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TITLE PAGE:

Nurses delivering person-centred multiple long-term condition reviews in primary care: a secondary analysis of qualitative data

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Background

General practice nurses in England often manage long-term conditions, with more people now living with multiple conditions (MLTC). Evidence on the effectiveness and delivery of person-centred care for MLTC is limited, and the nurse's role — including necessary training — remains underexplored.

Aim

To identify and characterise general practice nurses' experiences of undertaking person-centred multiple long-term condition reviews in England.

Design and setting

Secondary analysis of qualitative data gathered from general practice staff in England.

Methods

Two-part review consultations for people with three or more long-term conditions (rather than separate single-condition reviews as per usual care) in sixteen English general practices, part of a larger implementation project (PP4M). Empirical qualitative data (healthcare staff interviews and researcher fieldnotes) and theoretical approaches (chronic care model, normalisation process theory) analysed abductively.

Results

Two overarching themes identified:

- (1) Healthcare professionals' understanding of MLTC reviews' purpose
- (2) Challenges and opportunities for nurses delivering MLTC reviews.

Some nurses utilised reviews as data-gathering exercises, facilitating collection of nationally set, quality-driven, financial incentives linked to single-conditions. Other nurses used reviews as opportunities for meaningful discussion of complex problems, leading to action.

MLTC reviews allowed nurses a new way of thinking. Some found this empowering, others found it challenging.

Conclusion

General practice nurses are central to MLTC care. They value organisational support for training in person-centred MLTC management, but it remains unclear how best to achieve necessary training. Further research is needed on skills and training required for all healthcare professionals caring for people with MLTC.

Key words: nursing, general practice, annual review; multimorbidity; organisation of care

How this fits in?

Healthcare professionals may view the purpose of MLTC reviews differently. Provision of meaningful multiple long-term condition reviews is important. Research on the skills and training needed for all healthcare professionals caring for people with multiple long-term conditions is required.

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Introduction

A major global healthcare challenge is the rapid rise of long-term conditions (LTCs). Mortality from communicable disease has declined, resulting in longer life expectancy and an increase in non-communicable age-related LTCs (1). Deaths owing to LTCs have increased, from 61% of all deaths in 2000, to 74% in 2019 (2). Multimorbidity or multiple long-term conditions (MLTC), defined as two or more LTCs in one individual (3), has also become increasingly common, with a recent global prevalence estimate of 37.2% (4).

Despite this, health systems, clinical guidelines and healthcare professional training are typically predicated on single-condition care which may facilitate disease-orientated, rather than person-centred, care (5). Healthcare systems globally have advocated for person-centred care (PCC) to meet the needs of people living with MLTC. PCC recognises the considerable work of multiple treatments for people living with MLTC, in addition to the illness itself (6) needing to be considered in relation to individual circumstances and priorities (7). We define PCC as care affording people dignity, compassion, and respect; coordinated and personalised; empowering individuals to build on their strengths for independent, fulfilling lives (8). There is a lack of evidence both for the effectiveness of PCC in improving outcomes for people living with MLTC, and how this should be delivered (9).

In the UK, general practice plays a central role in managing LTCs (10). Patients typically receive single-condition annual reviews from general practice nurses (GPNs), incentivised through the Quality and Outcomes Framework (QOF) (11). Single-condition focused care for people with MLTC may lead to conflicting management recommendations and/or adverse health outcomes, e.g., interactions between medications for single conditions (12).

Evidence demonstrates variation in GPNs' knowledge of LTC management, skills, experience, and employer-supported training (13,14). Nurses' role in person-centred MLTC care—and training needed to support it—is often overlooked, constituting a significant gap for policy-makers aiming to deliver health systems providing high-quality, efficient, PCC for MLTC (15). This paper aims to identify and characterise views and experiences of nurses undertaking MLTC reviews in UK primary care.

