Learning from evaluations of crisis-exercises

"A truthful evaluation of yourself gives feedback for growth and success" – Brenda Johnson Padgitt

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1 Preamble

In front of you lies the thesis 'learning from evaluations of crisis-exercises. This thesis is the final product for the master 'Public Administration; Public Safety' at the University of Twente. This thesis means for me the end of an interesting career as a student. In that career I have always chosen for the things that interest me. This means that it was not always that easy, due to long travelling distances, long periods away from home, and taking some risks. But this made the chosen path more fascinating and instructive.

In the summer of 2013 I have earned my bachelor of business administration – Applied safety & security studies. After completing this study, I started working at VR Academie, a concern that is specialized in consulting and training municipalities in the crisis management organization. After a while, I felt that I was not done with learning. During my study at the University of Applied Sciences, I concluded that I was not at my top. After a year of working, I decided I wanted to study more in the context of safety & security. Working for a commercial company made me also realise, that I was more oriented towards the government. The combination: focus on government, and a new safety study, made me to choose for the master 'public administration; public safety'. In order to start with the master, I first had to complete the pre-master. Both trails were incredible instructive for me. Compared to applied sciences, scientific education gives you really a different way of thinking and looking at things. It made me more investigative. Two important terms, which describe the master period for me, are: *analysing* and *causalities*.

One important demand for the subject of my thesis was: interest. My interest lies in the world of safety & security, so a thesis in that direction was obvious. VR Academie confronted me with a problem they experience often: evaluations of crisis exercises that they organize all indicated the same, tasks/facts that went wrong in 2013 are still going wrong in 2014 and 2015 and the expectation is that they will go wrong in 2016 and further. In today's world, people care about the outcome of certain processes. This is especially the case for the outcome of crisis management. Crises management is nowadays an essential aspect, with crises like: the firework disaster Enschede, crash of Turkish airlines Amsterdam, the chemical fire Moerdijk, high water Groningen and the crash with the monster truck Haaksbergen. I can go on for a while though. Everybody makes a mistake, but in crisis management the impact of a mistake can be huge. Therefore it is essential that persons learn from their mistakes, and it cannot be the case that things that went wrong in 2013 are going wrong again in the following years. So I believe this subject of my thesis is very relevant for today's world.

The thesis period was an interesting and valuable period with ups and downs. I have learned a lot about evaluation as a process, and learning as a process. It is unbelievable to find out how much research already is done with regarding to evaluating and learning. I have found many theories about evaluating as a phenomenon and about ways of evaluating. Many of those theories have not made this research, because they were not that relevant, or the scope became too wide. This is also the case for the theories on learning. Forming the research question and the sub questions was another challenge. I often made minor adjustments, with the result that much of my writing was for nothing and had to be deleted. This resulted in disappointments and sometimes, even distrust in a good ending.

It became half way through the period more challenging because I got offered a fulltime job at the Gemeente Tynaarlo as safety advisor for the mayor.
Combining a fulltime job and finishing my study at the same time was a bigger challenge than I thought at the beginning. The support and feedback of my first supervisor Dr. H.G.M. Oosterwijk was very valuable and got me back on the right track. When I had lost my trust, a meeting with him restored my good feeling, and my energy came back.

The time flew by when I had discussions with him. I would like to thank him for the support, feedback and time he put in me as a person. Another person I want to thank is Dr. G. Meershoek as the second supervisor. My appreciation also goes to VR Academie to offer me the opportunity to write my thesis for them. My special thanks goes to N. Haupts, as practical supervisor for the support and supervising. Finally I want to thank my current manager R. Baas and the municipality of Tynaarlo for giving me the freedom to finish my study, besides my employment.

Broekland, 17-11-2016

M. Blanke

2 Abstract

Nowadays crises and disasters are fought via cooperation between different disciplines. The fire squad, police, emergency services and municipalities are working together to keep the impact of a disaster as low as possible. This way of emergency response was not always customary. A few, high impact, disasters made it the case that cooperation is very important. A few examples of those high impact disasters are: the firework-disaster in Enschede (13th of May 2000) and the fire at café "het Hemeltje" in Volendam (first of January 2001). Looking back at those disasters, it became clear that working together is essential in order to reduce the impact of a crisis. Together, the four partners (fire squad, police, municipality, and health services) created the safety-region by law on 1 October 2010. One of the 25 safety-regions is the safety-region Friesland. Just like the 24 other safety-regions, also Friesland organizes crisis-exercises in order to develop their employees, to keep them trained and up to date. Just like every other organization in these days, these trainings in crisis management are evaluated.

Evaluation aims to give insight and meaning to the outcomes of a certain process. Hurteau et al. (2009) are using evaluation: "to determine the quality of a program by formulating a judgement". The idea is that criticism, remarks, conclusions and recommendations about the quality of a certain process can be used as an input to develop new strategies and solutions. If we rephrase this, we can say that the idea is that individuals and organizations learn from evaluations. And there lies the problem. There are doubts about the learning capacity of organizations. What went wrong in 2013 still goes wrong in 2014 and 2015 and the expectation is that they will go wrong in 2016 and afterwards. Evaluating and evaluation reports are considered to be an important tool for the learning process. The recommendations give direction to the learning process and also provide ideas about the coherence of the actions and steps that should be taken, it provides ideas about the priority of actions and they provide a measuring tool for optimal performance.

Despite all these efforts it seems that the evaluation process does not motivate individuals and organizations to learn from observed mistakes. This observation, asks for an analysis of the learning and evaluation process that is used during those exercises. Is it indeed the case that actors in the crisis management organization do not learn? And if that is the case, what are possible reasons for this phenomenon? And which possible solutions can be formulated to solve this problem? In order to explain this, the following questions are formulated.

How did VR Academie evaluate the training in crisis management conducted in the safety-region Friesland and how can the impact of the resulting recommendations be strengthened?

1. *How did VR Academie organize and evaluate the training in crisis management in 2014 & 2015 in the safety-region Friesland?*
2. *What impact did the evaluation reports of the training in crisis management in 2014 & 2015 in the safety-region Friesland have on its participants?*
3. *What might be the causes, according to the scientific literature, that this method of evaluation lack impact?*
4. *Which actions can be taken to improve the impact of evaluation of training in crisis management by VR Academie?*

There is much theory available with regarding to evaluating and learning. The theories that are used for this research are just the tip of the iceberg. These theories are chosen because they have the most relevance for this research. Based on the chosen literature, we can extract six possible reasons for the phenomenon that the evaluation process lacks impact on the learning process:

- Insufficient motivation;
- Absence of experience based learning;
- The absence of drivers & enablers;
- Seeing the evaluation as the final part of the process;
- Not evaluating via the participatory evaluating method;
- Not learning via the double-loop learning method.

These theories and reasons are forming the spine of this research. They are necessary to produce answers on the sub questions 3 & 4, and the research question. But first we have to answer the first sub question. The exercises in crisis management that are organized in 2014 and 2015 had as goal to train the actors in the regional pool for 'team bevolkingszorg'. During the exercises observers observed the participants. Every task organization and the 'leader team bevolkingszorg' had its own observer. This means that six observers were watching the exercise. VR Academie requested them to pay attention on the following points: (1) cooperation inside the team, (2) cooperation with other team (3) formulating clear actions/agreements (4) techniques/disciplines for the meetings (5) Knowledge of organization, systems and tasks. Final product of this evaluation process is an evaluation report. The problem that stands central is that this evaluation process has too little impact on the learning process. When looking at all the evaluation reports, one can conclude that this is indeed the case for the participants of those exercises. The difference in performance between the first exercise in 2014 and the last exercise in 2015 is negligible.

To explain this phenomenon, the theories of the framework come in handy. All the possible reasons are compared with the situation in the safety-region Friesland. Which of those possible reasons are applicable? This investigation provided us the following overview: there are two reasons that are not applicable: insufficient motivation and absence of experience based learning. About the absence of drivers & enablers is some uncertainty. Therefore no clear conclusion about this reason can be formulated. There are three reasons applicable: seeing the evaluation as the final part of the process, not evaluating via the participatory evaluating method, and not learning via the double-loop learning. Let me shortly explain this.

The safety-region Friesland sees the evaluation phase as the final part of the process. The literature gives us that it is important for the learning process to use the learning points of previous exercises as a fundamental base for the following exercises. Their set-up does not use the output of evaluations as input for the next exercises. Based on the exercises and evaluation reports it can be concluded that they use the conventional method. An external actor now writes the evaluation report. Also the observations come from people outside the organization. And if we look at the examined evaluation reports, it can be concluded that the reports focus on detecting deviation in actions, and they try to control the participants towards the right directions (single-loop learning). This is instead of discussing/thinking about the underlying ideas of the fundaments, strategies, actions, and organizations (double-loop learning).

To solve the problem for the future, different actions are possible. The following actions can VR Academie take, to strengthen the impact of the evaluation and the recommendations:

- See evaluating as a continuous process and not as the final stage of the process

This means the following concrete action(s):
VR Academie can support the safety-region in this process by helping them to implement the recommendations, and by offering them a sort of database where all the data/plans can be stored. This makes them accessible in the future.

- Make the findings and recommendations a jointly product with the participatory way of evaluating;

This means the following concrete action(s):
VR Academie can organize this in different ways: involve the participants and stakeholders during the design-phase (writing scenarios and setting goals), involve them during the executing-phase (let them co-observe), and involve them during the evaluation phase (organize a meeting after the exercise to exchange experiences and discuss about the observations).

- Discuss the underlying ideas and beliefs of actions and structures and adjust them where necessary with the double-learning method.

This means the following concrete action(s):
VR Academie can introduce double-loop learning in the following ways: discuss the findings, and make the participants think about their actions, but also about the underlying ideas: what made me to act this way? Why is it wrong? What do I need to make the right action in the future? This is the first step in double-loop learning. The second step towards double-loop learning is to motivate the client to change underlying ideas and the foundation of the organization. To get them motivated it is important that VR Academie supports and advise them in the process of changing. Use the learning points to adjust the organization, strategies, and future trainings.

3 List of Abbreviations

- ACF - Advocacy Coalition Framework
- AGT - Achievement Goal Theory
- CMO - Crisis Management Organization
- EBL - Experience Based Learning
- EBP - Evidence Based Policy
- NPM - New Public Management
- PBE - Policy Based Evidence
- PDCA - Plan, Do, Check, Act
- SMART - Specific, Measurable, Achievable, Realistic, Time-bound
- VNG - "Vereniging voor Nederlandse Gemeenten" (Society For Dutch Municipalities).

4 Background & Introduction

4.1. Background

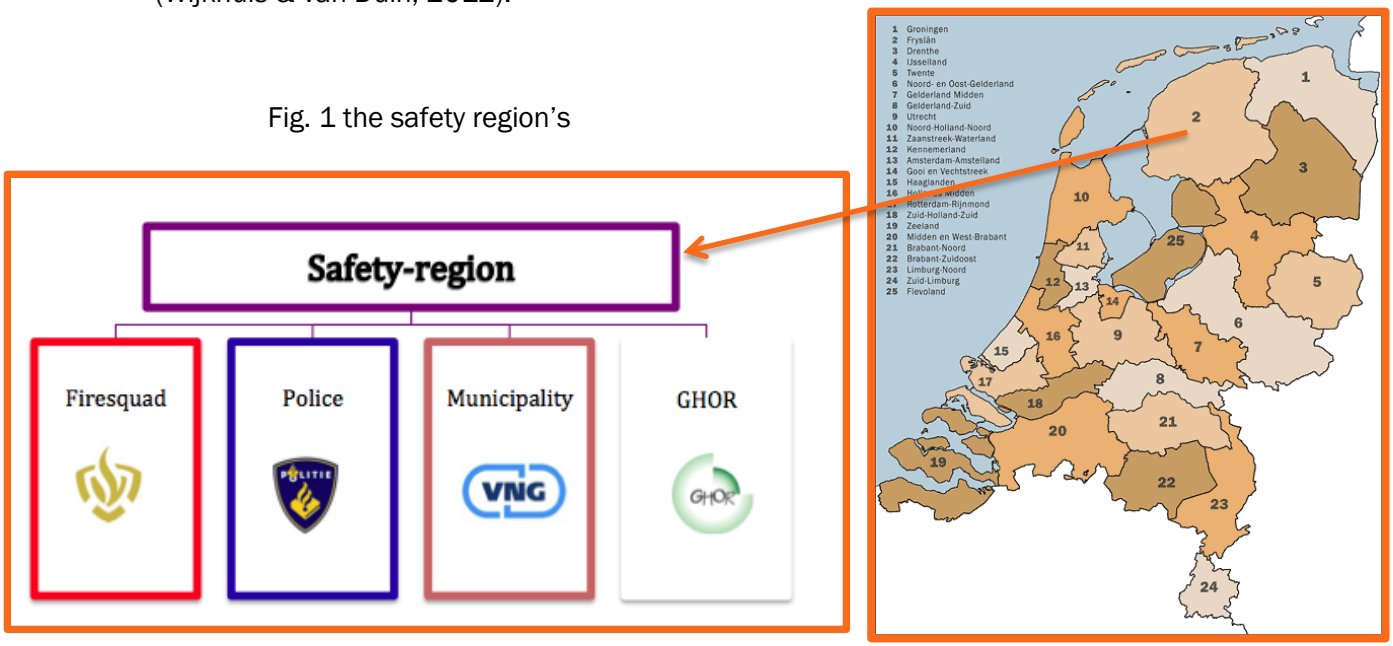
Nowadays crises and disasters are fought via cooperation between different disciplines. The fire-squad, police, emergency services and municipalities are working together to keep the impact of a disaster as low as possible. This way of emergency response was not always customary. These days a few, high impact, disasters made it the case that cooperation is very important. These high impact disasters are: the firework-disaster in Enschede (13th of May 2000) and the fire at café "het Hemeltje" in Volendam (first of January 2001) (see box 1).

Box 1: *Fire at café het Hemeltje, Volendam (2001)*

On New Year's Eve 2000-2001 fireworks started a heavy fire in café het Hemeltje in Volendam. Some fireworks set Christmas decorations on fire. The bar was very crowded, and had almost no emergency exits. Fourteen young people died, and more than 200 persons were heavily wounded. The bar was located at a boulevard with a dike. Therefore it was only reachable out of two directions. The first emergency responders arrived quickly. Persons with the most serious injuries were loaded in the ambulances that arrived first. However, in the mean time, a huge amount of fire trucks, police cars and other ambulances arrived from the two directions. So all these vehicles blocked the ambulances with the wounded persons. This resulted in a higher amount of deceased persons.

Looking back at those disasters, it became clear that working together is essential in order to reduce the impact of a crisis. Together, the four partners (fire squad, police, municipality, and health services) created the safety-region by law on 1 October 2010. Safety-regions are not part of the constitutional structure, and therefore have no own independent responsibility. A safety-region is based on an agreement between municipalities in a certain area to work together in the area of safety and security (Wijkhuis & van Duin, 2012).

Fig. 1 the safety region's



The main task of the safety-regions is: working together for a safe region. In the Netherlands, there are 25 safety-regions (see figure 1.). A safety-region aims on risks for life, health of persons, or society that are bigger than the boundaries of a municipality. Those risks are serious emergency situations, which require a large-scale performance from different actors, at the same time, under supervision of a central leading actor. The safety-region facilitates the emergency services to take actions. It is up to the mayor to take the central leading role. Good disaster management exists of:

- Prevention: plotting the risks and take appropriate preparations;
- Fighting; preform effectively to reduce damage as much as possible;
- Rehabilitation; help for victims, aftercare and restoration.

One of those 25 safety-regions is the safety-region Friesland. Just like the 24 other safety-regions, also Friesland organizes crisis-exercises in order to develop their actors, to keep them trained and up to date. One can make a distinction between a, so-called 'system-exercise' and a 'column-exercise'. A 'system-exercise' is an exercise, which trains the whole crisis-organization of the safety-region. So all the four partners are included. All those partners have field units, tactical teams and strategic teams. The 'column-exercise' is an exercise that focuses on one of the four actors. For instance: only the field units, tactical teams and strategic teams of the municipality are included in the exercise. A 'column-exercise' for the municipalities (in Dutch crisis terms: 'team bevolkingszorg') was also the chosen format for the exercises that are central in this research.

First the organic structure and the occupation of 'team bevolkingszorg' will be pointed out. Later on the process of organizing and evaluating the exercises is described. The national government establishes frameworks for the organization of the safety-regions. Inside those frameworks the policymakers are free to give their own swing on the structure of the safety-regions, and therefore also 'team bevolkingszorg'. So in general all the 25 safety-regions are equal. However, in more specific details there can be some differences. The safety-region Friesland and 'team bevolkingszorg' in the safety-region Friesland is organized as following:

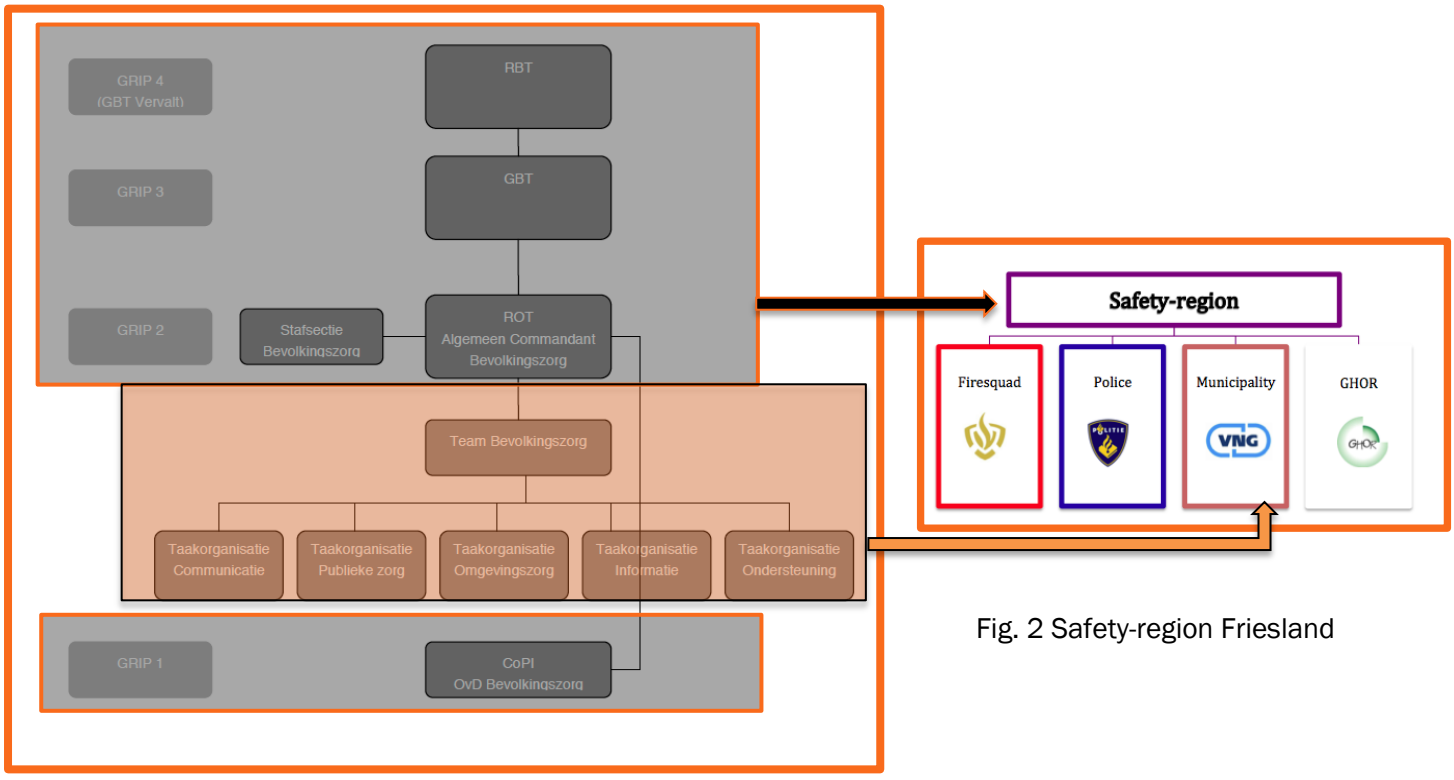


Fig. 2 Safety-region Friesland

The whole organogram exists out of two parts, the mono part (the orange section) and the multi part (the grey section). The multi part consists of teams of the safety-region. The composition and hierarchical position of these teams depends on the size of the disaster. In a so-called 'grip 1' incident, there is one team operational in the field. A 'grip 4' incident means that there are three teams in play on field, tactical and strategically level. These teams exist of players of all the columns (hence, multi). The orange section in the organogram is the mono team for the municipalities ('team bevolkingszorg'). The employees of this team are selected out of a regional pool of 30 volunteers. These volunteers come from all the municipalities inside the safety-region Friesland.

When the focus is placed more on this 'team bevolkingszorg' one can see that there are five task organizations (in Dutch: taakorganisaties). 'Team bevolkingszorg' has the task organizations: 'communicatie', 'publieke zorg', 'omgevingszorg', 'informatie', and 'ondersteuning'. (Free translated: communication, public care, environment care, information, and support). Every task organization has its own head. A closer look at this task organizations shows that those task organizations have underlying teams.

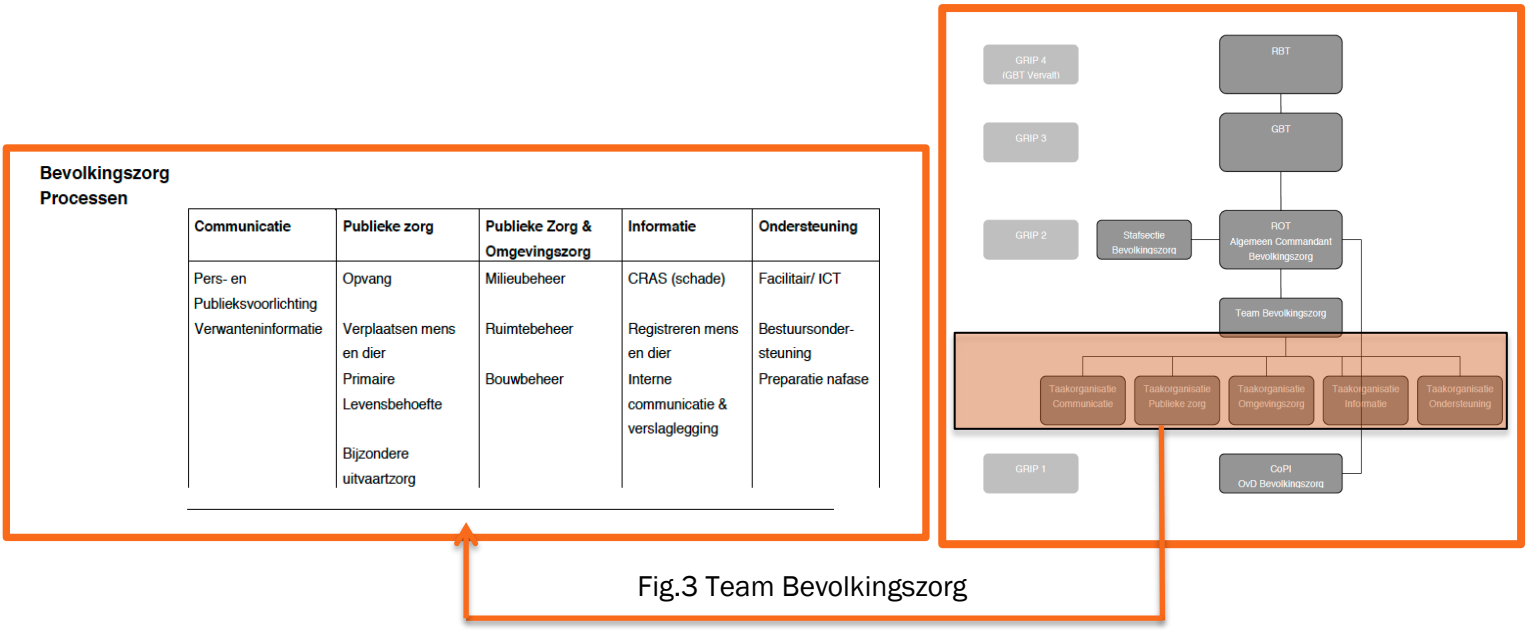


Fig.3 Team Bevolkingszorg

In total there are twelve teams in the mono organization of the municipalities ('team bevolkingszorg'). Every team has its own team-leader and its employees. This means that the structure in 'team bevolkingszorg' is as following: the chairman of this team is the 'leader team bevolkingszorg'. This person has meetings with the heads of the five task organizations. These heads have, after that meeting, a consultation with the team-leaders in their task organization. The team-leaders give the employees their tasks and responsibilities.

So, the exercises that are subject to this research are based on 'team bevolkingszorg'. So the 'leader team bevolkingszorg', the heads of the task organizations, the team-leaders and the employees are subject of these exercises and evaluations. Because 'team bevolkingszorg' is made out of a pool of 30 persons, the composition of the teams is not the same every exercise. Every person however, is trained several times. Twelve exercises (over 6 days) were held in 2014. 6 exercises (over 3 days) are held in 2015. The morning exercise had a scenario A, the afternoon exercise a scenario B. therefore in 2014, six times scenario A is used and six times scenario B. For 2015 two new scenarios were created. Again three times scenario A is used, and three times scenario B. During the exercises observers observed the participants. Every task organization, and the 'leader team bevolkingszorg' had its own observer (so a total of 6 observers).

