Fallow Time Rationale

14th May 2021

As you are all aware, Public Health England (PHE) have cascaded down that fallow time is 30 minutes. Fallow time begins when the aerosol generating procedure (AGP) has finished, not when the patient leaves.

Where did this 60 then 30 minutes come from?

It originates from data from a hospital environment and nothing to do with dentistry or the aerosols we produce. There are also no dental representatives on the government’s SAGE committee or NERVTAG.

We can use science and evidence to mitigate or bring down the time of fallow, PHE has brought out guidance, which is just that, guidance. We can also use our own common sense and research in order to drive our practice.

I will show here and share with you the science and evidence behind how we, at Dental Studio, are reducing the fallow time to 10 minutes if the mitigations are followed. You need to bear in mind that the evidence evolves continually.

Page 37 of the FGDP guidance (1st June 2020) states: (<https://www.fgdp.org.uk/sites/fgdp.org.uk/files/editors/Implications%20of%20COVID-19%20for%20the%20safe%20management%20of%20general%20dental%20practice%C2%A0-%20a%20practical%20guide.pdf>)

Examples of justifiable mitigation would be:

* ●  Type of procedure carried out – whether a high or low risk AGE
* ●  Use of rubber dam
* ●  Use of HVA
* ●  Duration of the aerosol generation
* ●  Dimensions of the room
* ●  Methods of ventilation

So why have a fallow time of 10 minutes?

The answer now lies in science. The size of the virus is stated to be around 0.3 to 0.5 microns in diameter. According to the Centre for Disease Control (CDC) in the USA the diameter size of an aerosol will determine how long it takes to settle. The virus can many hours to settle if it alone but we know it is attached to the water from air rota or cavitron and so this takes 7 to 8 minutes to settle. 99% of aerosol is aspirated using an 8mm bore aspirator and of the 1% that is not it lands on the patient upper chest, on the bib.

So, for % that has escaped, we now have to consider other factors:

1. If you read this in conjunction with the aerosol paper, there was no covid virus on any of the splatter on the patient bib and the surrounds
2. We screen patients, so now, at worst, they are asymptomatic or pre-symptomatic carriers. The viral load in a pre-symptomatic carrier are reported to be low. So, we ask patients to wear face coverings and we in turn also wear our masks or visors when working and with our colleagues.
3. We use rubber dam where possible, the aerosol is now not mixed with any saliva and the patient cannot emit secretions
4. We use high volume suction
5. We have ventilation in the room in the surgery – Covid does not like fresh air circulating

I have attached a possible risk assessment for fallow time

As a business we need to be viable but be viable safely and for all concerned. Otherwise there will be no business. We need to use the science and evidence to facilitate treatments and consider the safe delivery for our staff, patients and our business – in that order. CQC do not want us to breach Regulations 12 and 19 and the health and safety executive places the duty on the business owner. PHE defer to HSE at the beginning of all their guidance. There is a clear difference between regs and guidance. It has been established that the vaccination programme in place is effective against the current so called Indian Variant and the second dose regime has been accelerated to 8 weeks.

At the time of writing this, there have been no dental transmissions of COVID that have been found by test and trace. Our infection control measures in dentistry have always been the highest, quite frankly I would be more concerned with the other micro organisms we face over COVID. As I write this, vaccines have been delivered to over 35,000,000 people in the UK