Methods

We report results from a secondary analysis of the qualitative component of a concurrent mixed methods study evaluating the implementation of a person-centred 'smart' MLTC template: Personalised Primary care for Patients with Multimorbidity (PP4M) study <https://www.isrctn.com/ISRCTN40295449>. Reporting follows COREQ checklist (16). Full study results are published elsewhere (17)

Intervention design

UK healthcare professionals in general practice use templates for LTC management, supporting adherence to evidence-based quality indicators. Templates are computerised checklists facilitating structured data entry and coding, often acting as 'aide memoires' for clinicians (18) A commercial supplier of templates (Ardens) had

introduced a MLTC template to UK primary care in 2022 (17). The study team built on previous work (19) and NHS personalised care framework (20) to ensure this template was person-centred. This meant a focus on people's experience of their MLTCs; a biopsychosocial perspective aiming to develop a comprehensive understanding of individuals; identifying health and well-being priorities and agreeing care plans for these (19). The template operationalised these: asking what matters most to the patient; questions about wellbeing/mental health; links to social prescribing; a care plan centred on patient priorities.

The PP4M study recruited practices to conduct reviews using the MLTC template, emphasising the person-centred approach (17). This contrasts with usual care - separate reviews of LTCs often involving multiple appointments and duplication of work (12). PP4M recommended a short initial consultation (IC) recording relevant measurements (e.g. height), blood tests and general health enquiries (e.g. smoking status) followed by a longer annual review (AR) where results from ICs were available (17). Prior to AR, practices were asked to provide preparation materials to facilitate patient involvement in their own care (21). These included IC test results in addition to prompts supporting patients with discussion points for AR.

Ardens provided training on MLTC template and on care planning. The PP4M team provided guidance on process mapping. As an implementation study aiming offering 'real world' tools, PP4M did not offer any additional training. Practice staff implemented the template according to their specific practice needs and capacity (17).

Study design

This paper reports secondary analysis of qualitative data collected through interviews with healthcare staff and contemporaneous research fieldnotes. The PP4M researchers returned to qualitative data to undertake secondary analysis as the importance of nurses' role delivering MLTC reviews became apparent.

Study Setting and Recruitment

We recruited participants from 16 primary care organisations (general practices) across three areas in England: Bristol, Staffordshire and Southampton. We interviewed staff at 14 of these general practices based on geographical spread. We provided practice contacts with study information and staff contacted researchers if they wished to participate.

We purposively interviewed a range of staff (n=49) (using maximum variation (different practices and professional groups). Information power, a guiding principle in qualitative research, determined sample size. We stopped data collection when we had collected sufficiently rich data, discussing this (22). discussion as a research team. Information power is high when the aim is narrow, the sample all have relevant

experience, established theory is used, dialogue is rich, and a sound analysis strategy is used. All these criteria were met in this study.(22).

Theoretical frameworks

Our philosophical position of subtle realism layers evidence to create explanations of phenomena, mediated through cultural assumptions of researchers and subject(s) of research (23). This allowed a focus on individual experience and the application and relevance of these experiences to clinical practice and policy (24). In line with our subtle realist position, we took an abductive approach to data collection and analysis (25). An abductive approach moves iteratively and recursively between an initial analytical framework and accumulated empirical and theoretical materials to explain phenomena (25). In line with this, several theories guided data collection and analysis. We based staff interview guides on normalisation process theory (how complex interventions are routinised into everyday practice) (26) and personalised care (27). We adapted the House of Care (HoC) model specifically developed for UK primary care (28), itself based on Chronic Care model (29), to create an analytical framework. The Chronic Care model emphasises the importance of productive interactions between informed, activated patients and prepared, proactive practice teams. HoC centres on collaborative care and support planning for people with LTCs, upheld by informed individuals/carers, committed professionals, holistic commissioning, and robust organisational infrastructures (28).

Data collection and analysis

A range of experienced qualitative researchers (KL, AT, AM, CC, GS, DB; nurses, health service researchers, sociologists) undertook interviews between October 2022 and October 2023 either at professionals' places of work, online or by telephone according to participant preference, and audio-recorded. Researchers kept field notes to aid reflexivity and data analysis using structured templates based on normalisation process theory.

