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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.

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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.

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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

also agree that recording sufficient data during the time constraints of the consultation is a significant challenge. We need to be aware that the average UK primary care consultation with booking intervals of 10 minutes is on the short side for comparable countries and it may be that we need to consider giving ourselves more time.

The problem with the suggestion of typing while we talk (or listen) is that, from a patient's perspective, a doctor who is typing at the same time as they are listening is likely to be perceived as not listening as effectively as a doctor who is simply listening — and in many cases this perception will be correct.

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Aches and pains in primary care

GPs can do very positive things for some patients with aches and pains as many such patients are Vitamin D deficient. Vitamin D deficiency commonly presents with widespread aches, weakness, and tiredness, and can also present with focal symptoms. If a patient has several musculoskeletal diagnoses over time (for example plantar fasciitis, hip pain, back pain, and knee pain) then Vitamin D deficiency should be suspected. Deficiency can be confirmed biochemically by checking Vitamin D levels. Expert consensus suggests that optimal Vitamin D status requires serum levels of 25 OH Vitamin D of 75 nmol/l (that is, 30 μg/l) or more (repeat levels 3 months after initial treatment to ensure patients are replete). Recent work shows 'no credible evidence' for hypercalcaemia at treatment doses of Vitamin D.[1] Treatment must be with adequate doses (for example, 400 000 iu in the first 2 weeks and then 20 000 weekly) as low dose supplements containing calcium will not restore Vitamin D levels, nor give symptom relief. This condition is common in all ethnic groups, especially in the north and west of the country, and is often forgotten or missed.

I received this comment recently, after treatment (of a white middle-aged man). '*I feel 10 years younger with fewer aches and pains. Mood and energy levels are much improved. I can get about to go fishing much more easily*'. Many patients have similar positive experiences.

Moreover, treatment may improve general health as it is now well recognised that Vitamin D deficiency is a risk factor for many other conditions including cardiovascular disease, diabetes, cancer, and infections.[2]

Finally, patients may approach exercise with more equanimity if the hopeful phrase 'wear and repair' is used instead of the sinister 'wear and tear'.

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Stop and think or think and stop?

The editorial by Hall *et al*,[1] was a brief but fairly comprehensive overview of an area relevant to all GPs. The assessment of whether to continue previously prescribed medication need not, of course, be confined to terminal cancer sufferers. Motor Neurone Disease, end-stage organ failure, and advanced dementia are other conditions that spring to mind. My own feeling is that in current practice we probably leave such decisions until they are not decisions at all but rather when swallowing becomes an issue or other problems/side effects occur.

My wry observation is that their own rhetorical question to the title could be misinterpreted. I assume the authors mean it might be time to 'think and stop' rather than the more reactionary converse!

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Is stroke a 'trigger'?

The link between stroke and vascular dementia is known;[1] reports of psychological disturbance as a direct consequence of brain insult is noted. For example de Groot *et al*,[2] found white matter lesions after depressive episodes in patients with yet more curious phenoma emerging during counselling.

After working at the Neurorehabilitation Unit, Brighton, it was noted that stroke patients contended with an unusual legacy of past traumas. Disclosed psychological problems originated many years previously: childhood sexual abuse or the re-living of events gave rise to classical post-traumatic stress disorder (PTSD). A