Transforming Cardiovascular Disease (CVD) Prevention in Somerset

Resources in the Management of Hypertension

This guide is for Primary Care Networks and practices in Somerset aiming to take a proactive approach to managing their hypertensive patients and adapt the UCLPartners Framework for hypertension.

South West Academic Health Science Network

SOMERSET LOCAL PHARMACEUTICAL COMMITTEE

Fit for my future Somerset

Contents

Summary: Resources for the Management of Hypertension

This pack is designed to help Primary Care Networks (PCNs) and General Practitioner (GP) practices in the vital work of diagnosing hypertension and managing it optimally to improve patient care, prevent cardiovascular disease (CVD) and reduce health inequalities across Somerset. It has been produced collaboratively by Dr Marie-Joelle West, programme lead for Blood Pressure Optimisation (BPO) at the South West Academic Health Science Network (South West AHSN) with input from colleagues at NHS Somerset Integrated Care Board (ICS), Somerset County Council and the Local Pharmaceutical Committee.

It describes:

- The rationale for focusing on hypertension
- The national policy context aligned to GP practice contractual requirements
- Available search and risk stratification tools, implementation resources and data sources
- Information about the support available from the South West AHSN and Public Health teams to enable practices and PCNs to develop action plans
- Details about the NHS blood pressure check service in community pharmacy
- Contact details for all teams who can support primary care staff to develop their approach to managing hypertensive patients
- Patient Resources for sharing
- A comprehensive list of resources in the Appendix

This pack will be regularly updated. Feedback from primary care staff is encouraged in order to improve these resources for the future. Please send feedback to Dr Marie-Joelle West at marie-joelle.west@swahsn.com

1. Introduction: Why is the management of high blood pressure such an important priority?

Cardiovascular deaths constitute a quarter of all deaths in the UK and high blood pressure is the largest single known risk factor for cardiovascular disease and related disabilities. New estimates suggest the annual cost to the NHS in England from conditions attributable to high blood pressure is over £2 billion. Cardiovascular deaths are a leading contributor to health inequalities for death rates between those in the most and those in the least deprived populations. People living in the most deprived areas are 30% more likely to have hypertension[*].

The Size of the Prize for high blood pressure (*Figure 1*) was developed using Integrated Care System (ICS)-level data collected before and one year after the start of the COVID pandemic, to demonstrate the potential for preventing heart attacks and stroke through blood pressure optimisation. For Somerset ICS, it shows the impact of COVID in disrupting the treatment for people with high blood pressure and the 3-year ambition of preventing 66 heart attacks and 98 strokes by BPO.

[*] https://www.gov.uk/government/publications/health-matters-preventing-cardiovascular-disease/health-matters-preventing-cardiovascular-disease

