Ann Boyle,
Head of School of Psychiatry, East Midlands (South) Deanery, The Evington Centre, Leicester.

REFERENCES

1. Greaves I, Jolley D. National Dementia Strategy: well intentioned — but how well founded and how well directed? *Br J Gen Pract* 2010; **60(572):** 193–198.
2. Banerjee S. *The use of antipsychotic medication for people with dementia: time for action. A report for the Minister of State for Care Services*. London: Department of Health, 2009. http://www.nhs.uk/news/2009/10October/Pages/Antipsychotic-use-in-dementia.aspx (accessed 6 Apr 2010).
2. National Audit Office. *Improving services and support for people with dementia*. London: The Stationery Office, 2007. http://www.nao.org.uk/publications/0607/support_for_people_with_dement.aspx (accessed 6 Apr 2010).

DOI: 10.3399/bjgp10X501895

Greaves and Jolley[1] challenge the architects of the National Dementia Strategy and the army of builders trying to turn plans into a reality. Provocatively (to continue the building analogy) they query whether the 'right' buildings are under construction. Constructing a memory service for early recognition of dementia, repairing care homes, and re-fashioning hospital care to make it 'dementia friendly' all require equal attention and careful surveying; not least because the former may overshadow the latter. The possible creation of a National Care Service makes predictions of need at population level essential.

However, although the pay levels of care home staff are low and their skills are often taken for granted, it is also a matter of planning (or lack of it) that has erected fences — or sometimes dug moats — between this provision and other health and care services. While high turnover of frontline workers, and especially managers in care homes may cause problems in many areas, the greater problem is the isolation of the care home sector from primary care, voluntary, and community provision. What role does it play in the training of GPs, for instance, and why is 'institutionalisation' (a terrible word) so often seen as simply a negative option?

Greaves and Jolley are some of the few doctors working in the community to engage with this subject. Social care interest groups welcome their contribution to a debate that is about the building of a National Care Service, not just the strategy for people with dementia. Social care, like general practice, knows that most people with dementia have multiple disabilities. Strategies can be blueprints but they should not build higher walls around clinical conditions and imprison specialists in ivory towers.

Jill Manthorpe,
Professor of Social Work, Social Care Workforce Research Unit, King's College, London. Email: jill.manthorpe@kcl.ac.uk

REFERENCE

1. Greaves I, Jolley D. National Dementia Strategy: well intentioned — but how well founded and how well directed? *Br J Gen Pract* 2010; **60(572):** 193–198.

DOI: 10.3399/bjgp10X501903

More randomised controlled trials on frequent attendance

We appreciate the comments that Smits[1] *et al* made on our article.[2] From this reading we deduce that they would agree with its main findings: the way in which frequent attendance is defined has an impact on the factors associated with it and their discriminative power, and the use of the top decile cut-off seems to be more recommended than the top quartile.

They introduce an interesting idea that is clearly relevant to this discussion. We should focus on those frequent attenders that persist over time, as there is a significant proportion of those who left their status after 2 or 3 years. No doubt this is a reasonable and pragmatic approach. Unfortunately, no randomised control trials that show there is some kind of GP intervention to reduce these visits of persistent frequent attenders have been published. However, a randomised control trial of a successful GP intervention with frequent attenders in primary care was published in the *BJGP*.[3] Although further randomised controlled trials are necessary, this comprehensive GP intervention with frequent attenders resulted in a significant and relevant reduction in their consultations. In fact total visits of frequent attenders of the intervention group were reduced by nearly 40%, while in the control group there was virtually no change. Moreover, this effect was found for frequent attenders of only 1 year ('short frequent attenders').

Therefore, given the evidence available so far, we cannot conclude persistent frequent attending is of more importance and clinical usefulness than short-term frequent attending, but rather the opposite.

We believe it would be more interesting to concentrate scientific efforts to determine whether that or other interventions are effective in reducing frequent attendance and if it is achieved by cost-effectiveness and cost-utility.

Juan Bellón on behalf of the authors,
Universidad de Malaga, Departemento de Medicina Preventiva y Salud Publica, Campus de Teatinos s/n, Malaga 29071, Spain. E-mail: JABELLON@terra.es

REFERENCES

1. Smits F, Brouwer H, ter Riet G. Persistent frequent attenders. *Br J Gen Pract* 2010; **60(573):** 293–294.
2. Luciano JV, Fernandez A, Pinto-Meza A, *et al*. Frequent attendance in primary care: comparison and implications of different definitions. *Br J Gen Pract* 2010; **60(571):** 49–55.
3. Bellón JA, Rodríguez-Bayón A, de Dios Luna J, Torres-González F. Successful GP intervention with frequent attenders in primary care: randomised controlled trial. *Br J Gen Pract* 2008; **58(550):** 324–330.

DOI: 10.3399/bjgp10X501912

Non-verbal behaviour

We are grateful for Dr Hay's interest[1] in our editorial[2] and agree that the physical positioning of the computer screen is an important influence on non-verbal communication in the consultation. We