The observers wrote down their observations. Shortly after the exercises, there was a very brief moment to exchange experiences. The observers send their observations to 'VR Academie'. There, all the observations were put together to form the evaluation report. In total there are 9 evaluation reports with evaluations of 18 exercises. The evaluation reports were sent to the safety-region Friesland, with the goal to improve their 'team bevolkingszorg'.

4.2. Introduction

Evaluation aims to give insight and meaning to the outcomes of a certain process. Hurteau et al. (2009) are using evaluation: "to determine the quality of a program by formulating a judgement". The idea is that criticism, remarks, conclusions and recommendations about the quality of a certain process can be used as an input to develop new strategies and solutions. The effectiveness of an evaluation rests for one part on the quality of the evaluation itself. The process of evaluation, the tools and the final document/presentation must be state of the art and adequate for the situation that is observed. But equally important is the degree to which the evaluated organisation takes the recommendations of an evaluation aboard. Are organizations really willing and able to learn from the recommendations? Are they willing to implement the lessons learned in practice? Do they have the capacities and skills to implement recommendations? Central in this research is the learning capacity of an organization.

The reason for this is that there are doubts about the learning capacity of organizations. Why is it so difficult for organizations to implement the recommendations of an evaluation report; not once, but over and over again? That is the practice that we find in the field of crisis exercises. Despite evaluation reports, these teams make the same mistakes year after year, over and over again. It seems that the pointing finger of evaluations is largely ignored. There may be different reasons for this phenomenon. For instance; "the failure of the evaluator to establish a set of shared aims with the evaluated (organization), or creating overly ambitious aims, as well as failing to compromise and incorporate the cultural differences of individuals and programs within the evaluation aims and process" (*Reeve, J; Paperboy, D. (2007).* Another reason may be that the organization has not sufficient ability/motivation/skills to implement change.

4.2.1. Problem definition

This is the practice that we find in world of safety management. Crisis-exercises – meant to train the organization - are evaluated after each exercise, but it seems that organizations do not learn. What went wrong in 2013 still goes wrong in 2014 and 2015 and the expectation is that they will go wrong in 2016 and afterwards.
In this research I will focus on the team 'Bevolkingszorg'. The core assignment of this team is the division of labour between various organizations; the coordination of activities and the main focus of this team are the communication with and information of the population/ citizens at large. Under the team "Bevolkingszorg" we find five task forces for (1) communication, (2) citizens care, (3) environmental care, (4) information and (5) support/facility management. All in all the team "bevolkingszorg" consists of ± 30 people. However, these 30 people only work together in crisis situations and crisis-exercises. Their daily activities may vary widely.

To keep the work of the teams 'up to standards' there are several trainings-sessions to practice the effectiveness of the team. Each member of the team participates in these sessions. The sessions are organized as simulations and the performance of the team as well as the performance of the task forces is observed by professional observers. After each training session there is a (very short) moment to exchange experiences. Accordingly, the observers lay down their findings as input for 'VR Academie' and there the findings are reworked in view of general safety standards.

Finally the reports, with the recommendations are sent to the municipalities that bear responsibility for the composition and functioning of the 'team bevolkingszorg' and all members receive the evaluation reports with explicit remarks and recommendations. These evaluations help organizations to identify shortcomings in their behaviour. Through a set of recommendations the evaluation reports point out the route towards implementation. Improvement of the crisis organizations is the ultimate goal of the evaluation reports.

Evaluating and evaluation reports are considered to be an important tool for the learning process. The recommendations give direction to the learning process and also provide ideas about the coherence of the actions and steps that should be taken, it provides ideas about the priority of actions and they provide a measuring tool for optimal performance. 'VR Academie is keen on the formulation of the recommendations, because they should fit the capacities of the municipalities.

Despite all these efforts it seems that the evaluation process does not motivate individuals and organizations to learn from observed mistakes. This observation, asks for an analysis of the learning and evaluation process that is used during those exercises. Is it indeed the case that actors in the crisis management organization do not learn? And if that is the case, what are possible reasons for this phenomenon? And which possible solutions can be formulated to solve this problem? The aim of VR Academie is to constantly improve their exercise and evaluation process in order to develop their selves as learning institute.

This research does not focus on the evaluation reports as such. It sees the content of the reports as a given and does not question their professional quality. Yet the question remains how to improve the impact of the evaluations. How can the evaluator provide the tools to improve the learning capacity of the evaluated organizations? This research questions the way of evaluating. The current practice is that evaluators observe the crisis exercises, briefly discuss their findings with the participants and then withdraw to write the report. The evaluation reports are confined to the professional standards that are central in the world of safety and risk assessment. After completion, the reports are sent to the evaluated organization in the expectation that these organizations take the content and recommendations at heart. The question remains if the process – observation/evaluation, report/recommendations, and learning/implementation – is sufficient to motivate organizations to change their crisis behaviour? In order to provide an answer for this question, the following research- and sub-question(s) are formulated:

How did VR Academie evaluate the training in crisis management conducted in the safety-region Friesland and how can the impact of the resulting recommendations be strengthened?

1. *How did VR Academie organize and evaluate the training in crisis management in 2014 & 2015 in the safety-region Friesland?*
2. *What impact did the evaluation reports of the training in crisis management in 2014 & 2015 in the safety-region Friesland have on its participants?*
3. *What might be the causes, according to the scientific literature, that this method of evaluation lack impact?*
4. *Which actions can be taken to improve the impact of evaluation of training in crisis management by VR Academie?*

4.2.2. Research objective & scope

The first goal of this research is to determine whether or not the chosen set-up is insufficient capable to contribute to the learning process of (individuals inside) the crisis organization. To achieve this goal, this research analyse the process which VR Academie has chosen for the exercise cycle in the safety-region Friesland for the years 2014 and 2015. How is this process organized, and is it indeed the case that this way of working has some problems with contributing to the learning process of (individuals inside) the crisis-organization. In order to do so, the first part of this research focuses on the chosen exercise- and evaluation process. The first sub question describes the exercise, and the process of feedback and evaluating. The second sub question describes if it is indeed the case that this way of organizing is not helpful for the learning process. Is the presumption that the employees of 'team bevolkingszorg' do not learn from the exercises and evaluation reports, a right one? To give a conclusion for this question it is important that all the evaluation reports are investigated. Based on that what the observers have written down, a judgement can be given. In the end it can be seen whether or not an improvement on the different exercise objectives is noticeable.

The second goal of this research is to give possible reasons for this phenomenon. To achieve this goal, literature study is essential. Much research about evaluating and learning is already done. Via the literature, several possible reasons for this phenomenon can be formulated. When a collection of reasons is formed, it is essential to determine which of those reasons are applicable for the situation in Friesland. The third sub question of this research is about this second goal. The third and last goal of this research is to come with possible solutions for this problem. Three different scenarios will be worked out. Every scenario has its own way of organizing the exercise and evaluation process. A comparison of the effects/outcomes of every scenario makes it possible for VR Academie to determine which way of exercising and evaluating is the most useful.

4.3. Relevance

There is already much research done, but there is no research that combines all the aspects that will be combined in this research. This research will bring the relevant information from crisis management, evaluation, organizational learning and ways of learning together to come to a conclusion. Therefore this research is important for organizations that have a role in crisis management so, in the future, they can learn from evaluations of crisis exercises.

4.4. Reading guide

The part prior to this paragraph has described some background information about crisis management and training in crisis management. It furthermore introduced the problem that stands central in this research as well as the research question and sub questions that form the spine of this research. The following chapter (chapter 5) provides us with some relevant theories regarding evaluating and the learning process. These theories provide a framework for this research and are supportive by producing the answers on the questions. The methodology is outlined in chapter 6. The chosen method is explained and argued. Chapter 7 provides us with the findings. In this chapter all the sub questions are answered. The answers on those four sub questions help us to write the conclusion on the research question. This conclusion can be read in chapter 8.

5 Theoretical framework

In order to achieve the three goals of this research and to answer the sub questions and the research question, it is essential to describe theories that put the findings of this research in a context. This chapter provides those theories, which make it possible to give reasons for the phenomenon that stands central. The main goal of this theoretical framework is to deliver possible causes and solutions for the central problem. This framework makes it possible to formulate the answers on the questions. The first part of this framework focuses on reasons with regarding to the evaluation process. The second part aims on possible reasons that have a relation with learning as a process.

5.1. Evaluating and the evaluation process as a tool for learning

The Netherlands is famous of their strong evaluation culture; even a legal basis for evaluating is implemented (Wijkhuis & van Duin, 2012). Different governmental organizations, but also private and scientific parties are participating in evaluation. It is a booming business. If a crisis or disaster occurs, uncertainty is one of the main consequences. Lots of questions are asked: what went wrong? How could this happen? Could we prevent this? How did we fight the crisis/disaster? Are we better prepared in the future? So the last several years many disasters and crises are evaluated. Not only disasters and crises are evaluated but also simulations and exercises. This is because nowadays the outcome is very important. People are not interested about the process, but about the outcome. Before we go to the possible reasons of the central problem. I first want to explain you the reason for the shift of focus from process to output.

5.1.1. New Public Management (NPM)

Where in the early days the course of the process was important, nowadays the focus lies elsewhere. In these times all the attention goes to the outcome of a process. Did everything go according to plan? Is the quality of the outcome sufficient? This shift occurred thanks to a new way of thinking. Thinking according to the new public management (NPM) approach. New public management is a form of governing that focus more on generic approaches, managers, management, efficiency, creativity and results (Korsten, 2007) (Hill & Hupe, 2002). The NPM movement started in the 1970s & 1980s in the United Kingdom and the United States. In the USA, performance indicators to check efficiency of a public organization were used for the first time (Gruening, 2001). The main idea of NPM is a more commercial oriented government. Haynes (2003, as cited in Alonso et al. 2015, p.645) states this as the following: “an attempt to implement management ideas from the business and the private sector into the public services”. This does not mean that they have to earn big amounts of money, but it has a few assumptions similar to the ones that are important in the commercial world. One could think of more freedom to act, more decentralization, more focused on results and more about fulfilling the needs of the citizens (Korsten, 2007). The model of input-throughput-output can be used to describe the way of thinking in New Public Management. “In bureaucracy the process to create something (throughput) was important. In the view of new public management the emphasis is on the output” (Korsten, 2007). As a result of that, it is nowadays important to evaluate policy, actions and choices on the basis of output and their results.

Now we know why everybody is focussing on results in these days. But how can you measure results? This can be achieved via evaluating.

5.1.2. A definition and forms of evaluating

Because of the emphasis on output nowadays, the government spends more time, money and effort on performance measurement, and thus on evaluating in the public sector (van Thiel & Leeuw, 2002). In the past decades, the amount of evaluators and evaluations has grown considerably, and the expectation is that the number keeps growing (Leeuw, 2009, as cited in Guenther, Williams & Arnott). In these days, evaluation is a booming business. But what is evaluating exactly? Evaluation is a term that is used often. One sometimes speak of an evaluation, when they simple mean investigation (Reeve & Peerbhoy, 2007). Evaluation is however mostly known for the assessment of a performance. Evaluation is: "a study designed to assist some audience to assess an object's merit and worth (Stufflebeam, as cited in Reeve & Peerbhoy, p.121). This implicates that evaluations are not only about facts, but also about values. And that is one of the main challenges of evaluating.
Evaluations are always based (partially) on value judgments (Abrahamsson, Hassel, & Tehler, 2010) (Reeve & Peerbhoy, 2007). So evaluating is a study that can be used to assess an object's merit and worth. Like other studies, there are also different formats of evaluating that can be used. The process can be evaluated via process-evaluation. Also the plan/implementation can be subject of evaluation via plan-evaluation. Plan-evaluation evaluates the plan that is formulated during the policy-making process. One could think of giving insight in the proposed processes and are the plans achievable (Centrum voor criminaliteitspreventie en veiligheid, 2012)? Process-evaluation is about the course of the process. It investigates how the plans are translated to practice, does the process focuses on the right target group, and how experience the executors the process (Centrum voor criminaliteitspreventie en veiligheid, 2012). A form that is especially highlighted in the following paragraph is meta-evaluation. Meta-evaluation is the process that evaluates the evaluation process.

5.1.3. Meta-evaluation

This form is especially pointed out because this research is based on the meta-evaluation format. Meta-evaluation knows many different definitions. Some people define it as: "a systematic tool for the quality control of evaluation reports" (Uusikyla & Virtanen, 2000, p. 52). In this research the content quality of the reports is given, it investigates however the impact on the learning process. Impact of an evaluation report is also a part of the quality of the reports. When speaking about quality of evaluations in this research, we speak about the impact of the evaluation on the learning process. Patton (1997, as cited in Uusikyla & Virtanen, 2000) argues that meta-evaluation also should be concerned with the utilization of evaluations. He emphasizes that there are two important characteristics of meta-evaluation: it must be focused on utilization and dissemination. Utilization and dissemination can be closely related to the impact of evaluations. The impact is evaluated via an impact assessment (Centrum voor criminaliteitspreventie en veiligheid, 2012) (Centers for Disease Control, 2011). The impact assessment is about the output of the process. These assessments are important because they can show efficiency of a process, and which causal relations can be found (Centrum voor criminaliteitspreventie en veiligheid, 2012). Uusikyla & Virtanen (2000) are formulating the following with regarding to meta-evaluation in relation with learning: "meta-evaluation can be seen as a process that supports an open dialogue and collective judgement over the utilisation of evaluation results and in this way enhances organizational learning through evaluative inquiry" (Uusikyla & Virtanen, 2000, p. 52).

On this moment we know that, thanks to NPM evaluating is such an important process. Evaluating is a developing concept with many forms and manners. We further know that if we want to determine the quality and impact of an evaluation process, meta-evaluation is a useful method. Let us move on to theories that can give us possible reasons for the fact that an evaluation method possibly lacks impact.

5.1.4. Participatory Evaluation

The evaluations, that are subject of this meta-evaluation, are conducted via process evaluating. The forms that are mentioned above speak all about a different subject of the evaluation process. Another discussion can be: how to organize your evaluation. The discussion is therefore not about the subject of the evaluation but the way the evaluation is organized. In their article, Uusikyla & Virtanen (2000) used a citation from Patton Patton states that behavioural and organizational change result (direct or indirect) from participating in the evaluation process (Patton (2008, as cited in Uusikyla & Virtanen, 2000,)). This way of evaluating is sometimes called interactive evaluating, but more over as participatory evaluation. This is an approach that involve the stakeholders and participants. This involvement can occur on every stage of the evaluation process. For instance when the evaluation design is developed, or during the gathering of data, or by discussing the evaluation outcomes (Sette, 2015). Using participatory evaluation asks lots of time and commitment of the stakeholders, participants and the evaluating organization. Another challenge is to facilitate the participants enough. This method, however, has also many advantages.
Advantages of using participatory evaluation are according to Sette (2015):

- Identify locally relevant evaluation questions
- Improve accuracy and relevance of reports
- Establish and explain causality
- Improve program performance
- Empower participants
- Build capacity
- Develop leaders and build teams
- Sustain organizational learning and growth

Comparing participatory and conventional evaluation gives us the table on the following page (Zukoski & Luluquisen, 2002).

Table 1. Participatory vs. Conventional

(Zukoski & Luluquisen, 2002)	Participatory	Conventional
Who drives the evaluation?	Evaluators, project staff and other stakeholders	Funders & evaluators
Who determines indicators of program progress?	Evaluators, project staff and other stakeholders	Professional evaluators and outside experts
Who is responsible for data collection, analysis and preparing final reports?	Shared responsibility of evaluator and participating stakeholders	Professional evaluators and outside experts
What is the role of the local evaluator?	Coach, facilitator, negotiator, 'critical friend'	Expert, leader
When is this type of evaluation most useful?	When: • There are questions about program implementation difficulties • There are questions about program effects on beneficiaries • Information is wanted on a stakeholder's knowledge of a program or view of progress	When: • There is a need for independent judgment • Specialized information is needed that only experts can provide • Program indicators are standardized rather than particular to a program
What are the costs?	• Time, energy, and commitment from evaluators, project staff and other stakeholders • Coordination of many players • Training, skills development and support for key players • Potential for conflict	• Consultant and expert fees • Loss of critical information that only stakeholders can provide
What are the benefits?	• Local knowledge • Verification of information from key players (validity) • Builds knowledge, skills and relationships among project staff and other stakeholders. • Sustain organizational learning	

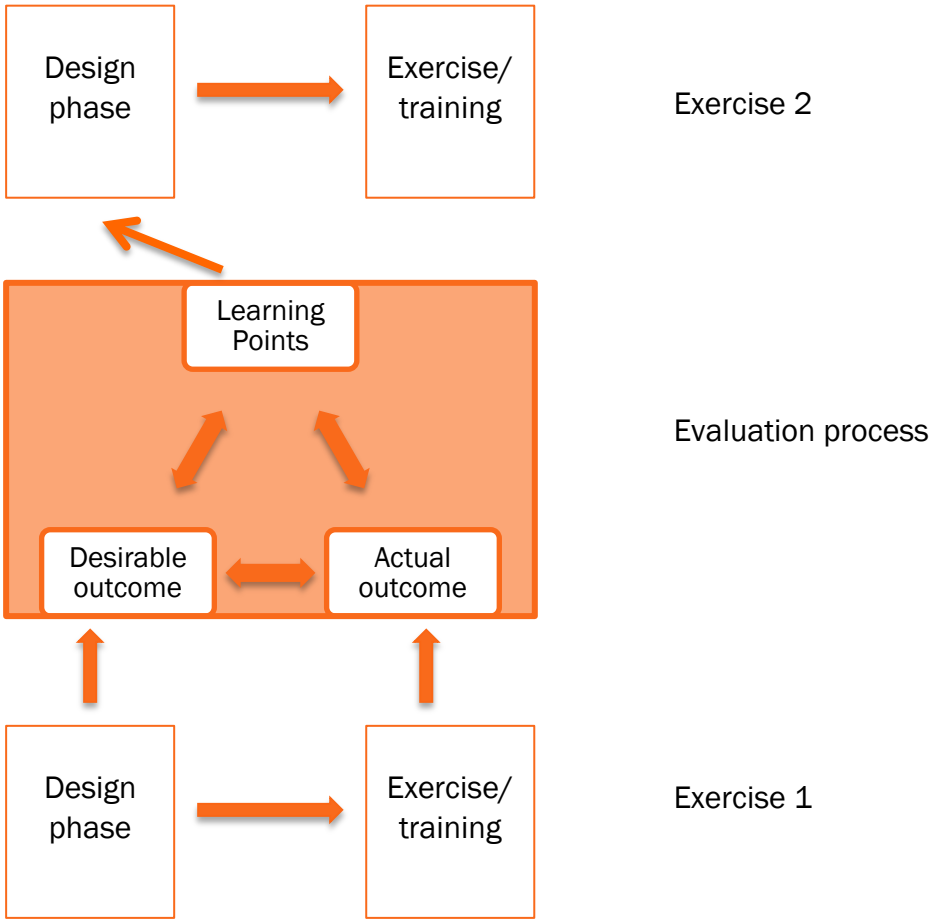
Strengthening the learning process is one of the major advantages of participatory evaluating. Learning from evaluations can be achieved when one choose for participatory evaluating (Helvetas, 2015). They argue the following: "ensuring that project staff, partners and primary stakeholders can contribute to the evaluation, reflect jointly and shape the recommendations that come out. So, one important achievement is that an evaluation leads to better project implementation" (Helvetas, 2015). This makes that the theory of participatory evaluating is of great value for this research. There are many differences between choosing for the conventional way or the participatory way of evaluating. Also with regarding to the learning process, so this theory gives us the first possible reason for the problem:

Not evaluating via the participatory evaluating method

5.1.5. Evaluation as a continuous process

Another discussion that we can start about evaluating is about the position of the evaluation phase. Many organizations see the evaluation as an end of a certain phase or project. To enhance learning for individuals and organizations, it is essential to see learning as a continuous process. Helvetas (2015) states the following:" A project evaluation is an integral part of project implementation in work and is a key moment for learning and change". In the design phase of a project (in this case the training in crisis management) it is already important to think about desirable outcomes of the exercise. When writing scenario's it is important to think about that desirable outcomes. This makes it possible that after the training the desired outcome can be compared with the actual outcome (Haupts, 2013). The difference between these two boxes can be defined as learning points. These points can be learning points for individuals, the organization or the progress. These learning points are the input for the following exercise/training cycle. In order to achieve maximal learning is it important to use the evaluating of the exercise in the design phase of the next exercise (Haupts, 2013).

Fig. 4 Evaluation as continuous process



Seeing evaluating as an on-going process is essential for the impact on the learning process. Therefore this theory is essential for this research. This theory has just given us the following possible reason:

Seeing the evaluation as the final part of the process

Evaluating as a part of a continuous process is also closely related to another on-going process, namely the plan-do-check-act cycle (PDCA cycle) of Deming.

5.1.6. PDCA Cycle

"The need for measuring output, outcomes and evaluation activities remains an important element in statements by politicians and administrators focused on improving government's performance" (van Thiel & Leeuw, 2002, p. 267). Hence, the huge increase of evaluations, evaluators, and quality indicators. A customer in recent times (of both commercial, as public organizations) demands that the products they request have the maximum added value (Gidey, Jilcha, Beshah, & Kitaw, 2014).
For crisis management and other safety related tasks, high quality of the output is essential. An important tool that can help with achieving high quality output is the quality assurance system.

Deming argues that a certain process must be analysed and measured to assure quality in the output" (Averson, 1998). An important factor of this system to achieve quality is the circle of Deming. "This model divides the management process in four phases, namely: plan-do-check-act (see table 2) (Wu, et al., 2015). It is mostly used as a model to solve problems in the context of quality management (Matsuo & Nakahara, 2013). The PDCA-cycle is an on-going process. "It involves an on-going refinements and structural problem-solving in response to continuous feedback from customers" (Gidey, Jilcha, Beshah, & Kitaw, 2014, p. 2). In the context of evaluating, and organizational learning from evaluating, the most important phases of the Deming circle are the check and act phase. "In the check phase the measurements are assessed. In the act phase lies the decision to change, the process to improve the process" (Averson, 1998).

Plan: • Create appropriate teams • Gather all available data • Understand customers needs • Describe the process that surrounds the problem • Determine root cause(s) • Design action plan • Develop plan	**Do:** • Implement improvement • Collect appropriate data • Measure progress • Document results
Act: • Standardize desired improvements • Formalize current best approach • Communicate results broadly • Identify next improvement	**Check:** • Summarize and analyze data • Evaluate results relative to targets & see differences • Review any problems/errors • Record what was learned • Specify any remaining issues or unintended costs

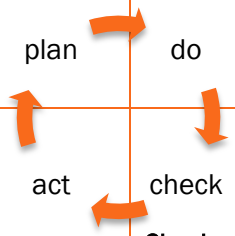


Table 2. PDCA Cycle + characteristics

The training activities of in the crisis management organization can be connected to the PDCA-cycle in two different manners. Organizing a training activity can be translated through the PDCA-cycle, and performing an evaluation can also be described via the PDCA-Cycle.

First the training activity:

Plan: develop with the organizing staff clear training-objectives and accompanying test-objectives. Take those objectives in mind when you are building the scenarios.

Do perform the activity and evaluate the outcomes with the desirable objectives that are formulated earlier. Evaluate every team but the results are considered as a whole.

Check discuss the outcomes of the evaluation and exchange experiences.

Act reformulate (where necessary) the training- and test objectives. And adjust (where necessary) the training organization.

And the evaluation:

Plan debrief and gather all the evaluation data

Do Analyse the incident/analyse the training (scenario)

Check compare with the plans, appointments and developed objectives

Act make conclusions and recommendations. Write them down in a report. Present the report to the organization and start with implementing the recommendations.

We have seen that evaluating has made several developments over the past years. It became real important when, thanks to new public management, the focus shifted from the process towards the output. NPM made it more important to concentrate on the results instead of the way towards the results. If you want to value the effectiveness and efficiencies of policies, processes, and trainings it is wise to observe this by results. The way of evaluating also shifted over the past years. The PDCA-circle of Deming is an on-going process and is an important theory to establish constant improvement. This circle can also be related to the evaluation process. For training (and evaluating) processes it is also important to consider them as continuous. If you do so, one can achieve the most influence on the learning process. Seeing evaluating as (a part of) a continuous process is one of the key theories of this research. The process of evaluating also developed with regarding to the distribution of roles. In the conventional way of evaluating the evaluators and the persons that are being evaluated had different separated roles. Modern approaches work with the assumption that involvement of the participants and stakeholders may strengthen the impact of the evaluation. Stakeholders and participants have their own, unique and important input, and thus can contribute to valuable recommendations. Making evaluating participatory is the second key aspect of this research.

5.2. Learning

In the previous paragraph we discussed the process of evaluation and the developments that this process went trough. Nowadays the focus lies on output instead of the throughput. More developments are: seeing evaluating as a part of a continuous process, and making evaluating participatory. These two (considered) key elements are important for positive influence on the learning process. They are therefore stated as two possible reasons for the lack of impact from evaluation reports on the learning process. The second part of this framework is focussing on learning. Are organizations open to learning and what is necessary to create a successful learning process?

Learning is the development, or adjustment of knowledge, behaviour or abilities. It is important to keep on learning in both private as professional circumstances, especially in dynamic working conditions. Dynamic working conditions are applicable for the employees of a municipality, which fulfil a role in the crisis management organization. Their daily tasks can differ widely from the task that they have to fulfil in crisis situations.

