Information for Clinicians

Chronic Pain Resources

Background

NICE guidelines no longer recommend opioid or gabapentinoid medications for chronic (primary) pain. These medications remain a key area of overprescribing in primary care which leads to unnecessary medication burden for the patient and cost to the NHS. Evidence suggests that patients can often be better supported through non-pharmacological approaches including supported self-management programs.

Toolkit Introduction

This toolkit is intended to support healthcare professionals in reviewing, and where appropriate deprescribing, pain medicines in patients with chronic (non-cancer) pain who may no longer be deriving meaningful benefit.

This toolkit does not promote a one-size-fits-all approach. Decisions about pain management should always be individualised and grounded in what matters most to the patient. Listening to a person's pain story, and understanding their goals, concerns, and preferences, remains central to good care.

This is not a comprehensive guide, but a practical reference designed for use during consultations. For more detailed resources, see Box 1.

Local guideline: Pain Management - NHS Somerset ICB

Local specialist pain service: Somerset Community Pain Management Service. | Information for GP's

National guidance: Opioids Aware | Faculty of Pain Medicine

Supported self-management: Professional tools - Live Well with Pain

Education: Chronic Pain | Primary Care Knowledge Boost (podcast)

Box 1: Clinical resources for Pain Management in Chronic (non-cancer) Pain

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Gabapentinoid Deprescribing Toolkit - Key facts	
Treatment efficacy Number Needed to Treat (NNT)	**Pregabalin** • Fibromyalgia: 300 mg/day NNT ≈ 14; 600 mg/day NNT ≈ 11 • Chronic neuropathic pain (e.g. diabetic neuropathy, PHN): NNT ≈ 7 **Gabapentin** • Painful diabetic neuropathy: NNT ≈ 6 • Postherpetic neuralgia: NNT ≈ 8 • Limited evidence for other types of chronic neuropathic pain *≥50% pain reduction vs placebo (Cochrane reviews Derry et al 2016; Wiffen et al 2017)* 💬 **Consultation prompt (efficacy):** "You mention that most days you experience a high level of pain, around 8 out of 10. This makes me think that this medicine might not be working very well to relieve your pain."
Side Effects	Side effects: ~6/10 affected; ~1/4 discontinue. Common: dizziness, somnolence, cognitive effects, ataxia, weight gain, nausea. (*Derry et al.; Wiffen et al. and* Royal College of Psychiatrists guidance)
Tolerance **Dependence** **Withdrawal**	Tolerance and physical dependence can occur with gabapentinoids, though many patients remain stable on long-term therapy. Abrupt stopping can cause withdrawal (e.g. sleep disturbance, anxiety, nausea, dizziness, rebound pain), which is usually minimised by gradual tapering. It can be helpful to explain this to patients. Feeling worse when a dose is delayed or missed may be mistaken for evidence that the medicine is helping, when it may instead reflect withdrawal. Understanding this distinction can help patients make sense of their symptoms and support the rationale for a gradual taper if the medicine is no longer providing meaningful benefit. *(MHRA Drug Safety Update, 2026)* 💬 *See Consultation Prompts (Page 7)*
Respiratory Depression	Gabapentinoids can cause respiratory depression, even without opioids. Risk is higher in people with respiratory disease (e.g. COPD), older age, renal or neurological disease, or when combined with other CNS depressants. Use caution in patients with respiratory disease and advise them to report any new or worsening breathing problems. Avoid co-prescribing with opioids where possible due to increased risk of respiratory depression, overdose, and death. *(MHRA Drug Safety Updates 2017/2021)*
Creatinine Clearance	Both gabapentin and pregabalin are eliminated via the kidneys. Creatinine clearance (CrCl) should be calculated using the Cockcroft–Gault equation and dose and/or dosing frequency adjusted where appropriate. *(See: Gabapentin - BNF (NICE)* | *Pregabalin – BNF (NICE))*
Gabapentinoid patient resources	• Frome Medical Practice: gabapentinoids • Live Well with Pain: patient decision aid • Live Well with Pain: Where do medicines fit in?
Supported Self Management	• Live Well with Pain –**Ten Footsteps programme** • Somerset Community Pain Management Service - Body Reprogramming – eight week group course for persistent pain (patients can self refer)

