

## Care Home Hub GP Extensivist

February 2026

### Job Description

#### Who?

An opportunity has arisen for an experienced, compassionate GP to join our award-winning, growing, multi-disciplinary team at the Ageing Well Care Home Hub. If you are passionate about providing high quality care for older people\* and would enjoy practicing holistic medicine within a friendly, supportive team then this job would suit you. The right candidate will have outstanding communication skills, alongside commitment to lifelong learning and clinical excellence. We seek a reflective, adaptive, collaborative practitioner with enthusiasm for team working. This unique role would suit a curious professional who thrives when working autonomously but with peer support. Experience of palliative care, multimorbidity, care of older people or those living with dementia or learning difficulties would be valuable. Understanding of the needs of our local community would be advantageous.

\*and those living with learning disabilities and severe mental illness

#### What?

The One Weston Care Home Hub is a true multidisciplinary team, established in 2021, bringing together a range of allied health professionals and GP's to work towards a common goal of improving care for care home residents in Weston Super Mare. Working alongside a friendly, dedicated team of GP's and allied health professionals (pharmacists, community nurses, advanced nurse practitioners, a paramedic and a mental health nurse) this innovative project is transforming community care in some of the most deprived wards in the country. Excellent admin support enables clinicians to focus on clinical matters.

The role of the GP within the team is as follows:

- To provide clinical assessment of care home residents, via a mix of preventative (proactive) and acute (reactive) medicine.
- To undertake holistic assessment of residents needs and devise creative solutions, utilising the skills of the MDT to best effect.
- To produce a dynamic personalised care plan for healthcare professionals and care staff to follow, which includes treatment escalation planning and a detailed, realistic ReSPECT form in keeping with the wishes of patients and their families where appropriate.
- To provide continuity of care to resident, family and care home staff.
- To provide senior clinical support for complex decision making, when clinical lead of the day.
- To take clinical responsibility for decisions and ongoing management of your patients, drawing on the skills of the MDT as needed.
- To contribute to peer learning and education, via significant event analysis, case based discussions and other formats.
- To provide support, clinical advice, supervision and feedback to students and other members of the MDT.
- To be actively involved in promoting adult safeguarding.
- To advocate for high quality, appropriate, patient-centred care for older or vulnerable adults.
- Record data and assessments in patient records systems promptly and accurately and to agreed standards ensuring appropriate use of read codes and templates, with awareness of QOF targets and local DES specifications.

- To compile and issue computer-generated acute and repeat prescriptions, prescribing in accordance with BNSSG prescribing formulary whenever this is clinically appropriate, working with our pharmacy hub.
- To instigate necessary invasive and non-invasive diagnostic tests or investigations and interpret findings/reports at a level that is appropriate for the patient's degree of frailty and their treatment escalation.
- To contribute and bring ideas for continuous improvement including developing / improving care pathways for older people and contributing to QIP and audit.
- To review medication using a Structured Medication Review, alongside team pharmacists.
- Lead and/or participate in specialist MDT meetings dementia/mental health, palliative care or complex care with support of the team and our community mental health and geriatrician colleagues
- To provide outreach input to cases in any of our care homes across the PCN identified as in need, to support our team of ANPs working across Pier Health. This may be complex cases, a home recognised to be in difficulty or to support our local safeguarding processes.

### **How?**

Each day starts with a whole team check-in either in person or via Microsoft Teams to check on wellbeing, discuss problems and ideas, share updates and to distribute workload.

Clinical lead of the day is assigned during this meeting.

The GP may then have a ward round in a care home, be completing comprehensive geriatric assessments, producing care plans and ReSPECT forms, liaising with families and other partners such as hospitals or district nurses, or dealing with requests for acutely unwell care home residents. There is protected time for learning activities, teaching, supervision, quality improvement work and meetings. This work takes place via a variety of formats – telephone, video, email and face to face. Career and personal development is promoted through regular 1:1 meetings with the team leader.

### **Where?**

This work mainly takes place from our town centre Care Home Hub in a newly built surgery and in the surrounding care homes. There is scope to work remotely at times.

## Person Specification

	Essential	Desirable
QUALIFICATIONS	<ul style="list-style-type: none"> <li>• Medical Degree</li> <li>• MRCGP (or equivalent)</li> </ul>	<ul style="list-style-type: none"> <li>• Diploma of Geriatric Medicine</li> <li>• MRCP</li> </ul>
	Adult Safeguarding Level 3	
EXPERIENCE	Experience of Multidisciplinary Working	
	Knowledge of current clinical evidence-based practice	
PERSONAL QUALITIES	<ul style="list-style-type: none"> <li>• Planning and Organising</li> <li>• Motivated and Proactive</li> <li>• High degree of integrity</li> <li>• Flexible and co-operative</li> </ul>	<ul style="list-style-type: none"> <li>• Ability to work and lead a team under pressure</li> </ul>
SKILLS	Experience working with Frailty (includes holistic assessments of patients, history taking, problem listing and management plan formation)	Additional experience in: <ul style="list-style-type: none"> <li>• Palliative Care</li> <li>• Mental Health</li> <li>• Learning Disability</li> <li>• Dementia</li> </ul>
	Risk holding in the community, patient clinical safety awareness	
	IT literate (MS Teams, EMIS,MS office)	Enhanced use of Microsoft Office suite, EMIS data searches, Power BI
	<ul style="list-style-type: none"> <li>• Good interpersonal skills</li> <li>• Effective time management (Planning and organising, prioritisation and handover)</li> <li>• Attention to detail.</li> <li>• Excellent communication and interpersonal skills (including emotional intelligence to deal effectively with sensitive patient information, distressed or aggressive patients or those with impaired understanding)</li> <li>• Resilience</li> </ul>	<ul style="list-style-type: none"> <li>• Evidenced Team leadership.</li> <li>• Forward thinking and planning</li> </ul>
	Influencing beyond your role; working with care home staff, owners, and managers	
	Understands Mental Capacity Act and process for best interests decision-making	
OTHER REQUIREMENTS	Willingness to travel and work across community locations and in care homes	
	Flexibility around working days and annual leave dates to ensure safe levels of clinical cover are maintained	