For employees of a municipality, their role in the crisis management organization is not one on a daily base. For them it is important to learn the abilities and knowledge they need to fulfil these roles, and to keep developing these abilities and knowledge. Fire- and policemen are learning via trainings, exercises and real life experiences. Officials from a municipality have no, or less, real life experiences with incidents. Learning how to be effective in crisis situations is mainly trained in exercises. Learning is a broad concept. When we narrow it down, we can specify two forms of learning: organizational learning and individual learning.

5.2.1. Organizational learning & individual learning

Organizational learning and individual learning are two different things. They are, however, closely related and dependent of each other. In the crisis management organization, responsibility lies with the whole column (fire squad, health services, police department and municipalities). If an individual fails, the whole organization fails. This can have huge consequences for the commander-in-chief. In crisis management organization the mayor fulfils this function. There are several examples of incidents where the mayor had to step down after having failed in crisis management (Moerdijk, Project X Haren and Monster truck Haaksbergen). On the other hand, when an individual learns, he or she brings new insights, methods and skills to the organization and in doing so the whole organization learns. This makes individual and organizational learning a more or less intertwined concept.

Organizations cannot learn without their individual members, because one viewpoint of organizational learning is that individuals learn as agents for the organization, and that the knowledge they obtain must be stored in the memory of the organization (Waddell & Pio, 2015). Individual learning advances organizational learning (Kim, 1997). Organizational learning comes to an expression via the capacity of an organization to use experiences of individuals to improve the functioning of the organization (Gerrichhauzen, Korsten, & Fijen, 2002). Organizational learning is a continuous process and exists out of four components: drivers, enablers, learning, and outcome (Law & Chuah, 2015).

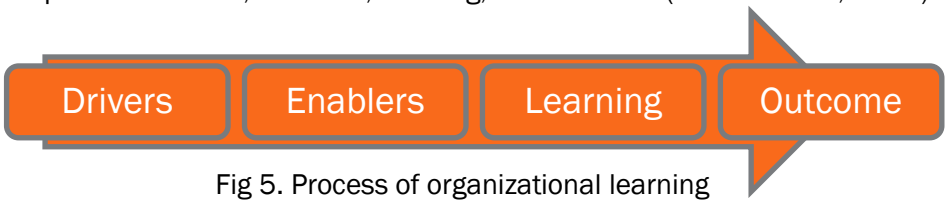


Fig 5. Process of organizational learning

The drivers are the persons who initiate organizational learning inside of an organization. They are motivated to take initiative and communicate new skills and insights to the organization. Enablers are factors that give the opportunity for successful organizational learning. One could think of organizational culture, individuals and internal forces (Law & Chuah, 2015). In current times there are many ways for exchange of ideas, skills, methods, concepts and insights. It depends on the organization how much room they provide for such learning opportunities.

The learning component is the main component, but this not means that the other components are less important. Important aspects of learning are: team learning, learning as part of work, and action learning (Law & Chuah, 2015). The last component is the outcome of the whole organizational learning process. This component shows how successful the process was. This can be done via the performance measurement of learning teams and by measuring organizational learning (Law & Chuah, 2015).

According to Torres & Preskill (2001) learning is a continuous process of growth and improvement and this process: "(a) uses information or feedback about both processes and outcomes (i.e., evaluation findings) to make changes, (b) is integrated with work activities, and within the organization's infrastructure (e.g., its culture, systems and structures, leadership, and communication mechanisms); and (c) invokes the alignment of values, attitudes, and perceptions among organizational members" (Torres & Preskill, 2001, p. 388). The strength of this description is the emphasis that learning has to be integrated into the organization's infrastructure. There are five activities for an organization to become an effective learning organization.

These five activities are: "(1) systematic problem solving, (2) experimentation with new approaches, (3) learning from their own experience and past history, (4) learning from experiences and best practices of others, and (5) transferring knowledge quickly and efficiently throughout the organization"(Garvin, 1993, p. 81, as cited in Preskill, 1994). Learning from experiences is an important aspect of this research, and will be handled further on in this framework. It is important for an organization to be hungry for information. This information must be passed on to the members who benefits from it (Preskill, 1994). Once again, it depends on the organizations how much opportunity they provide so that these activities can occur and become beneficial.

An organization constantly has to make sense out of information, which comes from inside the organization as well from outside the organization (environment). Organizing this information is essential in order to understand organizational learning (Cherin & Meezan, 2008). Organizing information can be seen as a three way process (Cherin & Meezan, 2008) (Waddell & Pio, 2015). The first step is enactment. The second step is selection, and the third step is retention (Cherin & Meezan, 2008). Waddel & Pio, (2015) are calling these steps: explorative learning, exploitative learning, and transformative learning. Enactment (explorative learning) is about where the information is obtained and used. Selection (exploitative learning) is about getting grip on the information and applies the right information to the work processes. Retention (transformative learning) is the process where organizations memorize information that was effective (Cherin & Meezan, 2008) (Waddell & Pio, 2015).

With regarding to this research it can be important for the safety-region Friesland that the organization have drivers and enablers because those persons have positive influence on the learning process, and an eventual process of change. The following possible reason presents itself:

The absence of drivers & enablers

It is also important to know that individual learning and organizational learning are closely related. The former is essential input for the latter. A crucial aspect of individual learning is motivation. This can best be explained via the achievement goal theory.

5.2.2. Achievement Goal Theory

On this moment it is clear that the learning capacity of organizations may differ. Another important issue that cannot be forgotten is that crisis management is not core-business for principals of municipalities. They only have to fulfil their tasks in exceptional situations. This is not helpful for the learning process. The principals only can perform their tasks during exercises and in a real crisis situation. But many of the volunteers will never experience a real crisis situation. In this case it may be more difficult to internalise certain skills. Here lies an important role for motivation and dedication.

An important aspect of (individual) learning is motivation. Officials that have a role in the crisis management organization must be committed to their role. They must have motivation to do their tasks next to their original activities. Describing the relationship between motivation and learning can be done via the achievement goal theory. It is long known that ability is not the only factor to seek challenges, and learn faster (Dweck, Motivational Processes Affecting Learning, 1996). During the 1980s several theorists and researchers focuses on how people (in specific children) construct a situation, interpret the situation, and process information about the situation (Dweck, Motivational Processes Affecting Learning, 1996). From that moment on, the approach was more social-cognitive.

The achievement goal theory (AGT) was developed to understand students' adaptive and maladaptive responses to achievement challenges (Dweck, 1986, as cited in Senko, Hulleman & Harackiewicz, 2011). AGT proposes that: "individuals adopt different goal orientations in line with their underlying beliefs about ability" (Chadwick & Raver, 2015, p. 960). The theory makes a distinction between to primary goals. On the one hand, they place mastery goals; on the other hand they have performance goals. Mastery goals (also called learning goals) are aiming on learning, obtaining and developing skills, overcoming a challenge, or increase their competences (Dweck, Motivational Processes Affecting Learning, 1996) (Dweck & Leggett, 1988) (Senko, Hulleman, & Harackiewicz, 2011) (Wolters, 2004). Performance goals are about acquire positive judgments on their competences, or avoiding negative judgments on their skills. People with performance goals will show their competences because they are proud, or because they are willing to outperform others (Dweck, 1996) (Dweck, 1996) (Senko, Hulleman, & Harackiewicz, 2011). Researches indicate that people with mastery/learning goals are more tenacious, will work together and find the learning material much more interesting.

Performance goals can be separated between performance approach goals and performance avoidance goals (Wolters, 2004) (Chadwick & Raver, 2015). People with a performance approach goal want to show their competence to others. People with a performance avoid goal, in the contrary, are avoiding showing competence to others. They do not want to look incompatible, or look less skilled than others (Wolters, 2004) (Chadwick & Raver, 2015). People, who are pursuing performance goals, believe that ability is a fixed attribute. This is in contrast with people who are chasing mastery/learning goals. Those people believe that ability can be developed and formed when they show some effort (Senko, Hulleman, & Harackiewicz, 2011). The last important distinction between mastery/learning goals and performance goals is the definition of success and failure. Success for learning goals is about achieving self-defined criteria (for instance: feeling that you have learned something). Success for performance goals is to gather positive judgment on a competence, or being better than another individual (Senko, Hulleman, & Harackiewicz, 2011).

Senko et al (2011, p. 27) says the following about success/failure: "Thus, only a select percentage of students can achieve a performance goal, but every student can in principle achieve a mastery goal". Table 3 shows the differences in behaviour between people with performance goals and learning/mastery goals.

Goal Orientation	*Confidence in present ability*	*Behavior Pattern*
Performance Goal	If high →	Mastery oriented (seek challenge, high persistence)
	If low →	Helpless (Avoid challenge, low persistence)
Learning Goal	If high →	Mastery oriented (seek challenge (that fosters learning), high persistence)
	If low →	Mastery oriented (seek challenge (that fosters learning), high persistence)

Table 3. Goal Achievement Theory

It can be concluded that it depends on the motivation whether an individual, and therefore an organization, is willing and able to learn. When participants have a performance goal in an exercise, they do not want to look incompatible. People with a learning goal, are willing to learn and their motivation is much more useful. So for an organization like the safety-region Friesland it is important to recruit volunteers, which live up to mastery/learning goals. These goals are the rest of this report seen as 'the right motivation'. Another possible reason derives from the goal achievement theory:

Insufficient motivation

Besides motivation, there is another important aspect for individual learning. This aspect is called Experience based learning (EBL).

5.2.3. Experience based learning

Experience based learning is another important element for individual learning. Like is mentioned earlier, the Fire- and policeman are learning via trainings, exercises and real life experiences. Officials from a municipality have no, or less, real life experiences with incidents. To let officials from municipalities get some experience, the safety-region organize on a regular base crisis exercises. These can be focused purely on the municipalities, but also in cooperation with the other columns.

If individuals or an organization wants to learn, it is important to realize that there are different ways to learn. "We can distinguish competence based learning, explanation based learning and experience-based learning (EBL).
Competence based learning is the learning of one competence at a time. Explanation based learning, is based on making generalizations or concepts from examples.

Candidates learn their material via those examples. EBL is about that experience takes the central place in the teaching and learning process" (Andresen, Boud, & Cohen, 1999) (Yardley, Teunissen, & Dornan, 2012) (Kolb D. A., 1984) (George, Lim, Lucas, & Meadows, 2015). Experiences in this case can be former events in their lives, current events in their lives or experiences from the activities that are implemented by the teacher in this learning process (Andresen, Boud, & Cohen, 1999).

Learning is a social and cultural concept and not a pure individual process. Learning occurs when people actively engage in communities of practice (Yardley, Teunissen, & Dornan, 2012). Vygotsky (1988, as cited in Yardley et al, 2012) states the idea that learning environments influence learners and that learners influence learning environments. Experiential learning is according to him: "located within bi-directional (or multi-dimensional) interactions" (Vygotsky, 1988, as cited in Yardley et al, 2012, p.162). There is a set of assumptions that is applicable to learning from experience. Yardley et al. (2012) states that people first have to recognize what is common between new and earlier experiences. After that they must be able to identify differences between new and earlier experiences. In his book, Kolb (1984) gives characteristics for experiential learning.

These characteristics, also mentioned by Boud et al. (1993, as cited in Andresen, Boud & Cohen, 1999) are:

- Learning is best conceived as a process, not in terms of outcomes
- Learning is a continuous process grounded in experience
- The process of learning requires the resolution of conflicts between dialectically opposed modes of adaptation to the world
- Learning is a holistic process of adaptation to the world
- Learning involves transactions between persons and environment
- Learning is the process of creating knowledge

"Key element of EBL is that the learner always analyses the experience by reflecting and evaluating it" (Andresen, Boud, & Cohen, 1999).

How this exactly works, can be explained using Kolb's learning cycle (see figure 5 on the next page). "Kolb argues that everybody who is in a learning situation goes through four phases". These phases are (Kolb, Boyatzis, & Mainemelis, 2011):

I. Concrete experience *(experience something)*
II. Reflective observation *(review/reflect the experience)*
III. Abstract conceptualization *(concluding/learning form this experience)*
IV. Active experimentation *(try out what is learned from this experience)*

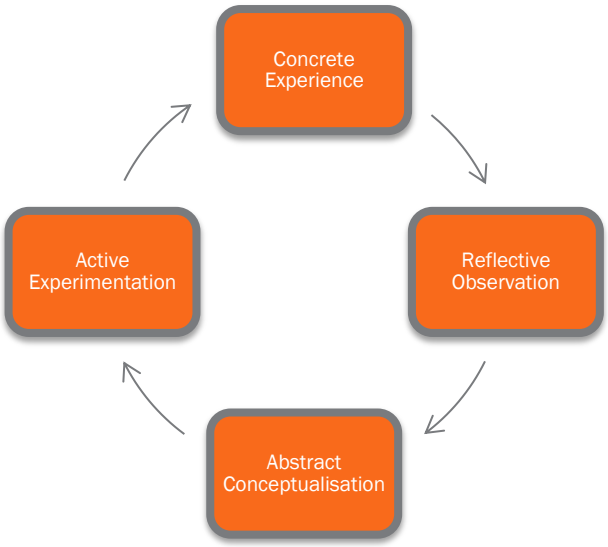


Fig 6. Kolb's learning cycle

Kolb, Boyatzis & Mainemels (2011, p.228) arguing the following: "concrete experiences are the basis for observations and reflections. These reflections are assimilated and distilled into abstract concepts from which new implications for actions can be drawn. These implications can be actively tested and serve as guide in creating new experiences".

There are some essential criteria that need to be fulfilled if someone can speak about EBL. The ultimate goal, and thus the ultimate criteria of experience-based learning is that students lay hold on something that is to them purposeful or meaningful (Andresen, Boud, & Cohen, 1999). Other criteria to label education as EBL are:

- A focus on the nature of the students' personal engagement with the phenomenon.
- Reflecting and debriefing are essential elements.
- There is acceptance about the fact that learning always includes the whole person (senses, feelings, intellect, affect, conation & cognition).
- Recognition of what students bring to the process is understood as important.
- An ethical attitude towards the students by those who educate.

The presence of one of these criteria is not sufficient to talk about EBL (Andresen, Boud, & Cohen, 1999). All of these criteria must conjointly be present.

Different types of learning can be used, and every type reaches their own goals. An organization can only learn, when the individuals inside the organization, also learn. The best type of learning for both organizational and individual learning is learning based on experience. EBL is also very important for this research. This research is about the impact on the learning process via training in crisis management and the evaluations of those training rounds. So they work with the assumption that individuals have to learn from experiences. Therefore it can be concluded that experience based learning is an important characteristic for this research. The fifth possible reason is therefore:

Absence of experience based learning

We now have discussed different theories that are important for the learning process. These theories provided us different reasons. There is one more reason coming up. Besides the forms of learning that are mentioned above, there is still one important distinction left. An important distinction, with regarding to organizational learning, is the difference between single-loop learning and double-loop learning.

5.2.4. Single-loop- and double-loop learning

Learning in an organization is often negative received by its employees. They show resistance, and do not see the point of changes. This is not different for the crisis management organization. No incident or exercise is the same. The development of threats, the changeability of incidents, and the occurrence of unexpected events makes every incident different. This means that the crisis management organization and their responsibilities have to adjust constantly. Changes in the organization or in the work processes occur. People often do not see the point of these changes, and therefore do not accept, or even fight them.

To fight this problem, the distinction between single-loop and double-loop learning is important. “Single-loop learning means that they focus mainly on the control of the change in the process in order to achieve their goals. It does not focus on the fundamental design” (Kemp & Weehuizen, 2005) (Greenwood, 1998). When an organization is able to learn via the single-loop model, this means that they are capable of detecting deviations in strategy, policy and procedures. It also means that they correct or control these deviations (Verheijden, 2010). These organizations can change in there own organization/framework. An organization that is capable of single-loop learning, are not capable to discuss (the fundamental base) of these strategies, policies and procedures. Organizations that are capable of double-loop learning can do this. Changes are not occurring inside a framework, but the framework is subject of the change/discussion (Verheijden, 2010) (Cartwright, 2002). “Argyris claims that double-loop learning is necessary in order to accept changes” (Argyris, 1976). “Double-loop learning means that they think more deeply about the occurring problems. Actions in the past are analyzed in order to prevent problems from occurring” (Argyris, 1976) (Greenwood, 1998). With double-loop learning the employees get insight in the causes of changes. With more insight they are better able to accept it.

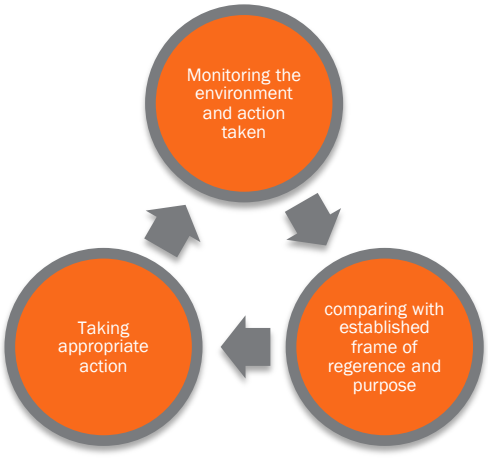


Fig 7. Single-loop learning

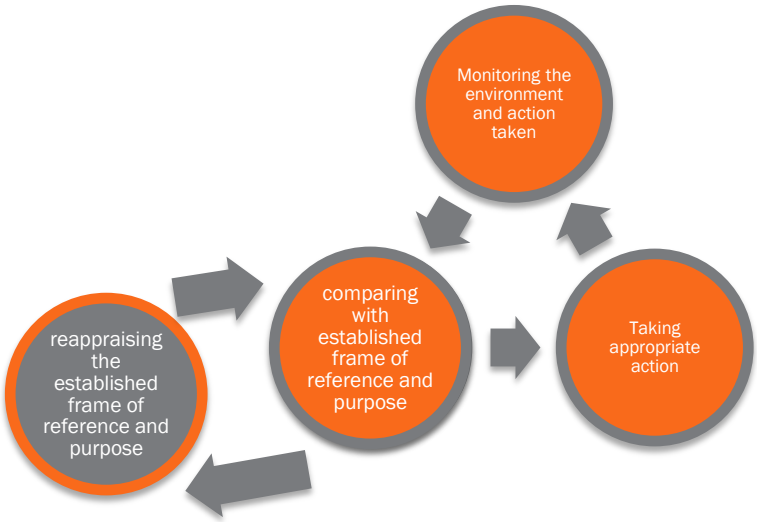


Fig 8. Double-loop learning

Figure 7 show that single-loop is about a single-loop where a certain situation (action or environment) is monitored. The observations of these monitoring are compared with an established frame and the accompanying purposes. When the observations diverge from the established frame, appropriate action is taken to solve this issue. Figure 8 shows us the same loop, but in addiction to that a second loop is included.

This second loop focuses on the established frame and the accompanying purpose. This loop questions if the current frame is still relevant and important, or that it needs to change.
Single-loop solutions are mostly obvious, while double-loop solutions are more unexpected and controversial (Verheijden, 2010). Cartwright (2002) explains the difference of single-loop and double-loop based on the thermostat of a house:" Single-loop learning is about achieving a given temperature, like a thermostat set to 68 degrees that turns up the heat whenever the temperature drops below 68 (the objective). Double-loop learning involves changing the setting of the thermostat (i.e. changing the objective of the system)" (Cartwright, 2002, p. 68).

Double-loop learning, and thus change of objectives/framework is a very important aspect for the learning process. One must go further than controlling certain actions (single-loop learning). It is necessary to discuss the underlying basis/framework. This can also be a very useful method of learning for the safety-region Friesland and VR Academie. We already pointed out five possible reasons. The last reason is:

Not learning via the double-loop learning method

5.3. Conclusion

We can conclude that there are many theories with regarding to evaluating and learning. The theories that are used for this research are just the tip of the iceberg. These theories are chosen because they have the most relevance for this research. According to this literature, there are six possible reasons for the phenomenon that the evaluation process lacks impact on the learning process. These reasons are:

- Not evaluating via the participatory evaluating method
- Seeing the evaluation as the final part of the process
- The absence of drivers & enablers
- Insufficient motivation
- Absence of experience based learning
- Not learning via the double-loop learning method

<u>Not evaluating via the participatory learning method</u>
Participatory learning is one of the reasons. This is because this approach involves the stakeholders and participants. By doing this, this approach has the advantage that it improves the program performance and it sustains organizational learning and growth (Sette, 2015).

<u>Seeing the evaluation as a the final part of the process</u>
The second reason is to see evaluation the final part of the process. It often occurs that an evaluation report is seen as the end of a process. In order to learn from evaluations, it is important the output of the evaluations is used as the input for the design phase of the follow-up project. Like Helvetas (2015) is arguing: "A project evaluation is an integral part of project implementation in work and is a key moment for learning and change".

<u>The absence of drivers & enablers</u>
The third reason is the absence of drivers & enablers. It is important for the safety-region Friesland that the organization has drivers and enablers because those persons have positive influence on the learning process, and an eventual process of change.

Insufficient motivation
The fourth reason is insufficient motivation. It depends on the motivation whether an individual, and therefore an organization, is willing and able to learn. People with a learning goal, are willing to learn and their motivation is much more useful.
So for an organization like the safety-region Friesland it is important to recruit volunteers, which live up to mastery/learning goals.

Absence of experience based learning
The fifth reason is absence of EBL. An organization can only learn, when the individuals inside the organization, also learn. The best type of learning for both organizational and individual learning is learning based on experience. EBL is also very important for this research. This research is about the impact on the learning process via training in crisis management and the evaluations of those training rounds. So they work with the assumption that individuals have to learn from experiences.

Double-loop learning
The reason is not learning via the double-loop learning method. Double loop learning is about discussing the fundamental base of chosen strategies, organizations, and actions. Double-loop learning helps the participants to get insight in their actions, and in the causes of changes. With more insight they are better able to learn and to accept the changes. To make the most out of the learning process it is important to go further than controlling the actions (single-loop learning). It is necessary to discuss the underlying basis/framework.

These theories and accompanying reasons are seen as the leading theories for the continuation of this research. During the answering of the sub-questions and the research question this literature plays an important role. Before going to the answering of the questions, we first discuss the methodology that is used.

6 Methodology

This chapter describes the methodology of this research. It describes what kind of research is conducted, it further describes the unit of analysis, the method of data collection and the way the data is analysed. In short, this chapter describes the whole structure of the research.

6.1. Research design

This research is evaluating the held exercise- and evaluation process of all the exercises. By exploring those exercise- and evaluation processes, this research aims to determine if it is the case that the chosen way of exercising and evaluating is not sufficient capable to let (individuals inside) the crisis organization learn. This research further aims on giving possible reasons for this phenomenon.

There are two kinds of scientific research, namely quantitative and qualitative. A scientific research aims to:

- Find answers to a question;
- Use a predefined set of procedures to answer the question,
- Collects evidence;
- Produce findings that were not determined in advance;
- Produce findings that are applicable beyond the immediate boundaries of study.

Qualitative research differs from quantitative research because additionally, it seeks to understand a given problem or topic from the perspectives of the local population it involves. Qualitative research is especially effective in obtaining culturally specific information about the values, opinions, behaviours, and social contexts of particular populations (Family Health International). Qualitative research gives insights in the "human" side of a subject (Family Health International). This kind of research is mostly used in political science. Methods for qualitative research are for example, interviews and case studies. This research is non-numerical and exploratory. It tries to explain a phenomenon with the help of theories and evaluation reports. This means that this research is qualitative.

The method of research (evaluating the exercise- and evaluating process) will be a meta-evaluation. Also known as review evaluation.
Meta-evaluation can be used to gather findings from a series of evaluations. These findings include a judgement about the quality of the series of evaluations (Ministry of Foreign Affairs Denmark, 2004). According to Stufflebeam (2000, as cited in Olsen & O'Reilly 2011) meta-evaluation is: "the process of delineating, obtaining, and applying descriptive information and judgemental information – about the utility, feasibility, propriety, and accuracy of an evaluation and its systematic nature, competent conduct, integrity/honesty, respectfulness, and social responsibility – to guide the evaluation and/or report its strengths and weaknesses".

This research is not about testing theories, and not about developing theories. The aim of this research is to use theories to describe and explain the phenomenon that stands central in this research question: the possible lack of impact of the evaluation. And how can this impact be strengthened? Meta-evaluation is the best method to describe this phenomenon. The data that stands central in this research is a series of evaluations. With meta-evaluation, this research attempts to draw lessons from those eighteen different evaluations. By studying literature and the evaluation reports, this meta-evaluation wants to offer descriptive and judgemental information about the evaluation process.

The theories in the theoretical framework are used to give more insight in the process of evaluating and learning. These insights are coupled with evaluating, as an expertise. This is done, with the intention to explain why evaluations are insufficient capable to support people in their learning process.

The meta-evaluation that is conducted for this research is based on 18 evaluations about 18 exercises. These evaluation reports are bundled in 9 evaluation reports. It is further based on desk studies and literature searches. This means that this meta-evaluation study is performed through a document study (the first phase of this research). The literature that is studied via this document study forms the basis of the theoretical framework. This framework is used to line out different theories that are important in the fields of evaluation and learning to give one more insight in the learning- and evaluation process. These theories will be related to the collected data. The second part of the study consists of collecting the data. This means collecting the evaluation reports of crises exercises from the last two years in the municipalities in the safety-region Friesland. The third part of the study consists of analysing the data. To apply this into practice, the evaluations reports of the municipalities will be investigated. Which characteristics or a mix of characteristics are applying to the evaluation reports. The final part of this study is describing the phenomenon based on the analysed data, and used theories, answering the sub questions and finally formulating a conclusion about the central question.

