South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
17 October 2024 (Online via MS Teams)
Final Minutes

1. **Welcome, introductions and apologies**
   The Chair welcomed attendees to the meeting. Apologies and observers were noted. The meeting was noted to be quorate.

2. **Conflict of interests – declarations and DOI refresh**
   The Chair asked that any conflicts of interest with the meeting agenda be declared and that any outstanding declarations be returned. No conflicts were raised.

3. **Minutes, detailed action notes of the last meeting, and action log:**
   The minutes and detailed action notes were accepted as an accurate record of the meeting subject to the correction of typographical errors. Members were provided with an update on progress against actions due for this month, these were noted, and items closed were agreed

4. **Supply disruption memo for insulin Fiasp® FlexTouch® 100 units/ml pre-filled pen (re-approval of triage panel decision)**

The author was in attendance to present this item and outlined that the Department of Health & Social Care (DHSC) released a Medicine Supply Notification (MSN) in March 2024 highlighting that Fiasp® (insulin aspart) FlexTouch® 100 units/ml solution for injection 3ml pre-filled pens will be out of stock from April 2024. Initially this supply disruption was expected to end in January 2025, however an updated MSN notes an extended date until September 2025. The memo was originally approved via the IMOC urgent Triage Panel approval process in April 2024 to support primary care in the management of the shortage. Urgent Triage Panel approvals are only valid for a maximum period of up to six months and as the shortage will be ongoing for the next year, the memo is being presented to the Committee to extend the approval timescale so that the duration of the shortage is covered. Usually such memos reiterate advice in the MSN, thus IMOC approval is not normally required. However, the memo contains additional local clinical advice from the IMOC's diabetes sub-group, which was previously approved via the urgent Triage Panel process. The additional clinical advice relates to the management of urgent /emergency switches in primary care.

The request to the Committee is to approve the memo which extends the review date to October 2025, in line with the expected timescales for the continuing shortage and updated MSN. The Committee approved the memo with the extended review date, by consensus.

ACTION: Author to arrange for finalised memo to be uploaded to appropriate SEL webpage

5. **Updated Clinical Effectiveness South East London (CESEL) hypertension guide**

The CESEL Clinical Lead was in attendance to present this item with support from the Lead supporting Integrated Care Boad (ICB) Pharmacist. The Committee were informed of updates to the following areas of the guide:

- Health inequalities - inclusion of socio-economic factors and learning disabilities
- Ambulatory blood pressure monitoring - inclusion of clinical coding information
- Hypertension management in people who are planning pregnancy, pregnant or breastfeeding – new section including medicines

Committee members were reminded that the Committee provides governance to the medicines elements of CESEL Guides. The approval being sought is for the medicines elements of the hypertension guide – for the current iteration this is the new section containing medicines recommendations for pregnancy and breastfeeding. Previous recommendations on medicines in hypertension remain unchanged. Members were informed that guide will require presentation and discussion at the Cardiovascular (CV) sub-group – the CV Medicines Working Group (CVMWG) - for their oversight and approval. It was noted that the CVMG has reviewed the guide through the

consultation process. It was agreed that any changes proposed by the CVMWG after approval by the Committee could be submitted for ratification by IMOC Chair's action. It was also confirmed that the CESEL guide is in line with current guidance from the National Institute for Health and Care Excellence (NICE) and, pending discussion/agreement via the CVMWG, the desire is to retire the IMOC hypertension guideline to avoid duplication.

As part of the Committee discussion, the presenters agreed to include signposting to the Specialist Pharmacy Services (SPS) guidance on the treatment of hypertension during pregnancy, which also includes links to NICE guidance and the UK Teratology Information Service (UKTIS). In response to a query, the presenters also agreed to include information about overprescribing and deprescribing. It was noted that spironolactone use in hypertension is included in the Guide historically but requires inclusion on the SEL adult Joint Medicines Formulary (JMF) for this indication. This is considered off-label, however, is in line with NICE recommendations made in their hypertension guideline. It was agreed that the CVMWG will be asked to support inclusion in the formulary and agree a "Red, Amber, Green, Grey" (RAGG) category and this will be fed back as part of the Chair's action for the Guide. The SEL adult JMF will be updated once the Guide is approved via IMOC Chair's action.

