South East London Integrated Medicines Optimisation Committee (SEL IMOC) Meeting
20th November 2025 (Online via MS Teams)
Final Minutes

1. Welcome, introductions and apologies

The Chair welcomed attendees to the meeting. Apologies and observers were noted, and the meeting was confirmed 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. The declaration of interest for the Consultant Pharmacist in Diabetes was noted for item 8. Although not in attendance, they have been involved in the request being made to the committee.

3. Detailed action notes of the last meeting, minutes, and action log

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

The committee received an update on an action for the alimemazine in paediatric dystonia with poor sleep and/or vomiting formulary recommendation and agreed by consensus the updated formulary recommendation can be approved via IMOC Chair's action.

4. Formulary request for the re-categorisation of sevelamer for hyperphosphataemia in chronic kidney disease (CKD) from Red to Amber 2

The applicant was in attendance to present this request in line with the National Institute for Health and Care Excellence (NICE) guideline (NG 203) and local clinical practice. Sevelamer carbonate is used as a second-line phosphate binder in this setting for adults, particularly when calcium acetate is unsuitable. The rationale for re-categorisation in adults includes improved patient access, cost-effectiveness and alignment with national and regional practice. Secondary care will continue to initiate treatment and provide the first three months' supply, including titration and monitoring, before transfer to primary care for ongoing prescribing. Monitoring of phosphate levels and dose adjustments would remain the responsibility of the specialist renal team, with clear communication to primary care. From a cost impact perspective, this formulary request is within the financial threshold delegated to the committee.

A comment was raised noting the formulary should clearly reflect the indication for sevelamer carbonate as per NG 203 in CKD stages 4, its position as a second-line treatment option after calcium acetate and that the specialist team will provide the supply of sevelamer carbonate for the first three months, before maintenance prescribing is required from primary care and monitoring will remain under the specialist service.

Concerns about the potential confusion between the different sevelamer salt forms and the risk of metabolic acidosis were raised and clarification regarding whether the carbonate or hydrochloride salt is preferred in practice. The presenter confirmed the carbonate salt is preferred, in line with this, committee members agreed the formulary entry should explicitly specify sevelamer as the carbonate salt to reduce the risk of prescribing and dispensing errors in primary care. Reassurance was provided that metabolic acidosis is not typically a concern with phosphate binders and clinic letters can clearly state that patients have been counselled on potential side effects.

Committee members approved by consensus the re-categorisation of sevelamer carbonate for the management of hyperphosphataemia in CKD from Red to Amber 2, with an enhanced formulary entry covering the discussion points above.

ACTION: Sevelamer carbonate in this setting to be updated on the SEL adult Joint Medicines Formulary (JMF) to Amber 2 with an enhanced formulary entry

5. Updated Chronic Obstructive Pulmonary Disease (COPD) guideline including inhaler pathway and associated formulary request

Members of the respiratory sub-group were in attendance to present this item which has been discussed and approved via the respiratory sub-group. Committee members noted the main updates to the COPD guideline which includes the addition of Trixeo® (budesonide 160mcg, formoterol 5mcg, glycopyrronium 7.2mcg per dose) triple therapy pressurised metered dose inhaler (pMDI) and a new section on non-invasive ventilation (NIV) for COPD. The NIV section of the guideline is not for approval via the IMOC, as it is not medicines-related, this will be approved via a different committee.

A formulary request for the inclusion of Trixeo® triple therapy pMDI (off-label) as Green was considered by committee members. Trixeo® is the first triple-therapy inhaler (inhaled corticosteroid/long acting beta agonist/long acting muscarinic antagonist – ICS/LABA/LAMA) pMDI licensed for COPD which is delivered via an aerosphere co-suspension delivery technology. Trixeo®, is equivalent to Trimbow® (beclometasone 87mcg, formoterol 5mcg, glycopyrronium 9mcg per dose) triple therapy pMDI which is approved locally as Green for the management of COPD (off-label). This request is proposing the use of Trixeo® as per the locally approved use for Trimbow® in the following patients:

- Experience ≥1 severe (hospitalised) or ≥2 moderate exacerbations required systemic steroids) in the last 12 months AND
- Eosinophil count >100 cells per microlitre

Trixeo®, is expected to cut propellant (HFP-1234ze) Global Warming Potential (GWP) by over 99.9% compared to current propellants (HFA-134a) which is included in Trimbow®. Considering the environmental benefits associated with Trixeo®, Trixeo® is recommended as the first line triple inhaler therapy pMDI for new eligible patients. However, Trimbow® is preferred over Trixeo® for patients whose symptoms are better controlled on beclometasone over budesonide.