6.2. Validity

Important parts of social science are the aspects validity and reliability. Measurement instruments must be valid and reliable. Reliability is a key condition for validity, but it does not mean that reliability guarantees validity. Shortly said is validity about the meaningfulness of research components (Drost, 2011). Are researchers measuring what they are intended to measure? That is the central question that can describe the validity of a study. This question can never be answered with 100% certainty, but the researchers can develop support for the validity of their research (Bollen, 1989, as cited in Drost, 2011). There are four types of validity. These are: statistical conclusion validity, internal validity, construct validity and external validity. The types that are relevant for this research are: internal validity and external validity. Internal validity is about the question whether or not a certain relationship is a causal one. The second type of validity, external validity is describing to which extend a causal relationship between x and y is generalizable across persons, settings and times.

Internal validity is about the question whether or not a certain relationship is a causal one. Are the presences of some reasons, really the reason why evaluation reports are insufficient capable to guide people towards more framework-accepted actions? The combination of using theories and examining the data ensures the internal validity. When theories deliver possible reasons for the phenomenon, and it turns out that one or two reasons are applicable for the evaluation reports, it can be concluded that there is causality between those reasons and the occurring phenomenon.

External validity is about generalising the research across persons, settings and times. This is also called generalizability. External validity is important because based on that, one can determine if the outcomes of this research are useful for other circumstances. 100% generalizability is not possible for this research, because we had to deal with specific characteristics of, in this case, evaluation reports from the municipalities inside the safety-region Friesland.
The population is not composed in a way that the characteristics and protocols of every safety-region and municipality in the Netherlands, are represented. This does not mean that this research is not generalizable at all. The theories which have been used in order to reach the conclusions are relevant for a broader audience. These theories are applicable for every safety-region, municipality and even commercial organizations.

So the external validity of the theories, upon which the conclusions are based, is fine. Other municipalities, in other safety-regions are working with other methods and protocols. These methods and protocols differ in detail. In general, however this sample is representative for the other safety-regions and municipalities. So in small details, this research is not generalizable across other safety-regions municipalities and settings. In general however, the researched aspects are also applicable for other circumstances.

6.3. Reliability

"Reliability is the extent to which measurements are repeatable – when different persons performs the measurements, on different occasions, under different conditions, with supposedly alternative instruments which measure the same thing" (Drost, 2011, p. 106). This research is executed via document-analysis. A distinction can be made between analysing books and scientific articles to gather theories on the one hand, and on the other hand analysing the evaluation reports. Analysing books and articles is done to gather static information about learning and evaluation. This way of document-analysis is reliable. The analysis of the evaluation reports has as footnote that judging about the evaluation report is bounded by a person's norms, values and way of judging. Another researcher can use other norms, values and judgements. So this can differ on little parts. The overall conclusion on the evaluation reports however, is not influenced by little differences in norms, values and judgements. This in combination with the static theories from the articles and books makes this research reliable.

7 Findings

In this chapter the results of the research will be presented. This chapter is based on the four sub questions, and answers them. The documents that are studied are evaluation reports of crisis exercises held in the safety-region Friesland. The documents date from the year 2014 and 2015. With the answers on the sub questions, in chapter 8 the conclusion on the research question can be formulated.

7.1. Sub question 1

7.1.1. The exercises

On the 17th of March 2014 VR Academie started with a training cycle for two years in the safety-region Friesland. These training in crisis management are organized to train the actors in the regional pool for 'team bevolkingszorg'. Like is mentioned in the background chapter, the regional pool is a group of 30 volunteers. These volunteers are employees from the municipalities inside the safety-region Friesland. The tasks they fulfil for the 'team bevolkingszorg' is not their core business. These trainings and exercises are essential to develop their knowledge and skills. The whole organization of 'team bevolkingszorg' has participated in this training cycle. So the 'leader team bevolkingszorg', the heads of the task organizations, the team-leaders and the employees are subject of these exercises and evaluations.

Because 'team bevolkingszorg' will be formed out of a pool of 30 persons, the composition of the teams is not the same every exercise. Every person however, is trained several times. Twelve exercises (over 6 days) were held in 2014. 6 exercises (over 3 days) are held in 2015. The morning exercise had a scenario A, the afternoon exercise a scenario B. therefore in 2014, six times scenario A is used and six times scenario B. For 2015 two new scenarios were created. Again three times scenario A is used, and three times scenario B. The four different scenarios are put together as followed:

Scenario A (2014) Box 2:

Het incident zal zich afspelen tijdens het bevrijdingsfestival Fryslân in Leeuwarden Het gaat dan om maandag 5 mei 2014. Het gaat hierbij om een GRIP 2 situatie.

Meteo: Zuidwesten wind, Windkracht 2, Regenachtig, +11 graden Celsius

Op maandag 5 mei om 14.33 rijdt een tankwagen met melk over de Stationsweg richting het westen. Ter hoogte van de Baljéestraat, ziet een fietser, die de stationsweg oversteekt en de Baljéestraat in wil fietsen, de vrachtwagen compleet over het hoofd. De chauffeur van de wagen probeert nog uit te wijken, maar kan een aanrijding niet voorkomen. De tankwagen boort zich in de gevel van restaurant/bar TAO. De tank scheurt open en de 34.000 liter melk stroomt naar buiten.

Het restaurant zit op het moment van het ongeval helemaal vol. Onder deze bezoekers zit een grote delegatie van het bestuur van het Bevrijdingsfestival Fryslân. Het bestuur had een laatste overleg om de avond probleemloos te laten verlopen. Het evenement is al de hele dag aan de gang.

Scenario B (2014) Box 3:

Het incident zal zich afspelen tijdens het bevrijdingsfestival Fryslân in Leeuwarden Het gaat dan om maandag 5 mei 2014. Het gaat hierbij om een GRIP 2 situatie.

Zuidwesten, windkracht 7, windstoten tot 100 km/h, regenachtig +10 graden celsius

Op maandag 5 mei om 14.33, op het Oldehoofsterkerkhof in Leeuwarden is het bevrijdingsfestival aan de gang. Als gevolg van een hevige storm, met onweer, is een deel van het hoofdpodium van het evenement ingestort. Ook is de bliksem ingeslagen in de aggregaat. Door de aanhoudende storm bestaat het risico dat de rest van het podium het ook begeeft.
De aggregaat die getroffen is door de bliksem, loopt op diesel. De diesel ontsnapt. Vanaf de middag had de beveiliging van het evenement al last van een groep beschonken jongens. De instorting van het podium, is “de druppel die de emmer doet overlopen” en deze jongens slaan door. De chaos is compleet.

Scenario A (2015) Box 4:

Het incident speelt zich op in de gemeente Oosterwolde. Het is donderdag 5 maart 2015, 9.00 uur. Na overleg met de Operationeel Leider is er door de burgemeester opgeschaald naar GRIP 3.

Meteo
Zuid-Oost, windkracht 4, ±12 graden Celsius

In een grote loods, aan de Houtwal 27, op het industrieterrein van Oosterwolde is vanochtend vroeg een zeer grote brand ontstaan. Het gaan om het bedrijf Buisman’s Veem bv.

Het pand moet volgens de brandweer als verloren worden beschouwd, daarnaast is er een reële kans op overslag naar de naastgelegen panden.
Er waren in de loods explosies, vermoedelijk van gasflessen, die tot in de wijde omtrek te horen waren. Ook is er asbest vrijgekomen, daarom heeft de politie een ruim gebied rond de brand afgezet.
Vanwege de enorme (zwarte) rookontwikkeling is de aangrenzende woonwijk ontruimd. Overige inwoners moeten ramen en deuren dicht houden in verband met de vele rook, die richting de stad trekt.

Al snel blijkt dat de asbestverspreiding groter is dan aanvankelijk werd gedacht. Dit betekent dat de gehele wijk, inclusief het winkelgebied is afgezet. Mensen mogen het gebied wel verlaten, maar voorlopig niet meer in. De verwachting is dat het schoonmaken zo’n twee dagen zal duren. Het ROT heeft de opdracht gegeven aan de stafsecties en het TBz om een plan te maken over de voortgang van het incident. Wanneer mogen bewoners weer terug, wanneer kunnen de winkels weer open?

Scenario B (2015) Box 5:

Het incident speelt zich af in de gemeente Oosterwolde. Het is donderdag 5 maart 2015, 13.30 uur. Na overleg met de Operationeel Leider is er door de burgemeester opgeschaald naar GRIP 3.

Meteo
Zuid-Oost, windkracht 3, ±12 graden Celsius

Op de N381, ter hoogte van de gemeente Oosterwolde, heeft een ernstig ongeluk plaatsgevonden tussen een vrachtwagen en een tankwagen die zoutzuur vervoerde.

Bij Oosterwolde lekt de tankwagen zoutzuur. De automobilisten erachter staan precies in de baan van de vrijkomende gifwolk.
Zoutzuur, de waterige oplossing van het gas waterstofchloride, is een gevaarlijke stof. Bij aanraken kan het de huid aantasten en brandwonden veroorzaken, ogen en luchtwegen irriteren en als het ingeslikt wordt, tast het de keel en slokdarm aan. Bij contact met metalen kan corrosie optreden en kan het uiterst ontvlambaar waterstofgas worden gevormd.

Hulpdiensten zijn bezig met het evacueren en opvangen van de automobilisten. Ambulances zijn ook ter plaatse om mensen die zich onwel voelen na te kijken.
NL-Alert en WAS zijn in de omgeving afgegaan en omwonenden moeten ramen en deuren gesloten houden, ventilatie zoveel mogelijk uitzetten en binnen blijven. Het ROT heeft opdracht gegeven een plan aan te maken om bewoners aan de oostkant van de N381 te evacueren. De gaswolk verspreidt zich over de grond door de gemeente en kan zich gaan ophopen in de woningen. Verwachting is dat de omgeving in een straal van 500 meter geëvacueerd moeten worden. Meetploegen van de brandweer zijn druk bezig om metingen te verrichten, om het gebied met gevaarlijke concentraties in kaart te brengen.

7.1.2. The objectives, goals and evaluation reports

The training cycle knew several objectives:

- Practicing the format of the meetings between the ‘leader team bevolkingszorg’ and the heads of the task organizations;
- Giving commands/information resulting from the meeting between the heads of the task organizations towards the team leaders;
- Executing the received tasks;
- Judge the quality of the resulting products;
- Offer enough training possibilities for the actors.

Furthermore the evaluation report had its own goals:

- Determine the quality of 'team bevolkingszorg' and its actions;
- Identify certain points of attention inside the crisis management organization so that the municipalities and the safety-region can make improvements in their system,

During the exercises observers observed the participants. Every task organization, and the 'leader team bevolkingszorg' had its own observer (so a total of 6 observers). To determine the quality of 'team bevolkingszorg' and its actions, the observers paid attention on the following points of attention:

- Cooperation inside the team;
- Cooperation with other teams;
- Formulating clear actions/agreements;
- Techniques/disciplines for the meetings;
- Knowledge of organization, systems and tasks.

The composition of the team of observers is not equal for every exercise. Planning the same observers for 18 exercises over two years is almost impossible. VR Academie did a very good job on this. Most of the exercises the observers were the same. Only three observers are replaced for another person during the training cycle. This means that 97,2% of the observers was equal. The observers did not fill in a scoring- or checklist but they wrote down their observations in short bullets. These bullets were meant as input for the evaluation report. After two hours and thirty minutes the exercise is stopped. Shortly after the exercises, there was a very brief moment (15 minutes) to exchange experiences.

The observers send their observations to 'VR Academie'. There, all the observations put together to write the evaluation report. In total there are 9 evaluation reports with evaluations of 18 exercises. The evaluation reports were sent to the safety-region Friesland, with the goal to improve their 'team bevolkingszorg'. One of the evaluation reports is added in the attachments.

7.1.3. This set-up translated to the theories

This set-up of the training in crisis management can be translated to some theories that are handled in chapter 5 (theoretical framework). If we do so, the following can be concluded: the set-up that is chosen by VR Academie (in consultation with the safety-region Friesland) shows aspects of the following theories:

- Single-loop learning;
- Conventional way of evaluating;
- Evaluation as the final part of a process;
- Experience based learning.

<u>Single-loop learning</u>

The chosen way of organizing those training processes is largely based on the single-loop learning method. The objectives of the exercises, the points of attention of the evaluation process, and the way of formulating the observations are all focusing mainly on the control of the participant's actions in order to achieve their goals. When they see a deviation in some actions they want to control these actions in the right direction. During the observations, the evaluators sometimes take the role as coach. They guided the participants in the right directions. In the evaluation reports the observations and recommendations are written down to guide the people toward the right actions.

Some citations: “ensure awareness with LCMS, and make sure that also other team members know the credentials”, “always start with a round of introduction and a division of tasks after everybody has arrived”, “tasks must always be executed, when an colleague is missing make sure he/she is replaced”, and “make sure that external persons get to work fast and effective, welcome them and guide them in a strange environment” (VR Academie, 2014) (VR Academie, 2014) (VR Academie, 2015).

Conventional way of evaluating

The team of observers are all free-lances that are hired by VR Academie. As an external observer they wrote down their observations in short bullets. There was a very short moment after the exercise (15 minutes) to exchange experiences. The observations were delivered to VR Academie. They wrote the evaluation report and send this to the safety-region Friesland.
These are all important elements that can be related to the conventional way of evaluating. According to the literature some characteristics of the conventional way are:

- Data collection and preparing final reports by professional evaluators and outside experts;
- No important information that only participants/stakeholders can provide
- The final-product is more a product from the outside instead of a jointly produced report.

Evaluating as the final part of the process

This research focuses on the impact on the learning process of evaluation reports during 2014 & 2015. In that period it appeared that the safety-region Friesland sees an evaluation as the final part of a process. When VR Academie in 2014 was asked (for the first time in that region) to organize those exercises in crisis management, they had carte blanche when formulating the goals and objectives. The safety-region Friesland did not delivered any input deriving from previous exercises. The same happened in 2015. The output from the evaluations of 2014, are not used as input for the new scenarios. The goals and objectives also remained the same. This shows us that it is indeed the case that the safety-region Friesland sees evaluating as closure of a process.

Experience based learning

The main goal that is formulated in the evaluation reports shows that the set-up can be related to experience based learning. Literally the evaluation report says: “the goal of these exercises is to let the participants experience the aspects that occur inside the crisis management organization”. This means that, with the current set-up they are trying to let the participants learn via experience.

7.1.4. Conclusion

This paragraph gives answer on the following sub question:

How did VR Academie organize and evaluate the training in crisis management in 2014 & 2015 in the safety-region Friesland?

The training in crisis management that is organized in 2014 and 2015 had as goal to train the actors in the regional pool for ‘team bevolkingszorg’. This is a regional group of 30 volunteers. The tasks they fulfil inside this ‘team bevolkingszorg’ are not their core business so these trainings are essential to develop their knowledge and skills. The team in this training process consists out of: the ‘leader team bevolkingszorg’, the heads of the task organizations, the team-leaders and the employees. In 2014 twelve exercises are held, and in 2015 6 exercises are held. In those two years four scenarios are handled, namely morning scenario (2014), an afternoon scenario (2014), a morning scenario (2015) and an afternoon scenario (2015).

These training processes knew several objectives:

- Practicing the format of the meetings between the 'leader team bevolkingszorg' and the heads of the task organizations;
- Giving commands/information resulting from the meeting between the heads of the task organizations towards the team leaders;
- Executing the received tasks;
- Judge the quality of the resulting products;
- Offer enough training possibilities for the actors.

The evaluation reports are written to determine the quality of 'team bevolkingszorg' and to identify points of attentions inside the crisis management organization. These evaluation reports are written based the observations from the observers. Every task organization had its own observer. They paid attention on the following fields:

- Cooperation inside the team;
- Cooperation with other teams;
- Formulating clear actions/agreements;
- Techniques/disciplines for the meetings;
- Knowledge of organization, systems and tasks.

The observers wrote down their observations in short bullets. Shortly after the exercise there was a very brief moment (15 minutes) to exchange experiences. All the observations are put together. 9 evaluation reports with evaluations of 18 exercises are produced.

If we relate the chosen set-up to the theory, the following relations can be found:

- Single-loop learning;
- Conventional way of evaluating;
- Evaluation as the final part of a process;
- Experience based learning.

The chosen set-up is largely based on the single-loop learning method. It uses the conventional way of evaluating, and it sees the evaluation as the final part of the process. The goal of these exercises is based on experience-based learning. The goal is literally: "the goal of these exercises is to let the participants experience the aspects that occur inside the crisis management organization".

7.2. Sub question 2

Evaluating and evaluation reports are (in an ideal case) considered as an important tool for the learning process. It seems however that evaluating and the evaluation reports that are conducted in the safety-region Friesland do not motivate individuals and organizations, to learn from the observed mistakes. Is it indeed the case that actors in the crisis management organization do not learn? Or is this phenomenon not applicable to the exercise-cycle in the safety-region Friesland and is the impact of the evaluation reports on the participants sufficient?

Like is mentioned before, evaluating is a continue process. It seems however, from past experiences, that the safety-region Friesland sees an evaluation report as the end of a process. This is the opposite of seeing evaluating as a continue process. When you see the evaluation report as the final station, it is not possible to define the right problems in the future. Defining the right problems is essential to provide the right learning points. Because the safety-region Friesland did not provide certain learning points, they did not provide any valuable input deriving from previous trainings. The training cycle that stands central in this research is a stand-alone process. It is not a result from previous training cycles. To increase the value of this training cycle, it was wise if the safety-region Friesland had provided the most important learning points from previous exercises and evaluations. Because this is not the case, VR Academie had carte blanche when they formulated these objectives. These objectives, however, are not randomly chosen, but derive from leading function profiles like “GROOT-GROOTER” and “Bevolkingszorg op orde”.

The impact of the evaluation reports will be determined based on the findings with regarding to the 5 objectives:

- Cooperation inside the team;
- Cooperation with other teams;
- Formulating clear actions/agreements;
- Techniques/disciplines for the meetings
- Knowledge of organization, systems and tasks.

The first three tables show different objectives of the exercise in the rows. For the columns the different evaluation reports are filled in. For every objective and evaluation report different signs can be filled in:

- -- : The certain objective is highly insufficient present
- - : The certain objective is insufficient present
- +/- : The certain objective is meanly present
- + : The certain objective is sufficient present
- ++ : The certain objective is good present

The evaluation reports are created as following: six different teams are practiced and evaluated. For these six different teams, the same objectives were formulated. The six teams are: “team bevolkingszorg”, “omgevingszorg”, “publieke zorg”, “communicatie”, “informatie” & “ondersteuning”. The average performance of all the teams on the different objectives is taken, and represents the performance of the whole organization in the certain exercise. How the teams have performed over the 18 exercises is presented in table 4 till 6.

	E:12014A	E:12014B	E:22014A	E:22014B	E:32014A	E:32014B
Cooperation inside the team	+	+	+/-	+/-	+	+/-
Cooperation with other teams	+/-	+/-	+/-	+/-	+/-	+/-
Formulating clear actions/agreements	+/-	+/-	+/-	+	+/-	+/-
Techniques/disciplines for the meetings	+/-	+/-	+/-	+/-	+/-	+/-
Knowledge of organization, systems and tasks	-	+/-	+/-	+/-	+/-	+/-

Table 4. Performance table 1/3

	E:42014A	E:42014B	E:52014A	E:52014B	E:62014A	E:62014B
Cooperation inside the team	+/-	+	+/-	+/-	+/-	+/-
Cooperation with other teams	-	+/-	+	+/-	+/-	+/-
Formulating clear actions/agreements	+/-	+/-	+	+/-	+/-	+/-
Techniques/disciplines for the meetings	+/-	+/-	+/-	+/-	+/-	+/-
Knowledge of organization, systems and tasks	+/-	+/-	+/-	+/-	+/-	+/-

Table 5. Performance table 2/3

	E:12015A	E:12015B	E:22015A	E:22015B	E:32015A	E:32015B
Cooperation inside the team	+	+/-	+/-	+	+	+
Cooperation with other teams	+	+	+/-	+/-	+/-	+/-
Formulating clear actions/agreements	+/-	+/-	+/-	+/-	+/-	+/-
Techniques/disciplines for the meetings	+/-	+/-	+/-	+/-	+/-	+/-
Knowledge of organization, systems and tasks	+/-	+/-	+/-	+	+/-	+/-

Table 6. Performance table 3/3

In general, the tables show that the performance of the teams stays the same. On some moments it seems that the performance of the whole organization increase, and on other moments it could appear that the performance is decreasing. Seen over the whole two years, and all of the exercises it can be stated that the performance of the team is stagnating at the same level. They did not develop themselves in cooping with manageable issues. Table 7 shows the difference of the performances on the six objectives of the first exercise (conducted at the 17th of March 2014) and the last exercise (conducted at the 8th of October 2015). The last column shows the progress. If the box is red, there is a decrease in performance. An orange box indicates that the performance stays the same. Green indicates an increase in the performance.

	E:12014a	E:32015B	Progress
Cooperation inside the team	+	+	
Cooperation with other teams	+/-	+/-	
Formulating clear actions/agreements	+/-	+/-	
Techniques/disciplines for the meetings	+/-	+/-	
Knowledge of organization, systems and tasks	-	+/-	

Table 7 Overview of performances

One can see that on the first five objectives, the performance of the organization stays the same. Only on the last objective, - knowledge of organization, systems and tasks – an increase of the performance is discovered. The performance went from insufficient present, to meanly present. 5 objectives out of 6 that are not improved, this given, makes clear that in general, the organization does not learn from the crisis exercises and the accompanying evaluation reports.

7.2.1. Conclusion

This paragraph gives an answer on the second sub question:

> *What impact did the evaluation reports of the training in crisis management in 2014 & 2015 in the safety-region Friesland have on its participants?*

The three tables, that are showing all the eighteen evaluation reports and the five learning objectives of the exercises, are indicating that in general the individuals and therefore also the organizations do not learn from the exercises and the evaluation reports. The three tables show a relatively stable level of performance on the six objectives. At some points, the performance is lower, and at some points the performance is higher. The average however, does not increase or decrease. Table 7 shows the difference between the first exercise in 2014, and the last exercise in 2015. The performance does indeed not increase or decrease for the first five objectives. A small increase can be observed on the last objective. So it can be concluded that the impact of the evaluation reports of the training in crisis management had no or little impact on the participants and their learning process.

7.3. Sub question 3

The previous chapter has shown us that the chosen method of evaluation lacks impact. It seems that individuals and the organization do not develop improvements on the formulated objectives. Much scientific research is already done on the fields of evaluating and learning. In the theoretical framework are possible underlying reasons displayed for the fact that this way of evaluating lacks impact. It is important to state again that this research sees the content of the reports as a given and does not question the professional quality of the content. The theories are mainly used to give possible causes for the lack of impact with this way of evaluating. Those reasons will be explained in this paragraph. This paragraph will show that the cause can lie by the participants, by the organization, or by the way the evaluation process is conducted. All these reasons are briefly explained and discussed in general. After that I argue whether or not, they are applicable for the safety-region Friesland. This is displayed in the separated text boxes with the following symbols:

- ✓ : Applicable
- X : Not applicable
- ? : Cannot be determined

Motivation

In general:

Despite the fact that this research focus mostly on organizational learning, individual learning cannot be ignored. The knowledge that individuals obtain, are essential for organizational learning. Before moving on to the important aspects that influence organizational learning, the aspects that influence individual learning are handled. *Motivation* is one of the aspects. If there is sufficient motivation, the learning process will be positively improved. The presence of sufficient motivation can be translated to so-called mastery goals (learning goals). People who chase these goals are willing to learn and develop. When there is a lack of motivation, people reject the process of learning and developing, or the people chase so called performance goals. With these goals people are willing to outperform others.

In Friesland:

Like is mentioned earlier, the composition of the crisis organization is different every exercise. This has also consequences for the observation regarding to the motivation of the actors. The average tendency shows that the motivation of the participants is good and high. They are eager to fulfil their tasks. A few citations of the evaluation reports are: “everybody executed their tasks well and enthusiastic”, “later in the exercise, the team became more active and enthusiastic”, “the team started expeditiously”, “the cooperation inside the teams went well”, “the actors were enthusiastic during the meetings”, “the whole team acts very pro-active”, and “the members of the team were very motivated and eager to learn” (VR Academie, 2014) (VR Academie, 2015). These citations emphasize that the motivation of the participants, in general, is sufficient. However, not every person or team is that enthusiastic and positive. There are also other citations traceable in the reports. For example: “the performance of the team was insufficient and in the beginning there was some resistance”, “there was a reactive attitude in the team”, “in the beginning the wait and see attitude was very present”, and “the team seems to show: it is only an exercise, it is not that important” (VR Academie, 2015) (VR Academie, 2014). These citations show that in some cases, motivation of the participants is not sufficient. However, the negative citations were rare, and the positive citations are more dominant present. So in general, with a few exceptions, the motivation of the actors is right and sufficient, and therefore is insufficient motivation not one of the reasons.

