

Brain Tumours (Children) – 26th April 2004

Motion made, and Question proposed, That this House do now adjourn.—[Joan Ryan.]

9.21 pm

Mr. John Bercow (Buckingham) (Con): There can surely be few more tragic or heartbreaking experiences than for a parent to discover that his or her child has a brain tumour. As the Under-Secretary will doubtless be aware, 16,000 people a year are diagnosed with brain tumours. Of those, no fewer than 350 are children. About 100 children die each year as a result of a brain tumour. Furthermore, the prognosis for children so diagnosed is poor, with only 20 per cent. surviving beyond five years. Research now shows that brain tumours have overtaken leukaemia as the biggest killer of children under the age of 15.

In the year 2000, six children aged under five from my own county of Buckinghamshire were diagnosed with brain tumours. Without wishing to induce in right hon. and Members statistical fatigue, it needs to be understood that the phenomenon is neither simple to detect nor uniform in type. Rather there are more than 120 different types of brain tumours, which present themselves in a variety of ways.

I put it to the House that the issue of children with brain tumours is under-debated, under-reported and underfunded. In this Parliament, the issue has attracted minimal—dare I say it, derisory—attention. There has been not one Adjournment debate until now, not one oral parliamentary question, and only two written parliamentary questions, tabled by my hon. Friends the Members for Ribble Valley (Mr. Evans) and for West Chelmsford (Mr. Burns). However, there is early-day motion 737, which commends—and rightly so—the BBC online reporter Mr. Ivan Noble for his personal and moving website diary of the diagnosis and treatment of a malignant brain tumour. That motion has so far attracted no fewer than 28 signatures.

While the media have justifiably devoted coverage to other cancers, they have seemingly overlooked the plight of children diagnosed with brain tumours, giving scant coverage to that plight. The apparent low incidence of this type of cancer, by comparison with other forms, has caused the brain tumour community to be poorly supported and funded.

A score of charities, through a plethora of fund-raising methods, finance research to help child sufferers. Most of them are small, dependent on volunteers and in limited or no contact with each other.

At the other end of the spectrum, Cancer Research UK is the largest supporter of the UK children's cancer study group, an organisation that treats all children with cancer, ensuring that they receive the most up-to-date treatment. For example, the point has been made to me that many children with brain tumours are given chemotherapy to keep their tumours under control until they are old enough safely to receive radiotherapy. Yet coverage—this is the gravamen of the argument—is not comprehensive, and because the change is recent, its full impact remains unknown. In short, there is no ground whatsoever for complacency. In any case, charitable effort can only ever be a supplement to, not a substitute for, public financial support. That support is needed, needed on a substantial scale, and needed now. All the charities, countless individual campaigners and many tumour victims could deservedly be mentioned. Time prevents me from doing so. Instead, I shall tell the House candidly that my motivation for seeking this debate was an approach in January from a constituent, Sue Farrington-Smith, a woman of intelligence, courage and unflinching resolution to tackle the horror of brain tumours in general and among children in particular.

Sue's sister, Julie Phelan, had a daughter, Alison, who died on 7 June 2001, just three weeks before her eighth birthday. After noticing that Alison had developed a squint in her eye, Julie Phelan became concerned that her daughter was unwell. She had two

appointments with her general practitioner. The GP referred Alison to an optician. The optician said that the squint was common and that it would correct itself. Julie and her husband, Gary, felt that something was wrong. They went back to the doctor. They then went to another optician. They appealed for someone to listen to them. Julie eventually went to a third optician. That optician advised Julie to take her daughter to accident and emergency with a letter detailing the fact that something was making the muscles in Alison's eye deteriorate. The hospital staff referred the family to a leading eye hospital. The advice was that there was no reason to worry. After a further visit to doctors and a children's hospital unit, Alison's parents were again told not to worry. Eventually, following test after test after test, a visit to hospital led to a scan and a meeting with a specialist and a verdict:

"There is nothing we can do. The tumour is untreatable."

That is a summarised version of a human tragedy that no words can adequately describe. Alison underwent intensive radiotherapy, but she suffered a haemorrhage into the tumour and died eight weeks later—10 months after the tumour was first diagnosed. Following her death, appalled by the lack of research funding and horrified that a cure might not be found for years, Alison's family and friends set up the charity Ali's Dream with the objective of raising funds for research into childhood brain tumours, to discover their causes, advance treatments and find a cure.

