Table 1. Comparison of PHE estimates with the QOF 2018/2019 data from general practice in London boroughs

	QOF 2018/2019	Gov. estimate 2019	% increase
Tower Hamlets	1861	3170	70
Camden	2955	3790	28
Islington	2375	3510	32
Newham	2218	4520	100
Waltham Forest	2901	4870	68
City & Hackney	2442	3820	56

Gov. = government. PHE = Public Health England. QOF = Quality and Outcomes Framework.

underestimating prevalence by up to 100%.

PHE used a small study from 2010 in northern Sweden with a population of 76 000 to estimate the rates in an ethnically diverse population of 50 million people in England. Twenty per cent to 50% of people in some urban CCGs are from BAME groups with lower AF prevalence than white populations. Bradford AF prevalence was reduced by 70% in South Asians in comparison with the white population.[2]

The Swedish study was conducted over 7 years and included all cases of AF, including all transient hospital inpatient cases that occurred in one in three cardiac operations. When the authors analysed cases identified in a single year rather than over 7 years, numbers were reduced by half. A Scottish study based on GP diagnoses showed that the annual prevalence was less than half that in Sweden. AF in people over 85 was 22% in Sweden and 7.1% in Scotland.[3]

Comparing PHE estimates based on Sweden with the QOF 2018/2019 data from general practice in London boroughs shows overestimates of between 28% and 100% (Table 1), the higher figures being most pronounced in boroughs with large black or South Asian populations.

These data from Sweden are not reliable for the estimation of annual AF prevalence as determined by GPs and substantially overestimate annual reports of prevalence in these populations. Commissioners and GPs should beware of the gap between flawed estimates and the reality of their local community prevalence.

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Respiratory clinics and rural and Aboriginal health

Since late March 2020, Australia has established 141 GP-led respiratory clinics with more than half situated in rural areas and 16 based in Aboriginal Community Controlled Health Services.[1]

With the clear remit to augment the response of primary care by providing a pathway for the in-person assessment of acute respiratory illness, the respiratory clinics have broadly been successful in managing the escalating demand for respiratory assessment in a safe manner for health practitioners and the community. Furthermore, in our community we have benefited from good engagement with local general practices and take responsibility for closing the loop with updates to a patient's regular GP.

Our respiratory clinic has been assessing all patients with respiratory symptoms; this provides not only an opportunity to test for COVID-19 but also, critically, to deliver care for other respiratory conditions including asthma, pneumonias, and exacerbations of COPD. This focus has allowed us to rapidly become skilled in primary care management of respiratory conditions and symptoms. This opportunity to provide comprehensive care has been particularly important for people with underlying respiratory illness at a time when symptom investigation and management was challenging. The model of reimbursement is independent of time spent with each patient, allowing for greater depth of investigation and more support when required. The non-time-based funding model for respiratory clinics has also freed us to focus on in-depth work-ups of those vulnerable complex patients whose care is poorly remunerated in traditional practice.

Respiratory clinics were established through a local commissioning process, allowing for development of services that are broadly where they are needed and address community needs.

We recognise that we are a small part of a so-far successful strategy outlined by Professor Kidd,[2] but critical to the experience of COVID-19 will be the consolidation of the learning from the respiratory clinics and their application to community general practice for seasonal influenza, as well as preparation of a 'respiratory clinic in a box'[3] in the event of a future pandemic, which has been demonstrated in those countries with experience from SARS.

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Competing interests

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