Insufficient motivation:
X

Experience based learning

In general:

Another important aspect that can positively affect individual learning is *experience-based learning* (EBL). Experiences are playing a central role in the learning process. The person experiences something. Then he or she is going to reflect his experience. Thereafter they draw a conclusion and learn from the experience. The next time they end up in a similar situation, they can practice what is learned from the past experience. If an organization is able to use those experiences of the individuals to change their processes, than one can speak about successful learning.

In Friesland:

Experience based learning (EBL) is one of the important aspects that can positive influence individual learning. Participating in an exercise does always mean that you experience certain aspects belonging to the exercise. However, this does not mean that EBL learning is always applicable by an exercise. The form and tone of an exercise plays an important role. The form and tone of evaluation depends on the goal of the exercise. An exercise can have a testing characteristic, it can have a develop characteristic, or it can have an experiencing characteristic. The main goal that is formulated in the evaluation reports shows that the last characteristic (experiencing) is applicable. Literally the report says: "the goal of these exercises is to let the participants experience the aspects that occur inside the crisis management organization". This means that learning based on experiences is one of the present aspects. Therefore is absence of EBL not one of the reasons.

Absence of experience based learning:
X

Drivers & enablers

In general:

Like is mentioned above, individual learning is essential input for organizational learning. However, individual learning is not a guarantee for organizational learning. There are also important aspects that must be present in order to learn as an organization. One of those aspects is *the presence of drivers and enablers.* These are essential if an organization wants to learn. Drivers are persons who initiate organizational learning inside an organization. Factors that give the opportunity for successful organizational learning are called the enablers.

In Friesland:

An essential aspect for organizational learning is the presence of drivers and enablers. Drivers are persons who initiate organizational learning inside an organization. Factors that give the opportunity for successful organizational learning are called the enablers. On the moment of writing it cannot be determined to what extend the municipalities in the safety-region Friesland have drivers and enablers in their environment. Based on the evaluation reports of the last exercise, it can be concluded that the organization is at the same level of competence as the first exercise. There are also no noteworthy changes observed. This however does not mean that there are no drivers or enablers present. They initiated the 18 exercises with the goal to let the participants learn. They also asked VR Academie to conduct evaluations and to write reports of their findings. This can suggest the presence of a learning environment (enabler).

The presence of persons who initiate learning is not clear at this moment. It is possible that there aren't any drivers, but it is also possible that there are some. Perhaps the organization or their superiors do not support them. Therefore, absence of drivers and enablers as one of the reasons is not clear at this moment.

The absence of drivers & enablers:
?

Deming Cycle

In general:

The quality assurance system is a method to assure quality. In order to assure the quality of a process over, and over again, the actors in this process have to adapt and learn constantly. According to Deming (Averson, 1998) a certain process must be analysed and measured to assure the quality of the output. An interesting tool effectuate this, is the circle or Deming or plan, do, check, act circle. To value the quality of the output, the check phase is useful (evaluating). In line with learning from evaluations, it can be stated that the presence of the act phase from the circle of Deming, is essential for an organization's learning process.

Two important aspects of the act phase are, according to the theories important for the impact and the learning process. These reasons are*: seeing evaluating as part of a continuous process* and *making evaluating (the check-phase) participatory*. The circle of Deming works with the assumption that evaluation is not the end of a process. The outcomes of the check-phase are used as input for the plan-phase. In practice this is not always the case though. The way the check-phase is organized (conventional vs. participatory) can also be an important reason for the lack of impact.

In Friesland:

The fact that the eighteen exercises are observed and evaluated indicates that the check phase is present. It seems however, from past experiences and the training process that stands central in this research, that the safety-region Friesland sees an evaluation as the end of the process. The training cycle that stands central in this research is a stand-alone process. It is not a result from previous training cycles. VR Academie had carte blanche they formulated the learning objectives of this training process. They were also not involved in the previous training cycles so assurance of the learning points from those previous trainings is the responsibility of the safety-region Friesland. The learning-objectives that are used in 2014 are the same that are used in 2015. This means that they did not adjust the learning points because of insights they gathered in 2014. Because of this, it is unlikely that the findings of these evaluations are used as input for the future. This means that it can be stated that seeing the evaluation as the final part of the process is applicable for the safety-region Friesland.

Seeing the evaluation as the final part of the process:
✓

Like is mentioned before, there are also different ways to organize evaluations (the check phase). For these exercises and evaluation reports, VR Academie decided to observe the participants with an observer for each team. With the input of those observations, evaluation reports are created. In those reports VR Academie proposes some recommendations to improve the crisis management organization. This way of evaluating can be seen as the conventional way of evaluating. The participatory way of evaluating is the counterpart of the conventional way.

The participatory way works with the assumption that it is important, for the impact of the findings, to come together with the stakeholders and participants to these findings. This can be arranged in many forms. One of these forms is to putting the observers and the participants together in one room and evaluate by discussion and interaction. Discuss the findings, underlying ideas and beliefs and ask why they handled like they did. However, VR Academie did not choose for this interactive way of evaluating. They choose for the conventional way. Downside of the conventional method is that the company gives a value judgement over actors without consulting them. The participatory way of evaluation, with consulting the participants and clients can create more apprehension and support for the suggested recommendations. Those recommendations would be more a collective product, instead of recommendations from outsiders. The latter one is now the result. Collective recommendations are more likely to be implemented. Shortly it can be concluded that not evaluating via the participatory evaluating method is applicable for Friesland.

Not evaluating via the participatory evaluating method:
✓

Single-loop – and double-loop learning

In general:

It can also occur that learning and accompanying changes are negative received by the actors in the process. In order to take this problem away, the nature of these changes must be pointed out to the actors. *Learning via the double-loop method* is therefore important. When an organization is capable of double-loop learning, then this means that the organization can discuss the fundamental base of certain strategies, procedures and protocols. Double-loop learning means that actors in the process think more deeply about the occurring problems. Their actions in the past are analyzed. These analyses give the actors more insight in why they have to learn different things. With this extra insight they are motivated extra to develop the new necessary skills and knowledge.

In Friesland:

The last important aspect of organizational learning is learning via the double-loop method. Cartwright (2002) explains the difference of single-loop and double-loop based on the thermostat of a house:" Single-loop learning is about achieving a given temperature, like a thermostat set to 68 degrees that turns up the heat whenever the temperature drops below 68 (the objective). Double-loop learning involves changing the setting of the thermostat (i.e. changing the objective of the system)" (Cartwright, 2002, p. 68). The evaluation reports describe certain goals of the exercise. Besides that, every exercise had its observations and recommendations. Looking at the way the goals, observations and recommendations are formulated; the evaluation report is mostly aimed at single-loop learning. They want to correct and guide the participants to the right direction. This is emphasized by the following citations: "ensure awareness with LCMS, and make sure that also other team members know the credentials", "always start with a round of introduction and a division of tasks after everybody has arrived", "tasks must always be executed, when an colleague is missing make sure he/she is replaced", and "make sure that external persons get to work fast and effective, welcome them and guide them in a strange environment" (VR Academie, 2014) (VR Academie, 2014) (VR Academie, 2015). This emphasizes that this is way of evaluating is based on steering people to the right direction (single-loop learning). There are no examples available that work via the double-loop learning principal. Therefore it can be concluded that the double-loop learning aspect is missing in these 18 evaluation reports.

Not learning via the double-loop learning method:
✓

Concluding

When putting the information above together, it can be concluded that individual learning is essential input for organizational learning. Important aspects which positively influence individual learning are the right motivation, and learning via experience. These aspects are therefore also important input for organizational learning. Important aspects for organizational learning are: seeing evaluating as an on-going process, the presence of drivers & enablers, the presence of the check phase via the participatory method and learning via the double-loop method. When putting al these aspects together, an organization can successfully engage in the learning process.

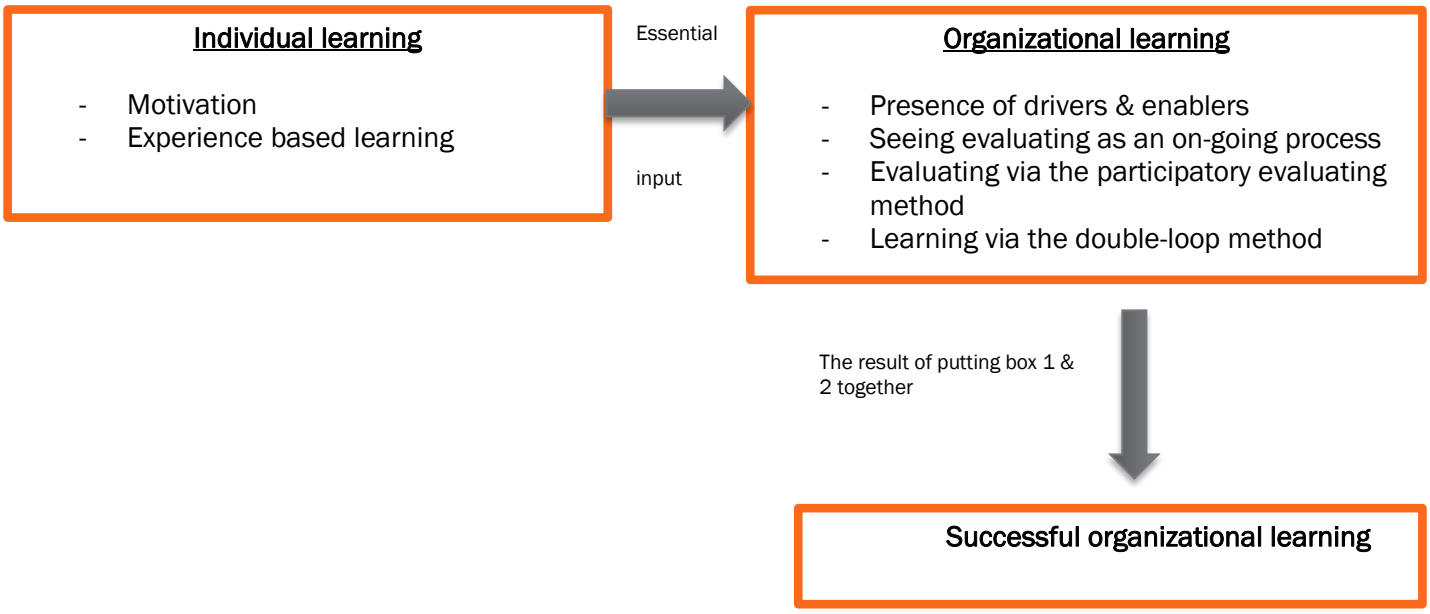


Fig 9. Successful organizational learning

If we compare the set-up (way of evaluating & the chosen learning method) of the exercises in the safety-region Friesland to the literature, than the following can be concluded. According to the literature, a good learning process is created, among other things, with three key elements: participatory evaluation, evaluation as a continue process, and double-loop learning. The chosen set-up for the safety-region Friesland is actually the opposite this. They organize the training with the focus on single-loop learning. They used the conventional way of evaluating instead of the participatory way. And as last, they see the evaluation as the final part of the process.

So the chosen set-up lacks on the following aspects:

- It focuses on detecting deviation in actions, and it tries to control the participants towards the right directions, instead of discussing/thinking about the underlying ideas of the fundaments, strategies, actions, and organizations.
- An external actor now writes the evaluation report. Also the observations come from people outside the organization. According to the literature, it is positive for the learning process when the stakeholders and participants are involved in the whole process. Than the final report is more a jointly product.

- And finally, this set-up does not use the output of evaluations as input for the next exercises. The literature gives us that it is important for the learning process to use the learning points of previous exercises as a fundamental base for the following exercises.

7.3.1. Conclusion

This paragraph gives answer to the following sub question:

> *What might be the causes, according to the scientific literature, that this method of evaluation lack impact?*

The aspects, which are important for the learning process, can be grouped under both individual learning and organizational learning. Enough motivation, and learning via experience positively influences individual learning. Seeing evaluating as an on-going process, the presence of drivers & enablers, the presence of the check phase via participatory learning, and learning via the double-loop method are aspects which positive influence organizational learning. Individual learning however, is essential input for organizational learning. So motivation and experience-based learning are also important for organizational learning.

Summarizing all of the aspects, gives the following overview:

- Insufficient motivation
- Absence of experience based learning
- The absence of drivers & enablers
- Seeing evaluating as the final part of the process
- Not evaluating via the participatory evaluating method
- Not learning via the double-loop learning method

In the next table, all the possible reasons are listed. For every reason, is indicated if it is applicable or not. It is also indicated if a clear conclusion cannot be given.

Possible causes:	Applicable	Not applicable	Not clear
• Insufficient motivation		X	
• Absence of experience based learning		X	
• The absence of drivers & enablers			?
• Seeing evaluating as the final part of the process.	✓		
• Not evaluating via the participatory evaluating method	✓		
• Not learning via the double-loop learning method	✓		

Table 8. The eight reasons

The safety-region Friesland sees the evaluation phase as the final part of the process. So this can be one of the causes why their method of evaluating lacks impact. This set-up does not use the output of evaluations as input for the next exercises. The literature gives us that it is important for the learning process to use the learning points of previous exercises as a fundamental base for the following exercises.

Based on the examined documents, a clear conclusion about the absence of drivers and enablers cannot be given. Therefore it is not clear at this point, if the absence of drivers and enablers is a possible cause for the lack of impact. Closely related to the presence of drivers and enablers, is the presence of the check-phase of the PDCA cycle from Deming.

Based on the exercises and evaluation reports it can be concluded that the check phase is present via the conventional method. This means that the cause: not evaluating via the participatory evaluation method is applicable for the evaluations that are subject to this research. An external actor now writes the evaluation report. Also the observations come from people outside the organization. According to the literature, it is positive for the learning process when the stakeholders and participants are involved in the whole process. This makes the final report a more jointly product.

The last possible reason can be that, the whole crisis and evaluation process is not organized to learn via the double-loop learning method. This method is essential for an individual and for an organization to learn. Based on the examined evaluation reports, it can be concluded that these reports focus on detecting deviation in actions, and they try to control the participants towards the right directions, instead of discussing/thinking about the underlying ideas of the fundaments, strategies, actions, and organizations. Therefore it can be concluded that absence of the double-loop learning method is definitely one of the reasons why evaluation reports are insufficient helpful.

The reasons that are labelled as uncertain (presence of drivers and enablers) will not be further discussed by sub question 4. The uncertainty is too high, and this possibly can influence the conclusion of sub question 4. A quick overview shows that there are three possible reasons, according to the literature and compared to the practice, for explaining why the chosen way of evaluating lacks impact. These reasons are: seeing evaluating as the end station of a process, using the conventional way of evaluating & not learning via the double-loop learning method.

7.4. Sub question 4

So based on the previous chapter, it can be concluded that there are three possible reasons why this way of evaluating lacks impact on the learning process. These reasons are: seeing evaluating as the end station of a process, the way of organizing the check phase and the absence of learning via the double-loop method. In this paragraph three different scenarios will be described. These three scenarios' describes three different methods of organizing exercises with an accompanying evaluation process. Characteristics as well as resulting effects will be aligned.

7.4.1. Scenario 1:

The client asks the VR Academie to organize trainings in crisis management. One of the agreements is that these trainings will be evaluated and that t VR Academie comes with recommendations. The coaching organization organizes those training moments and they also make available, a team of observers. These observers observe the different teams in the crisis management organization. They write down what went wrong, and they give advises how the participants have to act, to make sure they do it right next time. These findings are reported to the coaching organization. They bundle those observations and make some conclusions. This bundle of observations with accompanying recommendations is sent as an evaluation report towards the client.

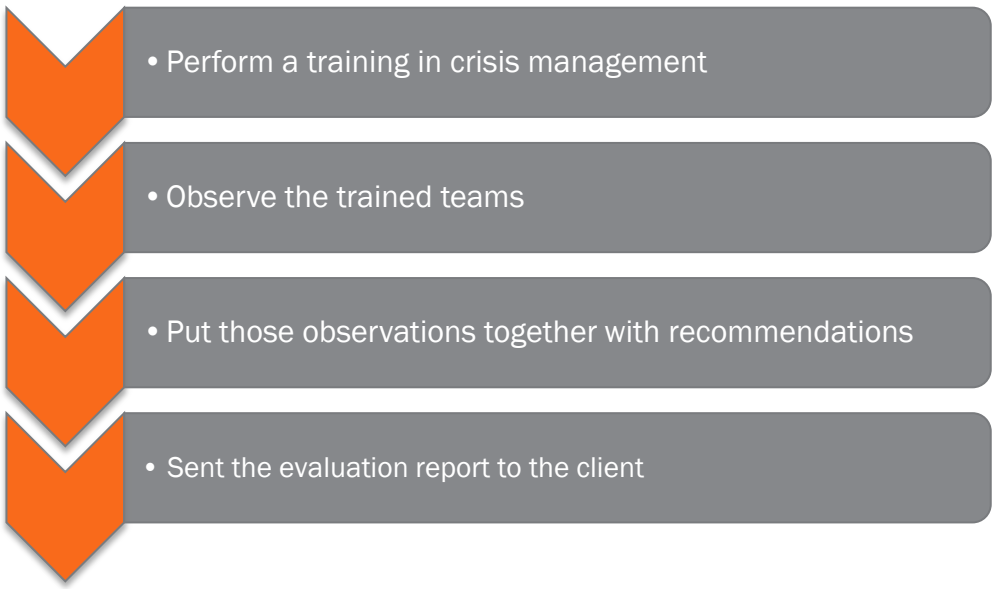


Fig. 10 Scenario 1

7.4.2. Scenario 2:

The client asks VR Academie to organize trainings in crisis management. One of the agreements is that these trainings will be evaluated and that VR Academie comes with recommendations. The coaching organization organizes those training moments and they also make available, a team of observers. These observers observe the different teams in the crisis management organization. When the exercise is over, the observers plan a moment with the observed team. Important is to take the time so that he can share his findings and gives the participants the possibility to comment on that. Discuss with the participants why they did their actions as they did. Focus on underlying ideas and fundaments. Do not send them in the right direction, but let them see why they went wrong. The outcomes of this discussion together with the observations are reported to VR Academie. They bundle those observations and make some conclusions. This bundle of observations with accompanying recommendations is sent as an evaluation report towards the client.

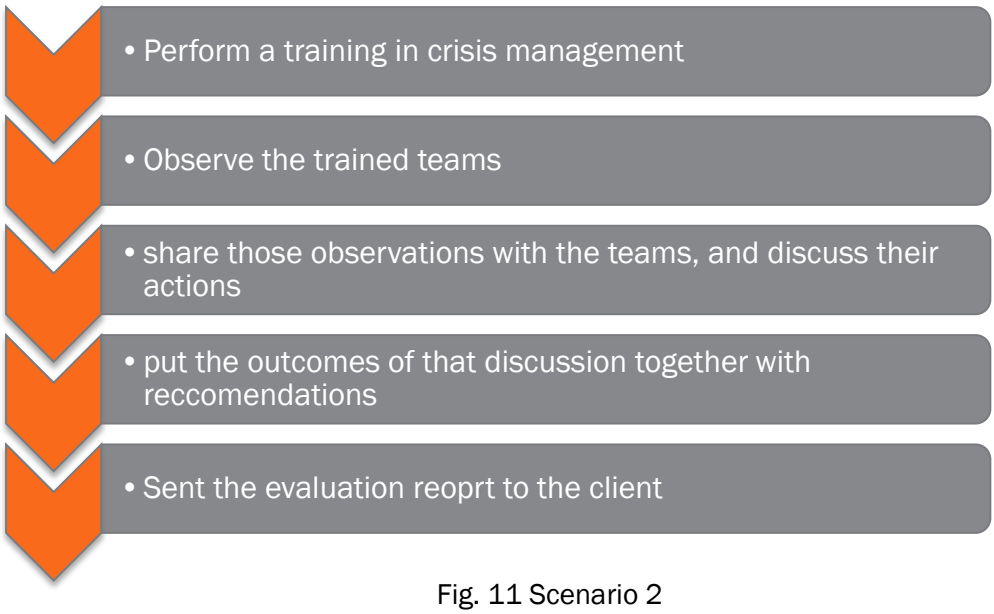


Fig. 11 Scenario 2

7.4.3. Scenario 3:

The client asks VR Academie to organize trainings in crisis management. One of the agreements is that these trainings will be evaluated and that VR Academie comes with recommendations. The coaching organization organizes those training moments and they also make available, a team of observers. These observers observe the different teams in the crisis management organization. When the exercise is over, the observers plan a moment with the observed team. Important is to take the time so that he can share his findings and gives the participants the possibility to comment on that. Discuss with the participants why they did their actions as they did. Focus on underlying ideas and fundaments. Do not send them in the right direction, but let them see why they went wrong. The outcomes of this discussion together with the observations are reported to VR Academie. They bundle those observations and make some conclusions. This bundle of observations with accompanying recommendations is presented to the client. Together they discuss a plan of action to implement the recommendations. During that process, VR Academie supports the client with implementation. They also support the client with the securing of the learning points. This to make sure that evaluating is used as a continue process and not as closure of a project. Those learning points can function as input of the following training process. A way to support the client in this is to develop a sort database were all the information and data is saved and accessible for all the partners.

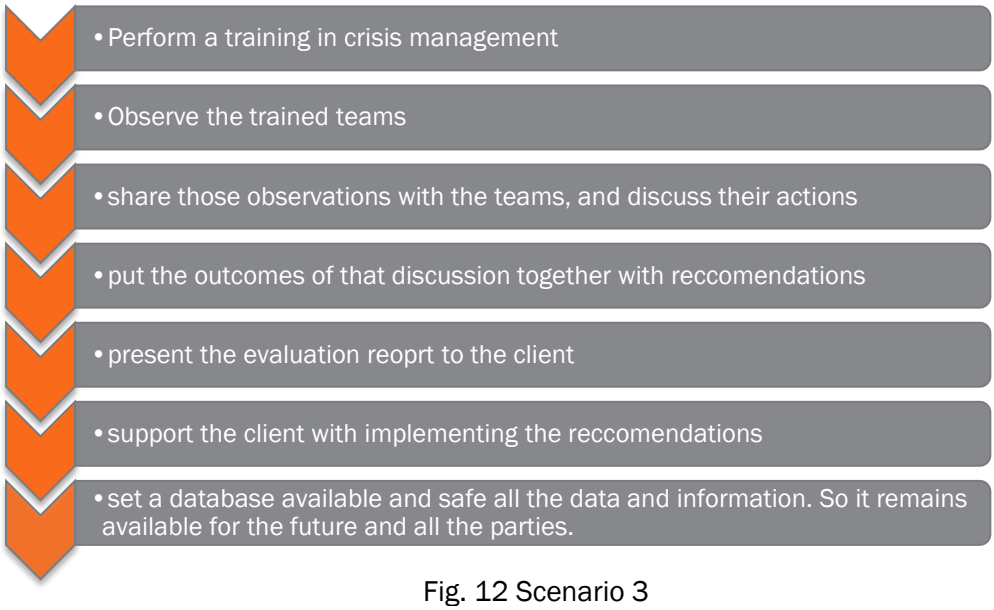


Fig. 12 Scenario 3

These scenarios differ from each other on different aspects: how to organize the evaluating phase (evaluating as a continue process, and the way of evaluating) and the way of learning (double-loop vs. single loop learning).

7.4.4. The aspects in relation with the scenarios

Evaluating as the end of a process vs. evaluating as a continue process

Scenario 1 is the scenario that is the closest related to the process that VR Academie has chosen for the training cycle in Friesland. It is not 100% corresponding with scenario 1 because VR Academie did organize a very short moment to give the participants feedback. Fifteen minutes for this moment is to short though. Like is mentioned before, the evaluating process can be seen and organized in different forms. In scenario 1 it is the case that evaluating is seen as the end of a training process by the safety-region Friesland. Scenario 2 also works with the assumption that the evaluation reports are the end of the training process. Scenario 3 differs from scenario 1 & 2. This scenario is based on the assumption that evaluating is a continue process. In this scenario the coaching organization can support the client with securing the outcomes of the evaluation reports by saving them into a database. Doing this makes it possible that evaluation outcomes and learning points can be re-used for following training processes.

Participatory evaluation vs. conventional evaluation

Besides the role of evaluations, there are also two ways of evaluating; the participatory method and the conventional way of evaluating. In the whole process of eighteen exercises and supplementary evaluation reports, VR Academie has chosen for the "conventional evaluating method. Downside of the "conventional method" is that the external persons are giving value judgements over actors. This goes without any discussion with them. The product of this way of evaluating is suggestions for implementations, which have possibly less support because they are made by an external organization. Scenario 1 is, just like the training process in the safety-region Friesland, based on the conventional way of evaluating. Scenario 2 and 3 are conducted via the participatory way of evaluating. This approach has as pros that the discussion that comes with this kind of evaluation is very informative for the participants, as well as the observers. The observers and the participators jointly discuss what went wrong, and what went well. The outflowing recommendations are collective products of the evaluation process.

Double-loop vs. single-loop learning

Scenario 1 is characterised via absence of learning via the double-loop method.
The evaluation reports are formulated to correct the actions of the participants, and points them in the right directive (single-loop learning). In this way, the participants do not think about the underlying ideas. They do not think about why something is wrong. They know in the future that a certain action is not correct, but they do not know why this is the case. The single-loop method of learning is therefore less reliable. The chance occurs that over time, participants fall back in old errors. Scenario 1 is based on observing via the single-loop learning method. Write down what went wrong, and make advises so that they do not make that mistake again.