UK brain tumour charities are striving for increased funding to improve education, information, specialisation, support and research. I deal first with education. General practitioners and other health professionals need information to be widely available, and they need also to receive training in order to identify the differing symptoms of the various tumours. Often, GPs either do not recognise the symptoms or choose to eliminate other causes first. The reality, of course, is that there is a multiplicity of symptoms. Part of the problem is that those symptoms are the same as those for other illnesses and diseases.

They include headaches, convulsions, vomiting, nausea, subtle changes in personality or mental ability, blurred or double vision, muscle weakness, stumbling, lack of co-ordination, slurred speech, problems with smelling and hearing, and the inability of eyes to gaze upwards. In the circumstances, a screening programme for individuals who present with such symptoms should be more readily available so that treatment can start earlier rather than later—or sadly, as in many cases at present, too late.

Secondly, I turn to the issue of information. The empirical evidence that I have adduced thus far testifies that a reliable and up-to-date source of information is necessary, because there is no central repository of information on this cancer, leaving patients, carers and families having to hunt for knowledge. The options and the treatments available should be fully explained, and in layman's terms. For example, if surgery is proposed, what is available? What drugs are available? Better information is also needed on what support—financial, physical and emotional—is available, on the NHS or privately through charities, because that is a vital lifeline in such circumstances.

Thirdly, I turn to the issue of specialisation. In the UK at present, there are only 17 locations with the facilities to treat brain tumour patients. Eight of the children's cancer hospitals do not have the facilities to treat brain tumour patients. Each hospital that treats brain tumour patients should have a multidisciplinary team, including speech therapists, occupational therapists, physiotherapists, epilepsy nurses, nutritionists, social workers, neurologists, oncologists, neurosurgeons and neuro-oncology nurse specialists. Specialised therapy equipment should also be available both in hospitals and at home. Specialised counselling, night-sitters and respite care are also necessary. That is the essential infrastructure without which the lives of those who seek to cope in such circumstances become unimaginably grim and awful.

Support in its widest sense is also invaluable. Hospitals should provide facilities for families that include overnight facilities, rest rooms and showers. Families who are bereaved should have freely available professional counselling. Funding is desperately

needed for families who have to travel to receive treatment and to pay for accommodation. No hon. Member should work on the assumption, consciously or unconsciously, that such costs are insignificant and can be readily borne. That is often simply not true. Additional money is also needed for hidden costs, such as parental leave, new clothes for children on steroids whose clothes no longer fit, and treating patients and siblings to special holidays to ease the pain.

Research, research and research must be of the essence. Dedicated laboratory-based research on brain tumours is carried out at only 10 centres nation wide and clinical trials are undertaken in only eight hospitals—half the total number of brain tumour hospitals in the UK. An integrated research programme and dedicated brain tumour research centres are required, focusing on types of tumour, genetics and molecular genetics, brain tumour invasion and the effectiveness of treatment.

It is glaringly obvious that this country still has high hurdles to overcome if the scourge of brain tumours is to be successfully fought. I say that the hurdles are high, but—with effort, skill and focus—they should not be insurmountable.

Medical science continues to advance, to create new cures and, inevitably, to produce new lists of expectant patients in the process. Yet the research that leads to treatment, that can provide relief and offers the ultimate prospect of a cure demands political will and financial support.

Members of all political parties and of none, and parents, patients and professionals, look to the Government to give a lead and to make the fight against brain tumours a key priority. I look forward to the contributions that other hon. Members will doubtless make to the debate. I look forward, in particular, with interest, courtesy and respect to the response of the Minister and to the policy of the Government. I think that I can confidently say that tens of thousands across the country will do so too.

9.35 pm Mr. Bob Blizzard (Waveney) (Lab):

I rise briefly to pay tribute to the work of the Ellie Savage Memorial Trust, a charity based in my constituency and established just last year in memory of Ellie who tragically died of a brain tumour when she was just 14 years old. From what I have been told, her circumstances were similar in many ways to the circumstances of the young lady described by the hon. Member for Buckingham (Mr. Bercow). Ellie first became aware that something was wrong when she suffered an epileptic fit, but she was told not to worry too much. Many youngsters in their teenage years suffer in that way, but Ellie found out some time later that she had a brain tumour that was inoperable. She eventually died about a year after the problems were first brought to the attention of the medical authorities.

Ellie's family discovered in the course of her illness, as I guess many families have, that there is a shortage of support services; there is not a good network of support and there is a lack of readily available information. As the hon. Gentleman pointed out, there is a dearth of good, dedicated medical research.