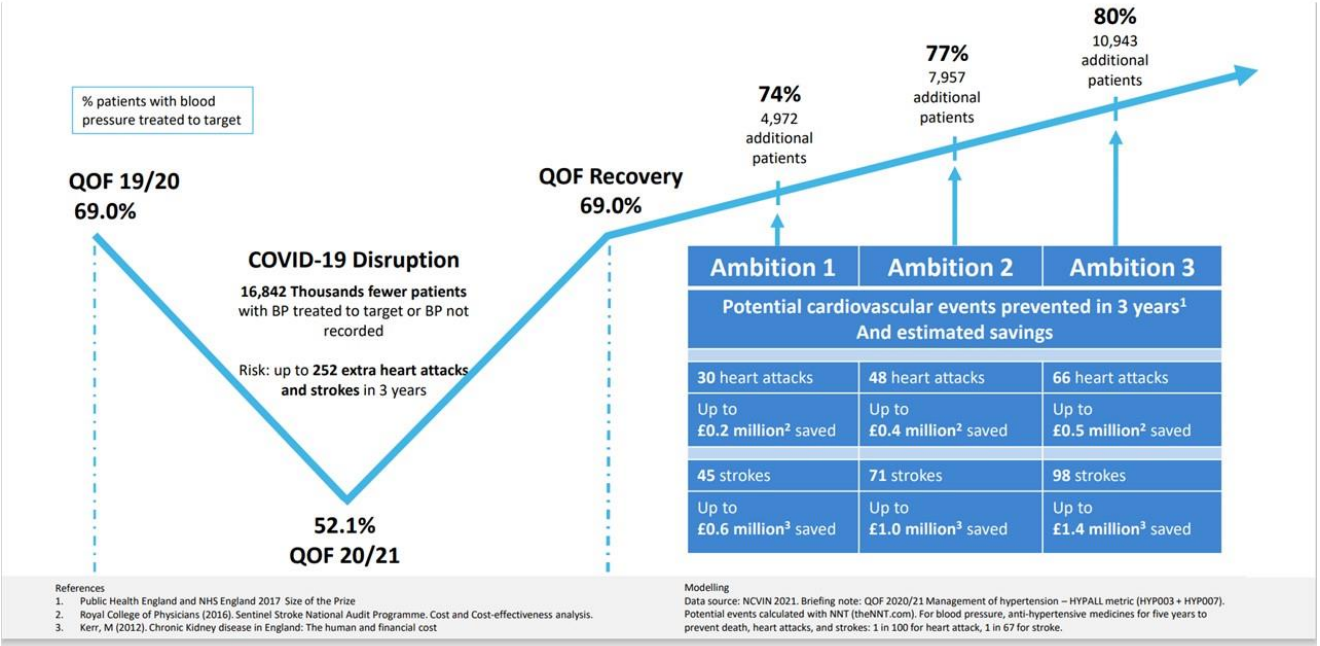

Figure 1: Size of the Prize for Someret ICS showing the number of preventable heart attacks and strokes by 2025

2. Hypertension Agenda for Primary Care

The agenda for hypertension management is informed by the ambitions of the NHS 10-Year Long Term Plan and incentivised through the Network Contract Directed Enhanced Service (DES) and Quality and Outcomes Framework (QOF) payments. In addition, hypertension case finding and management, and lipid management is a clinical focus area in the national health inequalities programme: CORE20PLUS5.

The financial incentives are summarised below and illustrated in the Appendix to support practices meet their contractual requirements.

2.1. NHS 10 YEAR PLAN

The ambitions for the management of hypertension in the NHS 10-year plan are:

- Detection: 80% of the expected number of people with hypertension are diagnosed by 2029
- Treatment: 80% of the total number of people diagnosed with hypertension are treated to target as per NICE guidelines NG136 by 2029. The treatment target for hypertension is 140/90 in people aged under 80, and 150/90 in people aged 80 and over.

2.2. NETWORK CONTRACT DES

The CVD Prevention and Diagnosis component of the Network Contract DES (see Appendix) sets the following requirements in the management of hypertension:

- Improve diagnosis of patients with hypertension, where a blood pressure of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded. This will include proactive review of historic patient records.
- Undertake activity to improve coverage of blood pressure checks, by: i. increasing opportunistic blood pressure testing; ii. undertaking blood pressure testing at suitable outreach venues, as informed by local data on health inequalities and potentially at-risk groups; iii. working pro-actively with community pharmacies (see section 5).

In addition, a PCN must:

- Improve the identification of those at risk of atrial fibrillation.
- Undertake network development and quality improvement activity to support CVD prevention including: reviewing outputs, sharing key learning amongst PCN staff, supporting system pathways, collaborating with commissioners, collaborating with community pharmacies.

2.3. PCN IIF TARGETS

- CVD-01: Percentage of patients aged 18 or over with an elevated blood pressure reading (≥ 140/90mmHg) and not on the QOF Hypertension Register, for whom there is evidence of clinically appropriate follow-up to confirm or exclude a diagnosis of hypertension.
- CVD-02: Percentage of registered patients on the QOF Hypertension Register.

2.4. QOF REQUIREMENTS

- BP002. The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years BP002 (Value: 15 QOF points; Thresholds: 50-90%).
- HYP001. The contractor establishes and maintains a register of patients with established hypertension (Value: 6 QOF points).
- HYP003. The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less s (Value: 14 QOF points; Thresholds: 40-77%).
- HYP007. The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less s (Value: 5 QOF points; Thresholds: 40-80%).

These targets require a community wide approach to BP detection and management working in collaboration with NHS Somerset, Public Health teams, Community Pharmacy and South West AHSN (see below for contact details).

Dr Marie-Joelle West, BPO Programme Manager, marie-joelle.west@swahsn.com

2.5. Core20PLUS5 - Introduction

Core20PLUS5 *(Figure 2)* is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. CVD is one of the biggest contributors to the life expectancy gap between the most and least deprived population groups. Hypertension case-finding and optimisation and optimal lipid management is one of the 5 focus clinical areas in the Core20PLUS5 approach.