To really learn as an organization, it is important to learn via the double-loop method. The participants think more about underlying ideas and the foundation of the organization. In scenario 2 this is already put to work with the participatory evaluating method. After the exercise the observer sits down with the team. Discuss his findings, and make the participants think about their actions, but also about the underlying ideas: what made me to act this way? Why is it wrong? What do I need to make the right action in the future? This is the first step in double-loop learning.

To stimulate double-loop learning, it is important that the client is motivated to change underlying ideas and the foundation of the organization. To get/keep them motivated it is important that VR Academie supports and advice them in the process of changing. Therefore, scenario 3 differs from scenario 2. In scenario 3 the client is supported by the coaching organization during the implementation process. Thinking about underlying ideas and fundaments is important for double-loop learning. Using the conclusions that arise from this is more important for successful double loop learning. Also the continuous character of scenario 3 is important for double-loop learning. The learning points of the evaluation can be used to re-organize, and as input for, the next training processes. So the evaluations are not use to guide people towards the right actions, but to re-organize the organization and underlying assumptions with a (new) adapted training session.

7.4.5. Recommended actions

Based on the scenarios and aspects that stand above the following actions can be recommended:

- See evaluating as a continuous process and not as the final stage of the process;
- Make the findings and recommendations a jointly product with the participatory way of evaluating;
- Discuss the underlying ideas and beliefs of actions and structures and adjust them where necessary with the double-learning method.

7.4.6. Conclusion

This paragraph gives answer on the fourth sub-question:

> *Which actions can be taken to improve the impact of evaluation of training in crisis management by VR Academie?*

Based on the theories and the descriptions that stand above it can be concluded that scenario 1 has the least impact. Seeing evaluating as the end of a training process, evaluating via the conventional method, and using single-loop learning is according to different theories not an ideal combination if you want that evaluations have high impact on the learning process. Scenario 2 has more impact than scenario 1. Scenario 2 still sees the evaluation reports as the end of a training process. Using the participatory way of evaluating, and a cautious start with double-loop learning (by discussing underlying ideas and beliefs in the discussion) makes it that the evaluation reports have a higher impact than scenario 1. Scenario 3 is, however, the most ideal scenario. In this scenario evaluating is seen as a continuous process. This is supported by the coaching organization by making a database available where the information and learning points can be saved. In the future this data can be used as input for the following training processes. Besides this aspect, scenario 3 also works with the participatory method and the double-loop learning method. Shortly it can be concluded that the following actions can be taken to improve the impact of evaluation of training in crisis management:

- See evaluating as a continuous process and not as the final stage of the process

VR Academie can support the safety-region in this process by helping them to implement the recommendations, and by offering them a sort of database where all the data/plans can be stored. This makes them accessible in the future.

- Make the findings and recommendations a jointly product with the participatory way of evaluating;

VR Academie can organize this in different ways: involve the participants and stakeholders during the design-phase (writing scenarios and setting goals), involve them during the executing-phase (let them co-observe), and involve them during the evaluation phase (organize a meeting after the exercise to exchange experiences and discuss about the observations).

- Discuss the underlying ideas and beliefs of actions and structures and adjust them where necessary with the double-learning method.

VR Academie can introduce double-loop learning in the following ways: discuss the findings, and make the participants think about their actions, but also about the underlying ideas: what made me to act this way? Why is it wrong? What do I need to make the right action in the future? This is the first step in double-loop learning. The second step towards double-loop learning is to motivate the client to change underlying ideas and the foundation of the organization. To get them motivated it is important that VR Academie supports and advice them in the process of changing. Use the learning points to adjust the organization, strategies, and future trainings.

8 Conclusion

This chapter is about answering the research question that stands central in this research. The input for the conclusion on the research question comes from the answers on the four sub questions.

How did VR Academie evaluate the training in crisis management conducted in the safety-region Friesland and how can the impact of the resulting recommendations be strengthened?

The training in crisis management that is organized in 2014 and 2015 had as goal to train the actors in the regional pool for 'team bevolkingszorg'. During the exercises observers observed the participants. Every task organization and the 'leader team bevolkingszorg' had its own observer. This means that six observers were watching the exercise. VR Academie requested them to pay attention on the following points:

- Cooperation inside the team;
- Cooperation with other teams;
- Formulating clear actions/agreements;
- Techniques/disciplines for the meetings;
- Knowledge of organization, systems and tasks.

The observers wrote down their observations in short bullets. Shortly after the exercise there was a very brief moment (15 minutes) to exchange experiences. The composition of the team of observers was not equal for every exercise. Three observers are replaced for another person during the training cycle. This means that 97,2% of the observers was equal. The observers send their observations to 'VR Academie'. There, all the observations put together to an evaluation report. In total there are 9 evaluation reports with evaluations of 18 exercises. The evaluation reports were sent to the safety-region Friesland, with the goal to improve their 'team bevolkingszorg'. These evaluation reports are written to determine the quality of 'team bevolkingszorg' and to identify points of attentions.

If we compare this way of evaluating with the theories in the theoretical framework, the following can be concluded. This way of evaluating shows big similarities with the following theories: experience based learning, single-loop learning, the conventional way of evaluating, and evaluation as the final part of a process. The theoretical framework provided us also six possible reasons for the lack of impact of evaluation reports on the learning process. These six reasons are:

Possible causes:	Applicable	Not applicable	Not clear
• Insufficient motivation		X	
• Absence of experience based learning		X	
• The absence of drivers & enablers			?
• Seeing evaluating as the final part of the process.	✓		
• Not evaluating via the participatory evaluating method	✓		
• Not learning via the double-loop learning method	✓		

We can see in the table that from those six reasons, three are applicable for the safety-region Friesland. For one reason can not be determined whether it is applicable. Before we discuss what we can do about those reasons to improve the impact of evaluations, we first discuss briefly why these reasons are applicable.

- Seeing evaluating as the final part of the process: The chosen set-up does not use the output of previous evaluations as input for the next exercises. Therefore the safety-region Friesland sees the evaluation phase as the final part of the process. So this can be one of the causes why their method of evaluating lacks impact.
- Not evaluating via the participatory method: An external actor writes the evaluation report. Also the observations come from people outside the organization. These observations are not discussed with the participants and stakeholders. Based on these observations, it can be concluded that they evaluate via the conventional method.
- Not learning via the double-loop method: This method is essential for an individual and for an organization to learn. Based on the examined evaluation reports, it can be concluded that these reports focus on detecting deviation in actions, and it tries to control the participants towards the right directions, instead of discussing/thinking about the underlying ideas of the fundaments, strategies, actions, and organizations. Therefore it can be concluded that absence of the double-loop learning method is one of the reasons that is applicable.

Based on these reasons, three scenarios are outlined in the answer on sub question 4. These scenarios differ from each other on the different aspects: how to organize the evaluating phase (evaluating as a continue process, and the way of evaluating) and the way of learning (double-loop vs. single loop learning). Without repeating the scenarios all over again the following recommendations can be made to improve the impact of evaluation of training in crisis management:

- *See evaluating as a continuous process and not as the final stage of the process*
  - *VR Academie can support the safety-region in this process by helping them to implement the recommendations, and by offering them a sort of database where all the data/plans can be stored. This makes them accessible in the future.*

- Make the findings and recommendations a jointly product with the participatory way of evaluating;
  - *VR Academie can organize this in different ways: involve the participants and stakeholders during the design-phase (writing scenarios and setting goals), involve them during the executing-phase (let them co-observe), and involve them during the evaluation phase (organize a meeting after the exercise to exchange experiences and discuss about the observations).*

- Discuss the underlying ideas and beliefs of actions and structures and adjust them where necessary with the double-learning method.
  - *VR Academie can introduce double-loop learning in the following ways: discuss the findings, and make the participants think about their actions, but also about the underlying ideas: what made me to act this way? Why is it wrong? What do I need to make the right action in the future? This is the first step in double-loop learning.*

> *To stimulate double-loop learning, it is important that the client is motivated to change underlying ideas and the foundation of the organization. To get them motivated it is important that VR Academie supports and advice them in the process of changing.* Use the learning points to adjust the organization, strategies, and future trainings.

If we summarize all the information above, the following conclusion on the research question can be formulated. The research question is split into two parts:

How did VR Academie evaluate the training in crisis management conducted in the safety-region Friesland?

The training in crisis management that are organized in 2014 and 2015 had as goal to train the actors in the regional pool for 'team bevolkingszorg'. During the exercises observers observed the participants. If we look at the evaluating process and the evaluation reports, the following methods could be discovered:

- Seeing evaluating as the final part of the process;
- Not evaluating via the participatory method;
- Not learning via the double-loop method.

And how can the impact of the resulting recommendations be strengthened?

- *See evaluating as a continuous process and not as the final stage of the process*
- Make the findings and recommendations a jointly product with the participatory way of evaluating;
- Discuss the underlying ideas and beliefs of actions and structures and adjust them where necessary with the double-learning method.

9 Reflection

9.1. Discussion

The document analysis that is performed for this research can be divided into two parts. This is being done to ensure the reliability of this research. On the one hand static input is gathered via document analysis of scientific articles, books and other sources. Theories and protocols gathered from books and scientific articles form a reliable foundation for the research. On the other hand, the evaluation reports are analysed. This is done via personal judgement, norms, and values. This means that one researcher defines something as good or wrong, while another researchers define this different. This could have a negative influence on the reliability. In order to avoid this, there is also chosen for a stabile foundation via theories and protocols out of scientific articles and books. Besides that, the value judgements of persons differ on very tiny details. This means that the general conclusion about the evaluation report will not differ if another researcher has conducted this research. Choosing the combination (static interpretation of) theories and (value judgements on) the evaluation reports ensures the internal validity. The external validity is more difficult to ensure because this research is a case study. Every case has its own characteristics. In general however, the outcomes of this research are also applicable for other safety-regions and organizations.

This research points out that there are, at least, two reasons why the evaluation reports are insufficient capable to guide people towards more framework-accepted actions. Of course there is the uncertainty on the presence of drivers, enablers and the act phase. It is possible that the two reasons, which are pointed out, are not the only two reasons. Besides that, there are many more theories to be found, but they are left out to control the scope of the research. There are many more reasons thinkable outside the scope of this research. This research gives also two recommendations to prevent this problem from happening in the future. When organizations (municipalities, safety-regions but also external organizations like VR Academie) in the future organize an exercise with an observation and evaluation process, it is wise to organize the evaluation process in an interactive way. Further they have focus the whole process on double-loop learning instead of single-loop learning. Implementing this takes time, money, and effort. It is well possible that, in these times of cuts, organizations do not have the budget to realise these recommendations. It is also not unthinkable that in the future, the focus of crisis management, evaluating or learning shifts to a whole different aspect. A result can be that there are enough budgets, time and willing to implement the recommendations, but it is not worth the effort anymore because of those shifts.

Crisis management however, remains an essential aspect of governing. And probably (thanks to all unpleasant developments, like new forms of terror, more acts of terror, and new epidemics) it becomes more important in the future. Therefore it is very important for organizations to aim for the best results. This means that, both municipalities in the safety-region and external partners must continue to develop the organizations and the skills and knowledge of the actors.

9.2. Further research

This research gives insight, for the evaluation reports of the past two years in the safety-region Friesland, which reasons are there to explain why the reports are insufficient capable to guide participants of exercises towards more framework-accepted actions in the future. In the discussion above is pointed out that there are some discussion points on this research.
Further research can help to examine the problem more extensive, or it can place this research more in context. By further research one could think of:

- *Widen the scope of the theories:* Like is mentioned, much more theories about learning and evaluating are available. In a following research the scope of the research can be taken wider. This to give insight in other theories. These theories can come with different reasons or explanations for the given problem. And therefore also with possible new solutions.
- *Execute the research over a longer period:* In this research the evaluation reports of the past two years (2014 & 2015) were subject. To take this research over more years (let's say four, or five years) it gives a more reliable answer on the question whether it is indeed the case that participants of exercises do not learn from the evaluation reports.
- *Execute the research over different municipalities from more safety*-regions: The data from this research comes only from municipalities inside the safety-region Friesland. It could be interesting to see if it is indeed the case that other safety-regions occur exactly the same problems. This also improves the external validity of the research.

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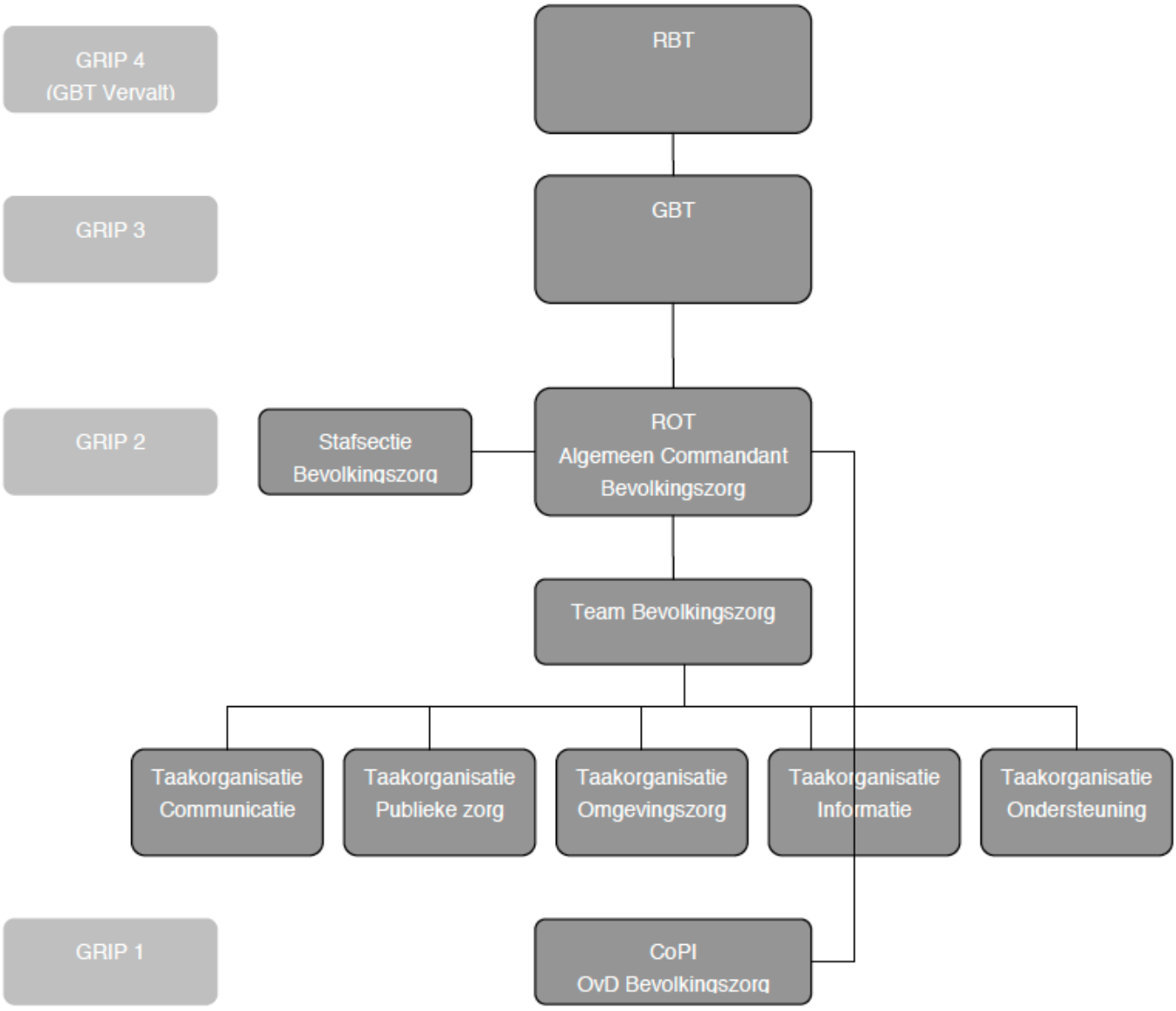
11 Appendices

11.1. Appendix one: Organogram municipality in crises-situation



11.2. Appendix two: processes of municipalities in crises-situation.

Bevolkingszorg
Processen

Communicatie	Publieke zorg	Publieke Zorg & Omgevingszorg	Informatie	Ondersteuning
Pers- en Publieksvoorlichting	Opvang	Milieubeheer	CRAS (schade)	Facilitair/ ICT
Verwanteninformatie	Verplaatsen mens en dier	Ruimtebeheer	Registreren mens en dier	Bestuursonder-steuning
	Primaire Levensbehoefte	Bouwbeheer	Interne communicatie & verslaglegging	Preparatie nafase
	Bijzondere uitvaartzorg			

11.3. Appendix three: Evaluation report 'Gemeente Heerenveen'

[OEFENING BEVOLKINGSZORG GEMEENTE HEERENVEEN]

Evaluatie van de oefening gehouden op 30 oktober 2014 in opdracht van de Veiligheidsregio Fryslân.

Waarneming & Evaluatie

Oefening Bevolkingszorg Heerenveen

Dit rapport is in opdracht van de Veiligheidsregio Fryslân tot stand gekomen. Het rapport is geschreven door V&R Academie te Heerenveen

Inhoudsopgave

1. Inleiding

In dit rapport vindt u de evaluatie van de oefening team bevolkingszorg gehouden in de gemeente Heerenveen. Dit document is opgesteld op basis van de waarnemingen die zijn gedaan tijdens de oefening op 30 oktober 2014.

1.1. Doel

Aan de oefening bevolkingszorg hebben de volgende functionarissen meegedaan: Leider Team Bevolkingszorg, Hoofden taakorganisaties, teamleiders van alle teams, medewerkers van elle teams (met uitzondering van medewerkers uitvaartzorg & opvanglocatie)

Het doel van de oefening was om de medewerkers ervaring op te laten doen met:

- Het oefenen van de vergaderstructuur tussen de Leider team bevolkingszorg en de Hoofden Taakorganisaties, en de Hoofden Taakorganisaties en teamleiders.
- Het doorzetten van opdrachten/informatie vanuit de vergadering tussen de Hoofdentaakorganisaties, naar de teamleiders. De teamleiders zetten op hun beurt de opdrachten/informatie door naar de medewerkers.
- Het uitvoeren van ontvangen opdrachten door medewerkers.
- De producten die door de medewerkers worden afgeleverd beoordelen.
- Alle deelnemers voldoende laten oefenen met de taken die hun functie bevat.

Het doel van de rapportage is om op basis van de resultaten van de oefening de aandachtspunten in de rampenorganisatie identificeren waardoor de gemeente Heerenveen en de Veiligheidsregio Fryslân verbeteringen kunnen aanbrengen in het systeem.

1.2. Scenario

1.2.1 Scenario A (Ochtend)

Het beginscenario zag er als volgt uit

> Het incident zal zich afspelen tijdens de Skoattermerke in Heerenveen. Het gaat dan om maandag 8 juni 2015. Het gaat hierbij om een GRIP 2 situatie.
>
> *Meteo: Zuidwesten wind, Windkracht 2, Regenachtig, +11 graden Celsius*
>
> Op maandag 8 juni 2015 om 13.15 rijdt een tankwagen met melk over de Rotstergaastweg richting het westen. Ter hoogte van de kruising met de Uraniumweg ziet een auto, die uit de Uraniumweg komt, de vrachtwagen compleet over het hoofd. De chauffeur van de wagen probeert nog uit te wijken, maar kan een aanrijding niet voorkomen. De tankwagen boort zich in de gevel van café De Start. De tank scheurt open en de 34.000 liter melk stroomt naar buiten.
> Het café zit op het moment van het ongeval helemaal vol. Onder deze bezoekers zit een grote delegatie van het bestuur van de Skoattermerke in Heerenveen. Het bestuur had een laatste overleg om de laatste uurtjes probleemloos te laten verlopen. Het evenement is al de hele dag aan de gang en de laatste uren zijn ingegaan. Het evenement vindt ongeveer 1 kilometer verderop plaats in de omgeving Marktweg/Kolfbaan

Het scenario kent een directe opschaling naar GRIP 2.

1.2.2 Scenario B (Middag)

Het incident zal zich afspelen tijdens de Skoattermerke in Heerenveen. Het gaat dan om maandag 8 juni 2015. Het gaat hierbij om een GRIP 2 situatie.

Zuidwesten, windkracht 7, windstoten tot 100 km/h, regenachtig +12 graden Celsius

Op maandag 8 juni 2015 om 12.15, rondom de marktweg in Heerenveen is de Skoattermerke. Als gevolg van een hevige storm, met onweer is een deel van een tent van het evenement ingestort. Ook is de bliksem ingeslagen in de aggregaat. Door de aanhoudende storm bestaat het risico dat de andere tenten het ook begeven
De aggregaat die getroffen is door de bliksem, loopt op diesel. De diesel ontsnapt. Vanaf de middag had de beveiliging van het evenement al last van een groep beschonken jongens. De instorting van de tent, is “de druppel die de emmer doet overlopen” en deze jongens slaan door. De chaos is compleet.

Het scenario kent een directe opschaling naar GRIP 2.

1.3. Wijze van waarneming en evaluatie

Tijdens de oefening zijn waarnemers aanwezig geweest die de verschillende teams van bevolkingszorg hebben waargenomen.

1.4. Leeswijzer

Hoofdstuk 2 van dit document bestaat uit een analyse van de oefening op basis van de waarnemingen. Per dagdeel worden de taakorganisaties en de Leider Team Bevolkingszorg behandeld. Er wordt een beschrijving gegeven van het verloop van de oefening. Hierbij is aandacht voor de oefendoelen die geformuleerd zijn door de veiligheidsregio Fryslân

Het document wordt besloten met conclusies en aanbevelingen in hoofdstuk 3. Per onderdeel wordt ingegaan op de conclusies die kunnen worden getrokken uit de analyse en de aanbevelingen die hier uit voortvloeien.

2. Analyse

2.1. Inleiding

De bevindingen van de oefening worden in dit hoofdstuk beschreven. Er is een verdeling gemaakt tussen het team dat in de ochtend is beoefend en het team dat in de middag is beoefend. Achtereenvolgens komen aan de orde de Leider Team Bevolkingszorg en de verschillende taakorganisaties.
Per team wordt er ingegaan op:

- Samenwerking team
- Samenwerking andere teams
- Afspraken
- Opdrachten
- Eigen taakuitvoering
- Teamwerk
- Draaiboeken
- Bijvangst

2.2. Ochtend

2.2.1. Leider Team Bevolkingszorg

Samenwerking team

Het was even weer zoeken naar de juiste ruimte in een 'vreemd' gemeentehuis. Verwacht niet een gespreid bedje 'als een vanzelfsprekendheid'.
Het is de verantwoordelijkheid van voorzitter om een vergaderagenda aan te houden. Vooral in het eerste overleg is het écht noodzakelijk om (meer dan gevoelsmatig nodig is) aandacht te besteden aan de rol- en taakverdeling van de ondersteuners en journaalschrijvers: wie doet wat m.b.t. actie- en besluitenlijst.
Voor de Hoofden TO is de rol duidelijk, maar zij hebben net als de voorzitter een verantwoordelijkheid m.b.t. het stellen van een doel voor elk overleg. Afhankelijk van beschikbare informatie, eventuele bijzonderheden en/of prioriteiten is het goed om (juist in het begin) goed af te stemmen wat de belangrijkste doelen zijn en hoeveel tijd er ongeveer voor nodig is om die te behalen.
Doordat bovenstaande (rol- en taakverdeling + doelstelling benoemen) te weinig expliciet werd uitgesproken is het team in de oefening een beetje achter de feiten aan blijven hobbelen.
Teamleden waren op tijd aanwezig en de vergaderingen duurden ook niet heel lang. Er werd ook goed naar elkaar geluisterd.
Relevante info werd gedeeld en daar ontstonden bilateraaltjes uit (wat goed is voor de teamgeest en de bereidheid om met andere taakorganisaties mee te denken).
Qua rol- en taakverdeling voor ondersteuners en/of journaalschrijvers belangrijk om aandacht te hebben voor wat 'achteraf' van belang is (verantwoording) en voor wat tijdens het plenaire overleg van belang is, bijvoorbeeld gebruik van whiteboard voor *Integrale beeld- en besluitvorming*.

Samenwerking andere teams

Met betrekking tot de samenwerking met het ROT was de pro-actieve rol van de ondersteuner Leider Team Bevolkingszorg opmerkelijk. Zowel inhoudelijk als procesmatig, dat werd als zeer prettig ervaren door het Hoofd Bevolkingszorg.

Eigen Taakuitvoering

HTO's krijgen steeds meer grip op hun eigen rollen en taken. Ze weten elkaar ook te vinden als ze elkaar nodig hebben, zowel binnen als buiten het plenaire overleg (bilateraaltjes).
Ondersteuning moest enorm wennen aan de rol/taak. Dit is een gedeelde verantwoordelijkheid van Leider en betreffende teamleden. Zoek elkaar op, maak afspraken, (werk samen). Voornamelijk als het gaat om gebruik van hulpmiddelen (laptop/I-pad, whiteboard, printers, etc.).

Teamwerk
Ondanks wat 'rommelige' overleggen en moeite met hanteren van een strakke vergaderstructuur, worden inhoudelijk goede besluiten genomen.

Draaiboeken
n.v.t.

Bijvangst
Zoals vele (zo niet alle) crisisteams te snel de inhoud van het incident ingedoken. Meer aandacht voor het groepsproces/samenwerking als team!