The formulary pharmacist provided a brief overview of the evidence to support this formulary request. The use of Trixeo® (and Trimbow®) is off-label in this setting, however use is in line with recommendations form the 2025 Global Strategy for Prevention, Diagnosis And Management of COPD (GOLD) report. There were no comparative studies found between Trimbow® and Trixeo®, evidence supporting the use of Trixeo® in this setting are from the pivotal licensing studies. The ETHOS trial concluded Trixeo® significantly reduced the rate of moderate/severe exacerbations. Adverse-event rates across the treatment arms were similar, in terms of serious events. The KRONOS RCT demonstrated Trixeo® improved lung function (FEV_1) between 0–4 hours when compared to Symbicort® (budesonide/formoterol). Rates of treatment-emergent adverse events were similar across treatment arms, and the incidence of pneumonia remained under 2% in all groups.

From a cost impact perspective, this formulary request will be a substitution cost to the local health economy and is therefore within the financial threshold delegated to the committee.

A query was raised regarding patients who may require a higher dose triple therapy inhaler and would patients need to be switched from Trixeo®, to Trimbow®. The presenter clarified higher strength Trimbow® is only licensed for asthma and not for COPD. If a COPD patient also has asthma, the local asthma pathway should be followed for appropriate treatment therapies. Updates to the online resources signposted to for inhaler information within the COPD guideline will also be discussed and agreed via the respiratory sub-group. Minor comments on formatting were shared with the presenters in advance of the meeting and will also be followed up.

Committee members approved by consensus the updated COPD guideline including the inhaler pathway (medicines content only) and the formulary inclusion of Trixeo® triple therapy pMDI as Green for the management of COPD (off-label) as per the locally agreed use for Trimbow®.

ACTION: Updated COPD guideline to be amended as per the discussion as progressed for ratification via IMOC Chair's action

ACTION: Trixeo® to be added to the SEL adult JMF as per the locally approved use for Trimbow®

6. **Local response to Vivaire® (beclometasone/formoterol) 100/6 and 200/6 pMDI discontinuation:**
   - **Updated Clinical Effectiveness South East London (CESEL) asthma adult guide (medicines content only)**
   - **Formulary request to remove Vivaire®**
   - **Formulary request to change Fostair® pMDI to generic beclometasone/formoterol pMDI**

A member of the respiratory sub-group presented this item following discussion and approval via the respiratory sub-subgroup. Due to competing products, the manufacturers of Vivaire® have confirmed Vivaire® 100/6 and 200/6 will be discontinued as of quarter three 2025/2026. As a result, the CESEL asthma adult guide has been updated to remove Vivaire®, with a recommendation to prescribe any branded generic beclometasone/formoterol pMDI provided the patient has been trained on the use of the product. Hyperlinks to RightBreathe have also been included within the updated CESEL asthma adult guide to support inhaler device selections. In line with this, committee members were requested to approve the removal of Vivaire® from the SEL adult JMF and change Fostair® pMDI to generic beclometasone/formoterol pMDI within the SEL adult JMF also. Committee members noted the inclusion of generic beclometasone/formoterol pMDI will be cost neutral to cost saving. .

A comment was raised regarding the updated formulary entry for beclometasone/formoterol pMDI and how to reflect cost-effective branded beclomethasone/formoterol pMDIs. Committee members agreed the formulary entry should still state Fostair® pMDI as an example of a beclometasone/ formoterol inhaler and include a hyperlink to the RightBreathe website so prescribers can see all available branded generic options.

Committee members agreed the following by consensus:
- Updated CESEL adult asthma guide (updated medicines content only)
- Removal of Vivaire® (beclometasone/formoterol) 100/6 and 200/6 pMDI from the SEL adult JMF
- Update Fostair® pMDI 100/6 and 200/6 to generic beclometasone/formoterol 100/6 and 200/6 pMDI within the SEL adult JMF and include a hyperlink to the RightBreathe website for branded generic beclometasone/formoterol pMDI inhaler devices.