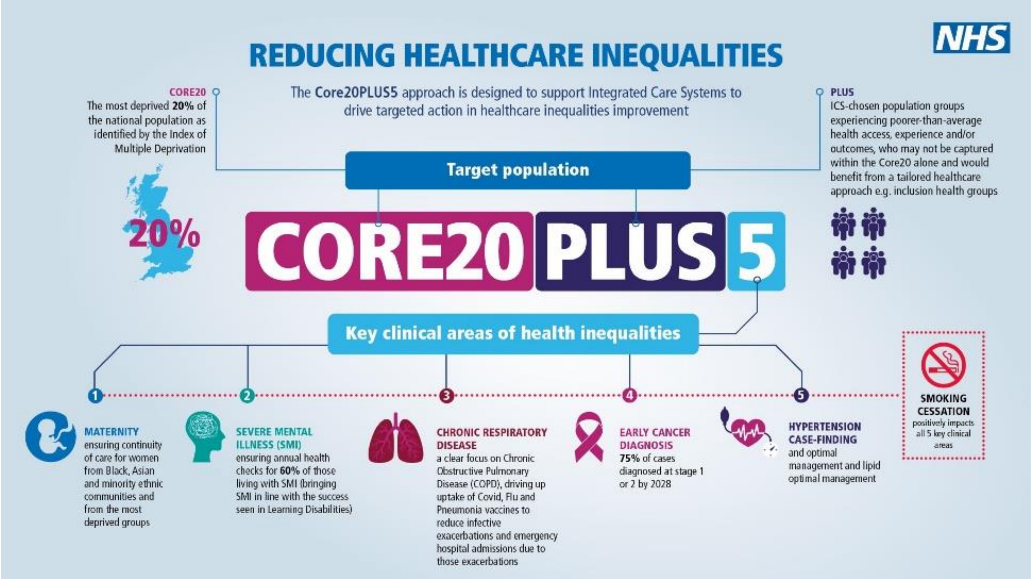

Figure 2: The Core20PLUS5 approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

2.6. Core20PLUS5 - Somerset System Target Population Cohort

At a system level in Somerset, the priority target population cohort includes the CORE20 (20% most deprived nationally, as defined by the Index of Multiple Deprivation (IMD) and the Somerset System Plus cohort which includes:

- Individuals, families and communities experiencing rural and coastal deprivation.
- Individuals, families and communities adversely affected by differential exposure to the wider determinants of health – for example, homeless persons, vulnerable migrants and/or those experiencing domestic abuse.
- Persons with severe mental illness and learning disability and people with autism.

3. A risk stratification approach to BP Management

The South West AHSN supports primary care staff to implement or adapt the hypertension management framework developed by UCLPartners (UCLP) and recommended by the Royal College of GP's Long Term Conditions Recovery Guidance.

3.1. Benefits of a risk stratification approach:

- Stratification informs workflow and workforce planning by prioritising and optimising clinical care.
- GP's workload can be reduced by utilising the wider workforce to manage different priority groups.
- A shift between priority groups demonstrates clinical impact and helps GPs to meet QOF and other targets.

3.2. The UCLP Proactive Framework

The free resources that are available via the UCLP Framework website (*see Appendix for a comprehensive list*), include:

- Search & stratification tools for Ardens, EMIS and SystmOne *(see priority categories in Figure 3).*
- Implementation guidance and resources for clinicians focussing on the HOW *(see example in Figure 4).*
- Case studies and video clips from clinicians.
- Protocols for Health Care Assistants (HCA) and similar roles.
- Digital resources for staff and patients.

3.3. Support from the South West AHSN:

The South West AHSN offers bespoke support to practices wishing to optimise blood pressure management, which includes:

- Implementing or adapting the UCLP Proactive Hypertension Framework into a local setting.
- Developing a workforce framework that is adapted to local requirements.
- Facilitating workforce training, coaching and peer-support sessions.
- Accessing and understanding relevant data.
- Providing targeted support for patient education, self-management and behaviour change.
- Gaining access to digital tools, data dashboards and emerging new technologies.
- Linking up with relevant service providers (e.g. pharmacies).

Interested practices can contact Dr Marie-Joelle West, BPO programme manager by email (marie-joelle.west@swahsn.com) or complete an expression of interest here

To find out more about the South West AHSN CVD Programme, visit the South West AHSN website.

