NHS
Lancashire and South Cumbria
Integrated Care Board

15th January 2026

Severe shortage of co-codamol 30/500 tablets

Support for the management of patients prescribed co-codamol 30/500mg tablets in long term chronic non cancer pain during upcoming national shortage.

We have been informed there will be a long-term supply shortage of co-codamol 30/500mg tablets, which is expected from February 2026 until June 2026. Up to half of the usual volumes may be unavailable for this time. The medicines supply notification is accessible here.

Based on prescribing in the last six months it is estimated that approximately 50,000 patients in Lancashire and South Cumbria have been prescribed this preparation regularly or on a 'prn/when required' basis.

Lancashire and South Cumbria ICB is the highest prescriber of opioids in England. Co-codamol 30/500 in all forms make up 31% of all opioid prescribing. No other co-codamol or other compound analgesic preparations will be able to fill this loss of volume.

While this will be enormously disruptive it is an opportunity to reduce the overall opioid burden and reduce side-effects such as constipation, lethargy, confusion, drowsiness, GI upset and psychological and physical dependence on codeine.

We are taking a pro-active approach prior to the anticipated stock shortage to minimise impact on your practice. A search has been built to help identify cohorts of patients within your practice (see appendix 1).

Key messages:

- Most pain medication, especially opioids are ineffective for long-term pain
- Do not switch to NSAIDs – which have significant cautions, contraindications and side-effects, including renal, GI and cardiovascular, especially in older and frailer patients. NSAIDs are also associated with avoidable unplanned hospital admissions.
- Consider **biopsychosocial options** (see appendix 2)
- Ask patients '*What matters most to you*?' to help agree a shared decision on ongoing care and support.

Please take the following actions with immediate effect:

Prescribing in acute pain

- Only issue up to 28 days' supply to reduce/avoid stockpiling by patients
- Consider prescribing as separate paracetamol and codeine (30mg or 15mg strengths if appropriate)
- Bulk/routine switching to other opioids (tramadol, higher dose opioids), or other co-codamol compound analgesic preparations (8/500mg, 15/500mg, soluble formulations, branded generics etc) is **not** recommended.

Prescribing for chronic (long-term) pain

- Identify prn/infrequent collections and take these off repeat
- Contact community pharmacies and stop all repeat dispensing of co-codamol 30/500mg tablets
- Consider moving all pain medication from repeat to acute supply and review and reduce quantities where possible
- Review patients, provide guidance to consider paracetamol alone and/or rationalising if multiple opioids are prescribed
- Outline risks of codeine prescribing but may need to be an option for some people.
- Review all weekly prescriptions
- Consider comms to care homes re; ordering and not wasting prn stock monthly (use care home team ordering resources)

Prescribing following discharge/outpatient appointments

- To reduce risk of inappropriate or unintended further prescribing do not routinely add acute medicines to the prescribing record (e.g. analgesics, laxatives, PPIs etc) unless these are expected to be continued
- If adding for information purposes use the 'Hospital Only' section.

System action

- We are working with acute trusts to reduce/move away from co-codamol usage on discharge and move to individual components.

We are very mindful of the enormous disruption this may cause. Please do not issue large quantities and be aware of potential orders for 'stocking up', including those on infrequent/ when required supplies.

We will keep practices informed of the situation as it evolves. If you need any further assistance, please contact your usual medicines optimisation pharmacist or pharmacy technician for support or email the shared team email address lscicb.mo-admin@nhs.net.

Thank you for your support.

Andrew White
Chief Pharmacist

On behalf of the Medicines Optimisation Team

15th Jan 2026

MSN_2026_001
Co-codamol 30mg_5

Appendix 1 - EMIS searches to support prioritisation

Review patients in your practice utilising the EMIS search provided to identify patients.

This can be found at: https://primarycare.lancashireandsouthcumbria.nhs.uk/medicines-optimisation/supply-issues/

Please link with your local Medicines Optimisation team member or lscicb.mo-admin@nhs.net if you are having trouble accessing or running the search.

