Salaried GP Complex Care and Care Homes

Job description · One Weston Care Home Hub · July 2026

ROLE PROFILE

Service	One Weston Care Home Hub, Pier Health Group
Clinical reach	Approximately 450 care home beds across Weston-super-Mare
Location	Based at 168 Medical, with work in surrounding care homes and some scope for remote working
Working pattern	Four sessions / two days per week preferred; other patterns considered
Hours	Weekday, in-hours service; no evening, weekend, ordinary practice or duty-doctor commitments
Salary	£11,400 per session per annum

PURPOSE OF THE ROLE

The postholder will provide high-quality, relationship-based general practice to an allocated caseload of care home residents. The role combines continuity with proactive and responsive clinical care, allowing the GP to understand the whole picture and make considered decisions with residents, families and care home teams.

Working as a senior medical generalist within a true multidisciplinary team, the GP will focus particularly on advance care planning, palliative care, multimorbidity and diagnostic uncertainty. They will provide clinical supervision and decision support to ACPs and senior nurses while drawing on the complementary expertise of colleagues across pharmacy, community nursing, mental health and palliative care.

This is complex, relationship-based general practice, not a narrow or routine care home role. The aim is to deliver thoughtful medicine with continuity, shared clinical reasoning and care that reflects what matters to each person.

HOW THE ROLE WORKS

- The GP holds an allocated caseload, supporting continuity with residents, families and care home teams.
- Each day begins with a whole-team check-in to share updates, discuss concerns, distribute work and identify the clinical lead for the day.
- Clinical work includes proactive reviews, ward rounds, comprehensive assessment, advance care planning, responsive assessment and family conversations.
- Time is built in for clinical supervision, peer learning, teaching, quality improvement and service development.
- Excellent administrative support enables clinicians to concentrate on clinical work and follow-through.

Key responsibilities

The responsibilities below describe the core of the role; they are intended to support good judgement, not replace it.

RELATIONSHIP-BASED CLINICAL CARE

- Provide proactive and responsive GP assessment for care home residents, using face-to-face, telephone, video and other appropriate formats.
- Undertake holistic assessment, identify and prioritise problems, and devise personalised management plans that use the skills of the MDT effectively.
- Maintain continuity with residents, families and care home teams, taking responsibility for follow-through and ongoing management.
- Lead advance care planning and treatment-escalation conversations, producing clear, realistic care plans and ReSPECT documentation in keeping with the wishes of residents and families.
- Assess acute deterioration and diagnostic uncertainty, arranging and interpreting investigations in a way that is proportionate to frailty, likely benefit and agreed treatment escalation.

SENIOR CLINICAL DECISION SUPPORT AND SUPERVISION

- Provide senior medical input for complex decisions and act as clinical lead of the day when allocated.
- Hold clinical responsibility for decisions concerning the GP's patients while drawing appropriately on the skills and perspectives of the MDT.
- Provide clinical supervision, advice, feedback and case discussion for ACPs, senior nurses, students and other members of the team.
- Contribute to a learning culture through significant-event review, case-based discussion, teaching and reflective practice.

MULTIDISCIPLINARY AND PARTNERSHIP WORKING

- Lead or participate in specialist MDTs for palliative care, dementia and mental health, and other complex-care needs.
- Work closely with care home staff and managers, pharmacists, community nurses, hospice colleagues, mental health teams, geriatricians and hospital services.
- Undertake structured medication review alongside pharmacy colleagues and support clinically appropriate prescribing and deprescribing.
- Provide outreach support where a complex case, a care home under pressure or a safeguarding concern would benefit from senior GP input.

CLINICAL GOVERNANCE, SAFETY AND PROFESSIONAL PRACTICE

- Promote adult safeguarding and apply the Mental Capacity Act, including best-interest decision-making, with support from colleagues where appropriate.
- Maintain timely, accurate clinical records and use agreed coding, templates and personalised care-planning standards.
- Prescribe safely and in accordance with the BNSSG formulary where clinically appropriate, working with the pharmacy team.
- Support delivery of relevant QOF, local enhanced service and contractual requirements without allowing process measures to displace person-centred care.
- Take part in audit, quality improvement, significant-event learning and other clinical-governance activity.

Development and person specification

What the postholder should bring, and what the Hub can help them develop.

DEVELOPMENT OFFER

The role is designed for a confident generalist who wants to deepen meaningful clinical practice. The Hub offers supported opportunities to build capability in safeguarding, mental capacity and best-interest decision-making, learning disability, dementia and mental health, and the care of deteriorating people living with frailty. These are increasingly important capabilities for general practice and neighbourhood health.

For those who want it, there is also scope to develop teaching, pathway improvement, quality improvement and clinical leadership. Career and personal development are supported through protected learning time, peer discussion and regular one-to-one conversations with the team leader.

PERSON SPECIFICATION

AREA	ESSENTIAL	DESIRABLE
Qualifications and registration	• Medical degree • MRCGP or equivalent • GMC registration • Adult safeguarding level 3	• Diploma of Geriatric Medicine, MRCP or a BGS Frailty Module completion • Palliative Care interest or experience
Generalist clinical capability	• Experienced GP generalist • Holistic assessment and management of complexity • Safe community risk-holding and sound clinical judgement • Current evidence-based practice	• Experience in palliative care, frailty, multimorbidity or care homes
Supervision and teamwork	• Able to clinically supervise ACPs and senior nurses • Experience of multidisciplinary working • Able to give clear advice, constructive feedback and appropriate challenge	• Teaching, educational supervision or team-development experience
Communication and relationships	• Compassionate communication with residents and families • Able to work with care home staff, managers and partner organisations • Emotional intelligence in sensitive or difficult situations	• Experience influencing or improving care beyond an individual clinical encounter
Personal approach	• Reflective, adaptive and collaborative • Values continuity and person-centred care • Organised, dependable and comfortable with uncertainty • High degree of integrity	• Interest in quality improvement, pathway development or neighbourhood health
Practical requirements	• Competent with EMIS, Microsoft Teams and routine digital tools • Willing to travel to community and care home locations • Able to work flexibly with colleagues to maintain safe clinical cover	• Enhanced digital, audit or population-health skills

This job description describes the principal responsibilities of the post. It is not exhaustive and may evolve, in discussion with the postholder, as the Care Home Hub and neighbourhood model develop.