A professional transcription company transcribed interviews. Researchers read transcripts repeatedly to ensure accuracy and familiarity. The HoC analytical framework was added to inductively from interview data. KL undertook line by line coding abductively exploring variation and generalisation through grouping related codes into datasets (practice and professional perspectives) (25). To ensure rigour and transparency, perspectives of other researchers and of study public contributors challenged the application of analytical framework. Researchers generated simple explanatory propositions to characterise variation and generalisation (30), discussed and refined propositions into themes with summarised fieldnotes to support analysis. Public contributors were involved in analysis through half-day workshops (discussing researcher defined areas of analysis) and through regular drop-in sessions (discussing public contributor defined areas of analysis) (31). Data were managed with NVivo software.

Reflexivity

Researchers used fieldnotes to think reflexively about data collection and met weekly to debrief. Researchers used their multiple perspectives, including those of public contributors, to support their reflexive thinking and challenge their normative assumptions about their interpretations arising from the data.

Findings

Researchers interviewed 49 staff across 14 practices.

Table 1: Participant characteristics

N	49
Job role	
Admin & Managerial	15
GP	6
Healthcare Assistant	7
Nurse	17
Advanced Nurse Practitioner	3
Social Prescriber	1
Gender*	
Female	46
Male	3

* Self-described

Table 2: Practice characteristics

Practice ID	List size*	IMD quintile**
21	Medium	1
22	Small	1
23	Small	1
24	Medium	3
26	Small	2
27	Medium	1
28	Large	3
29	Small	5
31	Medium	3
32	Small	2
33	Medium	4
34	Medium	4
41	Medium	5
42	Medium	2
43	Large	2
51	Large	2

* (Small < 10,000; Medium 10,000-20,000, large > 20,000)
 ** 1=more deprived.

Nurses conducted MLTC reviews in 15 of 16 practices. Typically, ARs were longer than single-condition reviews (20-45 minutes).

We derived the following themes:

1. Healthcare professionals' understanding of MLTC reviews' purpose
 - 1.1 Data gathering exercises versus meaningful reviews of complex problems
 - 1.2 Delivering PCC driven by patient priorities versus biomedically orientated care driven by organisational priorities
2. Challenges and opportunities for nurses delivering MLTC reviews
 - 2.1 Empowerment versus fear
 - 2.2 Access to appropriate training

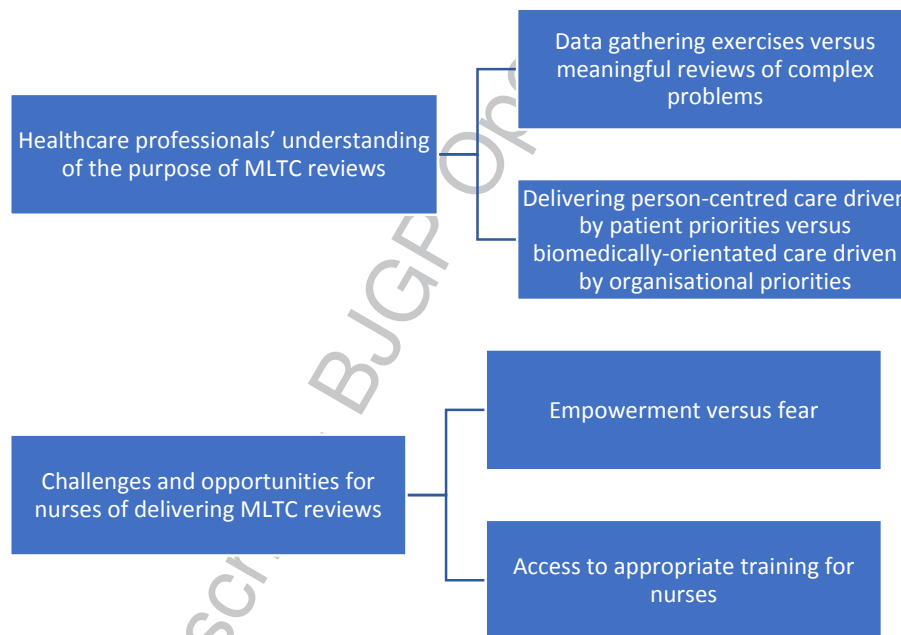


Figure 1: Overview of themes derived from the data

1. Healthcare professionals' understanding of purpose of MLTC reviews

1.1 Data gathering exercises versus meaningful reviews of complex problems

This theme characterises the spectrum of views of general practice on MLTC review's purpose and how this impacted on nurses undertaking reviews. Healthcare professionals could view MLTC reviews as data gathering exercises to support safe clinical care delivery and ensure collection of financial incentives. Protocolised care dictated rather than supported reviews. Conversely, healthcare professionals could

view MLTC reviews as opportunities for meaningful discussion of complex problems leading to action, requiring considerable expertise.

