on end of life care and be able to pick up on patients' cues about what they need. There is a skill in integrating palliative care alongside cancer care, where the focus is on improvement, and being able to hold these two conversations is a challenge. But there is evidence that this is the best model of care.'

Getting the balance right improves symptom control and leads to better multidisciplinary working, which means the right people are there at the right time, says Ms Mula.

However, her colleague Anne-Marie Raftery, a clinical nurse specialist in palliative care, says advances in cancer treatment could be making it more difficult for specialist nurses to broach the subject earlier. 'Some people think the end of life conversation can be delayed,' she says. 'Patients may feel they are not ready if there is another treatment on the horizon. There is an ongoing need for more sensitive communication skills to engage empathetically in this difficult conversation. We can't rest on our laurels.'

Best practice in this situation, Ms Raftery believes, is to work from the patient's agenda, but revisit their awareness of what is happening to them.

The RCP audit showed that only 21% of hospitals met longstanding recommendations for seven-day face-to-face access to specialist palliative care teams. At the Christie, cancer nurses have direct access to the palliative care team for advice and support five days a week, and by telephone at weekends.

'There are some areas for improvement and end of life care needs to be high on organisations' agendas,' says Ms Mula.

It is hoped this can be achieved through the recommendation for all trusts to have a designated board member and lay member with responsibility for care of the dying – the audit found only 53% had taken this measure – and for end of life care to be examined and discussed annually.

Louise Hunt is a freelance writer

Find out more

To read the RCP audit go to tinyurl.com/careofdying

Experts join forces to tackle variation in London's rates of diagnosis

Cancer alliance will focus on reducing numbers of emergency department presentations. Jennifer Sprinks reports

DIAGNOSIS AND survival rates across England vary significantly, but even in the capital there is considerable variation.

In Croydon, nearly one quarter of people are diagnosed in emergency departments (EDs), while the figure in Kensington and Chelsea is 19%, according to Cancer Research UK. Just 68% of patients in Croydon diagnosed in 2010 survived their disease for at least one year, compared with 73% in Westminster.

With a view to reducing variation and improving patient outcomes across south and west London, an alliance comprising more than 60 clinicians and chief executives from 16 London NHS organisations, including Croydon Health Services NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust, was set up in 2011. The London Cancer Alliance's (LCA) 12 strategic priorities include: implementing best practice guidance, addressing workforce variation and reducing emergency admissions for cancer.

Rates of emergency presentation in London – 25% for oesophageal and 36% for gastric – are higher than the national average of 22% and 33% respectively, National Cancer Intelligence Network figures reveal.

LCA clinical director and Royal Marsden NHS Foundation Trust chief nurse Shelley Dolan says that as well as striving to boost diagnosis rates, the alliance wants fewer people diagnosed in EDs. She explains: 'As well as having a much worse experience, people are also less likely to survive cancer because it often means diagnosis is later.'

One of the LCA's 20 cancer pathway groups is leading a study to explore why colorectal cancer patients in London receive a late diagnosis. It aims to identify gaps in service provision and opportunities to diagnose these cancers earlier.

Leadership

Turning the conversation to leadership, I ask whether Dr Dolan agrees with NHS England national clinical director for cancer Sean Duffy, who expressed concerns last year at the UK Oncology Nursing Society conference that there is a crisis in cancer nursing leadership since the demise of the cancer networks.

She disagrees: 'There is a fantastic wealth of cancer nurse leads in this country. We also have around 20 lead cancer nurses in the LCA who influence our pathways and are very vocal.'

However, Dr Dolan says there is patchy provision of clinical nurse specialists (CNSs) in London, emphasising that trusts have struggled to recruit to these roles because of the high cost of living in London and availability of CNSs in some tumour types. 'Research shows that if a person is cared for by a CNS, they receive more consistent care and outcomes are improved as well,' she explains.

To help trusts recruit CNSs and reduce variations in standards, the LCA's lead cancer nurses group has developed a CNS job description, outlining that the role should be Agenda for Change band 7 or 8, and a career development framework.

Dr Dolan thinks the requirement for all trusts to publish their staffing levels for every shift on every ward from June 10 will improve ward nurse staffing and future CNS provision. 'It will tell us how many are CNSs and their specialist areas. Very soon we will have an idea of how bad the shortage is and where the gaps are.'