I ask my hon. Friend the Minister to pay particular attention to this aspect of health and of the national health service. In particular, will he consider how best the NHS can work with charitable bodies, such as the Ellie Savage Memorial Trust, to fund more research, to provide proper networks of health advice and information, and to establish better screening facilities? The trust certainly thinks that more children and youngsters now die from brain tumours than from meningitis and possibly leukaemia. My hon. Friend will have the figures for that, but it is clearly a serious problem that demands attention. Can the NHS work closely with bodies such as the Ellie Savage Memorial Trust? Like the charitable trust founded in the hon. Gentleman's constituency, they are determined to do something to help others in memory of the loved ones that they have lost.

9.38 pm Bob Spink (Castle Point) (Con):

It is always an honour to follow the hon. Member for Waveney (Mr. Blizzard) who spoke so passionately and wisely on this important subject. My hon. Friend the Member for Buckingham (Mr. Bercow) will know that I have tabled many questions on neurosurgery over the weeks and months that have gone by. I am delighted that we have such an excellent Minister—the Under-Secretary of State for Health, the hon. Member for South Thanet (Dr. Ladyman)—to respond to the debate. I notice how carefully he is listening to it.

I declare an interest: my son is a London neurosurgeon and spends some of his time removing nasty things from children's heads. He and surgeons like him know how very important this subject is and how painful and serious the outcomes often are for families.

No one can imagine how terrible and traumatic it can be for parents and the wider family to lose a child in such circumstances. I therefore warmly congratulate my hon. Friend on introducing this important debate and on describing so movingly what happened to a young girl in his constituency.

I know how important this issue is and, as my hon. Friend said, how crucial it is to get more funds into research in this area. I know, too, how important it is to increase the number of consultants coming into neurosurgery. As the Minister knows, because he is burdened with responding, I have tabled quite a number of questions on that subject over recent weeks. I know also how important, and difficult, diagnosis is. MRI is a good, non-invasive method of diagnosing tumours, but it is not very child friendly: children are often frightened by the noise and paraphernalia that go with it, so spiral CT methods are sometimes much better. However, we need more MRI and spiral CT equipment to diagnose tumours so that when children present with persistent headaches and other symptoms—other hon. Members have described those adequately, so I will not go into them—GPs and even, perhaps, opticians will be able to refer them for investigation more easily, quickly and efficiently.

One specific area of research which is very important is the timing of surgical intervention for low-grade tumours in children; it is critical to the outcome and to the child's survival. Sometimes in the NHS, in fact too often, surgery is performed too late in the tumour's development, when nothing can be done. We need specific research into how chemical and other changes in tumours develop so that the critical timing of surgery to remove the tumour can be got right. I know that the Minister is listening very carefully and that he will look at that matter. That would be very helpful to all neurosurgeons practising in this specialised and important area of the NHS.

Again, I congratulate my hon. Friend the Member for Buckingham on introducing the debate in such warm and moving terms.

9.43 pm The Parliamentary Under-Secretary of State for Health (Dr. Stephen Ladyman):

It is usual practice to congratulate hon. Members on securing Adjournment debates, but on this occasion that sentiment is more deserved than usual. I had not realised that Parliament had so little considered these matters until the hon. Member for Buckingham (Mr. Bercow) spoke, and I hope that opportunities can be found further to debate them in coming months because they clearly need to be explored. We need to work together on initiatives to move forward. The debate is timely, given that last month was brain tumour awareness month, when a number of charities throughout the UK organised a host of fund-raising and awareness-raising activities. I have no doubt that Ali's Dream and the Ellie Savage Memorial Trust were involved.

My hon. Friend the Member for Waveney (Mr. Blizzard) described, in very moving terms, the experience of his constituent, and the hon. Member for Castle Point (Bob Spink) raised issues of great interest. I hope that all the Members who spoke will take it as

given that I will ensure that officials study all their comments with care, and that their constructive suggestions will be taken on board.

Before coming to the main part of my speech, let me respond to my hon. Friend the Member for Waveney on how individual charities can engage with debates such as this. If a charity is engaged in developing a project that is of national significance and is related to the priorities of the Department of Health, the Department can provide some funding under a scheme called section 64. Any charity that thinks it has an idea of national significance and is interested in taking that route will find the means to make an application on the Department's website. If the charity is engaged in purely local work, it needs to engage with its local primary care trust—PCTs are responsible for commissioning services in their local area. I would encourage all PCTs to have thorough and constructive discussions with reputable charities that have good ideas, even if at the end of those discussions the PCT might say that it has other means of meeting local needs, or it is not especially interested in the charity's idea. Similarly, I would encourage all charities and lobby groups to take that route.