ACTION: Vivaire® 100/6 and 200/6 pMDI to be removed from the SEL adult JMF
ACTION: Fostair® pMDI 100/6 and 200/6 to be updated to generic beclometasone/formoterol 100/6 and 200/6 pMDI with a hyperlink to the RightBreathe website for branded generic beclometasone/formoterol pMDI inhaler devices.

7. **Formulary inclusion of tranexamic acid injection for topical use for uncontrolled bleeding as Amber 1 (off label) - historical addition**

The applicant was in attendance to present this historical use request with support from the formulary pharmacist. Tranexamic acid injection is applied topically on gauze to control bleeding from wounds that are difficult to manage is commonly used within secondary care settings in various acute bleeding scenarios. such as epistaxis.

The topical use of tranexamic acid for the management of uncontrolled bleeding is off-label; this request is for the use of tranexamic acid topically as Amber 1 specifically in palliative care settings. Committee members noted whilst oral tranexamic acid may be used in this setting, there is an increase in the risk of systemic side-effects and topical tranexamic acid has been proven to be useful to manage uncontrolled bleeding. Committee members discussed the practicalities of administration in the community, including training for carers and district nurses, supply issues, and the need for clear protocols. This approach has been used successfully both in the community and when patients are discharged from hospice care, with district nurses already familiar with this method. Usage may be intermittent or continue for weeks to months depending on the wound.

Topical tranexamic acid is currently being administered in the community, with no issues associated with nurse led administration. From a cost perspective, this formulary request is within the financial threshold delegated to the committee.

A query was raised regarding the process of requesting prescriptions in primary care for tranexamic acid in this setting. The presenter confirmed the process would be as per current arrangements for palliative care prescriptions in primary care. In most cases patients will be under a specialist palliative care team who will review the continual need for tranexamic acid. A follow up question was raised regarding how patients who remain on topical tranexamic acid for a long period are reviewed. The presenter clarified that such patients are routinely monitored by the palliative care team and the long-term use of topical tranexamic acid in this setting is uncommon.

Committee members agreed by consensus the formulary inclusion of topical tranexamic acid injection for uncontrolled bleeding as Amber 1 (off-label) in palliative care settings. The formulary entry should include administration by healthcare professionals and that training will be provided where healthcare professionals are not involved.

ACTION: Tranexamic acid injection for topical use for uncontrolled bleeding as Amber 1 (off label) in palliative care setting to be added to the SEL adult JMF in line with discussions

8. Local response to Levemir® (insulin detemir) discontinuation:

- **Formulary inclusion of Semglee® (biosimilar insulin glargine)**
- **Levemir® discontinuation plan for adults**

The applicants were in attendance to present this item which has been discussed and approved via the diabetes sub-group. Levemir® is being discontinued nationally, with stock expected to be exhausted by December 2026. This discontinuation will have a significant impact, mainly for people living with type 1 diabetes (T1DM), but also some patients living with type 2 diabetes (T2DM) across both adults and children and young people (CYP). There is no direct replacement for Levemir®, however there are insulin alternatives on the market which patients can be switched to. There is national guidance available to support this from the Association of British Clinical Diabetologists and Primary Care Diabetes and Obesity Society.

In line with the discontinuation of Levemir®, and to support the availability of suitable alternatives on the local formulary, committee members were requested to consider a formulary request for Semglee® (biosimilar insulin glargine). This request is for the use of Semglee® in adults only, as children and young people are still considering use in this patient cohort. The Department of Health and Social Care (DHSC) have advised that Abasaglar®, which is also a biosimilar insulin glargine, cannot support any increased demand in the market as a response to the discontinuation of Levemir®, however Lantus® (originator insulin glargine) and Semglee® can.

Semglee® is a cost-effective biosimilar insulin glargine considered clinically equivalent to Lantus® and Abasaglar®. Semglee® is licensed for once-daily use only, which is the same for Abasaglar® and Lantus®, although it (and the other insulin glargine preparations) may need to be used twice daily (off-label) for some patients to ensure 24-hour coverage, as described in national guidance. The request is for Amber 1 categorisation to enable primary care clinicians to initiate alternative insulin treatment when required. From a cost perspective, this formulary request is within the financial threshold delegated to the committee and will be cost saving compared to the current cost of Levemir®. For new patients, the cost of initiation with Semglee® will be less in comparison to other basal analogue insulins on the formulary.