2.2.2. Omgevingszorg

Samenwerking team
Nadat het team elkaar gevonden heeft –de meeste medewerkers zijn niet op de hoogte van de kamerindeling- verloopt de samenwerking goed. De HTO verzoekt de medewerkers om elders te gaan zitten; hij wil uitsluitend overleg met de teamleiders. Dit creëert rust. De medewerkers ondergaan dit gelaten; ze snappen dit. Wanneer de HTO vertrekt voor het overleg, komen zij terug en gaan ze goed aan de slag. De samenwerking is goed.

Samenwerking andere teams
De HTO neemt berichten van de andere teams mee naar het overleg met de eigen taakorganisatie. Wanneer de HTO niet zelf aanwezig is, neemt geen van de teamleden contact op met andere teams. In het overleg wordt hier ook nauwelijks bij stil gestaan.

Afspraken
Het team maakt onderling goed afspraken; de HTO heeft een duidelijk beeld van wat hij verwacht van het overleg met de teamleiders. De medewerkers maken onderling afspraken over de werkzaamheden en voeren een goede, korte, discussie als ze er onderling niet uit komen.

Opdrachten
De HTO heeft een strakke lijn in de opdrachtverlening; hij geeft opdrachten door aan de teamleiders die het daarna weer verdelen. De teamleiders sturen de teams goed aan maar zij kunnen/mogen ook best eigen initiatief tonen; ga niet zitten wachten tot de teamleider iets vraagt.

Eigen Taakuitvoering
Het team functioneert goed alleen eigen initiatief is nauwelijks waar te nemen, ook niet bij de teamleiders. De opdrachten die thuis horen bij omgevingszorg worden wel goed opgepakt maar er zit winst in de tijd die het kost om ze te voltooien.

Teamwerk
Het team werkt goed samen. De medewerkers vinden het in de opzet van de oefening gek dat ze hier aanwezig zijn en niet zoals gebruikelijk 'buiten',.

Draaiboeken
De draaiboeken zijn niet gebruikt; er waren verouderde draaiboeken aanwezig.

Bijvangst
Belangrijk voor volgende oefeningen is om voor dit team operationeel (dus buiten) te oefenen, samen met het team (HTO en teamleiders) dat binnen zit.

2.2.3. Publieke zorg

Samenwerking team

De start is vrij gelaten. Medewerkers kennen soms hun rol en/of taak niet. Medewerkers helpen elkaar in het zoeken naar rol en taken door in draaiboeken op zoek te gaan naar informatie. Medewerkers zijn ook flexibel en nemen andere rol/taken op zich. Aandachtspunt voor de teamleider is wel: check of je team compleet is. Als dit niet het geval is alarmeer dan medewerkers.
Elk actiepunt dat volgt uit een overleg met de HTO publieke zorg wordt onderling verdeeld. De basis hier is de actie en besluitenlijst. Deze wordt bijgehouden door de medewerker opvanglocatie, zij zorgt ook voor een actueel overzicht van de stand van zaken t.a.v. de actiepunten.

Samenwerking andere teams

De samenwerking met andere teams was minimaal. Men wacht totdat de HTO aanwezig is en wacht besluiten en acties van de HTO af.
In de rol van coach is door de waarnemer gevraagd of zij wat verder vooruit kunnen denken wat er op de processen af komt. Het team signaleert dat er mogelijk familie naar de opkomstlocatie gaat die te woord moet worden gestaan. Op de vraag of dat misschien al met team communicatie kan worden gedeeld antwoord de teamleider opvang: ‘dat loopt via de HTO’.

Afspraken / opdrachten

De HTO had een duidelijke agenda (voor zichzelf bekend): actiepunten, stand van zaken en actiepunten benoemen. De teamleider Opvang verdeelt taken als HTO weg is.
Het team voert alleen de opdrachten van de HTO uit.

Eigen Taakuitvoering

Kennis van de eigen taakuitvoering wisselt. Een medewerker wist exact wat haar taak was. Uit navraag blijkt dat zij altijd een taakomschrijving bij zich heeft voor als ze gealarmeerd wordt. Andere medewerkers konden benoemen in welk proces zij werkzaam waren maar kenden de functie niet. Uiteindelijk is aan de hand van draaiboeken e.e.a. duidelijk geworden.
Een medewerker is twee dagen van tevoren gevraagd om deel te nemen aan de oefening. Deze had helemaal geen opleiding of ervaring maar kon op basis van eigen competenties heel goed uit de voeten met de opdracht waar het team voor stond.

Teamwerk

Er was rust in het team, mensen lieten elkaar goed uitspreken. De zaak oogde onder controle. De vraag is echter of dat echt het geval was of niet.

Draaiboeken

Draaiboeken worden gebruikt. Dit lijkt het enige houvast van mensen tijdens een oefening. De vraag is ook of de inhoud van de draaiboeken bekend was. Het leek alsof mensen soms wat verrast waren over de informatie die daar te vinden was.
Wat opviel was dat de teamleider opvang beschikte over een draaiboek en dit ook bij haar hield en medewerkers hele concrete opdrachten gaf en vervolgens contactpersoon en telefoonnummer opnoemde.
De draaiboeken waren niet beschikbaar in de ruimte. Enkele teamleiders hadden zelf het draaiboek mee.

Bijvangst

Locatie: als dit de werkruimte is van het hele team publieke zorg dan ontbreken er faciliteiten: werkruimtes etc.
Locatie is ook direct toegankelijk
Regel dat mensen van buiten worden opgevangen en weten waar ze naartoe moeten.

2.2.4. Communicatie

Samenwerking team

Het team start vanaf het eerste moment als team, er wordt geïnventariseerd wie welke rol kan vervullen en er wordt geschoven met rollen om als volwaardig team te kunnen opereren. Positief opvallend is dat een teamlid deze rol op zich neemt bij afwezigheid van het Hoofd taakorganisatie (zit op dat moment bij startvergadering TBZ). Wordt positief opgepakt door iedereen.
Leden van het team starten direct met hun werkzaamheden, voorbeeld: omgevingsanalist vraagt direct om inloggegevens voor virtuele oefenomgeving en persvoorlichter start met formuleren eerste communicatieboodschappen voor Twitter en media.
Het Hoofd Taakorganisatie en bij zijn afwezigheid de teamleider zorgen ervoor dat informatie bij alle leden van het team bekend is. Leden van het team zoeken actief contact met elkaar om informatie te delen.

Samenwerking andere teams

Het team haalt informatie uit andere teams zoals publieksnummer en locatie opvanglocatie. Kost hen alleen moeite om deze informatie boven water te krijgen. Alle besluiten lopen via TBZ en dat vertraagt in communicatie. Team zorgt er voor dat informatie ook gedeeld wordt met andere teams. Het gemis van het kunnen gebruiken van LCMS is voelbaar en zorgt voor lichte irritatie. Alle informatie die het team nodig heeft om te kunnen communiceren moet nu opgehaald worden uit TBZ of andere teams.

Afspraken / opdrachten

Afspraken worden gecheckt op kwaliteit en uitvoering. Voor iedereen is duidelijk wat een opdracht inhoudt.

Eigen Taakuitvoering

Alle leden van het team zijn bekend met hun taken en verantwoordelijkheden. Ze durven discussies aan over ontbreken snelheid bij verkrijgen van informatie door maatregel om LCMS niet meer toegankelijk te maken voor teams.
Het ruilen van rollen bij de start van de oefening levert geen problemen op. Teamleden zijn ook goed op de hoogte van de andere rollen dan waarvoor zij getraind zijn
Het team is gewend om onder druk te werken, leden zijn in staat de vele vragen die opduiken te voorzien van antwoorden. Zo wordt een foutieve incidentlocatie op nu.nl opgemerkt en gecorrigeerd.
Vanuit tegenspel ontstaat op gegeven moment druk op team om burgemeester een eerste verklaring af te laten leggen, daar wordt actief op geacteerd.
Opvallend is dat ruim anderhalf uur na de start van de oefening nog geen actieve perswoordvoering wordt opgepakt, wordt alleen gereageerd op persvragen. Wel worden in weblog en tweets feiten gecommuniceerd, onduidelijk of die voor inwoners/getroffenen zijn en/of ook voor pers.

Teamwerk

Zie ´Samenwerking team´ en ´Eigen taakuitvoering´.

Draaiboeken

Teamleden kennen hun taak goed, taak ligt veelal dicht bij normale werkzaamheden Ook als er van rol gewisseld moet worden levert dat geen probleem op. Draaiboeken hoeven nauwelijks gebruikt te worden. Slechts een keer om de juiste naamgeving van een functionaris in een andere team op te zoeken

Bijvangst

- Het niet kunnen gebruiken van LCMS in team Communicatie wordt als groot gemis gezien. Informatie die nodig is voor communicatie komt niet langzaam en met mondjesmaat binnen bij team. Vraag is ook wie nu tabblad crisiscommunicatie in LCMS vult.
- Het team moet meer aandacht besteden aan advies voor HTO-Communicatie dat hij meeneemt naar de vergadering TBZ.
- Het team moet actiever nadenken over ‘gebruik’ van burgemeester in communicatie.
- Wederom discussie over slachtofferbeeld en wat daarover te communiceren. Afspraak dat doden alleen door burgemeester mag worden gemeld moet heroverwogen worden.

- Veiligheidsregio en gemeenten zouden nog een keer naar het mandaat dat taakorganisatie Communicatie heeft moeten kijken, om te bepalen of dit voldoende is om aan de maatschappelijke vraag om informatie te kunnen voldoen.
- Veel leden van het team nemen eigen laptops en/of tablets mee, maken geen of minder gebruik van faciliteiten incidentgemeente, door het gebruik van eigen middelen wordt printen lastig.

2.2.5. Informatie

Samenwerking team

Bij de start van de oefening bestaat de taakorganisatie uit twee personen, een teamleider CRAS en een medewerker CRAS. Het lijkt alsof het niet helemaal duidelijk is wat er van ze verwacht wordt, maar na een vraag hierover van de waarnemer gaan ze actief in het draaiboek kijken om meer informatie te krijgen. Aangezien de ruimten, die normaalgesproken bestemd zijn voor de diverse taakorganisaties, zijn gewijzigd zit het team het eerste half uur te wachten totdat het Hoofd Informatie naar hen toekomt. Nadat een lijst wordt gepakt met een organogram van de crisisorganisatie blijkt dat het Hoofd Informatie in een andere ruimte zou moeten zitten. Er wordt afgesproken dat de teamleider CRAS op zoek gaat naar de juiste ruimte en de medewerker wacht op het Hoofd Informatie. Nadat de ruimte is gevonden die tijdens de oefening is bestemd voor de taakorganisatie CRAS, wordt ook de medewerker CRAS gehaald en kan worden gestart met de afstemming met het Hoofd Informatie.

Samenwerking andere teams

Doordat de teamleider CRAS ervaring heeft opgedaan bij een eerder incident (als medewerker CRAS) weet hij Salvage en het Verbond voor Verzekeraars snel te benoemen als extern deskundigen en partner. Ook weet hij dat hij contact moet leggen met de taakorganisatie publieke zorg om te weten te komen welke opvanglocatie wordt gebruikt. Daarnaast weet hij ook dat hij met de taakorganisatie omgevingszorg dat hij met hen en Salvage moet afstemmen over het eventueel slopen van gebouwen en pakt dit ook actief op. Op aangeven van het Hoofd Informatie wordt contact gezocht met de taakorganisatie communicatie over de publieksinformatie die gegeven kan worden. Vanwege het ontbreken van een medewerker SIS tijdens de oefening heeft het Hoofd Informatie afgestemd met de taakorganisatie publieke zorg, dat zij dit voor hem zullen oppakken.

Afspraken / opdrachten

Tijdens de overleggen met het Hoofd Informatie wordt geen actiepuntenlijst bijgehouden (wel een besluitenlijst) en deze wordt niet gebruikt om bij een volgend overleg te checken of alle acties zijn afgehandeld. Het Hoofd Informatie geeft wel aan ‘volgens mij zijn alle actiepunten afgehandeld’.

Eigen Taakuitvoering

Zowel de teamleider CRAS als de medewerker CRAS zijn op de hoogte van hun taken en verantwoordelijkheden, maar bij de uitoefening van deze taken lijkt het onwennig. Er is nog niet veel geoefend in deze functies, waardoor de taken nog niet ‘eigen’ zijn. Wel zijn ze pro-actief op zoek naar de wijze waarop zijn hun taken het beste kunnen uitvoeren.
Het Hoofd Informatie kent zijn rol, taken en verantwoordelijkheden redelijk goed. Hij weet dat alle relevante informatie te vinden is in LCMS, maar beseft zich niet dat de leden van het team dit niet bekend is. Daarnaast spreekt hij uit normaal gesproken alleen af te stemmen met de teamleider CRAS, maar dat hij het nu met het hele team doet. Hij geeft niet aan waarom dit het geval is en wordt voor waarheid aangenomen.

Teamwerk

Het team werkt goed samen door informatie met elkaar te delen en acties te verdelen. Er wordt goed overleg gevoerd over wat het team te doen heeft en wie wat zou kunnen betekenen. De medewerker CRAS is pro-actief door te vragen wat zij in het logboek en de besluitenlijst kan opnemen en checkt of zij het juiste heeft opgeschreven. Het team denkt gezamenlijk na over de taken die zij moeten oppakken of die zij nog verwachten.

Draaiboeken

Vanwege de verschuiving van werkruimtes wordt gedacht dat het draaiboek niet actueel is. Dit is het echter wel. Sommige informatie is niet te vinden in het draaiboek (zoals het organogram van de crisisorganisatie), maar

wordt op een andere manier opgezocht. De taakkaarten uit het draaiboek geven houvast bij het oppakken van taken.

Bijvangst
n.v.t.

2.2.6. Ondersteuning

Samenwerking team
Er was maar één teamleider aanwezig waardoor er geen sprake was van onderlinge afstemming. Wanneer de HTO terug kwam uit het TBZ dan deelde zij informatie maar inhoudelijk werd er niet gespard.

Samenwerking andere teams
Na aansturing van de waarnemer heeft de teamleider Nafase een keer contact gelegd met een ander team. Dit was het team milieu om te achterhalen wat het effect van melk is. Het contact verliep telefonisch en de uitkomst was dat melk effect heeft op het leefmilieu (bijv. vis in het water sterft door zuurstofgebrek). Deze uitkomst nam hij mee in de nafase.
De TL nafase dacht niet actief na over de wijze waarop hij informatie ging vergaren bij de andere teams over de nafase. Dit kwam enerzijds ook doordat er een algemeen e-mailadres werd geopend waar alle teams hun informatie naar toe moesten sturen.

Afspraken / opdrachten
De HTO schetst elk overleg met de Teamleider het beeld en zet vervolgens de acties uit. Daarna geeft de Teamleider aan wat zijn beeld en acties zijn. Acties werd helder geformuleerd en weggezet bij de teamleiders (in geval van Facilitair werd dit fictief weggezet). Later sloten 2 medewerkers aan die de uitgezette acties daadwerkelijk oppakte. Deze acties waren voldoende SMART geformuleerd om opgepakt te worden.
Dit overleg verliep rustig en redelijk gestructureerd. Er is geen gebruik gemaakt van de flip-over, de HTO gaf aan dat hij dit normaal wel zou doen, maar doordat er maar 1 Teamleider was, hij dit nu niet deed.

Eigen Taakuitvoering
De HTO is bekend met taak en verantwoordelijkheid. Stelt zich proactief op, neemt de leiding en stuurt de teamleider en later de 2 medewerkers aan. Aandachtspunt is nog het team nafase. De HTO stapte daar iets te makkelijk overheen waardoor de HTO de rol van nafase onderschatte. Hij focuste zich voornamelijk op ICT en facilitair, bij dit team had hij duidelijker voor ogen wat er op het team af zou komen. Voorbeeld: dit incident gaat langere tijd duren, er moet catering verzorgt worden, callcenter moet ingericht worden want er zullen veel telefoontjes komen.
De teamleider was wel bekend met rol, maar doordat er geen medewerkers aanwezig waren is geen beeld te geven van zijn functioneren in het team. Doormiddel van vragen te stellen leek hij wel een beeld te hebben. Echter, zijn visie is dat hij pas vanaf een groot incident een rol heeft, terwijl hij al eerder een rol kan hebben.

Teamwerk
Zie ‘Samenwerking team’.

Draaiboeken
Er is geen gebruik gemaakt van draaiboeken. Er is wel langs de receptie gelopen voor een draaiboek maar die wist van niets. Later bleek het draaiboek bij de bode te liggen, maar dat wisten ze niet waardoor het draaiboek niet is gebruikt.

Bijvangst
- De HTO haalt normaliter bij binnenkomst een informatiepakket op bij de receptie (draaiboek, pas, plattegrond etc.), de receptie wist echter niets. Later bleek dat de pakketten bij de bode lagen, maar dat wist de receptie niet. TIP: of bij de receptie de pakketten neerleggen of de receptie informeren waar de pakketten liggen zodat zij de HTO’s door kunnen verwijzen

- Onduidelijk is wie het callcenter aanstuurt. Is dat de Teamleider facilitair, zo ja, dan moet deze persoon ook contactgegevens tot zijn beschikking hebben om een callcenter in te richten. Zover bekend waren deze gegevens niet beschikbaar.
- Mogelijk lag het aan de beperkte bezetting qua teamleiders, maar de waarnemer miste de laag met medewerkers tijdens deze oefening (voornamelijk het ochtend deel). De Teamleider werd alleen gevoed door de HTO en had geen tegenspel vanuit zijn team. Hierdoor bleef de Teamleider een beetje passief. Door vragen te stellen hebben de deelnemers en de waarnemer het wel over het team nafase gehad, maar voor een Teamleider is het leuker om ook met zijn team te werken (tip voor een volgende oefening?).
- Behoefte aan het meelezen in LCMS. Nu was het team volledig verstoken van informatie en kreeg alleen input van de HTO.

2.3. Middag

2.3.1. Leider Team Bevolkingszorg

Samenwerking team

De leider TBZ heeft als voorzitter, op prettige en rustige wijze, een strakke vergaderagenda aangehouden. En voordat inhoudelijk op de beeld- en besluitvorming werd ingegaan zijn eerst kort de rollen toegelicht. Zeer effectief.

Samenwerking andere teams

De samenwerking met het ROT ging goed. Opvallend moment: de leider TBZ had het idee ‘de boel goed onder controle te hebben’. Al na het 2e overleg. Na het 3e overleg heeft hij bij de AC ROT gecheckt of dat in lijn is met de ervaringen en het gevoel ‘aldaar’. Dat was inderdaad zo. De leider TBZ heeft gedubbelcheckt of er niet mogelijk sprake was van een schijncontrole (hij gebruikte dat woord er ook voor). Top!

Eigen Taakuitvoering

HTO’s hadden grip op hun eigen rollen en taken en wisten elkaar ook te vinden als ze elkaar nodig hadden (middels de welbekende bilateraaltjes).
Ondersteuning moest wel wennen aan de verdeling van rollen en taken, maar door het bespreekbaar te maken kwamen ze er ‘op natuurlijke wijze’ erg goed uit. Dat is niet vaak het geval, compliment!

Teamwerk

Prima teamwerk!

Bijvangst

Het was de slotoefening van een langer oefentraject. Complimenten aan dit team, hele mooie laatste!

2.3.2. Omgevingszorg

Samenwerking team

Het team werkt zeer goed samen. Het team, inclusief medewerkers, zit volledig in de ruimte. Hierdoor lijkt het massaal maar iedereen kent zijn taak.

Samenwerking andere teams

Er is geen samenwerking met de andere teams. Bij de terugkoppeling is er ook geen sense of urgency dat dit mogelijk een toegevoegde waarde heeft, bijvoorbeeld richting communicatie. Het team gaf aan hier te weinig kennis van te hebben en dit eigenlijk een taak van de HTO te vinden. Het team had wel behoefte aan informatie over de andere teams.

Afspraken

Afspraken worden helder door de teamleiders verwoord en ieder overleg met de HTO wordt hierover teruggekoppeld. Afspraken met andere teams zijn niet gemaakt. Er is niet een duidelijke besluitenlijst waardoor de kans bestaat dat hier het overzicht in verloren raakt.

Opdrachten
De HTO komt terug met duidelijke boodschappen. Een van de teamleiders vraagt zich af waarom LCMS niet meer beschikbaar is:'…hier stond namelijk veel informatie in waardoor we al aan de slag konden met bepaalde zaken.' De teamleiders controleren uitgezette opdrachten bij medewerkers maar gaan soms zelf ook aan de slag met opdrachten. Vermoedelijk komt dit door de lokale kennis maar zij kunnen dit beter delegeren.

Eigen Taakuitvoering
De eigen taken zijn goed bekend. Het team is op elkaar ingespeeld en kent elkaars rollen. Er blijven geen zaken liggen maar dit is niet te controleren omdat er geen verslag wordt gemaakt. Alle medewerkers kennen hun rol.

Teamwerk
Het team is een geheel. Valkuil hierbij is de samenstelling; door iedereen aanwezig te laten zijn, kan het voorkomen dat er een brede discussie ontstaat. Iets dat je in deze situaties niet wilt. In deze oefening is dit echter niet gebeurd, een compliment aan het team!

Draaiboeken
De draaiboeken waren aanwezig en actueel. Echter, niet iedereen was op de hoogte van de inhoud van de draaiboeken. Ook de plaats waar de draaiboeken gevonden konden worden, is niet bekend. Belangrijk is dus dat hier regio breed dezelfde afspraken over gemaakt worden.

Bijvangst
De ruimte waar in vergaderd werd, is niet geschikt. De ruimte is al snel te warm en bevind zich in het publieksdeel van het verder afgesloten gemeentehuis. Als de HTO weg is kan de rest van het team dus niet naar andere teams of collega's toe.

2.3.3. Publieke zorg

Samenwerking team
Er vindt zeker samenwerking plaats. Teamleider primaire levensbehoeften heeft weinig te doen en ondersteunt zijn collega teamleiders. Medewerker primaire levensbehoeften ondersteunt ook waar mogelijk.
Als de druk bij teamleider vervoeren mens en dier is afgenomen vraagt hij heel nadrukkelijk aandacht voor de drukte bij de teamleider opvang en vraagt of anderen kunnen ondersteunen.
Wat opvalt is dat er weinig onderlinge afstemming is terwijl de teamleiders bij elkaar zitten. Men voert de werkzaamheden vanuit het eigen proces uit. Voorbeeld: teamleider vervoer mens en dier belt als eerste om het NRK in te schakelen met de opdracht om mensen mee te sturen met de bussen. Twee mensen per bus.
De teamleider opvang heeft het NRK nog niet ingeschakeld maar belt 1 minuut later met het NRK om ze in te zetten voor de opvanglocatie. Op dit punt was afstemming op zijn plaats geweest.

Samenwerking andere teams
Men wacht eigenlijk af totdat de HTO aanwezig is en wacht besluiten en acties af. Een van de teamleiders zoekt wel contact met ondersteuning om een kostenplaatje aan te leveren (op verzoek van HTO). Verder stelt hij voor om actief met communicatie contact te zoeken en te checken hoe e.e.a. is geregeld m.b.t. publieksinformatie. Er volgt enige discussie in het team. Uiteindelijk wordt op advies van de waarnemer besloten om geen zaken aan te nemen maar actief te checken of communicatie de persvoorlichting/publieksvoorlichting op de opvanglocatie voor elkaar heeft. Dit blijkt een goede zet want men was daar nog niet aan toe gekomen.

Afspraken / opdrachten
De HTO maakt duidelijke vergaderafspraken en hanteert duidelijk de BOB structuur.
Het lijkt er op dat de teamleiders minder/niet bekend zijn met deze structuur. Vanuit inhoud, enthousiasme en betrokkenheid wordt informatie gedeeld. Dit komt de vergaderstructuur niet ten goede.

Eigen Taakuitvoering
Niet iedere functionaris is op de hoogte van de eigen rol en taak.

Teamwerk
Niet iedere functionaris is op de hoogte van de eigen rol en taak.

Draaiboeken
Draaiboeken worden gebruikt. De een is duidelijk bekend met het draaiboek, de ander lijkt het draaiboek niet te kennen of in bezit te hebben. Uiteindelijk worden checklists en gegevens uit het draaiboek gebruikt. Men heeft zeker houvast aan het draaiboek.
Wat opviel was dat de draaiboeken niet beschikbaar waren in de ruimte. Enkele teamleiders hadden zelf het draaiboek mee.

Bijvangst
Locatie: als dit de werkruimte is van het hele team publieke zorg dan ontbreken er faciliteiten: werkruimtes etc. Locatie is ook direct toegankelijk
Regel dat mensen van buiten worden opgevangen en weten waar ze naartoe moeten.

2.3.4. Communicatie

Samenwerking team
Het team gaat vanaf het begin aan het werk als team, slechts vijf deelnemers: twee webredacteuren, twee omgevingsanalisten en HTO. Besloten wordt tot herverdeling van functies: een webredacteur wordt pers/publieksvoorlichter. De andere webredacteur wordt plv. HTO, maar kan als dat nodig is naar opvanglocatie worden gestuurd als daar behoefte aan is. Wordt niet gedacht aan aanvraag extra personeel. Contactgegevens van iedereen worden direct genoteerd, de HTO besteedt ruim tijd aan inrichten van taakorganisatie, maakt bijv. een standaardagenda.

Samenwerking andere teams
Het team zoekt actief contact met andere teams van TBZ, voorbeeld: gegevens van een huisarts die zich aanbiedt voor de opvanglocatie worden doorgegeven aan team van de opvanglocatie. Team is goed gespitst op welke activiteiten wel van het team zijn en welke niet.
Team krijgt van andere teams TBZ niet altijd met dezelfde snelheid antwoorden op hun vragen; voorbeeld: aanvraag publieksnummer wordt pas na twee uur gehonoreerd.