Cancer in children is mercifully rare: about 1,100 new cases are diagnosed in England each year, of which about one fifth are cancers of the brain and spinal cord. I do not want the hon. Member for Buckingham to take anything I say as being complacent in any way. Of course even one child's death is one too many. However, that said, I should put it on the record that improving the care of children with cancer is one of this country's success stories. I am delighted to be able to say that, according to Cancer Research UK, we now have some of the best children's cancer services in the world. Survival rates for the most common forms of children's cancers match those in the United States, which is regarded as setting the gold standard.

Since the 1960s, there have been great advances in the treatment of most childhood cancers, which have resulted in markedly higher survival rates. Only last month, the Office for National Statistics published a report on children's health, which detailed that a child diagnosed with Hodgkin's disease in the mid-1960s had a 39 per cent. chance of being alive five years later, whereas a child diagnosed with the same disease in the mid-1990s had a 94 per cent. chance. Similarly, survival rates of children diagnosed with acute lymphoid leukaemia—the most common form of cancer in children—have risen from a mere 4 per cent. in the mid-1960s to 81 per cent. in the mid 1990s.

Those improvements in survival rates occurred during a period of great technical advances in childhood cancer treatment, but there were also major changes in the patterns of referral. At one time, most children with cancer were treated at local hospitals; there were few clinicians specialising in paediatric oncology and opportunities to participate in collaborative studies of treatment were limited. Treatment has gradually become more centralised and larger numbers of children have been entered in national and international clinical trials or studies. The hon. Member for Buckingham mentioned the relatively limited number of specialised services available in this country. Although it would be wonderful to have services on everyone's doorstep, 26 Apr 2004 : Column 727 creating centres of excellence requires the creation of specialised services, which, inconvenient though that might be in some cases, has been a major factor in driving up success rates. All hon. Members should take that success into consideration as we debate hospital reconfiguration and concentrating into centres of excellence.

As a consequence of the improved survival rates, the number of adult survivors of childhood cancer has greatly increased. In 1971, there were about 1,400 adult survivors, compared with almost 15,000 in 2000.

In 1971 only around 1,000 adult survivors were aged over 30, compared with 7,000 in 2000. Although there is a small risk of very late relapse, the great majority of five-year survivors of childhood cancer do appear to be cured, with only a 10 per cent. risk of death from recurrent tumour or a treatment-related effect during the 10 years after diagnosis

That said, I am aware that survival rates for children diagnosed with brain tumours are

not as impressive, but significant progress has been made none the less. The Office for National Statistics report showed that a child diagnosed with cancer of the brain and central nervous system back in the 1960s would have a 37 per cent. chance of surviving more than five years. Sixty-eight per cent. of children diagnosed with the same disease in the mid-1990s survive longer than five years. I listened carefully to the comments of the hon. Member for Buckingham, and I am not entirely sure that the figures he gave correspond with the figures that I have just given. I can assure him that the figures I gave are accurate, according to the Office for National Statistics.

In the past 30 years the mortality rate for children with brain tumours has been more than halved—18.3 deaths per million in 1971, compared to 8.9 in 2002—but as the hon. Gentleman said, there is no room for complacency. I assure him we are not complacent. We are committed to building on these major improvements. Research, as the hon. Member for Castle Point and others said, is essential if the burden of cancer is to be reduced as quickly as possible.

Through the National Cancer Research Institute we are changing fundamentally the way cancer research is carried out in the UK. The NCRI draws together major cancer research funding organisations from Government and the charitable and private sectors. For the first time these organisations have come together in a single body to collectively map out research activities and jointly plan for the future.

The NHS plan announced that the Department of Health would provide an additional £20 million per year to establish a national cancer research network. The National Cancer Research Network and the National Translational Cancer Research Network were established as a result. NCRN and NTRAC are helping to ensure that patients, including children, from all parts of the country benefit sooner from new developments in cancer care. Within the NCRN the Department of Health provides specific funding for a specialised research network on paediatric oncology, led by the UK Children's Cancer Study Group. The brain tumour group of the UKCCSG is currently running eight trials.

In addition, several other trials are under development and a number of recently closed studies are being analysed.