As part of the local response to Levemir® discontinuation, a stakeholder meeting has taken place, with further engagement planned as communications and primary care system searches are developed. The next steps are to finalise communications and then reconvene stakeholders in December 2025 to agree a definitive plan.

As the switch from Levemir® to an alternative insulin is not a direct like-for-like change, all patients will require individual assessment and monitoring. The aim is to ensure that all patients are identified

and reviewed within an appropriate timeframe before stock exhaustion of Levemir®. Specialist teams have already begun discussing switches opportunistically during current annual reviews with patients to avoid large numbers of patients requiring changes close to the deadline.

The committee discussion included:

- Noting on the formulary for insulin glargine preparations that twice daily dosing of Semglee® is off-label but in line with national guidance on managing the discontinuation of Levemir®.
- The timeline for plans regarding managing CYP prescribed Levemir®. The presenter explained the paediatric teams are still reviewing the appropriateness of using Semglee®, as evidence is more limited in this patient cohort.

Committee members agreed by consensus the formulary inclusion of Semglee® (biosimilar insulin glargine) in adults with T1DM and T2DM as Amber 1.

ACTION: Semglee® to be added to the SEL adult JMF as Amber 1 for adults with T1DM and T2DM, and entries for insulin glargine preparation to note that twice a day dosing is off label

9. i. Updated rheumatoid arthritis (RA), seronegative spondyloarthropathy (SpA) pathway and updated outcomes and monitoring framework

- **RA pathway and cost tool**
- **SpA pathway and cost tool**
- **Rheumatology outcomes and monitoring framework**

Acute Trust specialist Pharmacists from the rheumatology sub-group were in attendance to present this item which has been updated and approved via the rheumatology sub-group. The main updates to the RA and SpA pathway include the following:

- For patients with a co-morbidity of interstitial lung disease (ILD), in line with the American College of Rheumatology (ACR) guideline for the treatment of ILD in people with systemic autoimmune rheumatic diseases, tocilizumab and JAK inhibitors have been included as second line treatment options alongside abatacept. A significant cost impact is not expected with the use of tocilizumab and JAK inhibitors in this setting.
- Addition of monoarthritis to the SpA pathway

Committee members noted, no updates have been made to the associated cost tools and the rheumatology outcomes and monitoring framework has been updated to include two new areas for review associated with the RA and SpA pathway.

ii. Proposal for the use of biologics in the management of monoarthritis

The Specialist Pharmacist in Rheumatology presented this item which has been discussed and approved via the rheumatology sub-group. In line with the proposed update to the SpA pathway, committee members were requested to consider a proposal for the use of biologics in the management of monoarthritis under the psoriatic arthritis pathway. Monoarthritis is a form of psoriatic arthritis characterised by persistent pain and swelling in a single large joint. The existing local SpA pathway does not clearly distinguish monoarthritis from oligoarthritis, which has led to inconsistent interpretation and, in some cases, patients with monoarthritis being managed under the oligoarthritis criteria.

The treatment requirements remain unchanged; patients must still fail two disease-modifying antirheumatic drugs (DMARDs) and short-lived or no response to intra-articular corticosteroid before a first biologic can be initiated.

The formulary pharmacist provided a brief overview of the evidence to support this request. NICE recommends advanced treatments such as biologics for the management of psoriatic arthritis in patients with peripheral arthritis with ≥3 tender joints, and ≥3 swollen joints where 2 previous DMARDs have failed. However, this criteria for use, reflects the inclusion criteria used in pivotal trials rather than a requirement in product licences. The 2022 British Society of Rheumatology

(BSR) guidance for the management of PsA with biologic and targeted synthetic DMARDs recommends supports use of advanced treatments in both monoarthritis and oligoarthritis, aligning with the European League Against Rheumatism (EULAR) guidance, though both acknowledge this is based on expert opinion rather than robust data.

It was noted that the Pan Mersey Area Prescribing Committee has approved the use of biologics for the management of monoarthritis. Their 2022 review found little evidence to guide decision-making but adopted a pragmatic approach to the management of monoarthitis with advanced treatments.