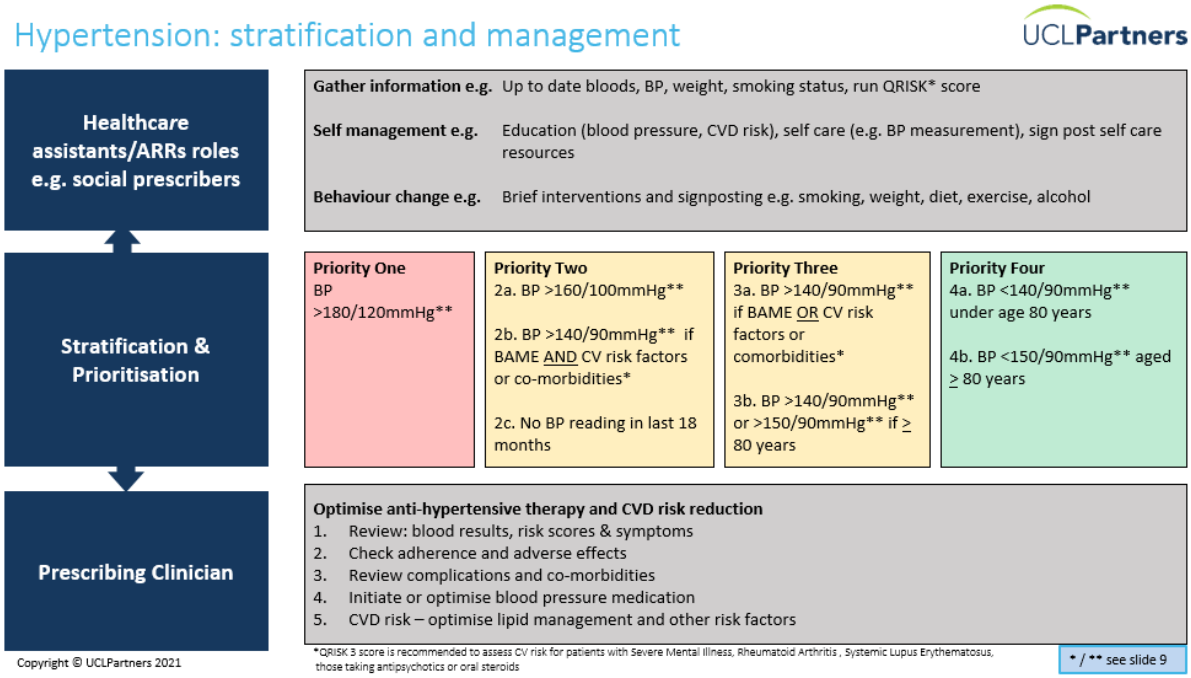

Figure 3: UCLPartners' risk stratification searches organise all the patients on the hypertension register into patient cohorts based on their last recorded blood pressure reading and other factors such as ethnicity, cardiovascular risk factors and co-morbidities. In addition to the clinician intervention, the wider workforce can be used to provide proactive care to patients.