It was acknowledged that the wording related to the use of alpha blockers and vasodilators in pregnancy needed clarification and would be updated to advise which medications should be reserved for specialist only prescribing in pregnancy. It was also agreed that the wording would be amended to note that patients under 40 years old should be considered for referral to a specialist if there is a risk of secondary causes of hypertension. Committee members also requested that the CVMWG discuss whether the Guide should include another calcium channel blocker as an alternative to amlodipine if ankle swelling is a problem. The presenters agreed to include signposting to the available community pharmacy hypertension services which may support with diagnosis and to include signposting to Vital 5 around alcohol consumption. Following a comment from a member relating to the patient support page where its mentions SEL/National resource, the presenters agreed to reformat the dietary advice section to make clear that recommendations are not set out by borough.

The Committee agreed by consensus to approve the updated CESEL hypertension guide pending follow up and amendments in line with the meeting discussions.

ACTION: Amendments to the guide to be discussed, reviewed and approved at CV sub-group (including formulary inclusion of spironolactone)
ACTION: Following review at the CV sub-group, author to share amended guide with IMOC team for IMOC Chair's ratification

6. Follow up for formulary application on the use of carvedilol in the prophylaxis of variceal bleeding in children with portal hypertension (PHT) - re-categorisation from interim Red to Amber 2

The specialist paediatric pharmacist supporting this item was unable to attend the meeting and the item was instead presented by the Lead Formulary Pharmacist. The formulary application for carvedilol in this setting was discussed at the December 2023 IMOC meeting. Committee members had requested that clear guidance is offered to the primary care clinician taking on the responsibility of prescribing in the form of a patient information leaflet (PIL) to support primary care. An interim Red category was approved until the PIL was created, at which point the re-categorisation to Amber 2 would be considered by the Committee. The PIL developed by the Trust was presented for the Committee to consider re-categorising carvedilol to Amber 2. It was noted that the Trust is a tertiary centre for patients with this condition; the PIL is only for use within KCH and has been approved via their internal governance process. Members discussed the PIL and the request to re-categorise carvedilol. Committee members requested some amendments are considered to the PIL, including:
(i) clarity that carvedilol is only continued until the patient has had a liver transplant
(ii) Under section 'How do I give my child carvedilol,' re-format the paragraphs so that 'taking tablets with food and or water' is one paragraph and 'taking part of the tablet' is a separate paragraph, this would provide clarity for users.
(iii) Within the side effects section, provide consistency by advising when/ if side effects will resolve as done for with the 'dizzy/light headed' side effect.

GP members felt that given the small number of patients and the specialist nature of the condition, it would be more suitable and safer for carvedilol to remain a Red category drug. As patients remain under specialist care, they would have the opportunity to collect prescriptions regularly. Members were advised that the Amber 2 category request reflected the categorisation of other PHT medications to allow for continuity of patient care. These patients are pre-transplant and therefore most prescribing is through the GP. Some GP members queried how patients would access treatment if they lived outside of SEL if a category of Red were assigned. A GP member felt they would find it acceptable to take on prescribing under Amber 2 if a framework of support were in place, such as contact with the specialist team. It was noted that there is familiarity of prescribing carvedilol for heart failure in children under an existing Amber 2 category in SEL. Given the varied opinions from members, a consensus decision could not be reached and as the main presenter was not in attendance, it was agreed for this item to be re-presented to the Committee. Members felt further information about stabilising patients on their dose, ongoing monitoring responsibility, patient management plans and lines of communication between GP's and specialists would be helpful to understand. At this point, the Amber 2 categorisation could be re-considered, however at the present time, carvedilol remains categorised with an interim RAGG category of Red.

ACTION: Carvedilol formulary decision (recategorisation from Red to Amber 2) to be reconsidered at a future meeting

7. Daily dose tadalafil 5mg & 2.5mg tablets for the treatment of erectile dysfunction (ED)

This formulary submission originates from a Consultant Urologist and Andrologist and requests formulary inclusion of daily tadalafil for the management of erectile dysfunction (ED) in adult males (licensed indication). The application requests the use of daily tadalafil in those who have failed to respond to on demand sildenafil and/or tadalafil, which are phosphodiesterase 5 inhibitors (PDE-5i). On demand PDE-5i's are already available on the SEL JMF and are prescribed by primary care. This is a re-submission to the Committee – daily tadalafil is currently RAGG categorised as Grey in SEL following a previous formulary application. The current application requests an Amber 1 or Green category for daily tadalafil in this setting following changes to NHS England's (NHSE) guidance 'Items which should not be routinely prescribed in primary care'. Original guidance published by NHSE in 2017 did not recommend that daily tadalafil is prescribed in primary care. However, following a review in 2023, daily tadalafil has been removed from this guidance as it is now available generically, thus making the price comparable with the "as required" treatment and an option for primary care prescribing.