Gabapentinoid Deprescribing Toolkit - Tapering Guidance	
Invite patient	AccuRx text example: *You're taking Gabapentin or Pregabalin for long-term pain. We suggest reviewing this medicine with your GP or clinical pharmacist and talking about other options to help support you better. Here's some information about your medication and why we think a discussion would be helpful:* *https://www.fromemedicalpractice.co.uk/gabapentinoids*
Tapering Schedules (gabapentinoids)	Somerset ICB gabapentinoid tapering guidance Available from: https://nhssomerset.nhs.uk - NHS Somerset ICB [(direct PDF)]() General guide: • Pregabalin ↓ 50 mg every 1–2 weeks • Gabapentin ↓ 300 mg every 1–2 weeks
Practical steps and housekeeping When deprescribing gabapentinoids (	Prescribing • Prescribe Gabapentinoid as acute (remove from repeat*) • ⚠️ Controlled drug: limit quantity to maximum 1-month supply Tapering plan • Create a personalised tapering plan using the patient letter (see Appendix: 'Gabapentin Deprescribing' or 'Pregabalin Deprescribing' - *includes tapering plan to stop and withdrawal information*) • Edit the table to reflect the patient's current starting dose • Send the letter via AccuRx or provide a printed copy Patient information • Send patient resources via ✅ AccuRx: *fromemedicalpractice.co.uk/gabapentinoids* ✅ Pharmacy communication (EMIS) • In the medication screen, select 'Additional prescription information' • Enter a message in 'Pharmacy information' *Example:* "Tapering dose as per consultation [date]." * *In some cases, a variable repeat may be appropriate if follow-up delays are anticipated.*
Gabapentin formulations and taper example	💊 Formulations**:** 100 mg, 300 mg, 400 mg capsules; 600 mg, 800 mg tablets FP10 – Example 1: *Take one as directed as a reducing course.* Example 2 (edit / cut and paste): *(Adjust according to starting dose and patient tolerance)* • Week 1: 900 mg morning, 900 mg midday, 900 mg evening • Week 2: 600 mg morning, 900 mg midday, 900 mg evening • Week 3: 600 mg morning, 600 mg midday, 900 mg evening • Week 4: 600 mg morning, 600 mg midday, 600 mg evening
Pregabalin formulations and taper example	💊 *Formulations:* 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg, 300 mg capsules/tablets FP10 – Example 1: *Take one as directed as a reducing course.* Example 2 (edit / cut and paste): *(Adjust according to starting dose and patient tolerance)* • Week 1: 300 mg morning, 300 mg evening • Week 2: 250 mg morning, 300 mg evening • Week 3: 250 mg morning, 250 mg evening • Week 4: 200 mg morning, 250 mg evening
Follow-up	Arrange follow-up via appointment or future-dated AccuRx text. ✅ *AccuRx: Send ▾ → Schedule message → Custom date/time → ☑ Allow reply* Example text: *I wanted to check how you're getting on with lowering your [Gabapentin / Pregabalin]. What dose are you taking now? Would you like me to send your next prescription?*

Opioid Deprescribing Toolkit - Key facts	
Risks of opioid medication	Long-term opioid use carries significant population-level risk; NHS MedSIP estimates that **for every 62 people who stop opioids, one death is prevented**. Recognised harms of long-term use include falls and fractures, endocrine dysfunction, infections, opioid-induced hyperalgesia, cardiovascular events, and gastrointestinal bleeding. (Faculty of Pain Medicine – Long-term harms of opioids) Harm increases substantially with dose, with little or no additional benefit above 90 mg oral morphine equivalent (OME)/24 h; where possible, aim for <50 mg OME/24 h. (Faculty of Pain Medicine – Opioids Aware) Opioids increase the risk of sleep-related respiratory depression, particularly in people with sleep apnoea or when combined with other sedating medicines (e.g. benzodiazepines, gabapentinoids, TCAs). Co-prescribing opioids with other sedating medicines (e.g. tricyclic antidepressants, benzodiazepines, gabapentinoids) significantly increases the risk of respiratory depression and death. A Coroner's Prevention of Future Deaths report involving **amitriptyline and oxycodone** highlights the need for caution with sedating co-prescribing and regular review.
Assessing readiness to taper opioids	Reducing long-term opioids can be challenging; patients often fear withdrawal or worsening pain. Engagement and shared control are key, and for some patients the aim may be dose reduction rather than cessation. Before tapering, assess readiness and mental health, including suicide risk, and consider timing and support carefully if there is acute distress or suicidal ideation.
Review side effects	Use The Great Opioid Side Effect Lottery (Live Well with Pain) to review and document opioid side effects. Reassess after tapering to identify any improvement. ✅ *Tip:* A friend or relative may provide valuable additional perspective on how higher-dose opioids affect the patient.
Tolerance Dependence Withdrawal	Long-term opioid therapy often leads to tolerance and physical dependence, although the extent varies between individuals. Explaining these concepts to patients -particularly withdrawal -can be helpful. Symptoms that occur when a dose is delayed or missed may be mistaken for evidence that the medicine is helping, when they may instead represent withdrawal. Clarifying this distinction can help patients understand that the opioid may no longer be providing meaningful benefit and can support the rationale for gradual dose reduction. Abrupt discontinuation can cause opioid withdrawal symptoms, such as anxiety, restlessness, sweating, insomnia, abdominal cramps, nausea, diarrhoea, and increased pain. Gradual tapering usually prevents or minimises withdrawal symptoms. 💬 See Consultation Prompts Page 7
Calculate Total Opioid Dose (MED)	Calculate the morphine equivalent dose (MED) using a validated conversion tool: Pain Management Opioid Dose Converter Visual tools (e.g. the Opioid Thermometer) help explain dose-related harms and support shared decision-making.
Patient resources (opioids):	• MHRA opioid addiction when initiating opioids (documents risk discussion). MHRA patient leaflet or Local NHS Somerset pdf version available *here* Frome Medical Practice: Frome Medical Practice: Tramadol • Understanding Pain – Brainman stops his opioids (TGA) • BSW Medicines Safety Programme: reducing and stopping opioids leaflet
Supported self-management	• Live Well with Pain –**Ten Footsteps programme** • Somerset Community Pain Management Service - Body Reprogramming – eight week group course for persistent pain (patients can self refer)

