Interactive GCSE and A level data visualisations updated

News story

Data on A level and GCSE comparative outcomes, centre variability and results across England can now be viewed in series of interactive visualisations.

Ofqual has today updated 7 interactive visualisations which show summer 2020 A level and GCSE grade outcomes, centre variability and results across England.

The search tools are updated every year and present data in an engaging way. Each of the visualisations allows users to compare results from 2020 to previous years.

This year the 2020 grades displayed are the final grades the candidate received – the centre assessment grade or calculated grade, whichever was higher.

The visualisations updated with this summer's results are:

1. **GCSE centre variability**: these interactive graphs show the centre variability at grade 4/C and above or grade 7/A and above for selected GCSE subjects.

2. **A level centre variability:** these interactive graphs show the centre variability at grade A and above for eighteen larger entry subjects in A level.

3. **GCSE 'map app':** the map shows, for each county in England, reformed GCSE full course results (the percentage of students achieving specific grades) for the summer 2020, as well as recent summer examinations series.

4. **A level ‘map app’:** the map shows for each county in England, A level results (the percentage of students achieving specific grades) for the summer 2020, as well as recent summer examination series.

5. **GCSE grade outcomes:** interactive graphs which show outcomes across all subjects for all students for the years 2008 to 2020 and for 16-year olds for the years 2013 to 2020.

6. **A level grade outcomes:** interactive graphs show A level outcomes across all subjects for all students for the years 2008 to 2020 and for 18-year olds for the years 2017 to 2020.

7. **9 to 1 app (GCSE only):** these graphs allow users to see grade distributions for all full course GCSE 9 to 1 subjects for students in schools and colleges in England. You can select a combination of three subjects, which shows how performance on one GCSE relates to performance on other GCSEs.

To view the interactive visualisations, visit the Ofqual Data Analytics page.

Published 12 November 2020

Minister for Equalities speaks to pre-eclampsia experts at global event

- Minister to question experts at global ‘Action on Pre-eclampsia’ meeting

- Maternal mortality now occurs in fewer than 1 in 10,000 pregnancies, but the disparity between Black women and White women has widened in the past decade and we still lose more than 1000 babies per year to pre-eclampsia

The Minister for Equalities, Kemi Badenoch, will today [12 November] attend the annual Expert Meeting held by Action on Pre-Eclampsia, speaking to frontline clinicians and specialists from around the world on pre-eclampsia post COVID-19.

She will set out what the Government has been doing on maternal health, and question the experts on how to tackle pre-eclampsia and protect women and their babies.

It is safer to have a baby in the UK than it was 10 years ago, and the UK has one of the lowest rates of maternal mortality in the world. Tragic maternal deaths now occur in fewer than 1 in 10,000 pregnancies.

But evidence shows that black British mothers are five times more likely to die in pregnancy or six weeks after childbirth, than white women. Women of mixed ethnicity have three times the risk, and Asian women almost twice the risk. Ethnic minority women are also at an increased risk of having a pre-term birth, stillbirth, neonatal death or a baby born with low birth weight.

The Minister will say at the event: “there is a need to debunk the myth that all complications and fatalities are due to childbirth, when it is pre-existing health conditions like heart disease, diabetes, and mental health that largely explain the disparities.”

She will also emphasise that we need to shift the conversation to avoid misleading black women into thinking that giving birth is unsafe, whilst emphasising the importance of personal health and fitness, and presenting early to doctors, even during the pandemic.

Minister for Equalities, Kemi Badenoch, said:

“This year I returned from maternity leave after having my third child, so this is a topic that is very close to my heart.

“The UK is one of the safest places in the world to give birth and clinicians manage pre-eclampsia well. Seeking care before and throughout pregnancy is important and we want all women to have the access and confidence in this care the NHS provides. Particularly in a pandemic.

“Although maternal deaths are fortunately very rare, behind these tragic statistics, there are devastating consequences for families and children, so it is vital that we tackle this complex and concerning issue.”

Marcus Green, CEO of Action on Pre-eclampsia, said:

“Disparities in outcomes for pregnant women are complex, even more so in the UK which remains one of the safest countries for a woman to give birth. We need to break down the barriers to ensure all women get the care they need. It is fantastic that the Minister used this occasion to engage with experts in pre-eclampsia which remains a leading cause of maternal mortality and leads to the unnecessary death of over 1000 babies a year.”