Afspraken / opdrachten
Briefing door HTO na vergadering TBZ gebeurt via vaste agenda, geeft rust en duidelijkheid in team. Informatie wordt met flip-over-vellen met team gedeeld. Net als in ochtendoefening lichte irritatie over het ontbreken van mogelijkheid LCMS uit te lezen.
Informatie die nodig is wordt actief uit andere teams gehaald en met de teams gedeeld.

Eigen Taakuitvoering
Het team start vrijwel direct met werkzaamheden, heeft moeite met inloggen op computersystemen incidentgemeente (al eerder in andere oefeningen geconstateerd). Enkele leden hebben eigen laptop en/of tablet bij zich, kunnen via open netwerk gemeente Heerenveen wel aan de slag.
Alle leden van het team zijn bekend met hun taken en verantwoordelijkheden. Ook na wisseling van taken bij de start van de taakorganisatie worden taken naar behoren uitgevoerd. Voor de webredacteur die plotseling de taak van pers/publieksvoorlichter moest uitvoeren was het even lastig, maar ze heeft zich meer dan goed van haar taak gekweten.
Alle leden van het team kunnen prima onder druk presteren. De taken liggen dicht bij hun normale werkzaamheden. Ook bij wisseling van taak wordt er voldoende gepresteerd.
Opmerking: team bestond slechts uit vijf leden en dat had een negatief effect op de geleverde producten, de kwaliteit van de producten (omgevingsanalyse, webteksten, tweets, Q&A's) is goed.

Teamwerk
Zie 'Samenwerking team' en 'Eigen taakuitvoering'.

Draaiboeken
Teamleden kennen hun taak goed, wordt nauwelijks gebruik gemaakt van draaiboeken.

Bijvangst
- Het niet kunnen gebruiken van LCMS in team Communicatie wordt als groot gemis gezien. Informatie die nodig is voor communicatie komt niet langzaam en met mondjesmaat binnen bij team. Vraag is ook wie nu tabblad crisiscommunicatie in LCMS vult.
- Het team moet meer aandacht besteden aan advies voor HTO-Communicatie dat hij meeneemt naar de vergadering TBZ.
- Het team moet actiever nadenken over 'gebruik' van burgemeester in communicatie.
- Wederom discussie over slachtofferbeeld en wat daarover te communiceren. Afspraak dat doden alleen door burgemeester mag worden gemeld moet heroverwogen worden.
- Veiligheidsregio en gemeenten zouden nog een keer naar het mandaat dat taakorganisatie Communicatie heeft moeten kijken, om te bepalen of dit voldoende is om aan de maatschappelijke vraag om informatie te kunnen voldoen.
- Veel leden van het team nemen eigen laptops en/of tablets mee, maken geen of minder gebruik van faciliteiten incidentgemeente, door het gebruik van eigen middelen wordt printen lastig.

2.3.5. Informatie

Samenwerking team
Bij de start van de oefening bestaat de taakorganisatie uit vijf personen, het Hoofd Informatie en vier medewerkers CRAS. Er wordt afgesproken dat één van de medewerkers de rol van teamleider op zich zal nemen. Het Hoofd Informatie geeft aan eerst naar het overleg met het Team Bevolkingszorg te gaan, zodat hij de nodige informatie kan halen.
In het team wordt duidelijk samengewerkt. Alhoewel het de leden van het team niet helemaal bekend is wat hun taken en verantwoordelijkheden zijn helpt iedereen elkaar en worden er goede vragen aan elkaar gesteld. Iedereen heeft zijn eigen beeld bij het proces CRAS en deelt dit ook. Dit leidt aan de ene kant tot enigszins overbodige discussies, maar schept ook duidelijkheid in de taken van het team. Het daadwerkelijk oppakken van acties lijdt hieronder, maar is zinvol voor het leerproces.

Samenwerking andere teams
Er wordt niet actief contact gezocht met andere functionarissen of teams. Het is de leden niet helemaal bekend wat de andere teams doen en wat hun taken en verantwoordelijkheden zijn (voor een evenementenvergunning wordt doorverwezen naar communicatie). Na tips van de waarnemer wordt het contact in het laatste half uur van de oefening wel gelegd.
Alhoewel de contacten pas aan het einde van de oefening worden opgepakt is wel helder wat ze nodig hebben van het andere team. Hier wordt ook concreet naar gevraagd. Wat er gedaan kan worden met de verkregen informatie is niet meer besproken vanwege het beëindigen van de oefening.

Afspraken / opdrachten
Tijdens de overleggen waren het Hoofd Informatie, de teamleider CRAS en alle medewerkers CRAS aanwezig. Het was duidelijk te merken dat het Hoofd Informatie voelde in tijdsnood te komen. Hij gaf dit ook duidelijk aan in het laatste overleg.
Het eerste overleg verliep enigzins rommelig, omdat er niet duidelijk sprake was van een structuur of vergaderagenda. Door het ontbreken van een actielijst en het afvinken ervan is niet duidelijk geworden of alle werkzaamheden verliepen zoals afgesproken.
Het team neemt een aantal besluiten, namelijk het registreren van schade op de incidentlocatie. Later wordt, na een tip van de waarnemer, ook besloten contact te leggen met de taakorganisaties omgevingszorg en communicatie. Er worden geen besluiten genomen over de afhandeling van het incident of de schademeldingen.

Eigen Taakuitvoering
De teamleden zijn op hoofdlijnen op de hoogte van hun taken en verantwoordelijkheden, maar zijn niet helemaal bekend met de praktische uitvoering ervan. Direct vanaf het begin worden twee medewerkers naar de incidentlocatie gestuurd om schade te registreren. Die opdracht is echter niet SMART geformuleerd en er wordt ook niet over nagedacht of dit praktisch gezien wel handig is. Daarnaast wordt geen aansluiting gevonden met de taakorganisatie publieke zorg om eventueel een loket in de opvanglocatie in te richten. Tot slot wordt besloten een schademeldpost op het gemeentehuis in te richten, maar de organisatie daarvan (wie gaat daar zitten en hoe weten mensen dit te vinden) wordt niet besproken.

Teamwerk
Zie ‘Samenwerking team’.

Draaiboeken
De draaiboeken worden grotendeels gebruikt. Voornamelijk de taakkaarten en de formats (schadeformulieren e.d.) worden tijdens de oefening erbij gepakt. Voor zover bekend zijn deze actueel.

Bijvangst
n.v.t.

2.3.6. Ondersteuning

Samenwerking team
Binnen het team wordt zeer proactief samengewerkt. De Teamleiders en adviseurs denken in afwezigheid van de HTO na over het incident. Wat betekent dit, wat gaat er op ons afkomen. In gezamenlijkheid formuleren ze vragen die ze aan de HTO willen stellen wanneer hij weer terug is om het beeld compleet te maken.
De leden hadden de neiging om soms over zaken te praten die niet hun verantwoordelijkheid waren, maar veelal corrigeerde ze elkaar waardoor de leden over juiste onderwerpen blijven praten (vb. was de bereikbaarheid van het plaats incident, al snel werd gezegd dat dit niet voor ondersteuning was).

Samenwerking andere teams
De Financiële adviseurs attendeerden de HTO op de uitgaven die door teams worden gedaan, de adviseurs vroeg of de HTO in het TBz wilde inbrengen dat elk team een overzicht van de uitgave (hoogte, opdrachtgever en wat) moeten aanleveren bij de adviseurs. Dit is ingebracht en andere teams zijn ook daadwerkelijk gaan bellen met de kosten die zij gemaakt hebben.
Team nafase was zich bewust van het feit dat informatie gehaald moest gaan worden voor het PvA, maar nam hier nog geen concrete acties op. Dit zou ze pas op een later moment, verder in het incident op gaan pakken. Wel is ze langs het team Publieke zorg gelopen om af te stemmen over een locatie die ingericht kon worden als informatiepunt. Wie hier verantwoordelijk voor was, was onduidelijk.
Door de waarnemer is aangegeven dat in de acute fase het team Pz een rol inspeelt. Zij kunnen een opvanglocatie inrichten waar tevens betrokkene van informatie kunnen worden voorzien. Wil je in de koude fase een informatiepunt, dan is het voor het team nafase. Dit heeft de TL op verzoek van het HTO afgestemd met het team Pz.
Pluspunt: HTO stimuleerde de teamleden om actief contact te leggen met andere teams om af te stemmen.

Afspraken / opdrachten
Alle leden hebben bij elkaar gezeten tijdens het overleg. Dit verliep goed. In de evaluatie kwam naar voren dat de leden nog actiever en scherper door hadden moet vragen ten aanzien van de beeldvorming. Het beeld was achteraf gezien nog onvoldoende scherp.

Eigen Taakuitvoering
Alle leden waren zich bewust van hun taak en pakte deze op. De Teamleider facilitair moest even zoeken naar de wijze waarop hij acties uit moest zetten omdat zijn medewerkers ontbraken. Dit zorgde voor wat verwarring. Maar dit kwam meer door de oefensituatie dan onwetendheid over zijn rol en verantwoordelijkheid.
De leden hadden over het algemeen voldoende scherp waar ze over gingen, maar twijfelde soms over bepaalde onderwerpen. Dus nog wat strakker in wat, hoort bij mijn team/taakorganisatie en wat bij een ander.

Teamwerk

Zie ‘Samenwerking team’.

Draaiboeken

Het merendeel van de leden had een draaiboek en heeft deze gebruikt. Met de Teamleider nafase heeft de waarnemer de stappen besproken die je moet doorlopen om tot een overdrachtsdocument te komen.
Zover bekend waren de gegevens in het draaiboek up to date. Aandachtspunt is de plattegrond die is gebruikt tijdens de oefening, deze week af van de plattegrond in het draaiboek, maar dat had waarschijnlijk te maken met de oefensituatie.

Bijvangst

- Eén van de financieel adviseurs had al zijn informatie op een iPad staan, deze informatie was alleen toegankelijk als hij internet had. Advies om in de enveloppe met de toegangspas en de inlogcode voor de computer, ook de Wi-Fi code te zetten
- Financiële adviseurs hadden de behoefte om ook te kunnen oefenen vanaf een werkplek. Nu krijgen zij informatie binnen over uitgaven, maar ze beschikten niet over een computer met e-mail om een compleet overzicht te maken.

3. Aanbevelingen

In dit hoofdstuk worden per onderdeel enkele tips/aanbevelingen gedaan. Ook hier is er weer onderscheid gemaakt in de ochtend- en middagsessie.

Allereerst zijn er twee punten die op een groot deel van het team bevolkingszorg bij beide dagdelen van toepassing waren:

- Investeer in de teamleiders: rol, taak en vergaderstructuur. Maak mensen bewust van de verantwoordelijkheid. Het kan maar zo zijn dat je midden in de nacht voor een andere gemeente op moet komen. Weet je dan hoe de alarmering van je medewerkers is geregeld (dat was zowel in de ochtend als in de middag niet duidelijk). Weet je wie er in je team zitten, weet je waar je draaiboek te vinden is etc etc.
- Zorg dat je weet welke rol en taak je hebt tijdens een crisis.

3.1. Ochtend

3.1.1. Leider Team Bevolkingszorg

- Hanteer een strakke vergaderstructuur, maak gebruik van de BOB-structuur.
- Blijf naast de inhoud van een incident, ook aandacht houden voor de onderlinge samenwerking binnen het team.

3.1.2. Omgevingszorg

- Zorg dat het team in ieder geval mee kan lezen in LCMS; dit levert tijdwinst op, zeker bij een team dat andere operationele diensten direct ondersteunt.
- Zorg dat de medewerkers weten waar ze actuele draaiboeken kunnen vinden.

3.1.3. Publieke zorg

- Zorg ook dat je weet welke teamleider(s) je hebt en zorg dat je een telefoonnummer van hen hebt. Dat voorkomt dat je ‘verloren’ staat te kijken bij wie je moet zijn en waar je heen moet ten tijde van een alarmering. Je kunt dan contact opnemen.
- Werk onderling als teamleiders van de diverse taakorganisaties meer samen. Signaleer, anticipeer en geef een terugkoppeling aan de HTO. Daardoor ontlast je de HTO en vang je zaken af die niet in het blikveld van de HTO liggen.
- Neem niet automatisch aan dat zaken binnen een ander team worden opgepakt, ook al is dat een taak van een ander team. Pak de telefoon en check of iets daadwerkelijk ook gebeurd. Voorbeeld: communicatie op de opvang. Uiteraard hoort dit bij communicatie, maar check of dit is/wordt geregeld.

3.1.4. Communicatie

- Zet sneller als actie uit wie de perswoordvoering doet en hoe dat plaatsvindt en wanneer.
- Denk na over de invulling van de functie informatiemanager/informatiecoördinator in het team. Daarbij gaat het zowel om het halen als kunnen brengen van informatie, o.a. uit LCMS.
- Creëer kaders als het gaat om het communiceren over slachtoffers door de burgemeester.

3.1.5. Informatie

- Houd een actiepuntenlijst bij en check bij ieder overleg of alle acties zijn afgehandeld.

3.1.6. Ondersteuning

- Maak duidelijk afspraken over het wel of niet openen van een (nieuw) algemeen account waar alle informatie naar toe gestuurd moet worden. Nu was het voor de teamleider niet duidelijk waar alle informatie naar toeging en daarnaast raakte het overzicht kwijt.
- Werk proactief, bedenk welke acties er op je af kunnen komen en welke je alvast kunt voorbereiden.
- Weet waar de informatiepakketten voor het team liggen, zodat je deze direct bij binnenkomst kunt ophalen. Zorg dat zowel de receptie als de bode weten waar de informatiepakketten te vinden zijn.

3.2. Middag

3.2.1. Leider Team Bevolkingszorg

- Geen aanbevelingen, prima gewerkt.

3.2.2. Omgevingszorg

- Zorg voor goede verslaglegging; dit gebeurt nu niet of is niet waarneembaar.
- Zorg voor een geschikte ruimte, dicht bij de andere teams of in ieder geval in een deel van het gemeentehuis zodat de andere teams bereikt kunnen worden.
- Laat het team meekijken in LCMS om opdrachten snel te kunnen lezen en weg te zetten.

3.2.3. Publieke zorg

- Werk zowel binnen het team met elkaar samen, als daar buiten.
- Werk proactief, wacht niet op opdrachten van de HTO.
- Zorg dat alle teamleiders bekend zijn met de BOB-structuur om de overleggen gestructureerd te laten verlopen.
- Zorg dat je weet welke rol en taak je hebt tijdens een crisis.

3.2.4 Communicatie

- Wanneer het team te klein is om het incident aan te kunnen, vraag om bijstand van extra personeel.
- Denk na over de invulling van de functie informatiemanager/informatiecoördinator in het team. Daarbij gaat het zowel om het halen als kunnen brengen van informatie, o.a. uit LCMS.
- Creëer kaders als het gaat om het communiceren over slachtoffers door de burgemeester.

3.2.5 Informatie

- Zorg dat je bekend bent met de taken van andere team.
- Werk actief samen met de andere teams, om het beeld helder te krijgen, acties uit te zetten en elkaar te ondersteunen.
- Zorg dat alle teamleiders bekend zijn met de BOB-structuur om de overleggen gestructureerd te laten verlopen.

3.2.6 Ondersteuning

- Loop actief langs teams om informatie op te halen en/of laat teams de overzichten mailen. Telefonisch kost te veel tijd.
- Vraag de HTO actief uit en schrijf dit beeld op een flip-over. Dan is het beeld eenduidig en is direct inzichtelijk waar de blinde vlekken en onduidelijkheden zitten.

4. Bijlagen

Bijlage 1

Gemeente Heerenveen
BESLUITENLIJST Team bevolkingszorg

Datum: 30 oktober 2014

Tijd: 9.00 uur

Naam notulist: Jeannette de Best paraaf notulist:
Naam voorzitter: Wieke paraaf voorzitter:

nr	onderwerp	verantwoordelijk cq door wie?	afgehandeld
1	Ongeval met tankauto, Rotstergaastweg. GRIP 2 :mensen onder puin, omgeving afgezet,veel media aanwezig, veel ramptoerisme, veel getwitterd		
2	Afzetten De Sande	Matthijs	
3	knelpunten: veel mensen vermist er moeten hekken geregeld worden	omgevingszorg, ROT	
4	Opvanglocatie moet nog geregeld worden: 50 tot 100 mensen	Jessica	Thialf
5	slachtofferhulp is opgeroepen komen naar locatie als die bekend is	Jessica	Geregeld
6	slachtofferregistratie wordt geregeld	Pier laten bellen	
7	algemeen telefoonnummer geopend 140513, er moeten twee mensen bij zitten	Tiemen	Geregeld
8	expertise staat standby,materiaal en mensen		
9	meer gegevens pand volgen + kaart	Mathijs	Geregeld
10	Melk in riool, Wetterskip benaderd	Matthijs	Is opgelost
	Sluiting: 10.15 Afspraak/tijdstip nieuwe vergadering 10.30		
	Presentielijst		

Verzonden aan: .....
.....

Gemeente Heerenveen
BESLUITENLIJST Team bevolkingszorg

Datum: 30 oktober 2014

Tijd: 10.30 uur

Naam notulist: Jeannette de Best paraaf notulist:
Naam voorzitter: Wieke paraaf voorzitter:

nr	onderwerp	verantwoordelijk cq door wie?	afgehandeld
1	Aanrijroute regelen	Jessica	is bekend
2	Opruimen gebied	Matthijs	
3	Beveiliging onbeheerde panden	Matthijs	
4	Laptop primaire levensbehoefte	Willem	Niet beschikbaar
5	Te weinig politie/middelen	Matthijs	
6	Mediabeelden	Tymen	
7	Overlast op opvanglocatie	Jessica	Schaaf regelen
8	Slachtofferregistratie navragen bij ROT	Tymen	
	Sluiting: 11.00 Afspraak/tijdstip nieuwe vergadering 11.20		
	Presentielijst		

Verzonden aan: .....

Bijlage 2

Gemeente Heerenveen

BESLUITENLIJST Team bevolkingszorg

Datum: 30 oktober 2014

Tijd: 13.15 uur

Naam notulist: Henderika Buma paraaf notulist:

Naam voorzitter: Henry Meijering paraaf voorzitter:

nr	onderwerp	verantwoordelijk cq door wie	afgehandeld
1	vervoer slachtoffers	vdb	
2	afvoeren puin	sk	
3	opvanglocatie regelen slachtoffers	vdb	
		sietse	
4	contact met ovd over aantal slactoffers	vdb	
5	callcenter opstarten, welk nr? communiceert rechtstreeks met hoofd communicatie	jan p	
6	voorbereidingen treffen locatie mbt informatievoorziening naaste familie	vdb	
7	evt afzettingen voorbereiden	sietse	
	cis opstarten aantal slachtoffers	anko	
9	constructie bouw controleren	sietse	
10	telnr ovd bevolkingszorg	vdb	
	Sluiting:13.45 Afspraak/tijdstip nieuwe vergadering : 14.10 uur		
	Presentielijst		

Verzonden aan: .....

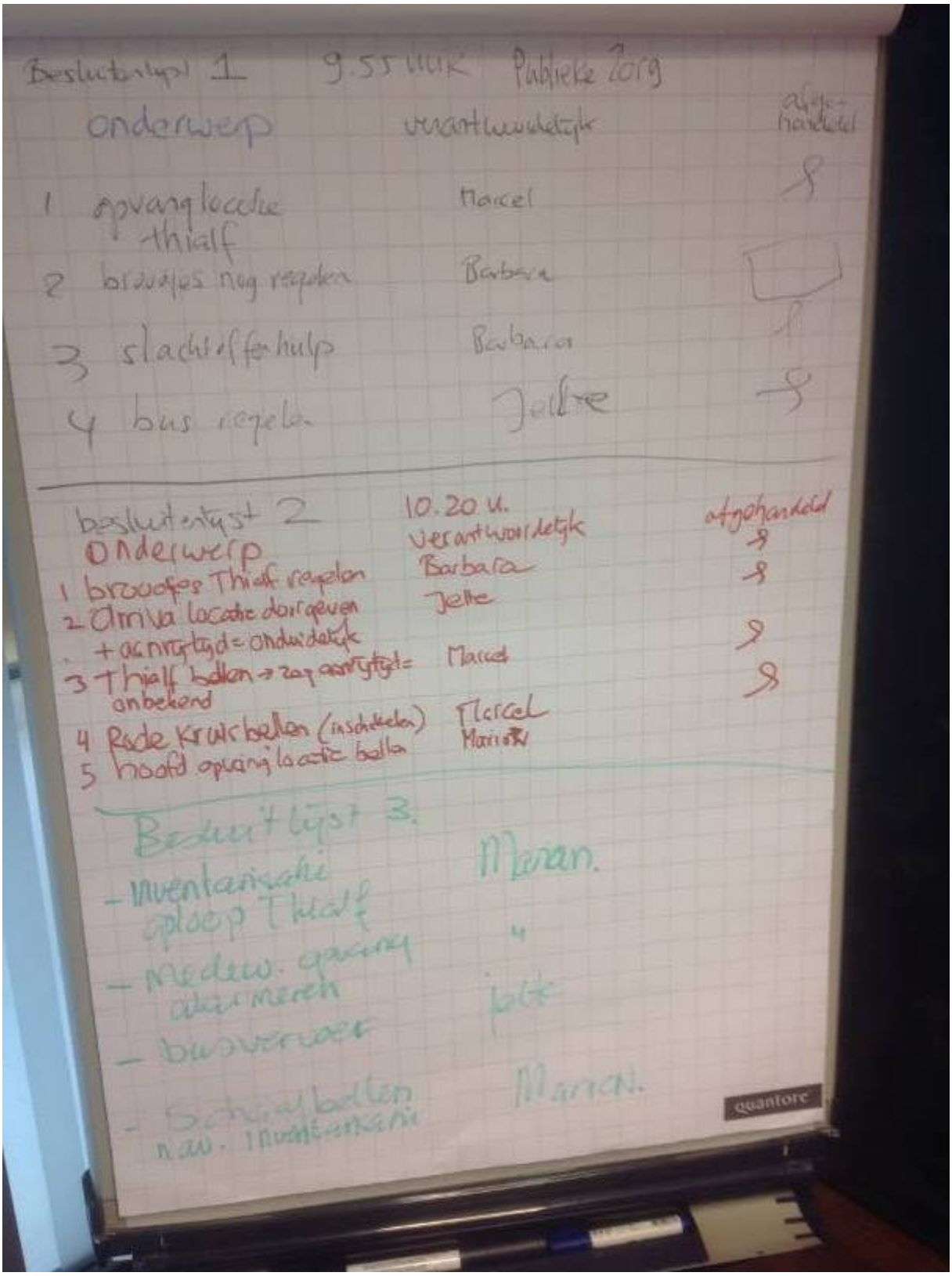
.....

	hoeveelheid diesel, wordt onderzocht gevolgen zijn minimaal
	waar kunnen mensen terecht die hulp aanbieden?
	exacte lokatie al meer duidelijkheid?
	voorbereidingen in gang zetten v persconferentie met burgemeester
	per direct een noodverordening, meenemen in overweging of t nodig is omdat burgemeester voldoende bevoegdheden heeft om t zo te regelen
	informeren bij politie wanneer terrein vrijgegeven wordt
	kosten in beeld brengen
	checken 2 dodelijke slachtoffers
	slachtofferhulp
	Sluiting: 14.30 Afspraak/tijdstip nieuwe vergadering 14.50
	Presentielijst

nr	onderwerp	verantwoordelijk cq door wie	afgehan deld
1	politie vraagt hulp bij hekken plaatsen	sietse	
2	bewakingsbedrijf vragen te helpen	sietse via de ovd	
3	verwijzing bij Thialf (slachtoffers/familie)	vdb	
4	hoe laat loco burg waar verwachten	wg komt er volgnde vergadering op terug	
5	mensen die naar thialf gaan, boos, onrust etc ; hebben we mensen nodig?	wg komt erop terug	
6	centraal nr voor schademelding?	communiceren dat mensen zich bij balie moeten melden	
7	kortdurende opvang regelen tot 23.00 uur is niet akkoord		
8	algemene nummer nog niet bekend, punt van aandacht	jp	
9	zijn er gegevens van de overledenen ivm		
	Sluiting: 15.05 Afspraak/tijdstip nieuwe vergadering 15.30 uur		
	Presentielijst		

Verzonden aan: .....
.....

Bijlage 3


Besluitenlijst 1 9.55 uur Publieke Zorg
onderwerp
verantwoordelijk
afgehandeld
1 opvanglocatie thialf
Marcel
2 brandjes nog regelen
Barbara
3 slachtoffer hulp
Barbara
4 bus regelen
Jelke
besluitenlijst 2
10.20 u.
onderwerp
verantwoordelijk
afgehandeld
1 brandjes Thialf regelen
Barbara
2 Arriva locatie doorgeven + aankomsttijd = onduidelijk
Jelke
3 Thialf ballen → zaq aankomsttijd = onbekend
Marcel
4 Rode Kruis ballen (inschakelen)
Marcel
5 hoofd opvang locatie ballen
Marcel
Besluitenlijst 3.
Meran.
- inventarisatie opzet Thialf
- Medew. opvang akkoord
- bus vervoer
Jelke
- Schaal ballen nav. inventarisatie
Maran.
quantore