- **Evidence review**

The Formulary Pharmacist provided an overview of the evidence base - a detailed evidence review was provided within the meeting agenda pack, covering background to the condition, a review of the evidence with strengths and limitations and rationale for use of daily tadalafil in this setting. The information presented also included the estimated resource impact for use of daily tadalafil. The resource impact of the submission is within the financial threshold that the Committee has delegated authority to approve.

Erectile dysfunction has been defined as the persistent inability to attain and/or maintain an erection sufficient for sexual performance and impacts physical health, mental health and quality of life. Tadalafil is a potent selective, inhibitor of PDE-5, resulting in an increase of cyclic guanosine monophosphate in the corpus cavernosum, smooth muscle relaxation and inflow of blood flow into the penile tissues, producing an erection. Randomised controlled trials (RCTs) comparing daily tadalafil with placebo are of good quality and point to clinically significant effect. Three pivotal, placebo controlled RCTs were the basis for European approval of daily tadalafil. The improvement in International Index of Erectile Function (IIEF-EF) score (where a 4 point change is considered a clinically significant improvement) ranged between 4.5 and 9.4 for tadalafil daily vs 0.9 and 1.5 for placebo. Meta-analyses of such studies were found to be of poor methodological quality, however, broadly point to similar efficacy of daily vs. on demand tadalafil. With respect to the safety, data suggest that daily tadalafil has a similar adverse effect profile to on demand use, with no new safety

concerns identified. The most commonly reported adverse reactions are headache, dyspepsia, back pain and myalgia. These effects are generally transient, and mild or moderate.

The current ED treatment pathway is contained within the Acute Provider Collaborative's urology guidelines. This notes first line treatment with when required sildenafil followed by when required tadalafil. The next step would be the locally applied treatments, such as transurethral and intracavernosal treatments. It was noted that some clarity is needed from the applicant on the proposed place in therapy for daily tadalafil.

- **Applicant's presentation**

The applicant was in attendance to present the submission and answer questions. The applicant's declaration of interest was noted. The applicant clarified that the intended use of daily tadalafil within the application is an alternative option to when required tadalafil for patients who have sexual activity more than twice a week, not as a second choice after when required tadalafil has failed. When required sildenafil remains the first line option. The compliance rate with daily tadalafil has found to be better as it requires less planning for patients.

In response to a query relating to the estimated patient numbers and anticipated cost impact with daily tadalafil prescribing, the applicant advised that daily dosing of tadalafil has been shown to be more effective and superior vs. when required dosing, including in meta-analyses, and a preferred choice for patients. Daily tadalafil prescribing has the potential to reduce escalation to more costly, locally applied treatment options. Additionally, an oral formulation is likely to be more acceptable to patients vs. locally applied treatments, such as intrapenile injections. Longer term, access to daily tadalafil could improve cardiovascular and psychosocial health. In relation to deprescribing and overprescribing the presenter advised that as required treatment would be stopped if daily tadalafil is initiated, in some cases tamsulosin could also be deprescribed with follow up reviews. It was noted that the Selected List Scheme (SLS) criteria are likely to still apply to tadalafil once daily dosing, including a limit to one treatment a week. The SLS criteria have been removed for when required sildenafil but still appear to be in place for both when required and daily tadalafil. The applicant informed the Committee that all patients were typically initiated on 5mg tablets and a dose reduction to 2.5mg daily would only occur if 5mg daily tadalafil is effective but is causing side effects. The 2.5mg dose is not used routinely. It was confirmed that tadalafil tablets could be halved for dose flexibility.