Nurses predominantly provided routine LTC management in primary care:

Chronic disease management – our nursing staff predominantly do, ...GPs are providing...continuity and...oversight. Practice43_P59 GP F

Healthcare staff in certain practices could view MLTC reviews' purpose as collecting information to support safe clinical care delivery whilst generating financial benefits through nationally mandated Quality and Outcomes framework (QOF). The ubiquitous phrase applied to MLTC reviews conducted in this way was a 'tick-box exercise'. Views on MLTC reviews tended to cluster at general practice level, rather than differing among individuals within the same practice, commonly shared across staff—including both clinical and administrative roles—rather than being confined to a specific professional group. In such practices, no particular knowledge or training seemed to be required from nurses undertaking MLTC reviews as there did not seem to be any action immediately contingent on data collection. Indeed, one general practitioner (GP) described how only the ability to read and write was required:

...I don't see any specific requirements for intense training of...any nurses...they just need to read out the question and then decide for...patient[s] to be able to answer and nurse[s], if they can read or write, they should be able to spell out the question to patient[s] and make sense of the answer Practice42_P34 GP M

In contrast, healthcare professionals within certain practices recognised the complexity of MLTC reviews:

I think [in a multimorbidity review] because you discuss areas...you wouldn't necessarily discuss in a [single-condition] review because you're discussing other things...mental health and pain... more social aspects whereas if I...do a [single-condition] review I'm...quite focused on the task...rather than the other bits that make up this person. They're not just a [single-condition], ...they might...have depression, they might also have pain... So...it opens up other avenues of discussion and problem solving rather than just concentrating on...one aspect of the person. Practice22_P27 Nurse F

The strength of MLTC reviews in opening up discussion and leading to meaningful and shared decision-making and problem-solving around health and wellbeing needs was echoed by participants in several practices. In such practices, healthcare professional participants emphasised the importance of training nurses delivering MLTC reviews, highlighting that lack of training might mean reviews were simply a data collection tool to capture QOF points

My team are not [yet] adequately trained to be able to run MLTC reviews properly and we don't want it being a tick box exercise. Practice41_P29 Nurse F

1.2 Delivering PCC driven by patient priorities versus biomedically-centred care driven by organisational priorities

This theme characterises the benefits of a person-centred approach to MLTC for patients, contrasting this against UK health policy (QOF), focusing on single-condition management (NHS England, 2025).

Despite the template's emphasis on person-centred care, in certain practices the focus of MLTC reviews appeared to be predominantly on clinically important, biomedically-centred care dictated by QOF. In these practices, some healthcare staff participants could view (and refer to) patients by their conditions:

diabetics will probably get done first week. CVDs will get done second week. Asthmas will get done third week and pre-diabetics and rheumatoid arthritis will get fourth week. Practice34_P26 HCA F

In other practices, the concept of PCC was fundamental to their review. Many nurse participants suggested such a holistic approach was particularly characteristic of nursing as a profession:

Ultimately as nurses we try not to be tick box people...we try and incorporate a holistic review. Practice33_P46 Nurse F

In practice, this person-centred approach appeared challenging for some nurse participants who suggested patients came with issues that could not possibly be covered in reviews:

*And they come...[with] this agenda...very important to them, but actually that's a whole other kettle of fish...They've come thinking...I can talk about my sleep and my this when...the agenda from a practice point of view is actually we need to get your reviews done
(Practice29_P16 Nurse F)*

Some nurse participants delivering reviews emphasised constraints on their time, suggesting that a focus on patient rather than practice agendas was inefficient:

This question 'What is most important to you in terms of improving your health? They could potentially...sit there for half an hour telling you all these. So you have to nip some things in the bud...I ...think some of those more generic things could be streamlined a bit so that you've got time to do what you need to do Practice42_P41 Nurse F