There is an absence of data on the use of advanced therapies in patients with monoarthritis in PsA. From the studies reviewed, there is data to suggest that patients with monoarthritis or oligoarthritis respond to conventional treatment approaches, and no signal that the response in these patients is weaker than in patients with polyarthritis. No health economic studies were found for monoarthritis, so cost-effectiveness is unknown. From a cost impact perspective, this formulary request is within the financial threshold delegated to the committee with lower costs expected where a best-value biologic is prescribed. In the longer term, outcomes will be monitored through the rheumatology sub-group.

Committee members approved the following by consensus:

- Updated RA pathway and cost tool
- Updated SpA pathway and cost tool
- Rheumatology pathways outcomes and monitoring framework
- Proposal for the use of biologics in the management of monoarthritis

10. Formulary entries for medicines used to treat and prevent migraines in paediatrics

The Lead Paediatric Formulary Interface Pharmacist presented this item following the approval of medicines used to treat and prevent migraines in paediatrics at the May 2025 IMOC meeting. As part of the approval, detailed formulary entries was requested to support primary care prescribing. Detailed formulary entries have been drafted for the use of sumatriptan, zolmitriptan, rizatriptan, pizotifen, propranolol, amitriptyline, topiramate and flunarizine in this setting and have been reviewed by GP committee members.

The committee discussion included:

- Update to the sumatriptan monograph to highlight that the Green category relates to the tablet formulation.
- A suggestion to include a note within the topiramate monograph, explaining that the responsibility for prescribing should transfer to primary care after the dose is stabilised.

Committee members approved by consensus the formulary entries for medicines used to treat and prevent migraines in paediatrics pending updates in line with the discussion.

ACTION: Sumatriptan and topiramate monograph to be updated and progressed for ratification via IMOC Chair's action

11. Standing Items:

- Formulary submissions tracker

Noted.

- *NICE Technology Appraisal (TA) Guidance Summary – Integrated Care Board and NHSE attributed medicines:*

The summary was noted, and RAG categories were approved by consensus, where it was possible to confirm the RAG status

- For NICE TA1105: Clascoterone for treating acne vulgaris in people 12 years and over - terminated appraisal, committee agreed a non-formulary - not recommended for prescribing category.

ACTION: Clascoterone for treating acne vulgaris in people 12 years and over to be added to the SEL adult JMF and paediatric joint formulary as non-formulary – not recommended for prescribing

- Agreeing a RAG category and review of cost modelling for NICE TA1087 - betula verrucosa (Itulazax®) for treating moderate to severe allergic rhinitis or conjunctivitis caused by tree: Based on cost modelling from the acute Trusts, the cost impact of implementing this NICE TA is within the financial threshold delegated to the committee. The committee agreed an interim Red categorisation in line with a broader proposal which will be presented at a future meeting for re-categorisation of betula verrucosa from interim Red, noting that in the event the proposal is not accepted, the red category will remain in place.

ACTION: Betula verrucosa (Itulazax®) to be added to the SEL adult JMF as interim Red

- For information and noting:

The following updated documents were approved via IMOC Chair's action following updates:

- Co-morbid insomnia formulary recommendations 142 and 143 (minor update to align formulary recommendations with updated co-morbid insomnia pathway)
- Narcolepsy and idiopathic hypersomnia formulary recommendations 046, 047 and 088 (minor update to align formulary recommendations with updated narcolepsy and idiopathic hypersomnia shared care guideline)

The above were noted by committee members.

12. Extension to expiry date for the IMOC terms of reference (ToR)

Committee members were informed that the IMOC ToR are due for review. Given on-going reform in the NHS, committee members were requested to consider if a six-month extension to the ToR would be acceptable, to be approved via Chair's action A minor amendment is also required in relation to the membership list. Committee members approved by consensus the minor amendment to the IMOC ToR and a six-month extension, for approval via Chair's action

ACTION: IMOC ToR to be updated in line with the discussion and progressed for ratification via IMOC Chair's action

13. Methylphenidate modified release (M/R) formulary entries and position statement:

- **Adult and paediatric proposed formulary entry update**
- **Retirement of SEL IMOC preferred choice of methylphenidate M/R position statement**

The Specialist Paediatric Formulary Interface was in attendance to present this item; currently the SEL adult JMF and SEL joint paediatric formulary list specific brands of methylphenidate M/R tablets and capsules, but ongoing supply issues and the increasing number of branded generics have made this approach less practical. In line with this, an update to the SEL adult JMF and SEL joint paediatric formulary is being proposed to note methylphenidate M/R tablets and capsules generically and include a link to the Specialist Pharmacy Service (SPS) methylphenidate medicines supply tool. This will enable prescribers to switch between bioequivalent branded generic products which are available, with a general expectation to use best-value options.

