put on our heads, and it will be as elegant as a pair of glasses, and we'd just tap it. And you'd be able to show people parts of the planet that they might never have seen or show them a virtual reality experience that will change the way they think, and the way they empathize with that scenario.

And soon as virtual reality, it becomes more infinite and it becomes more user friendly, that is when it will tip and it will make the difference that it has the potential to do.

Michelle Ockers:

When you talk, Leon, it makes me feel like we're just skimming the surface, still, of what might be possible with this technology, and where it might go, and what it might open up to us.

So, Dallas, speaking as a CEO, if we do have a business leaders that are listening, or if there's any learning and development people here who are looking to convince their business leaders to give this technology a go, and they think there's a good use case, what advice would you be giving or words of guidance would you be giving to someone in a business leadership position, around using VR in their organization, getting started with it?

Dallas Pounds:

Yeah. The first thing I would say is that we're not advocating VR to replace all other types of learning and training. There's an absolute place for classroom training, there's an absolute place for assisted learning, even for e-learning. But what I would say to people leading organizations, is to think about the training that you are providing to your staff, and think where that training is about people, is about appreciating and empathizing with people, either people that you're serving, people you're interacting with, patients, relatives, if you're in a healthcare setting, and really think about the people scenarios. Because the one thing that virtual reality can bring to your training suite, that the classroom and documents can't, is that immersive experience.

What situations would you like your staff to try out in virtual reality before you put them into that scenario in real life? Or even, what scenarios would you like to put an individual through, to see how they react before you take them on into your business? It doesn't need to be about training what somebody's in. Maybe virtual reality scenarios can be used within a recruitment setting, an aptitude setting as well, as we think we might have alluded to earlier.

It's all about people. Virtual reality is all about people, and empathy, and being authentic. So think about the training, and the learning that you are offering at the moment and think about what would be enhanced if it was done in an immersive way, done in a way that elicits that proper emotional and physical response in somebody.

And then, I would say... Do you know what? Be brave. Yes, it is based on technology, but actually, it's based on people. It's based on experience. IT's based on walking in other people's shoes or... So don't be put off by the fact that there is technology. Don't be put off by the fact that technology evolves all the time. Work with a really, really great partner who understands the technology, and can make the very best use of it with you. Stay true to what you're an expert in, trust another organization to be an expert in what they're an expert in, and in partnership, I think go for it. Use some time, use some energy, have some great leadership in your organization, maybe a bit of funding, because technology is not too expensive but it's not cheap, and you've got to pay for the time and energy of your partner company. But I would say, absolutely go for it. But think about the learning outcomes, think about how you're going to evaluate it, but don't be scared.

Michelle Ockers:

Fantastic. I think that's a great note to end this on. So for our listeners, if you'd like to connect with Dallas or Leon, we'll pop a link to their LinkedIn profiles with the show notes, and you can reach out to them. And of course, we post every episode on LinkedIn, and

encourage people, as they listen to it, to leave their comments, to leave any questions they have, so others can join in the conversation.

Thank you so much, Dallas and Leon, for sharing this really interesting and important body of work with us.

Dallas Pounds:

Thanks, Michelle. It's been an absolute pleasure.

Leon Ancliffe:

Thank you, Michelle. Take care.

About Learning Uncut

Learning Uncut are learning and development consultants that work with learning teams and/or business leaders to accelerate learning transformation. We specialise in supporting organisations to create or update their learning strategy, enhance their learning team's capabilities, align learning to business value, and implement modern learning approaches.

We are highly collaborative and pragmatic. We partner with organisations to align learning to their business needs, unleash continuous learning, and build capability to help them thrive.

Learn more about us at our website.

About your host, Michelle Ockers

Michelle is the founder of Learning Uncut. She is an experience, pragmatic organisational learning strategist, L&D capability builder and modern workplace learning practitioner. She also delivers keynotes, workshops and webinars for learning and broader professional or workforce groups at both public and in-house events.

Michelle received the following prestigious industry awards in 2019:

- Australian Institute of Training and Development Dr Alastair Rylatt Award for L&D *Professional of the Year – for outstanding contribution to the practice of learning and development*
- *Internet Time Alliance Jay Cross Memorial Award – for outstanding contribution to the field of informal learning*

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