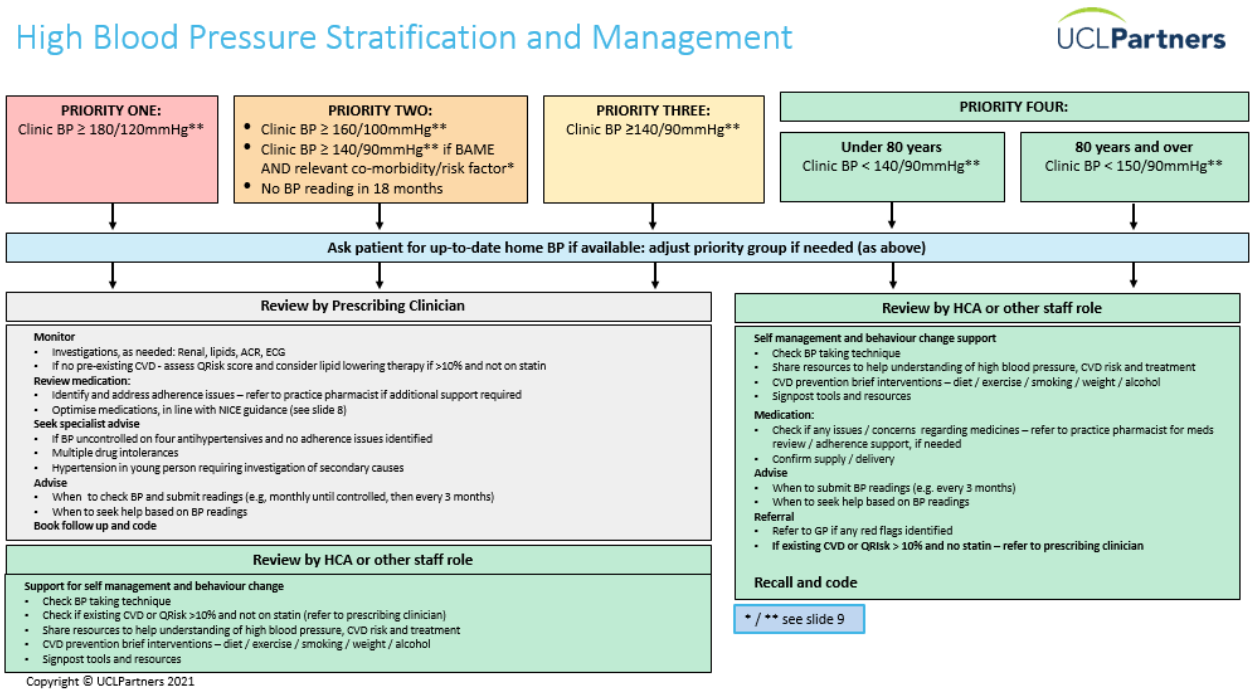

Figure 4: Workflow following blood pressure stratification.

4. Data

4.1. QOF dashboards

The dashboard allows you to see how your GP practice, and other practices, perform against the measures; and to find out the prevalence of disease, and the percentage of all patients who have the condition.

- Dashboard for QOF 2021 – 2022: Click here
- Dashboard for QOF achievement, prevalence and exceptions: Click here

4.2. CVD Prevent

The Cardiovascular Disease Prevention Audit (CVDPREVENT) is a national primary care audit that automatically extracts routinely held GP data. This tool provides open access to the data, with clear, actionable insights for those tasked with improving cardiovascular health in England.
Tools available:

- Quality Improvement Tool: See an overview of CVD data specific to your STP, ICS, PCN or Practice.
- Data Explorer: Explore the data for your practice or PCN, indicator-by-indicator, through different visualisations.
- Data Extracts: Download the raw data for each of the indicators at any system level.
- Resources: For the next steps aimed at supporting real-world change, including tools for GPs and patients, Toolkits, Data Packs, Tools for Lifestyle Changes, Treatment Pathways, Stratification tools.

4.3. SHAPE (Strategic Health Asset Planning and Evaluation)

SHAPE is a web enabled, evidence-based application linking national data sets, clinical analysis, deprivation indices, primary care and demographic data with information on healthcare estates performance and facilities location. The application also includes a fully integrated Geographical Information System mapping tool and supports travel time analysis.

Access to the SHAPE Place Atlas is free to NHS professionals and Local Authority professionals with a role in Health or Social Care. Access to the application is by formal registration and licence agreement.

For support with data, contact Dr Marie-Joelle West, BPO programme manager, marie-joelle.west@swahsn.com

5. Somerset Local Pharmaceutical Committee (LPC)

5.1. The Hypertension case-finding service

The Advanced service will support the work that general practices and wider PCN teams will be undertaking on CVD prevention and management. To improve diagnosis of patients with hypertension, PCNs must work pro-actively with community pharmacies via the hypertension case finding service.

In Somerset, there are 52 pharmacies signed up across the county and delivering the service. In public-facing communications, the service is described as the NHS Blood Pressure Check Service. See appendix for a map showing pharmacies providing the service in Somerset.

The service aims to:

- Identify people with high blood pressure aged 40 years or older (who have previously not had a confirmed diagnosis of hypertension), and to refer them to general practice to confirm diagnosis and for appropriate management.
- At the request of a general practice, undertake ad hoc clinic and ambulatory blood pressure measurements.
- Provide another opportunity to promote healthy behaviours to patients.

The service has two stages, that contractors must undertake to:

1. Identify people at risk of hypertension and offer them a blood pressure measurement (a 'clinic check').
2. Where clinically indicated, offer a 4-hour ambulatory blood pressure monitoring (ABPM). The blood pressure test results will then be shared with the patient's GP to inform a potential diagnosis of hypertension.