The Department of Health also provides funds for the childhood cancer research group at Oxford university, which maintains the national registry of childhood tumours, the largest population-based childhood cancer registry in the world. Sir Paul Nurse, Nobel prize winner and former chief executive of Cancer Research UK, said:

"In terms of the key successes of cancer research over the last few decades, childhood cancer is undoubtedly one of the jewels in our crown."

One of the key actions in the NHS cancer plan is to ensure that patients with suspected cancer are seen quickly and appropriately. GPs have a crucial role in ensuring that children with suspected cancer are referred for specialist treatment. Referral guidelines for suspected cancer were sent to all GPs in April 2000. The aim of these guidelines, which include a section on children's cancers, is to facilitate appropriate referral between primary and secondary care for patients whom a GP suspects may have cancer. The guidelines should help GPs to identify patients who are most likely to have cancer and will therefore require urgent assessment by a specialist.

In the case raised by the hon. Member for Buckingham, the GP did not suspect cancer and thought that it might be some sort of optical problem. Off hand, I do not know whether the guidelines issued in 2000 would have helped in those circumstances, but I will ensure that officials study the guidelines to see whether they offer any encouragement for the sort of situation that the hon. Gentleman described, by helping GPs to spot such conditions and refer them for specialist advice more quickly. It is hoped that the guidelines will also help GPs to identify patients who are unlikely to have cancer and who may appropriately be observed in a primary care setting, or who may require non-urgent referral to a hospital.

In that way, anxiety can be reduced for patients and their families. The National Institute for Clinical Excellence is currently reviewing the guidelines, and its review is due for publication early next year. Again, I shall make sure that NICE gets a copy of the Official Report of this debate.

Every child with cancer currently receives specialist treatment within one month of their being urgently referred by their GP. Improving patients' experience of care is at the forefront of all our plans for the NHS. To support that aim for cancer care, we have made £6 million available over the next two years for pilots to develop a service delivery model that supports patients as they move between primary, secondary and other specialist care. We envisage that the model will include input from social services, the voluntary sector and patients themselves, and hope that it not only improves patients' experience of care, but reduces avoidable hospital stays.

The distinct needs of children with cancer have been increasingly recognised over recent years, which is why we commissioned NICE to produce service guidance for the NHS on child and adolescent cancers. The guidance will include recommendations on optimal forms of diagnostic services, treatment, support services and palliative care. It will also include advice on research, the transition from paediatric to adult services and specialist follow-up services for patients who suffer long-term effects from treatment.

Bob Spink:

In those sad cases in which the condition is terminal and palliative care is needed, the child may eventually go to a children's hospice. The Minister will know that Government funding for children's hospices is dire. On average, the Government provide only 5 per cent. of funding for children's hospices, and they provide only 1.5 per cent. of the funding, which is far too low, for the Little Haven children's hospice in my constituency. Funding for children's hospices should at least be on a par with that for adult hospices, which receive an average of 18 or 20 per cent. of their funding from the Government. Will the Minister take that message back to his Department, and not give the usual answer that it is up to primary care trusts and strategic health authorities to make those decisions? He should make sure that funds are directed to those important caring services.

Dr. Ladyman:

I accept that those services are important, and wish that I could magically provide a pile of extra money for them. I also wish that I could avoid saying what the hon. Gentleman asks me not to say, but I cannot. Under "Shifting the Balance of Power", the reality is that we give the vast majority of the money for the national health service to local PCTs. We expect PCTs to commission services locally according to the needs of their local populations, which includes palliative services for both adults and children. It is important that those who run children's hospices, as well as those who run adult hospices, engage with their local PCT to ensure that it understands the services that they provide locally and to encourage it to fund them. That said, I am happy to give further thought to the hon. Gentleman's words, but I cannot promise that I will somehow come across a pile of money in the Department of Health to fund palliative services.

Mr. Bercow:

I know that the Minister would not seek to abdicate responsibility for that which properly falls within his bailiwick. First, if he is confident that real and worthwhile progress is being made, there can be no argument against the establishment and promotion of public service agreement targets for what the Government intend to do. Secondly, support for bereaved or affected families is a political matter, not a clinical matter—will he undertake to provide the additional support craved by those affected?

Dr. Ladyman:

We are currently writing a national service framework for children. The national service frameworks are the way in which we at the centre set the standards that we expect to be delivered locally. The national service framework for children is the most complex that we have yet written. It is occupying a great deal of my time, because I am determined to have it published as soon as possible. I assure the hon. Gentleman that all the comments made in the debate

It being Ten o'clock, the motion for the Adjournment of the House lapsed, without Question put. Motion made, and Question proposed, That this House do now adjourn.—
[Joan Ryan.]