- **IMOC discussion after departure of the applicant**

Members discussed the application and whether the use of daily tadalafil in this setting would be more suited with a RAGG category of Green or Amber 1. It was felt that the psychological pressure of using tadalafil for arousal would be present in both on demand and daily dosing. GP members felt that an Amber 1 category would be more appropriate for tadalafil in this setting at the current time. It was noted that if patients are referred to a specialist to initiate this treatment, they would be prescribed on demand tadalafil from primary care in the interim. Members agreed that the category could be re-visited if the SLS criteria were updated to remove daily tadalafil. The Committee agreed inclusion of daily tadalafil would need to be reflected within the APC urology guideline's ED pathway. The Committee discussed whether only the 5mg tablet strength should be added to the formulary, given the 2.5mg strength is not routinely used and has a higher cost impact per patient per year. Members suggested the 5mg tablet could be halved to obtain the 2.5mg dose.

The Committee agreed by consensus to approve 5mg tadalafil tablets for daily prescribing as Amber 1.

The Formulary Lead noted that both "when required" tadalafil and "when required" sildenafil currently have no RAGG category on the formulary but are routinely prescribing in primary care. Committee members agreed by consensus that these could be categorised as Green to reflect current practice.

ACTION: Formulary recommendation to be drafted and presented at a future meeting
ACTION: The SEL Acute Provider Collaborative urology guidelines – ED pathway - to be updated in line with discussions

ACTION: When required sildenafil and when required tadalafil to be categorised as Green within the SEL adult formulary

8. Updated SEL Chronic Obstructive Pulmonary Disease (COPD) guideline and associated formulary request

The authors from the respiratory sub-group of the Committee were in attendance to present this item. The broader COPD guideline has been updated via the sub-group following presentation of the specific inhaler pathway earlier this year. The inhaler pathway has now been incorporated into this update. Also being presented is an abridged formulary request for doxycycline as a second line treatment option for the prophylaxis of exacerbations in COPD (off-label).

The guideline has been updated to reflect Global Initiative for Obstructive Lung Disease (GOLD) 2024 recommendations and wider COPD interventions such as diagnosis, spirometry, tobacco dependence, rescue packs and exacerbation management. It was clarified that the IMOC will be responsible for approving the medicines content of the guideline and the associated formulary request for doxycycline. Approval of the general content on the management of COPD will require broader sign-off through the ICB. The process for this will be advised once a final draft of the guideline is available.

- *Formulary request for doxycycline as a second line option in preventing COPD exacerbations*

A brief evidence review was provided in the agenda pack to support the abridged formulary request for doxycycline. The Formulary Pharmacist presented an overview of the evidence base and background for the off-label use of doxycycline for the prophylaxis of exacerbations in COPD. The information presented also included the estimated resource impact for doxycycline use in this setting. The resource impact of the request is within the financial threshold that the Committee has delegated authority to approve.

The updated COPD guidance recommends doxycycline 100mg once daily as treatment for prophylaxis of infective exacerbations of COPD, as a second line option where azithromycin prophylaxis is unsuitable. NICE COPD guidance and GOLD guidance both recommend azithromycin as first-line for the pharmacological prophylaxis of COPD exacerbations. The evidence review section of the GOLD guidance notes long term doxycycline did not reduce exacerbations although acknowledges there may be responder sub-groups. No formal recommendations on its use are made in the GOLD 2024 guideline.

With respect to the evidence base, a Cochrane review and network meta-analysis (NMA; 9 trials) found that macrolides were the only class of drugs whose use increased the time to a subsequent exacerbation which was associated with improved quality of life. There were no clear benefits associated with use of quinolones or tetracyclines, and the difference for exacerbations with the use of tetracyclines was numerically worse than placebo. An RCT in 222 people aged ≥45 years with moderate to very severe COPD randomised patients 1:1 to doxycycline 100mg daily or placebo for 12 months. The findings showed no statistically significant differences in exacerbation rates between doxycycline and placebo. However, the findings suggested doxycycline may not be beneficial for every patient but may be useful in those with severe COPD or raised eosinophils (>300 cells/microlitre). However antimicrobial therapy in general would be expected to have an anti-inflammatory effect if inhibiting bacteria from stimulation inflammation. It has been hypothesised that the anti-inflammatory effect of azithromycin therapy may provide much of the basis for the positive response in exacerbation rates, and this property may not be transferrable to other antimicrobials.