Government is committed to supporting all pregnant women and their children. The Minister for Equalities co-hosted a roundtable on maternal mortality rates for ethnic minority women with Health Minister Nadine Dorries in September.

At the roundtable the Ministers heard expert evidence and listened to recommendations from top academics, frontline midwives and healthcare professionals, with the goal of developing joint solutions to benefit pregnant women and their babies.

Measures have been taken across the health services to protect women, with an aim to halve stillbirths, maternal mortality, neonatal mortality, and serious brain injury by 2025:

- NHS England has provided funding for Placental Growth Factor testing which detects the likelihood of a woman developing pre-eclampsia.

- Government has also set up a new model of community hubs, which bring a range of perinatal and sometimes intrapartum care services together in one setting closer to women's homes to identify potential problems sooner. They have been opened across the country, with more than 100 new hubs open as of December 2019.

- Recommendations from the landmark National Maternity Review: Better Births are being implemented through Local Maternity Systems – bringing together the NHS, local authorities and other local partners to ensure mother and baby receive seamless care.

- The National Health Service has also launched a new phase of its 'Help us Help You' campaign that focuses on maternity services. This campaign reminds pregnant women about the importance of attending check-ups, contacting their midwife or maternity team when something doesn't feel right, and reassures them that the NHS is here to see them safely.

Vijya Varshani, whose baby died because of pre-eclampsia, said:

"My son was taken from us by pre-eclampsia. Being a mum is something I have always dreamed of and it felt like my world came crashing down on me and all my dreams were shattered.

"On the evening of 26th September 2012 everything stopped around me, to be told my baby had no heartbeat and was gone. I had never felt so alone and helpless, the numbness that went through me and to have to make the call to inform my husband that our baby had gone was heart-breaking.

"Action on Pre-eclampsia (APEC) helped me so much with getting through the loss of my son, I was put in touch with experts who could help counsel me and see a light at the end of the tunnel. I remember being so scared about having another child and being able to speak with an expert helped me get through this phase. Without the help of APEC I would have always lived with the same questions; What did I do wrong? What if?"

Given that COVID-19 has fundamentally changed the way that women access maternity services, the National Maternity Safety Champion and Chief Midwifery Officer for England gave a four-point plan for all maternity services in England to follow.

That includes increasing support for at-risk pregnant women, tailoring

communications to reassure ethnic minority women, ensuring that hospitals discuss vitamin supplements and nutrition in pregnancy with all women, and ensuring that all providers record on ethnicity on maternity information systems.

Notes to editors

- Action on Pre-eclampsia (APEC) aims to raise public and professional awareness of pre-eclampsia, improve care, and ease or prevent physical and emotional suffering caused by the disease.

- APEC is a charity registered in the UK. They run a helpline and provide information to members of the public who are affected by pre-eclampsia – be this pregnant women, their family and friends and anyone worried about pre-eclampsia. They run study days for midwives and health professionals who work with pregnant women, providing expert training on detection and management of pre-eclampsia. They also facilitate a unique expert referral service, whereby women can be referred by their GPs to an expert on pre-eclampsia in their area. APEC also provides leaflets to hospitals and maternity units informing women about pre-eclampsia and the importance of antenatal care.

- From 2015–2020, National Institute for Health Research (NIHR) programmes invested £59.8 million on 61 awards conducting research into miscarriage, premature birth and stillbirth. Additionally, the NIHR Policy Research Programme funds a Policy Research Unit dedicated to Maternal and Neonatal Health and Care research (PRU-MHC) (2019-2023) based at the National Perinatal Epidemiology Unit, University of Oxford and led by Professor Jenny Kurinczuk.

Case study

Vijya Varshani's full story

My name is Vijya Varshani and this is my story of pre-eclampsia and how my son was taken from us by this condition.

Being a mum is something I have always dreamed of and it felt like my world came crashing down on me and all my dreams were shattered.

In early May 2012 we discovered that I was pregnant with our first child and I couldn't have been more excited about it.

I was always made to believe that carrying a child was the most amazing experience and enjoyable time but my pregnancy was not at all what I expected. In the early stages I had bleeding and was advised I may have suffered a miscarriage but the scan revealed otherwise and that was the first time I saw my baby.