Dr. Ladyman: I will ensure that all the comments made in the debate are used to inform the final preparation of the national service framework. Perhaps I can give the hon. Gentleman some comfort by saying that the national service framework is used to help us to create the performance framework for the national health service. In other words, it will be used to identify the factors that we set as the targets against which we expect to measure the NHS in future. Obviously, I cannot predict what the national service framework for children will contain, but it may well be that during the progression of the national service framework, and the creation of the planning frameworks that follows, we will be able to move forward on a lot of what the hon. Gentleman is asking for.

We expect the NICE guidance that I mentioned to be published in February next year, but a draft version will be available for consultation in July this year and will give the NHS a clear indication of the type of services that NICE thinks should be provided.

The hon. Gentleman suggested, as did my hon. Friend the Member for Waveney (Mr. Blizzard) and as have charities working in this field, that further work needs to be done on screening programmes to identify brain tumours in children. The National Screening Committee advises the Government about all aspects of screening policy. It assesses proposed new national screening programmes against a set of internationally recognised criteria covering the condition, the test, the treatment options, and the effectiveness and acceptability of the programme. Such assessment is intended to ensure that programmes do more good than harm, and at a reasonable cost. Although screening has the potential to save lives and improve quality of life through early diagnosis of serious conditions, it can never be 100 per cent. accurate. It should be seen therefore as a process of risk reduction.

We can screen only when there is the evidence to do so. There is currently insufficient evidence to support screening for brain tumours. Any screening activity would involve children having an image taken by using computerised tomography or magnetic resonance imaging. It is difficult to ensure that those procedures are carried out satisfactorily for children even where problems are already suspected. As the hon. Member for Castle Point said, such facilities are not necessarily child friendly; they can be rather frightening.

Even greater problems would be involved in attempting to screen all children—hon. Members did not suggest that, but some charities have—where there is no evidence of problems and no guarantee that we could make an accurate assessment. Such a move would absorb a disproportionate amount of professional expertise and staff time, with little to show for the child. Using computerised tomography would also involve significant radiation exposure. By screening children irrespective of whether they have symptoms, we run the real risk of identifying things that would never have caused a problem, but cause great worry to parents and perhaps even to older children and young people. In addition, many of the children would need to be sedated or given general anaesthetic, with all its associated risks, to ensure a satisfactory image when using those technologies. I am sure that those who call for these measures would appreciate the logistical difficulties involved in carrying out this procedure for hundreds of thousands of children.

In summary, screening for brain tumours would place tremendous pressure on services

that are needed for people with already-suspected problems. Not only that, but unnecessary worry may be caused to some parents and there is little, if any, evidence that the programme would have any benefit. However, these issues are always kept under review by the National Screening Committee and should new evidence emerge it would of course reconsider its position. I would certainly want to receive its advice as soon as such evidence was available.

At this point, I should like to set out my own personal support for the invaluable work and support carried out by the hundreds of charities dedicated not only to children with cancer but to those in the rest of the population who have been diagnosed with the disease. The voluntary sector and patient groups play a crucial role in raising awareness of cancer, and also in providing patients and their families with emotional and physical support. They also facilitate a stronger user voice, improve the experience of care and enable greater choice and responsiveness of the service for users.

Improving the prevention, detection and treatment of cancer and the care of people with the disease is a key priority for the Government. Through the hard work and dedication of staff working in the national health service and voluntary sector, and through record amounts of investment, we have made significant improvements since the NHS cancer plan was published. I know that there is work still to be done to improve services for children with cancer, but we have come a long way. I am confident that we can make even further strides forward in the coming years, and if we receive the same kind of co-operation that has been shown tonight on both sides of the House in future debates and when further initiatives to address this problem are announced, I have no doubt that we shall make rapid strides. I hope that, when the national service framework for children is published, we shall have another opportunity to debate these matters in much greater detail and that, in particular, we shall be able to look at that document to see what benefits it could bring to the children who have been mentioned in tonight's debate.

Once again, I should like to thank the hon. Member for Buckingham for securing this debate, and my hon. Friend the Member for Waveney and the hon. Member for Castle Point for their valuable contributions. I look forward to having further opportunities to debate this matter in the future.

Question put and agreed to.

Adjourned accordingly at six minutes past Ten o'clock.