The search will identify with potential actions:

- 1 - Not had issued in 3 months
  - **Action**: Move to past drugs
- 2 - eRD
  - **Action**: Has nominated pharmacy details on to aid linking with them. Contact nominated pharmacy and stop eRD.
- 3 - On other opioids - details of all current opioids inc on auto report
  - **Action**: Review to reduce/ stop opioids/ co-codamol
- 4a & 4b - PRN people issued within last 3months but lower dose/less frequently
  - **Action**: Review to stop – beware of 'stocking up'
- 5 - Care home patients - accuracy depends on coding
  - **Action**: Confirm usage – only renew if no stock/ consider alternatives
- 6 - Possible weekly patients - potentially higher risk patients
  - **Action**: Careful review – separate codeine may not be appropriate?
- 7 - Patients taking regularly and not in one of the above groups
  - **Action**: switch to alternatives – e.g. separate paracetamol; & codeine

Sample search report

Name	Population Count	%
All patients with co-codamol 30/500 on current meds	173	1%
1. Not ordered in 3 months	23	13%
Patient details Auto Report	23	
2. Co-codamol 30/500 on eRD	0	0%
Patient details Auto Report	0	
3. Patient has another opioid on current meds	18	10%
Patient details Auto Report	18	
4a. PRN co-codamol 30/500 (>168 lasting >6wks)	9	5%
Patient details Auto Report	9	
4b. PRN co-codamol 30/500 (1 - 168 lasting 4+wks)	27	16%
Patient details Auto Report	27	
5. Care home patients	1	1%
Patient details Auto Report	1	
6. Possible weekly patients	1	1%
Patient details Auto Report	1	
7. Patients to be switched to alternatives	94	54%
Patient details Auto Report	94	

Appendix 2 - Biopsychosocial Review and Prescribing Considerations

It is important that affected patients are reviewed holistically, with reference to the **biopsychosocial model of pain**, and that any prescribing changes are undertaken in a safe, patient-centred, and evidence-based manner.

1. Biopsychosocial Review of Pain

A structured review should consider the following domains:

Biological factors

- Indication for co-codamol (acute vs chronic pain, cancer vs non-cancer pain).
- Duration of opioid use and current total daily dose.
- Analgesic benefit versus adverse effects (e.g. constipation, sedation, cognitive impairment etc).
- Risk of opioid dependence, tolerance, or opioid-induced hyperalgesia.
- Co-morbidities (renal/hepatic impairment, respiratory disease).
- Concomitant CNS depressants (e.g. benzodiazepines, gabapentinoids).

Psychological factors

- Patient beliefs about pain and reliance on opioid medication.
- Anxiety related to medication changes or fear of pain worsening.
- Mood disorders (e.g. depression, health anxiety), which may amplify pain perception.
- Coping strategies and previous experience of dose reduction or medication changes.

Social factors

- Impact of pain on function, employment, and activities of daily living.
- Social support, caring responsibilities, and safeguarding considerations.
- Risk of medication misuse, diversion, or stockpiling due to anxiety around shortages.
- Health literacy and ability to engage in shared decision-making.

2. Prescribing Considerations During Shortage

General principles

- Avoid abrupt opioid discontinuation where there is established dependence.
- Use the shortage as an opportunity to reassess the ongoing appropriateness of strong opioid prescribing, particularly in chronic non-cancer pain.
- Engage the patient in **shared decision-making**, explaining the rationale for change clearly and empathetically.
- Document clinical reasoning and discussions carefully.

3. Dose Reduction and Alternative Strategies

Option A: Dose reduction using available strengths

- Alternatively, prescribe **paracetamol and codeine separately**, ensuring the total daily dose of paracetamol does not exceed recommended limits.
- Any reduction should be **gradual**, particularly in long-term users, to minimise withdrawal symptoms and distress.

Option B: Step-down or opioid-sparing approach

- Where clinically appropriate, consider stepping down to:
    - Paracetamol alone or
    - NSAIDs (if not contraindicated)
    - Topical agents (e.g. NSAIDs, capsaicin)
    - Do **not** consider lower dose co-codamol 8/500mg
        - No robust evidence that this strength is any more effective than paracetamol alone and stock unlikely to be available
- Reinforce non-pharmacological pain management strategies.

Option C: Review of overall pain management plan

- For chronic long term non cancer pain, opioids should not be first-line long-term therapy.
- Consider referral to:
    - First Contact Physiotherapy or equivalent if appropriate
    - Pain management services or other services e.g. escape pain
    - Social prescribing or community support services
- Encourage pacing, physical activity, and psychological approaches (e.g. CBT-informed pain management where available).
- Discuss and utilise the resources on LSCICB website

4. Monitoring and Follow-Up

- Arrange **planned follow-up**, particularly if:
    - The patient is on long-term opioids.
    - A dose reduction or medication switch has been initiated.
- Monitor:
    - Pain control and functional outcomes.
    - Withdrawal symptoms.
    - Mood and psychological wellbeing.
- Escalate or seek specialist advice if pain becomes unmanageable or safeguarding concerns arise.

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