All methylphenidate M/R tablets are considered bioequivalent and can be interchanged without the need for dose adjustment or re-titration. However, methylphenidate M/R capsules are not considered bioequivalent, and switching between brands should be specialist-led. Equasym XL® capsules has a differing release profile and is unsuitable for switching to alternative branded generics. For Equasym XL® capsules, prescribers would be advised to check with the specialist team before switching patients. In line with the proposed changes to the SEL adult JMF and SEL adult paediatric formulary for methylphenidate M/R, committee members were also requested to consider the retirement of the preferred choice of methylphenidate M/R position statement (Delmosart® and Xenidate® XL).

Concerns were raised regarding the requirement for primary care clinicians to carry out switches for M/R methylphenidate preparations and whether this should remain the responsibility of the specialist team, with primary care continuing prescribing under existing shared-care arrangements. The presenter highlighted that the formulary changes aim to allow greater flexibility for primary care to

switch between equivalent formulations during supply shortages, noting that primary care have already been prescribing generically and switching patients in practice to manage the supply issues. This highlighted the need both to improve brand prescribing and to create a pragmatic approach to managing unavoidable switches in primary care.

Committee members agreed the following by consensus:

- Methylphenidate M/R tablets and capsule to be noted generically within the SEL adult JMF and SEL joint paediatric formulary (noting that Equasym XL® capsules are not bioequivalent to other methylphenidate MR products and to seek specialist advice with this brand)
- Retirement of the IMOC preferred choice of methylphenidate M/R position statement

ACTION: Methylphenidate M/R tablets and capsules to be noted generically within the SEL adult JMF and SEL paediatric formulary (noting prescribing advice regarding Equasym XL® capsules and inclusion of SPS methylphenidate medicines supply tool link)

14. Formulary inclusion of unlicensed special suspension of co-careldopa for the management of neurometabolic disorders in paediatrics

The applicants were in attendance to present this item which supports the use of co-careldopa unlicensed special suspension as Amber 2 in paediatrics with metabolic and neurological conditions who require very small doses of levodopa. Currently co-careldopa 62,5mg tablets are the only formulation approved for use in this setting locally, which poses challenges for infants and young children due to difficulties with crushing and dispersing tablets and the risk of inaccurate dosing and associated side effects. Co-careldopa unlicensed special suspension is already used in other specialist centres and would be reserved for doses below 25 mg of levodopa, as larger doses can be achieved by halving the tablet formulation. GPs would only be asked to prescribe the co-careldopa suspension on the recommendation of the specialist team, and patients would be reviewed regularly to determine when a switch to tablets is appropriate.

From a cost perspective, this formulary request is within the financial threshold delegated to the committee. The use of co-careldopa suspension in this setting will be for newly diagnosed patients only as current patients are already established on the tablet formulation and the cost impact is expected to be negligible.

A query was raised regarding the around the practicalities of supply, including access for families through community pharmacies. The presenter confirmed co-careldopa unlicensed special suspension is already supplied in community settings for adult patients, so access routes should not present a barrier for paediatric use. A comment was also raised requesting the formulary entry to specify that co-careldopa unlicensed special suspension will be reserved for doses below 25 mg of levodopa with a recommendation for patients to be switched to co-careldopa tablets when the dose allows.

The committee approved by consensus the formulary inclusion of unlicensed special suspension of co-careldopa for the management of neurometabolic disorders in paediatrics as Amber 2.

ACTION: Co-careldopa unlicensed special suspension to be added to the SEL Paediatric Formulary as Amber 2

15. Any Other Business

Committee members were reminded that the December IMOC meeting will be a hybrid meeting with both in-person and virtual attendance options.

IMOC dates for the next 3 months

Date	Time	Venue
Thursday 18th December 2025	2pm - 4.30pm	Hybrid (MS Teams/in person)
Thursday 15th January 2026	2pm – 4:30pm	MS Teams
Thursday 19th February 2026	2pm – 4:30pm	MS Teams