Opioid Deprescribing Toolkit - tapering plans	
Tapering Schedules Opioids	Somerset guidance recommends reducing the total daily dose by ~10% every 1–2 weeks. Slower tapers may be required at higher doses or with transdermal patches (e.g. reducing the dose every 4 weeks). Somerset ICB pain management guideline
Preparation for tapering: simplify opioid regimen	Before tapering, it is helpful to rationalise PRN and multiple opioid prescriptions. Faculty of Pain Medicine guidance recommends simplifying to a single opioid agent before dose reduction. Multiple opioids often reflect tolerance, incomplete analgesia, or ad-hoc escalation, increasing harm without proven additional benefit. A single-agent approach enables clearer benefit–harm assessment, simpler monitoring, and more straightforward tapering by avoiding overlapping dependencies.
Switching	Where switching opioid formulation is necessary (e.g. oral to oral, patch to oral), incomplete cross-tolerance must be assumed; the new opioid may be more potent than predicted by conversion charts. Faculty of Pain Medicine guidance advises reducing the calculated equivalent dose by ~25%, or ~50% at very high doses* or in frail/elderly patients. *Very high dose defined as ≥500 mg oral morphine equivalent per 24 h.* Faculty of Pain Medicine
Codeine / Co-codamol	Formulations: 💊 Codeine: 15 mg, 30 mg, 60 mg tablets; 15 mg/5 ml linctus 💊 Co-codamol: 8/500 mg, 30/500 mg tablets (e.g. Emcozin, Solpadol, Zapain) Although often labelled a *"weak opioid"*, the maximum adult dose of 240 mg/day equates to approximately 24 mg oral morphine equivalent (OME)/day. A **Somerset ICB codeine tapering plan** is available, reducing the dose by 15 mg weekly
Tramadol	Formulations: 💊 Immediate-release: 50 mg capsules; 50 mg/5 ml oral solution; 50 mg soluble tabs 💊 Modified-release: 50–300 mg tablets/capsules (e.g. Marol®, Tramulief®) A **Somerset ICB tramadol tapering plan** is available for patients taking tramadol 100 mg four times daily, with gradual dose reduction. This taper applies to immediate-release tramadol. Patients prescribed modified-release formulations should first switch to an equivalent immediate-release preparation*before starting tapering.
Oral Morphine	Formulations 💊 Immediate release: Sevredol® 10, 20,50mg tablets; Actimorph® orodispersible 1,2.5, 5, 10, 20, 30mg tablets 💊 Modified release / sustained release: Morphine 5mg MR tabs, Zomorph® 10, 30, 60, 100, 200mg capsules, Morphgesic SR® 10-100mg tablets Somerset Prescribing Formulary A **Somerset ICB morphine tapering plan** is available for patients taking morphine MR 200 mg twice daily
Buprenorphine patch	The different formulations of patch range from 3-day, 4-day and 7-day, it is important to be aware of this when prescribing. Formulations: 🩹 Rebrikel® 5/10/20 mcg – 7 days | Bunov® 5/10/15/20 mcg – 7 days

