Food Standards Scotland

Root Cause Analysis Advice for Local Authority Food Law Enforcement Services

Food Standards Scotland's (FSS) audits of Local Authorities' food law enforcement arrangements have identified and recommended service areas that would benefit from the use of Root Cause Analysis. This guidance introduces the subject and highlights practical tips for addressing them.

This summary seeks to provide Local Authority Service Managers with some key information or prompts that may assist in introducing, developing and using Root Cause Analysis.

We would be pleased to receive any comments on the usefulness of this advice or, more widely, suggestions for any additional guidance that would be welcomed by Local Authority Service Managers.

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Document Information

Version	Date	Reason for Amendment	Summary of Changes	Author
1.0	July 2018	New Document	N/A.	Food Standards Scotland's Audit Branch
1.1	December 2019	Regulation (EU) 2017/625	References updated from Regulation (EC) No 882/2004	Food Standards Scotland's Audit Branch

Introduction

On the 31st January and 1st February 2018 the Food Enforcement Partnership Event organised by Food Standards Scotland along with the Scottish Food Enforcement Liaison Committee (SFELC) and the Society of Chief Officers of Environmental Health in Scotland (SoCOEHS) took place in Cumbernauld. The purpose of the event was to demonstrate the importance and value of collaborative working, reflecting on past and present achievements whilst looking forward.

Food Standards Scotland's (FSS) audits of Local Authorities' food law enforcement arrangements are published as Reports. These included recommendations which the Authority are required to address and document within Action Plans. It is requested by FSS that the Local Authorities address the cause of these recommendations with the use of Root Cause Analysis methods.

One of the workshops at that event was on Root Cause Analysis and this document takes into account the outputs from that workshop. The contributions made by all involved are greatly appreciated.

Root Cause Analysis

1.1 FSS is currently auditing the Capacity and Capability of Local Authorities (LAs) to deliver effective service management and achieve food business compliance. Audit Reports published contain Action Plans to address any recommendations arising from the audit and it is expected that LAs will carry out a Root Cause Analysis prior to developing the action plans to ensure that any changes are appropriately targeted and implemented to ensure that similar issues do not arise again.

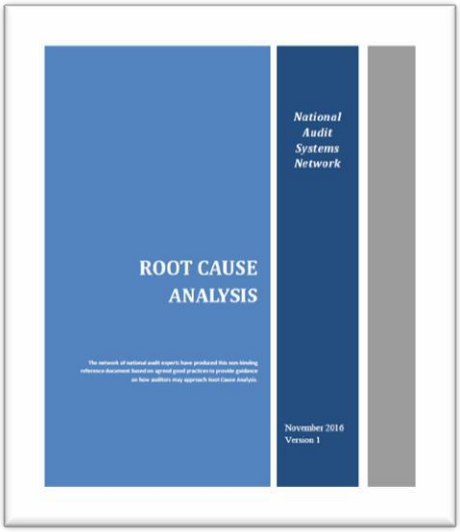
What is it?

1.2 Root Cause Analysis (RCA) is defined as the identification of the underlying cause of why an issue which is defined as a problem, error, instance of non-compliance, or missed opportunity occurred rather than only identifying or reporting on the issue itself.

What Guidance is available?

1.3 The relevant guidance on RCA for this document is published by the NAS network, which is a network of officials (auditors) from national competent authorities, responsible for the performance of audits of official control systems as provided for by Article 6 (1) of Regulation (EC) No 2017/625 The network meets regularly, under the chairmanship of, and facilitated by, Directorate F of the European Commission Directorate General for Health and Food Safety to exchange experiences in implementing national audit systems on official control activities.

1.4 To enable dissemination of information the network consolidates agreed principles and good practices on specific topics into reference documents. These reference documents may be used as guidance documents, however, they do not constitute an audit standard and are not legally binding. The relevant guidance in this case is “Root Cause Analysis” at *National Audit Systems Network - Root Cause Analysis - November 2016*



1.5 Using RCA introduces the collective term for a number of structured methods that competent authorities can use to assist in identifying the underlying factors which lead to the occurrence of an issue.

1.6 A "root cause" can be explained as a "cause" (a condition or a causal chain that results in the issue of interest), that is the "root", the origin or source of the issue. A "root cause" is usually used to describe the point in the causal chain where action could reasonably be taken to prevent or mitigate an undesirable outcome or to improve performance.

1.7 The benefits are:

a) the determination of corrective action

b) improving the system and

c) reducing the likelihood of recurrence

Cause or effect?