5.2. Inclusion

- Adults who are 40 years old or over, who do not have a current diagnosis of hypertension.
- Patients, by exception, under the age of 40 who have a recognised family history of hypertension.
- Patients between 35 and 39 years old who are approached about or request the service may be tested at the pharmacist's discretion.
- Adults specified by a general practice for the measurement of blood pressure (clinic and ambulatory blood pressure checks). This process should be agreed locally with general practices.

5.3. Exclusion criteria

- People who are unable to give consent to participate.
- People under the age of 40, unless at the discretion of the pharmacist or specified by a general practice.
- People who have their blood pressure regularly monitored by a healthcare professional.

5.4. General practice referrals

If practices want to refer patients who have already been diagnosed with hypertension for blood pressure checks, then contractors should work with their practices to agree a local process by which this will work; there are no specific requirements set for this process and it could involve the practice agreeing that a specific list of patients can access the service or a cohort of patients could be specified. General practices will also be able to refer patients requiring ABPM; in this scenario it is recommended that this referral is made electronically to the pharmacy.

To find out more about the service, visit the LPC website. For further support, contact Michael Lennox, michael.somersetlpc@gmail.com

6. Working with Somerset's Public Health Teams

6.1. Local Support

Public Health teams in Somerset encourage a local approach to CVD prevention at PCN level and can offer additional support, alongside the South West AHSN, to enable hypertension case finding and management of patients living in deprived communities or with severe mental illness. The support relates to:

- ABC agenda.
- Addressing Inequalities.
- NHS Health Checks, which i. assess seven of the top modifiable risk factors: blood pressure, cholesterol, blood glucose, alcohol, body mass index, smoking and physical activity; ii. support patients access services and clinical care; iii. are commissioned by local authorities with general practice as the main provider of the service.
- Supporting innovations and outreach (e.g. community outreach models).
- Behavioural pathways (e.g. social prescribing, lifestyle services).
- Data and Intelligence (e.g. Data sets, Community Connector Pilots).
- Enabling discussions about how best to engage Voluntary, Community and Social Enterprise (VCSE) and people with lived experience.

Please contact your public health consultants in your locality to discuss the opportunities to work together: Dr Orla Dunn, orla.dunn@somerset.gov.uk

7. Information for patients

7.1. CVD Central Offer

The CVD Central project is being delivered in collaboration by Kent Surrey Sussex (KSS) AHSN, British Heart Foundation and NHS Benchmarking to help with understanding and demonstrating the impact and outcomes in a variety of clinic and community settings. The freely available CVD Central resources that you can adapt to your own population include:

- Results cards for patients to keep track of their values (these can be ordered online from Kent Surrey Sussex AHSN free of charge by any organisation in England).
- 1st patient experience survey – on the day of check.
- 2nd patient experience survey – one month post check.
- Resource pack to support detection of high-risk conditions (*Appendix*).

7.2. Information for patients and support for self-management

- A guide about how to manage your blood pressure from Heart UK.
- A guide about High Blood Pressure from the Stroke Association.
- Home monitoring resource hub from Blood Pressure UK.
- Happy Hearts website shares local, practical information on self- management and control to lower CVD risk.
- Local support from One You Plymouth to self-manage health.
- Preventive health services for residents of Somerset County Council area to support weight management, smoking cessation, physical activity and managing alcohol consumption.

- NHS Diabetes Prevention Programme: the Healthier You programme, identifies people at risk of developing type 2 diabetes and refers them onto a nine-month, evidence-based lifestyle change programme.
- NHS Digital Weight Management programme: supports adults living with obesity who also have a diagnosis of diabetes, hypertension or both, to manage their weight and improve their health.

For further support about patient engagement and management, contact Dr Marie-Joelle West, CVD programme manager, marie-joelle.west@swahsn.com, or your consultant in public health, Dr Orla Dunn, orla.dunn@somerset.gov.uk