The pregnancy progressed and I had a scan at 13 weeks and everything was going well but as weeks went by I started to experience severe headaches and my blood pressure had started to rise. I was put on blood pressure medication to try to bring this under control.

At my 20 week scan I was told that my baby was smaller than what was normal at this stage of the pregnancy, as was referred to have growth scans. My blood pressure was monitored weekly and I was told I had early onset of pre-eclampsia.

I was feeling very ill with severe headaches, getting very bad swelling on my feet, flashing lights before my eyes.

At 24 weeks of my pregnancy I was admitted into hospital with very high blood pressure and protein in my urine tests I was kept in hospital in the high dependency unit I was stabilised and was able to move to another hospital where they would be able to take better care.

I was told by the doctors that I would not be able to go home until the baby was born; it was frightening with it being so early in my pregnancy, everyday I prayed for the safe arrival of my baby.

On the evening of 26 September 2012 everything stopped around me, to be told my baby had no heartbeat and was gone. I had never felt so alone and helpless, the numbness that went through me and to have to make the call to inform my husband that our baby had gone was heart-breaking.

At 9:21pm on 27 September 2012 our son Krishan Priyesh Varshani was born sleeping at just 27 weeks of my pregnancy.

After the loss of my son I was determined that I wanted to help raise more awareness of this condition as personally having gone through this I was asked by many family members and friends what this condition was.

We decided to do a fundraiser and came in contact with APEC and whom we decided we would do our fundraising for.

APEC helped me so much with getting through the loss of my son, I was put in touch with experts who could help counsel me and see a light at the end of the tunnel.

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Report 11/2020: Track workers struck by a train at Margam

PDF, 8.91MB, 115 pages

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Summary

At around 09:52 hrs on Wednesday 3 July 2019, two track workers were struck and fatally injured by a passenger train at Margam East Junction on the South Wales main line. A third track worker came very close to being struck. The three workers, who were part of a group of six staff, were carrying out a maintenance task on a set of points. The driver made an emergency brake application about nine seconds before the accident and continued to sound the train's horn as it approached the three track workers. The train was travelling at about 50 mph (80 km/h) when it struck the track workers.

The accident occurred because the three track workers were working on a line that was open to traffic, without the presence of formally appointed lookouts

to warn them of approaching trains. They were carrying out a maintenance activity which they did not know to be unnecessary. All three workers were almost certainly wearing ear defenders, because one of them was using a noisy power tool, and all had become focused on the task they were undertaking. None of them was aware that the train was approaching until it was too late for them to move to a position of safety. Subsequent acoustic measurements have shown that they would not have been able to hear the train's warning horn.

The system of work that the controller of site safety had proposed to implement before the work began was not adopted, and the alternative arrangements became progressively less safe as the work proceeded that morning and created conditions that made an accident much more likely.

RAIB's investigation found several factors which led to this situation, relating to the work itself, the way the safe system of work was planned and authorised, the way in which the plan was implemented on site, and the lack of effective challenge by colleagues on site when the safety of the system of work deteriorated.

The investigation also considered why Network Rail had not created the conditions that were needed to achieve a significant and sustained improvement in track worker safety. Four underlying factors were identified:

- Over a period of many years, Network Rail had not adequately addressed the protection of track workers from moving trains. The major changes required to fully implement significant changes to the standard governing track worker safety were not effectively implemented across Network Rail's maintenance organisation
- Network Rail had focused on technological solutions and new planning processes, but had not adequately taken account of the variety of human and organisational factors that can affect working practices on site
- Network Rail's safety management assurance system was not effective in identifying the full extent of procedural non-compliance and unsafe working practices, and did not trigger the management actions needed to address them
- Although Network Rail had identified the need to take further actions to address track worker safety, these had not led to substantive change prior to the accident at Margam.

Recommendations

RAIB has made eleven recommendations in this report. Nine of these are addressed to Network Rail and cover:

- improving its safe work planning processes and the monitoring and supervision of maintenance staff (three recommendations)
- renewing the focus on developing the safety behaviours of all its front-line track maintenance staff, their supervisors and managers
- establishing an independent expert group to provide continuity of vision, guidance and challenge to its initiatives to improve track worker safety

- improving the safety reporting culture
- improving the assurance processes, the quality of information available to senior management, and processes for assessing the impact of changes to working practices of front-line staff (three recommendations).