Committee members discussed the updated guideline and the doxycycline formulary request and raised several comments and queries:

Doxycycline formulary request:
In response to a query from the Committee, the presenters agreed to clarify within the guidance what conditions under which doxycycline would be used 2nd line after azithromycin They confirmed that only if azithromycin is contra-indicated or is unsuitable (e.g. QT interval prolongation) or the patient

has non-tuberculosis mycobacterium would doxycycline be prescribed in this setting. Doxycycline is mainly effective in patients with severe COPD and eosinophil counts of >300 cells/microlitre. Members were advised that the decision to prescribe would be determined by the reviewing clinician on a case-by-case basis. It was noted that the Chair of the SEL Forum for Antimicrobial Stewardship (SELFAS) has been asked for an expert view on the use of doxycycline in this indication and a response is awaited.

For patients on long term prophylaxis treatment, GOLD guidance notes that prophylactic antibiotic treatment is not effective after 1 year. The presenters advised that the duration of treatment would be determined on an individual patient basis, however patients would be reviewed after 6 months as routine. This will be made clearer in the guidance. The presenters confirmed that the intention is for doxycycline to be RAGG categorised as Amber 2 – which is aligned to the category for use of azithromycin in this setting. The first prescription would be provided by the respiratory team. Members queried how patients with an acute exacerbation would be managed if they were receiving doxycycline for long term prophylaxis of exacerbations. The presenters confirmed that there are other treatment options noted within the guidance (amoxicillin and clarithromycin) and this will be determined on a case by case basis. The presenters agreed to include a statement to discuss patients who are penicillin allergic with a microbiologist.

Broader guideline comments:
Following feedback from members, the presenters agreed that wording in relation to cytisine and bupropion would be amended to make clearer that these are currently non-formulary. These applications would be presented to the Committee at a later date and updated within the guideline, if approved. In terms of other formulary implications, Committee members were informed that formulary requests will be progressed for oxycodone and lorazepam to support breathlessness in end of life care for people with COPD. These will be presented to the Committee at a future date. The presenters also agreed to make more reference to community pharmacy in relation to smoking cessation and support for patients and signpost the relevant medications within the guidance to the SEL adult JMF website entries. In response to a suggestion to clarify overprescribing/de-prescribing elements, the presenters noted that space is limited within the guidance to expand on this element. It could be incorporated into the sustainable respiratory care section, however, the wording in the guidance will be amended to considering deprescribing/ overprescribing with a cross reference to relevant pages.

Following departure of the presenters, members discussed the guidance, the abridged formulary request for doxycycline and associated evidence. In relation to the formulary request for doxycycline, the Committee deferred its decision, pending expert advice and approval from the SELFAS. The Committee recognised there are concerns around long term antibiotic use, the risk of resistance vs. the benefits and the evidence, which indicates doxycycline is not effective. It was acknowledged by members that the cohort of patient receiving doxycycline in this setting will be small and complex. A RAGG category of Red was suggested, given the specialist nature, however, GP members noted that these patients will have regular contact with their GPs, who generally manage their COPD care. The broader amendments discussed will also need to be followed up by the presenters and actioned. Depending on the outcomes of the discussions at SELFAS, Committee members agreed that approval of the medicines elements of the COPD guideline could be sought via Chair's action once the revised guidance has been finalised.

ACTION: Authors to make amendments in line with discussions and submit updated guidance to the IMOC team (pending SELFAS approval of off-label doxycycline use)

9. New resource to support the hypoallergenic formula guideline: 'What to do from 1 year'

The Specialist Prescribing Support Dietician (GSTT) was in attendance to present this item. Following the approval of the SEL Hypoallergenic Formula guideline at the August 2024 IMOC meeting, the Committee were asked to approve an additional resource that supports primary care clinicians in the management of patients transitioning from hypoallergenic formula. Committee members requested minor amendments to the resource, including writing "mcg" in full as micrograms.

The Committee agreed by consensus to approve the hypoallergenic resource pending amendments in line with discussions.

Post meeting note: *The authors advised that the units of measure within the resource were incorrect and should have stated 'milligrams' not 'micrograms'. This was corrected by the authors prior to submission to the IMOC Chair for approval.*

ACTION: Author to make amendments as per meeting discussion and submit to the IMOC team for Chair's ratification.

10. Formulary recommendations:

- **Updated: Recommendation 092- Levosert® and Kyleena® (levonorgestrel) for heavy menstrual bleeding and contraception**

This recommendation has been updated following changes to the contraceptive licensing for Levosert®. The summary of product characteristics (SPC) for Levosert® was updated in August 2024 to state that it is effective for 8 years for contraception (previously was 6 years). This is now reflected in the formulary recommendation. There were no comments from members and the updated recommendation was approved by consensus.