8. Appendix

8.1. List of available resources

Name	Origin	Purpose	Object
Hypertension Framework	UCLPartners	Overview	Link
Search and risk stratification tools	UCLPartners	Search and Stratification tools, free of charge	Register here to download resources
Clips and protocols	UCLPartners	How to run the searches	Link
Workbook implementation modules 1-4	UCLPartners	1. Understand context 2. Identify workforce 3. Risk stratification 4. Using Quality Improvement	Register here to download resources
Digital resources for hypertension	UCLPartners	Monitoring, Management, Wellbeing	Link
Action Plan	CVD Prevent Action	Create bespoke CVD Prevention Action Plan	Available soon
Financial Incentives	UCLPartners	Details of QOF points, DES and IIF	See below
Size of the Prize Somerset	UCLPartners	Graphical representation of heart attack and stroke prevention	Link
Staffing example	UCLPartners	Workforce utilisation in primary care	Link
Protocol for remote consultations	UCLPartners	For HCAs and other staff	Link
Suggested training and education support	UCLPartners	Implementation support for wider workforce	Link
Case Studies	UCLPartners	Peer experiences and case studies	Link
Hypertension case finding service	LPC	Training for Community Pharmacy	Link
Core20PLUS5	NHS England	Overview	Infographic
NHS Health Checks Service	Office for Health Improvement and Disparities (OHID)	Guidance for staff to promote health	Link
CVD Central Offer patient resources	KSS AHSN	Resource Pack	Link

8.2. Financial Drivers for GP practices in BP optimisation and lipid management

This guide has been compiled by UCLPartners to provide key financial information for practices aiming to optimise BP and lipid management.

Drivers and Incentives in Primary Care

Blood Pressure Optimisation and Lipid Management

Quality and Outcomes Framework (QOF)

The Quality and Outcomes Framework (QOF) is a system designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced in 2004.

https://www.england.nhs.uk/wp-content/uploads/2022/03/B1333_Update-on-Quality-Outcomes-Framework-changes-for-2022-23_310322.pdf

Key hypertension indicators in QOF 22/23

- **BP002.** The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years (Value: 15 QOF points; Thresholds: 50-90%)
- **HYP001.** The contractor establishes and maintains a register of patients with established hypertension (Value: 6 QOF points)
- **HYP003.** The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90mmHg or less (Value: 14 QOF points; Thresholds 40-77%)
- **HYP007.** The percentage of patients aged 80 years and over with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (Value: 5 QOF points; Thresholds: 40-80%)

Other QOF indicators exist for control of BP in patients with co-morbidities such as CHD, diabetes, stroke and TIA.

Key lipid incentives in QOF 22/23

There are limited lipid incentives in QOF relating to use of statins in people with diabetes:

- **DM022.** The percentage of patients with diabetes aged 40 years and over, with no history of cardiovascular disease and without moderate or severe frailty, who are currently treated with a statin (excluding patients with type 2 diabetes and a CVD risk score of <10% recorded in the preceding 3 years)
- **DM023.** The percentage of patients with diabetes and a history of cardiovascular disease (excluding haemorrhagic stroke) who are currently treated with a statin

Primary Care Network (PCN) Directed Enhanced Service (DES)

The aim of the Network Contract DES is to support PCNs to deliver the ambition for improved standards of care across the country, setting realistic expectations for delivery that benefit patients. By 2023/24, the Network Contract DES commits an investment of £2.4 billion into primary care across the country, or £1.47 million per typical PCN. This includes funding for around 26,000 more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers.

https://www.england.nhs.uk/wp-content/uploads/2021/08/B0828-ii-annex-a-pcn-plans-for-21-22-and-22-23.pdf

Key hypertension indicators in PCN DES 22/23

- Improve diagnosis of patients with hypertension, in line with NICE guideline NG136, by ensuring appropriate follow-up activity is undertaken to confirm or exclude a hypertension diagnosis where a blood pressure of ≥140/90mmHg in a GP practice, or ≥135/85 in a community setting, is recorded. This will include proactive review of historic patient records, to identify patients who have had a previous elevated blood pressure reading but have not had an appropriate diagnostic follow up.

8.3. List of Pharmacies and their location that provide the NHS Community Pharmcacy Blood Pressure Check Service. The data was extracted from the Shape Atlas tool (December 2022)