Other healthcare staff participants, including nurses, expressed diametrically opposite views. Many healthcare staff participants emphasised the importance of PCC – seeing “a person [as] a person...not a health condition” H51_P31 Nurse F. Most participants reported they appreciated how MLTC reviews allowed them to explore patient-driven priorities:

Listening to the patient, understanding what their priority is and their needs are...so we might want them to stop eating cake, but they might just want a friend. ...So that was their priority..., and that's what we were focused on.
Practice21_P4 Managerial (Admin) F

Interestingly, several participants described patients raising issues that were “*not just about medicine*”: Practice24_P2 Nurse F. Psychosocial issues such as financial concerns (e.g., being unable to afford their prescription), or loneliness. Nurse participants described considerable effort and work addressing issues raised in MLTC reviews, providing care navigation, signposting to services (e.g. social prescribing), following up referrals and missed care transitions between organisations:

Often, I had ran over [laughs], I'm just gonna deal with it. We're gonna work out a plan and it's gonna be fine... I actually do quite a lot of follow up myself if I think patients need and that's often the work... I take on myself.
Practice29_P16 Nurse F

2. Challenges and opportunities of MLTC reviews for nurses

2.1 Empowerment versus fear

This theme characterises how MLTC reviews offered nurses an opportunity to move away from protocolised single-condition management to complex conversations with people living with MLTCs about their priorities and how these related to their health.

Given the two-part system of MLTC reviews with transactional tasks delegated to ICs and more time available for AR, nurses described being able to focus on conversation with patients. This appeared challenging, at least initially, for some nurse participants:

I found consultations almost alien to me because we're so used to...chucking a blood pressure cuff around their arm and chatting to them while you're doing numerous different things... so, it was almost alien to me I had to just sit and have a conversation with a patient, rather than poke and prod them. So, I...found it a little bit of a struggle to start with. Practice22_P27 Nurse F

Some nurse participants described the “luxury” of additional time with patients, recognising the value of the consultation as a conversation:

the luxury of just having a...conversation with somebody...It feels like a luxury... (Practice22_P27 Nurse F)

Participants reported MLTC reviews allowed them to identify and address psychosocial issues they might not have previously identified in their shorter, more transactionally focused single-condition reviews:

One chap wanted a gym membership...one ...wasn't managing at home...there's another ...he was quite lonely...in a normal consultation you

may not have got that information because you would be doing blood pressure...so...I'd say 'Have you got any other worries or concerns'? but they know I'm wrapping up the conversation at that point and so I think they feel I can't...say 'I'm really struggling to put my socks on'... So I think it opened different avenues...in conversations compared to a normal conversation you would have during a consultation Practice22_P27 Nurse F

Several nurse participants who found MLTC reviews challenging initially did describe growing in confidence as they undertook more MLTC consultations, increasing their job satisfaction:

My role has extended. It has been a definite learning curve for me...quite enjoyable actually that ability to spend...time with someone and come out with an outcome. Practice24_P2 Nurse F

Other nurses continued to find undertaking MLTC reviews challenging. Participants could be frightened of giving inappropriate care to patients owing to their lack of skills and/or experience: “*terrified of doing [MLTC] reviews...getting it wrong...not being able to do it properly*” Practice24_P8 GP F. One nurse left their organisation as she had been asked to practice outside of her perceived sphere of competence:

But...our then respiratory nurse, she...had a massive panic because she doesn't do diabetes...and, because it's such a complex area, she just well, left.... Practice22_P27 Nurse F

2.2 Access to appropriate training

This theme identifies a lack of clarity on skills and experience required to manage MLTCs, training required to support this and variability in access to nurses' MLTC training.