	🩹 Reletrans® 5/10/15/20 mcg – 7 days | Butec® 5/10/15/20 mcg – 7 days 🩹 Hapoctasin® 35/52.5/70 mcg – 72 h | Relevtec® 35/52.5/70 mcg – 96 h (Cost-effective brands strengths & intervals; NHS Somerset Formulary) Buprenorphine is a partial agonist – it binds very tightly to μ-opioid receptors and can displace other opioids. Full opioid agonists (e.g. Morphine or codeine) may have reduced effectiveness while buprenorphine is still present. Example (7-day patches): 20 mcg/hr → 15 mcg/hr → 10 mcg/hr → 5 mcg/hr → stop Example (3–4 day): 70 mcg/hr → 52.5 mcg/hr → 35 mcg/hr → then change to 7 day buprenorphine patch which enables a more gradual dose reduction e.g.: 20mcg/hr → 15mcg/hr → 10mcg/hr → 5mcg/hr * Tapering approach informed by Derbyshire JAPC guidance * ✅ Off-label tip: At the final stage of tapering, the 5 mcg/hr buprenorphine patch may be left on for longer than the usual replacement interval to help reduce withdrawal before stopping.
Fentanyl patch	Formulation: 🩹 72-hour (3 day) patches: 12, 25, 37.5, 50, 75, 100 μg/hr (Brands: Opiodur®, Matrifen®, Mezolar®, Fencino®) A **Somerset ICB fentanyl tapering plan** is available for gradual dose reduction. When converting from fentanyl patch to oral morphine, reduce the calculated equivalent dose by ~25% (or ~50%** for very high doses > 500 mg OME/24 h, or in frail/elderly patients). Calculate MED: Pain Management Opioid Dose Converter. If switching to another opioid, account for fentanyl's delayed offset*. A practical approach is to wait ~12 hours after patch removal before starting modified-release morphine. *Following a 72-hour Fentanyl patch application, the mean half-life ranges from 20 to 27 hours (Fencino® 75 μg/hour transdermal patch – SmPC) (Fentanyl patches: Discontinuing transdermal fentanyl – GPnotebook)
Specialists advise	Opioid reduction advice and guidance (Somerset Pain Service): For patients on >100 mg OME/24 h or where reduction is proving complex, GPs can request advice via PainService@SomersetFT.nhs.uk. The service liaises directly with Somerset Drug and Alcohol Services (SDAS) where appropriate.
Follow-up	Ensure follow up plan is arranged with the patient via an appointment or text. ✅ *Tip:* Schedule a **future-dated** text via AccuRx → **Send > Schedule message > Custom date/time > Allow patient to respond.* Example text: *"I wanted to check in and see how you're doing with lowering your medication. What dose are you taking now? Would you like me to send your next prescription?*

Appendix 1:

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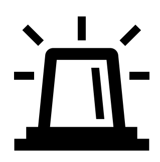
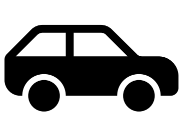
<tr><td>
</td><td>Explaining pain – the faulty car alarm analogy

"Normally, a car alarm goes off when there's a real threat - like someone trying to break in. But sometimes a faulty car alarm goes off when there's no real danger at all - a gust of wind, a cat passing by, or for no clear reason.

With chronic pain, the alarm system in your nervous system has become over-sensitive. It sends out pain signals even when there's no injury or ongoing damage. The pain you feel is very real - it's just that the system meant to protect you is now giving false alarms.

Our aim isn't to ignore the alarm, but to calm and retrain the system so it becomes quieter, or only reacts when it truly needs to."</td></tr>
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Patient Stories
Sharing patient stories can be inspirational – for patient experiences see True stories - Live Well with Pain

<table>
<tr><td>Consultation Prompts</td><td>💬 Tolerance
"Many people find these medicines help at first, but over time the benefit can fade and higher doses are needed for the same effect. How has it been working for you?"

💬 Dependence
"After taking this medication for a while, the body can get used to it and come to rely on it just to feel normal."

💬 Withdrawal
"If you feel worse after missing a dose, it isn't always because the medicine was working - it can be a withdrawal effect."

💬 What if my pain worsens?
"In my experience, what often happens is that the pain stays much the same, but the side effects reduce. Making changes slowly allows your body to adjust without unpleasant withdrawal symptoms. If your pain does worsen, we can pause the reduction or return to the lowest helpful dose."

💬 Side effects
"Some people notice side effects with this medicine, such as feeling drowsy, dizzy, or unsteady. This doesn't happen to everyone, but for some people the side effects can outweigh the benefits, which is why we sometimes review or reduce the dose."</td></tr>
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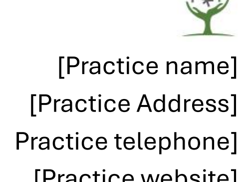


EXAMPLE PATIENT LETTER – Gabapentin Deprescribing

[Practice name]
[Practice Address]
Practice telephone]
[Practice website]

[Date] Private and confidential
Dear [Patient Name],

Here's your plan on how to reduce your Gabapentin. Lower the amount gradually by changing the dose once a week or every two weeks.