Code	Name	Address	Town	Postcode
FP116	Alcombe Pharmacy	39-41 Alcombe Road	Minehead	TA24 6BA
FAP59	Asda Pharmacy	Preston Road	Yeovil	BA20 2HB
FA296	Boots	6 East Street	Ilminster	TA19 0AJ
FDN85	Boots	St.James Medical Centre	Taunton	TA1 1JP
FF222	Boots	French Weir Health Centre	Taunton	TA1 1NW
FH013	Boots	Upper Holway Road	Taunton	TA1 2QA
FJ206	Boots	1 Coopers Mill	Taunton	TA2 6NX
FLA13	Boots	11 Market Place	Frome	BA11 1AB
FLV83	Boots	The Park Medical Practice	Shepton Mallet	BA4 5RT
FMG12	Boots	64-65 High Street	Taunton	TA1 3PT
FQ035	Boots	Wellington Medical Centre	Wellington	TA21 8BD
FRG31	Boots	5 Fore Street	Chard	TA20 1PH
FV860	Boots	Crown Medical Centre	Taunton	TA2 8QY
FWQ87	Boots	Wincanton Healthcentre	Wincanton	BA9 9FQ
FXL36	Boots	Unit 2A Townsend Shopping Park	Shepton Mallet	BA4 5TZ
FDG35	Boots	34-38 Fore Street	Bridgwater	TA6 3NG
FVK07	Bruton Pharmacy	19 High Street	Bruton	BA10 0AH
FMD79	Coleford Pharmacy	Crossways	Radstock	BA3 5NH
FG551	Cranleigh Gardens Pharmacy	Cranleigh Gardens Medical Centre	Bridgwater	TA6 5JS
FGC75	Creech Pharmacy	Creech Medical Centre	Creech St Michael	TA3 5FA
FGT85	Crewkerne Pharmacy	Middle Path	Crewkerne	TA18 8BX
FJG42	Day Lewis Pharmacy	Hendford Lodge Medical Centre	Yeovil	BA20 1UJ
FFR15	Day Lewis Pharmacy	The Pharmacy	Ilchester	BA22 8NH
FGN17	Day Lewis Pharmacy	Berrow Medical Centre	Berrow	TA8 2JU
FHT28	Day Lewis Pharmacy	The Medieval House	Axbridge	BS26 2AR
FLE02	Day Lewis Pharmacy	Hamdon Medical Centre	Stoke Sub Hamdon	TA14 6QE
FT109	Day Lewis Pharmacy	Abbey Pharmacy	Yeovil	BA21 3TL
FX068	Day Lewis Pharmacy	1 The Square	Taunton	TA4 2JT
FXE94	Day Lewis Pharmacy	Burnham Medical Centre	Burnham-on-Sea	TA8 1EU
FKQ23	Evercreech Pharmacy	Victoria Square	Shepton Mallet	BA4 6JP
FAP96	Jhoots Pharmacy	Victoria Park Medical Centre	Bridgwater	TA6 7AS

FEQ82	LloydsPharmacy	in Sainsbury's	Frome	BA11 4DH
FJ699	Merriott Pharmacy	31 Broadway	Merriott	TA16 5QG
FML59	Milbourne Port Pharmacy Limited	10 High Street	Sherborne	DT9 5AG
FVR21	Minster Pharmacy	15 Silver Street	Ilminster	TA19 0DH
FV219	Options Pharmacy	61b West Coker Road	Yeovil	BA20 2JD
FMQ12	Penn Hill Pharmacy	9 South Street	Yeovil	BA20 1QE
FG394	Preston Grove Pharmacy	The Pharmacy	Yeovil	BA20 2BQ
FME12	South Petherton Pharmacy	Primary Healthcentre	South Petherton	TA13 5EF
FK642	St Aldhelm's Pharmacy	Frome Health Centre	Frome	BA11 2FH
FVF04	Staplegrove Pharmacy	Unit 1 Livingstone Way	Taunton	TA2 6BD
FP032	Superdrug Pharmacy	15 High Street	Yeovil	BA20 1RQ
FDR89	Tesco Instore Pharmacy	Seaward Way	Minehead	TA24 5BY
FW386	The Blackbrook Pharmacy	Blackbrook Medical Centre	Taunton	TA1 2LB
FCW38	Tout's Pharmacy	Budgens Cheddar	Cheddar	BS27 3RB
FX097	Tout's Pharmacy	82 High Street	Street	BA16 0EN
FN345	Wedmore Pharmacy	1 Church Street	Wedmore	BS28 4AB
FAL04	Well	67 St John's Road	Yeovil	BA21 5NJ
FF236	Well	18 Victoria Street	Burnham-on-Sea	TA8 1AN
FFA77	Well	5 Priorswood Place	Taunton	TA2 7JW
FH826	Well	The Chantry	Martock	TA12 6JL
FWH16	Well	2 The Comeytrowe Centre	Taunton	TA1 4TN

8.4. Map showing pharmacies providing the NHS Community Pharmacy Blood Pressure Check Service