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1. 1 Whatis non-medical prescribing? Non-medical prescribers (NMPs) are healthcareprofessionals who, despite not being doctors or dentists, are legally permittedto prescribe medicines, dressings and appliances subsequent to attaining anadvanced level qualification in prescribing.

The development of non-medicalprescribing within healthcare settings enables healthcare professionals toenhance their roles and use their skills and competencies effectively, in orderto improve patient care in varied settings including the management of longterm conditions and medicines, emergency and palliative care, mental healthservices and much more (Cope, et al., 2016). Non-medical prescribers can range fromroles such as nurses, pharmacists, optometrists, chiropodists or podiatrists, radiographers and physiotherapists (Department of Health, 2017). 1. 2: Non-medicalprescribing – an international perspective Currently, only pharmacists and nurses havebeen granted prescribing rights outside of the United Kingdom and not healthcare professionals who are distinct from medicine, nursing and pharmacy (alsoknown as Allied Health Professionals).

In the United States of America, independentpharmacists currently have the ability to prescribe from a limited list ofmedications, however, this is only apparent in the state of Florida (Cope, et al., 2016). Pharmacists canonly prescribe alongside doctors within Collaborative Drug Therapy ManagementClinics (Drugs and Therapeutics Bulletin, 2006) in at least 16states. Other US states use dependent prescribing (supplementary prescribing)with the use of a clinical management plan or independent prescribing usinglocally agreed protocols, such as the Veterans’ Affairs

Centres run by theVeterans Health Administration (VHA) (Clause, etal., 2001, cited in Cope, et al., 2016).

In terms of nurse prescribing in the USA, in order fornurses to gain ' prescriptive authority', they must additionally qualify asAdvanced Practice Registered Nurses at postgraduate level, and then specialiseas Nurse Practitioners, only to then further apply for additional prescriptiveauthority credentials following board certification (Greenberg, et al., 2003 cited in Cope, et al., 2016). The extentof prescriptive author that nurses acquire varies between states, as theprofession is dependent on individual state regulation. However, 21 states andthe District of Columbia allow nurses to prescribe independently due to havingapproved full practice status for nurse practitioners. This is a controversialtopic, as many states disagree with this and some still hold ' restrictedpractice regulations for nurse practitioners' (Cope, et al., 2016). In a similar way to pharmacists, nursepractitioners employed by the VHA who have prescriptive authority, may begranted independent prescriber status whilst being a VHA employee (Konnor, 2007).

Other than in the UK, pharmacist prescribingis currently not permitted anywhere else in Europe. However, countries such as Finland, Ireland, Sweden, the Netherlands and Spain have introduced nurse prescribingand the consequent legal restrictions on the types of nurses that mayprescribe, what they are legally permitted to prescribe and for whom, andwhether they are able to do so independently (Kroezen, et al., 2011). Pharmacists inCanada with prescribing rights can prescribe independently or collaborativelywith a physician (American Pharmacists Association, 2014).

Similarly, NewZealand legislation has recently been introduced which allows qualifiedpharmacists to prescribe (Parliamentary Counsel Office, 2013).

In Australia, the Health Workforce hasdeveloped a national pathway for prescribing by other healthcare professionalsapart from doctors, dentists and nurses (Hale, et al., 2016). Nurse practitioners can currentlyprescribe medications if they are endorsed by the Nursing and Midwifery Boardof Australia (NMBA), and medications are limited by the nurse practitioner'sscope of practice, Medical Protection Society (MPS)/Pharmaceutical BenefitsScheme (PBS) requirements and by hospital formularies or hospital prescribing measures(South Australia Health, 2017).

The AustralianHealth Workforce Council has published a guidance document regarding developinga case in order for Health Ministers to ' considerendorsing the prescribing of scheduled medicines for health professions thatcurrently do not have this endorsement, such as physiotherapy', which willallow the profession to consider whether it wants to pursue prescribing rights (Physiotherapy Board of Australia, 2017). 1. 3: Non-medical prescribing in the United Kingdom Non-medical prescribing has been in existencein the UK since 1989 (Drugs and Therapeutics Bulletin, 2006), and played asignificant part in the Department of Health's agenda since. The CumberlegeReport (Department of Health and Social Security, 1986), indicated thatpatient access to treatment could be enhanced, and patient care improved andresources used more effectively if community nurses were able to prescribe aspart of their practices from a limited list of items. The recommendations fromthe Cumberlege Report, (Department of

Health and Social Security, 1986), were reviewedby an advisory group chaired by Dr June Crown and the Crown Report (Department of Health , 1989) proposed severalbenefits would occur with nurse prescribers – improved patient care, improveduse of nurses' and patients' time and communication between multidisciplinaryteam members from clarification of professional responsibilities. It required afurther 3 years until primary legislation permitting nurses to prescribe waspassed in 1992 (Department of Health and Social Security, 1992). Further to the success and acceptability of communitynurse prescribing, the prescribing of medicines was reviewed (Department of Health, 1999) and it was recommended that prescribing authority shouldbe extended to other groups of professionals with training and expertise inspecialist areas.