Gabapentin reduction plan

Change (e.g. Weekly or Fortnightly)	Morning Gabapentin dose	Midday Gabapentin dose	Evening Gabapentin dose
1	900mg	1200mg	1200mg
2	900mg	900mg	1200mg
3	900mg	900mg	900mg
4	600mg	900mg	900mg
5	600mg	600mg	900mg
6	600mg	600mg	600mg
7	300mg	600mg	600mg
8	300mg	300mg	600mg
9	300mg	300mg	300mg
10	Stop	300mg	300mg
11	Stop	Stop	300mg
12	Stop	Stop	Stop

Possible withdrawal symptoms
When you reduce your medication amount, you might notice some uncomfortable feelings, which are called withdrawal. Withdrawal can temporarily cause more pain or discomfort. This can be confusing because it may seem like the medicine was helping more than it really was. Often, you can reduce withdrawal symptoms by lowering the dose more slowly.

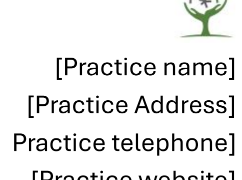
Some common signs of withdrawal include:

· Feeling restless or confused
· A fast heartbeat or heart palpitations
· Feeling anxious
· Sweating a lot
· Difficulty sleeping
· Feeling sick or nauseous
· Increased pain

If you do feel withdrawal effects, stay at your current dose until they settle. You can then reduce more gradually. If stopping completely isn't possible, aim to stay on the lowest helpful dose.

More information can be found at:
https://www.fromemedicalpractice.co.uk/gabapentinoids

Yours sincerely



EXAMPLE PATIENT LETTER – Pregabalin Deprescribing

[Practice name]
[Practice Address]
Practice telephone]
[Practice website]

[Date] Private and confidential
Dear [Patient Name],

Here's your plan on how to reduce your Pregabalin. Lower the amount gradually by changing the dose once a week or every two weeks.

Pregabalin reduction plan

Change (e.g. Weekly or Fortnightly)	Morning Pregabalin Dose	Evening Pregabalin Dose
0	300mg	300mg
1	250mg	300mg
2	250mg	250mg
3	200mg	250mg
4	200mg	200mg
5	150mg	200mg
6	150mg	150mg
7	100mg	150mg
8	100mg	100mg
9	50mg	100mg
10	50mg	50mg
11	Stop	50mg
12	Stop	Stop

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Yours sincerely

Acknowledgments

This toolkit draws on national guidance, regulatory safety communications, published evidence, quality-improvement work, and shared clinical experience to support safer prescribing and deprescribing for people living with chronic pain.

The author wishes to acknowledge the following contributions:

National guidance and evidence

- **National Institute for Health and Care Excellence (NICE)** – chronic pain guidance and safe prescribing principles.
- **Faculty of Pain Medicine (FPM)** – *Opioids Aware* resources, including dose thresholds, long-term harms, and tapering guidance.
- **Cochrane Collaboration** – systematic reviews informing the efficacy and harms of gabapentinoids.

Regulatory safety communications

- **Medicines and Healthcare products Regulatory Agency (MHRA)** – Drug Safety Updates, opioid and gabapentinoid risk communications, and patient safety leaflets.
- **electronic Medicines Compendium (emc)** – access to UK-approved Summaries of Product Characteristics (SmPCs).

Quality improvement and harm reduction

- **Medicines Safety Improvement Programme (MedSIP)**, including Bath and North East Somerset, Swindon and Wiltshire (BSW), for opioid safety data and patient information resources.
- **Derbyshire Joint Area Prescribing Committee (JAPC)** – opioid tapering principles that informed elements of this toolkit.F

Self-management and patient education

- **Live Well with Pain** – including the *Ten Footsteps* programme, Opioid Thermometer, Side-Effect Lottery, and patient decision aids.
- **Somerset Community Pain Management Service** – supported pain-management programmes and advice and guidance pathways.
- **Therapeutic Goods Administration (TGA), Australia** – for hosting open-access chronic pain education resources (*Brainman* series).

Local health system

- **NHS Somerset Integrated Care Board (ICB)** – locally agreed opioid and gabapentinoid tapering guidance and prescribing resources.

Patients

- The author also acknowledges people living with chronic pain whose experiences continue to shape safer, more compassionate approaches to pain management and deprescribing.

Any errors or omissions remain the responsibility of the author.