1.8 Frequently the issue identified by RCA is either a symptom or the end point of a causal chain and not the real systemic issue. Taking a purely compliance approach on a case by case basis will result in the issue being corrected but if the root cause is not addressed the issue will recur.

1.9 To avoid the recurrence of the same non-compliances the LA should carry out an exercise which should be focused on a more diagnostic system approach. This approach is more likely to provide long term solutions for the improvement of the system.

1.10 Use of Root Cause Analysis is requested and this document has been developed to raise awareness of its benefits in the context of LA Action plans arising from a Capacity and capability audit carried out by Food Standards Scotland.

Steps before performing Root Cause Analysis

Where to start

1.11 A choice may have to be made about which issues are worth investigating to establish the root causes. The first step is to state clearly / identify the issue that created the recommendation within the audit report. It is important to be specific and describe the issue strictly in terms of what was found or observed. Avoid defining the issue in terms of a possible solution, e.g. “inspection procedures are not sufficient”, because this could prejudice both the decision to carry out Root Cause Analysis and the outcome of the analysis.

1.12 Then the RCA team should be able to distinguish (based on their skills, training and experience) between an isolated issue which has either low or no impact on the overall performance of the official control systems (for example audits focusing on postholder) and any issue that has a clear and significant impact on the performance of the control system.

1.13 The RCA team should review the evidence to estimate the extent and the likely impact/consequences of the issue. This will determine if the issue is worthy of further investigation to determine the root cause.

Objectives of the Process

1.14 Root Cause Analysis is applied with the objective to address the system level root causes. When done as part of a purely compliance audit this does not happen. The objective is to diagnose the cause and to avoid taking a purely compliance approach that corrects an issue but **not** the root cause. It is not very effective to repeatedly conclude that elements of a system are behaving in a non-compliant way and only recommend the fixing of the issue and not its underlying cause.

1.15 A more diagnostic system approach to internal audits should encourage corrective actions that avoid recurrence of the same non-compliances. This approach provides a long term perspective for the improvement of the system where the focus is on addressing the root causes of the shortcomings in the system.

1.16 Root cause analysis is a method that can be used to assist in reaching appropriate conclusions and recommendations by helping to:

a) decide whether an issue is likely to be systemic rather than individual or localised;
b) distinguish between the immediately apparent cause of the issue and the underlying root cause(s) of the issue;
c) link various issues detected during an audit that have a common Root Cause;

d) identify in general terms the areas to be addressed by the auditee to correct or mitigate the issue;
e) evaluate the suitability of auditee corrective actions.

1.17 The authority carries out Root Cause Analysis with the objective of identifying and/or confirming the root causes and the specific preventative and/or mitigation actions to address.

When should root cause analysis be used?

- If a non-compliance is identified at a system level.
- Where evidence of issues of significant concern is found (i.e. issues related to effectiveness or suitability of controls).
- When factors giving rise to the issue are not immediately apparent.

When to stop root cause analysis?

- When root cause lies beyond the limits of the system being audited. As such it is external to it and therefore cannot be directly addressed by the auditee.
- When no longer proportionate to the issue at hand (cost-benefit and linked to the seriousness of the issue).

It is not about the person

1.18 When performing root cause analysis you should not focus on the person / persons performing the task and their individual shortcomings (which are a symptom rather than a cause of the issue) but instead focus on the system or environmental factors that led to that error, shortcoming, or missed opportunity.

1.19 Some recent recommendations from published audit reports that would benefit from RCA are:

- The current intervention programme does not comply with the Food Law Code of Practice or Regulation (EC) No 2017/625 (Article 44)
- The Policies and Procedures were not always current and many require a review. They do not comply with the Food Law Code of Practice.
- The Authority are not meeting the minimum inspection frequencies required by the Food Law Code of Practice.
- The Authority should access and evidence additional training and be able to demonstrate competence in terms of inspection of specialist or complex manufacturing processes.

Possible techniques to use

1.20 Some of the methods or specific questions that could help identify some root causes for these recommendations are listed below. The audience at the Partnership Event generally gave replies as independent questions or

statements, rather than following any model technique to demonstrated or show knowledge of RCA, such as;

- 5 Whys,
- Ishikawa “fish bone” cause and effect diagram,
- Pareto principle,
- Failure Mode and Effects Analysis (FMEA) or
- a combined method.

Records and documentation

1.21 It is important that these are kept to be able to evidence the thinking and actions used to reach an outcome that will be able to demonstrate that the actual issue identified has been addressed.