A further recommendation is made jointly to Network Rail, in consultation with the Department for Transport, relevant transport authorities, the Office of Rail and Road (ORR) and other railway stakeholders, to investigate ways to optimise the balance between the need to operate train services, and enabling safe track access for routine maintenance tasks.

The final recommendation addresses an observation noted during the investigation and is not related to the cause of the accident. It is addressed to the Rail Delivery Group, in consultation with Network Rail and RSSB, and recommends research into the practicability of enabling train horns to automatically sound when a driver initiates an emergency brake application.

RAIB has also noted two learning points: one reminds staff to only carry out maintenance on insulated rail joints when the relevant line has been closed to traffic, and the other reminds companies to update staff on revised maintenance practices as railway assets are modernised.

Simon French, Chief Inspector of Rail Accidents said:

> The death of the two track workers who were struck and killed by a train at Margam was a tragic loss for their families and friends. It has also had a profound effect on all of us at RAIB, and those who died and all those who were close to them, are in our thoughts. The railway is like a family, with a distinct culture all its own, and we all feel deeply the loss of colleagues.
>
> This accident has reinforced the need to find better ways to enable the safe maintenance of the railway infrastructure. The areas that need to be addressed to improve the safety of track workers have been repeatedly highlighted by 44 investigations carried out by RAIB over the last 14 years. The most obvious need is for smart and accurate planning to reduce the frequency with which trains and workers come into close proximity, while also meeting the need for access to assets on an increasingly busy railway system.
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> I believe it is essential that Network Rail addresses the fundamental requirements that have been highlighted by RAIB’s investigations over the years. These include:
>
> - developing leadership skills and involvement of the site team in the planning process, including the identification of site hazards and the local management of risk
> - better management of people who work on the track, including supervision and assurance, that will make sure correct working practices are in use, and to identify areas for improvement

- greater use of technology to control access to the infrastructure, to provide warnings of approaching trains or to protect possession limits.

The railway has a lot to do to cultivate and support a generation of leaders who are able to make a real difference to track safety. In recent years the industry has launched projects intended to achieve this, but they have not always been successful. It is frustrating that the railway has been unable to carry people with it in its attempts to bring about real change.

I remain hopeful that the rail industry will find a way to address these thorny and persistent issues. There is now a real sense that things must change. We've come a long way since the days when fatal accidents involving track workers were commonplace. However, it's now time for some clear thinking on how best to further reduce the risk to our colleagues who inspect, maintain and renew the railway's infrastructure.

Notes to editors

1. The sole purpose of RAIB investigations is to prevent future accidents and incidents and improve railway safety. RAIB does not establish blame, liability or carry out prosecutions.
2. RAIB operates, as far as possible, in an open and transparent manner. While our investigations are completely independent of the railway industry, we do maintain close liaison with railway companies and if we discover matters that may affect the safety of the railway, we make sure that information about them is circulated to the right people as soon as possible, and certainly long before publication of our final report.
3. For media enquiries, please call 07814 812293.

Newsdate: 12 November 2020

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- better management of people who work on the track, including supervision and assurance, that will make sure correct working practices are in use, and to identify areas for improvement
- greater use of technology to control access to the infrastructure, to provide warnings of approaching trains or to protect possession limits.

The railway has a lot to do to cultivate and support a generation of leaders who are able to make a real difference to track safety. In recent years the industry has launched projects intended to achieve this, but they have not always been successful. It is frustrating that the railway has been unable to carry people with it in its attempts to bring about real change.

I remain hopeful that the rail industry will find a way to address these thorny and persistent issues. There is now a real sense that things must change. We've come a long way since the days when fatal accidents involving track workers were commonplace. However, it's now time for some clear thinking on how best to further reduce the risk to our colleagues who inspect, maintain and renew the railway's infrastructure.

Notes to editors

1. The sole purpose of RAIB investigations is to prevent future accidents and incidents and improve railway safety. RAIB does not establish blame, liability or carry out prosecutions.
2. RAIB operates, as far as possible, in an open and transparent manner. While our investigations are completely independent of the railway industry, we do maintain close liaison with railway companies and if we discover matters that may affect the safety of the railway, we make sure that information about them is circulated to the right people as soon as possible, and certainly long before publication of our final report.
3. For media enquiries, please call 07814 812293.

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