A significant challenge identified by many healthcare professional participants was they (if nurses themselves) or nurse colleagues did not necessarily have the skills or experience required to manage MLTC. Many participants described how nurses in their organisations were trained to manage specific single-conditions (e.g. asthma but not diabetes)

When I look at...nursing skills...they are absolutely still in silos. So when we then push them to try and work with [MLTC template] suddenly... nurses have a wobble, because they don't feel that is within the remit or their expertise. Practice21_P28 Managerial (Admin) F

Thus, some nurses were able to manage certain individual LTCs, frequently to a specialist level, but lacked skills and experience to manage others. Other, but fewer, healthcare staff participants reported some or all nurses in their organisations had skills or experience necessary to manage MLTC. This did appear to be based on experiential learning, through years of being a nurse delivering LTC management, rather than formal training in MLTC, although it was often underpinned by knowledge accumulated through postgraduate training in one or more single-conditions (e.g.,

undertaking a postgraduate diploma in diabetes). Attitudes toward the importance of training nurses in MLTC management appeared to vary between practices:

...different practices work quite differently... one [practice] tends to be...holding back on what they allow their nursing staff to do and we're...almost the exact opposite here and we allow them to do training...to be more competent in what they do Practice29_P15 GP F

In some organisations, practice managers and/or GPs appeared to gatekeep access to post-graduate training for nurses, with little or no training available for nurses undertaking MLTC reviews. Operational pressures made it challenging to release nurses for training in all organisations, however, some organisations acknowledged the importance of training nurses in MLTC, developed training programmes and freed up time for nurses to attend additional external courses. Practices who were willing to release nurses for further training generally had dynamic and experienced nurse leaders with considerable experience in LTC management, determined not to allow MLTC reviews to become a tick box exercise:

*I'm a pretty tough cookie...I told the GPs it **had** to happen....There aren't practice nurses...fully qualified in these areas...so we've got to train our own.*
(Practice41_P29 Nurse F)

In all cases, nurse managers had to demonstrate to their practice manager/GP employers the value of taking nurses away from clinical practice to attend training. Anticipated added value was improved care to patients, freeing up of (more expensive) GP time and longer-term efficiencies such as reduced pressure on workforce and cost savings resulting from reduction in appointments contingent on changing from single-condition to MLTC reviews.

There was a lack of clarity as to MLTC training required for nurses . Interestingly, all suggested training was based on upskilling in single-conditions, rather than upskilling in cross condition management, MLTC and/or PCC.

Discussion

Summary

Nurses could face considerable challenges with complex, person-centred MLTC management. Many struggled—at least initially—with unstructured, conversational consultations, which contrasted with the task-oriented style they were accustomed to. Despite increased workloads, including follow-up actions often extending beyond consultations, many valued opportunities to identify and address biopsychosocial issues. However, some nurse participants appeared to suggest focusing on patient-driven priorities was inefficient, given limited time available. These nurse participants had a pre-set consultation agenda focused on nationally mandated, biomedically-focused quality indicators.

Strengths and limitations

A novel and important finding of this study is, whilst nurses may be an appropriate professional group to deliver PCC in MLTC, there is no agreement on the training required to deliver such care. Indeed, identified training was predicated on upskilling multiple single-condition management rather than considering training for MLTC and/or a person-centred approach. This is a vital area for future research, underscored by a recent study on research priorities for multimorbidity in primary care which identified as its first priority “What skill mix and training are needed for the primary care workforce to manage MLTC?” (45).

Another novel finding was nurse job satisfaction could be increased by overcoming initial challenges of a consultation that was a conversation; identifying and working with people with MLTC to address person-centred priorities, rather than simply biomedically-focused, clinical priorities. This was an important benefit of caring for people with MLTC for nurses working in primary care.

Given this study analysed secondary data, it was limited as there were areas related to nurse experiences not extensively explored as part of primary study goals, e.g. nurses’ views on training needs, and differences between nurses working in practices in areas of differing deprivation.

Comparison with existing literature

Most nurse participants understood MLTC management in primary care was a complex area of nursing, requiring PCC. These findings align with the other study in the field of nurses’ experiences of managing MLTC (32). Despite this recognition of the complexity of MLTC management, and political rhetoric advocating holism, the way in which LTC management in general practice in England is financially incentivised and structured may constrain nurses into undertaking single-condition reviews (33).