- **Withdrawal notification: Position statement 001 – biosimilar infliximab (Inflectra® and Remsima®)**

This position statement is being withdrawn following a query raised at the last Committee meeting during the discussion on biosimilar ustekinumab. The arrangements for considering biosimilars locally have evolved since the position statement was originally issued in 2015. There were no comments from members and the withdrawal notice was approved by consensus.

11. Updated primary care antimicrobial guideline for SEL – sections on meningitis and gastrointestinal (GI) tract infections

The lead authors presented this item with support from the ICB lead for the primary care antibiotic guidelines. A process is underway through the Primary Care Antimicrobial Stewardship Group (a sub-group of the SELFAS) to harmonise antimicrobial prescribing guidelines across the 6 SEL boroughs. This is being taken forward in a cyclical way, section by section and the current sections being presented are the meningitis and GI tract infections sections. The updated sections have been reviewed and agreed by the SELFAS and the SELFAS primary care working group. Each segment of the meningitis and GI updates were presented, with the key points noted as follows:

GI tract infections:

- Self-care and OTC options have been included within the gastroenteritis section for non-severe cases.
- Ciprofloxacin has been removed from the traveller's diarrhoea section due to concerns about resistance and an MHRA safety alert. Links to the National Travel Health Network have been included.
- Additional detail surrounding hygiene measures and signposting to the locally commissioned Pharmacy First services has been included in the threadworm section.
- A new section on diverticular disease has been included and aligned with NICE Clinical Knowledge Summaries (CKS).
- A new section on oral candidiasis has been included with specific treatment options for immunocompromised patients or those living with HIV.
- Examples of bismuth containing products and clarity on treatment options has been included in the *H. Pylori* eradication section.

The lead author agreed to include hyperlinks to the SEL adult JMF for medications that are listed and the RAGG category, for example fidaxomicin is Amber 1.

Meningitis:

- The meningitis section of the guideline has been updated to align with recently updated NICE guidance (NG 240) for bacterial meningitis.
- The advice is not to delay and transfer the patient to hospital as an emergency.
- Ceftriaxone is now recommended but is less commonly available in primary care, therefore benzylpenicillin also remains in the guidance.
- Whilst these two antibiotics are RAGG categorised as Red on the formulary, the guidance notes that there will be certain exceptional clinical scenarios where these may need to be administered outside of hospital, if the antibiotic is held in the healthcare setting concerned.
- The presenter noted that they will need to discuss the paediatric formulary entries for ceftriaxone and benzylpenicillin with the lead paediatric pharmacist to ensure the dosing recommendations are aligned.
- Members were advised by the lead author of a couple of additional changes that have been identified since circulation of the agenda pack. The statement 'within 24 hours' will be added to the orange title box that states 'Notifiable Infectious Diseases on Suspicion or Diagnosis (NOIDS)'. Listeria will be added to the common organisms listed.

Following comments from Committee members, the author agreed to add the wording 'for administration advice' after references where BNF monographs are linked and to include a statement noting the Red formulary RAGG category for ceftriaxone and benzylpenicillin
In response to a query relating to the statement that notes 'For people with strongly suspected meningococcal disease', the author agreed to include 'red flag symptoms' after the statement and hyperlink to the relevant NICE guidance where the red flags/symptoms are listed.

The Committee agreed by consensus to approve the GI and meningitis sections of the antimicrobial guideline pending amendments in line with discussions.

ACTION: Authors to make amendments as per meeting discussion and submit to the IMOC team for Chair's ratification.

12. Standing items/Items for information only

- *Formulary submissions tracker*

Noted.

- NICE Technology Appraisal (TA) Guidance Summary – ICS & NHS England attributed medicines:

The summary was noted, and RAGG categories were agreed by consensus, where it was possible to confirm the RAGG status.

- *For information and noting:*

- Adult and paediatric formulary update – noted by Committee members.

13. Any other business

No other business was raised by the Committee members.

IMOC dates for next 3 months

Date	Time	Venue
Thursday 21st November	2pm – 4:30pm	MS Teams
Thursday 19th December	2pm – 4:30pm	Hybrid meeting
Thursday 16th January 2025	2pm – 4:30pm	MS Teams