Thus, district nurses and health visitorsbecame legally able to prescribe independently from the renamed NursePrescriber's Formulary, and the range of medications nurses were able toprescribe was increased. However, this was permitted only within a supervisedframework, which was termed ' dependent prescribing' (Department of Health, 1999) which was laterrenamed as ' supplementary prescribing'. Theoriginal policy objectives for the development of non-medical prescribing wereset out in 2000, and were related to the principles in the National Health Plan(Department of Health, 2000). These were improvements in patient care, choice and access, patient safety, better use of health professionals' skills and flexible teamworking. In 2001, support was provided by the Government for the extension ofprescribing to nurses other than district nurses and from a wider selection ofmedicines (Department of Health, 2001). In November2005, it

was announced that qualified extended formulary nurse prescriberswould become able to prescribe any licensed medicine for any medical condition(and some controlled drugs for specified conditions) as independent prescribersin the following year, ending the existence of the Extended Formulary (Department of Health, 2005). Evaluation ofnon-medical prescribing (Department of Health Policy Research Programme 2010)indicated that nurse and pharmacist independent prescribing was becoming awell-integrated and established means of managing patients' conditions. 1.

4: Physiotherapist prescribing Physiotherapistsare registered healthcare professionals who help with the rehabilitation ofindividuals who are affected by injury, illness or disability through movementand exercise manual therapy, education and advice (Charterd Society of Physiotherapy, 2013). Physiotherapistscan be effective for people with a wide range of health conditions includingproblems affecting the bones, joints and soft tissue, brain ro nervous system, heartand circulation or lungs and breathing (NHS Choices, 2017). In addition to this role, physiotherapists are able to give medicinal advice to their patients, which isan expectation of reasonable physiotherapy practice for the management of manyconditions (Chartered Society of Physiotherapy, 2017). Physiotherapists, alongside other Allied Health Professionals such as podiatrists, were grantedprescribing rights to become Supplementary Prescribers (SPs) in 2005 (Statutory Instrument , 2005). Assupplementary prescribers, physiotherapists became be able to prescribe alimited range of medicines in partnership with a doctor, using an

agreedpatient specific clinical management plan, as well as administer some medicines.

Medications had to be defined in writing within a Clinical Management Plan(CMP) and appropriate to the needs of the patient (Chartered Society of Physiotherapy, 2016). Two yearslater, in 2007, optometrists became able to act as independent prescribers (Department of Health, 2007). Proposals tointroduce independent prescribing by physiotherapists were put forward to the Departmentof Health in 2012 to increase their quality of care, patient safety, experienceand effectiveness. Independent prescribing physiotherapists were predicted toenhance patient care by improving access to medicines (Department of Health, 2012).

They would reducethe patient care pathway as a follow up appointment with a GP to obtain aprescription would not be required. This was built on the white paper (Department of Health, 2010), which aimed toensure patients had increased access to timely treatment by liberatingfrontline healthcare staff to maximise the benefit they can offer to patient. In 2013 for England and 2014 for the rest of the UK, physiotherapist andpodiatrist prescribing was widened to include the independent prescribingstatus (Department of Health, 2013). Early last year, NHS England announced new legislationpermitting independent prescribing by therapeutic radiographers andsupplementary prescribing by dieticians (National Health Service England, 2016). 1. 5: The research problem Non-medicalprescribing has taken many years of planning, review, and discussion, and ithas been a long-fought and hard-won battle to reach today’s current status wherenot only

nurses and pharmacists have the ability to prescribe in the UK, butallied health professionals do also. In regard to physiotherapists, non-medicalprescribing is viewed as an essential component of expanding their scope of practice(Morris and Grimmer 2014), however current statistics indicate that out of54, 980 registered physiotherapists with the profession's regulatory body, theHealth and Care Professions Council (HCPC), only 1.

4% (n= 784) are supplementaryprescribers and 1. 25 (n-659) are independent prescribers. What are the reasons for these modest andsomewhat disappointing numbers, given that the UK is one of the leastrestrictive countries in regard to scope of prescribing practice fornon-medical prescribers (Afseth & Paterson, 2017) and is at the globalforefront of providing allied health professionals such as physiotherapistswith prescribing rights. Physiotherapy prescribing has been recognised asproducing a more consistent, transferable and recognised workforce (Atkins2003) yet Robertson et al 2016 indicated that a lack of published evidence onthe effectiveness of physiotherapists prescribing exists and more studies havebeen undertaken on other extended scope of practice roles such as orthopaedictriage (Kersten et al, 2007).

This study proposes to provide insight into theconundrum of the lack of published literature regarding any changes thatphysiotherapist prescribing rights has brought to the profession through the explorationof the attitudes and feelings physiotherapists have towards prescribing. Understandingthe reasons, whether they be barriers or reluctance (if any) thatphysiotherapists have towards becoming prescribers, as well as their generalattitudes

towards pharmacotherapy and medicines management will allow for thedevelopment of future interventions which may allow more physiotherapists toutilise their right to prescribe and become prescribers, whether supplementaryor independent.