In our study, some nurses struggled, initially, at least, with the freedom and lack of structure of a consultation that was a conversation. The literature shows nurses working in primary care are increasingly undertaking tasks previously solely performed by doctors. (34) Our study demonstrated nurses are the professional group most likely to undertake MLTC reviews which the literature identifies as complex (32). GPs are extensively trained in the “subtleties and intricacies” of primary care consultations (35, p.7). In contrast, nurse training tends to focus on single-condition management within a specific scope of practice with less emphasis on consultation skills (18, 36,37). Careful consideration needs to be given to the training nurses would require to become confident in undertaking this vital role in UK primary care.

Like the other study in this area (32), we found issues identified through MLTC consultations were often psychosocial or centred around care coordination or navigation, rather than biomedical. Many nurse participants valued time to explore these issues with patients, despite the obvious additional work it conferred on them (e.g. following up referrals), often beyond consultations’ time limits. Other literature supports the importance of person-centred rather than biomedically focused patient-healthcare professional interactions in primary care that may improve concordance

to treatment regimens, patients' self-management skills and lead to improvements in health outcomes for individuals and health systems (38). Contrary to the other study in this area (32), some nurse participants in our study suggested focusing on patient-driven priorities was inefficient. They highlighted the challenge of delivering PCC and the practice's pre-set agenda for patients' LTCs linked to evidence-based, nationally mandated quality indicators to ensure safe clinical management in time-limited consultations. The need for additional time for complex consultations, particularly in areas of socioeconomic deprivation has been highlighted (39). It is important the additional work and time to provide care going beyond ensuring clinically safe condition management and supporting people to live well with MLTC is recognised and resourced.

Importantly, many healthcare professional participants in our study reported they themselves (if nurses) or nurses in their general practices did not feel adequately trained to provide effective MLTC care, to the extent nurses could leave organisations insisting on them undertaking MLTC reviews. Undergraduate nurse training in UK and elsewhere tends to be centred on single disease management, predominantly in hospitals (43,44). There is postgraduate training available for LTC management for primary care healthcare professionals in UK, but it is predominantly single-condition specific and is of variable quality (13). In our study, some nurses were supported to access and attend appropriate external training by their general practice, which could also be underpinned by experiential 'on the job' learning and clinical supervision from more experienced practitioners. Other nurses were not given opportunities for either external or practical training. Nurses who were not supported to attend adequate training found the additional complexity of managing people living with MLTC difficult. Our findings, supported by wider literature, demonstrate the complexity of supporting a person living with MLTC, and the importance of appropriate education and training to underpin this (38, 40, 41, 42).

Implications for research and/or practice

The study highlights considerable variation in healthcare professionals' views on the purpose of MLTC reviews and the need for nurse training. Notably, these differences tended to cluster within general practices rather than across professional roles, suggesting shared practice culture may shape opinions more than professional identity.

Many healthcare professionals in our study valued MLTC reviews as a way to support PCC. However, delivery varied across practices. General practice professionals should view MLTC reviews not only as tools to ensure safe clinical management but as opportunities to collaborate with patients in setting biopsychosocial priorities for the year ahead. To enable this, nurses—and other relevant professionals—must be adequately trained, not only in the physiological knowledge and skills of conditions making up patients' LTCs but in the art of consultation and delivery of PCC – the consultation as a conversation.

Clinical guidelines generally focus on single rather than multiple LTCs which may create unnecessary and burdensome work for patients with MLTC, their informal carers and healthcare professionals (46). It is important guidelines take account of

MLTC as the National Institute for Health and Care Excellence (NICE) has begun to do (47). Pre and post graduate nurse training needs to reflect this.

Conclusion

The management of MLTCs is a complex area of care, requiring considerable skill, competence and the exercise of professional judgement. Such complexities need to be considered when designing training for healthcare professionals in the delivery of person-centred MLTC care.

Our study findings emphasise the purpose of MLTC reviews should be meaningful discussions of complex problems leading to action, rather than data gathering exercises. Training for healthcare professionals should be tailored towards this.

Organisational facilitation of training, with consideration given to clinical supervision, for nurses delivering person-centred, MLTC care is important. However, further research on the skills and training for all healthcare professionals working with people with MLTC is required.

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Ethical approval

This study received approval from Wales REC 6 NHS Research Ethics Committee (Ref: 22/WA/0018)

Competing interests

The authors declare that they have no competing interests.

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