

Translating AMR Research into Parliamentary Action: Interview with Rasha Abdelsalam Elshenawy

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Q1. Why is the window between the Westminster Health Forum on 21 April and the next UK National Action Plan (NAP) review the right moment to convene parliamentarians and researchers?

Because the diagnosis is settled, the window for translation is finite. The Westminster Health Forum on 21 April brought together UK Health Security Agency (UKHSA), National Institute for Health and Care Excellence (NICE), Medicines and Healthcare products Regulatory Agency (MHRA), the Veterinary Medicines Directorate (VMD), BSAC (British Society for Antimicrobial Chemotherapy), the Medicines Discovery Catapult, the Cystic Fibrosis Trust, primary care, and academic researchers around one shared conclusion: the evidence base on what works in antimicrobial stewardship is no longer the bottleneck. The bottleneck is the structural distance between what is known and what the system does. That distance is what closes within the NAP refresh cycle, or it does not close at all.

The Public Accounts Committee inquiry of June 2025 had already named the same problem from a parliamentary scrutiny perspective. The Westminster Health Forum named it from a multi-stakeholder evidence perspective. By April, the two halves of the system were saying the same thing. A Parliamentary Roundtable in May, with policy-ready recommendations going into the NAP refresh, is the natural next step. If we miss this window, the next opportunity to influence the plan is years away.

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The 18 May 2026 Parliamentary Roundtable is designed to bring parliamentarians, regulators, professional bodies, patient advocates, antimicrobial resistance (AMR) experts, and researchers around a shared evidence base, and to produce four interdisciplinary, peer-deliverable outputs: a policy brief; a peer-reviewed methodology paper; a final report; and a public engagement roadmap. It is timed precisely so that those recommendations can feed into the National Action Plan review while it is still being shaped.

Q2. The Public Accounts Committee (PAC) found that only one of five 2019-24 NAP targets was met. What does that mean clinically for patients today?

It means we are losing ground at exactly the moment we cannot afford to. The PAC report documented that inappropriate antibiotic prescribing remains around 20% in primary care. The shortfall in consultant medical microbiologists is similar. Slow progress in diagnostic implementation continues, and 20% of antimicrobials used in agriculture remain inappropriate. The Committee also confirmed that wastewater is now a primary microbial breeding ground in some parts of the country.

Clinically, this translates into outcomes I see in the evidence base every week. Patients with infections that should be treatable are increasingly facing therapeutic uncertainty. Frontline clinicians are making prescribing decisions in conditions where the support systems, diagnostic infrastructure, audit-and-feedback loops, and multidisciplinary review were dismantled during the pandemic and have not been fully rebuilt. And the next public health emergency, whether viral, bacterial, or environmental, will arrive in a system that has not yet recovered the antimicrobial stewardship resilience the previous one revealed it needed.

Our written evidence to the inquiry, cited as AR0005, drew directly on more than 5 years of implementation research conducted in NHS Foundation Trusts, including during the COVID-19 pandemic. What that evidence showed is structural. Antimicrobial stewardship programmes designed for stable conditions did not survive disruption. The Committee confirmed those findings. What is missing now is not further confirmation. What is missing is the implementation infrastructure that turns those findings into changed practice.

Antimicrobial stewardship cannot depend on stability. It should be designed for disruption, pandemics, workforce shortages, and system reorganisation. Disruption is not exceptional. It is the normal operating environment of the NHS.

Q3. Can you describe the GUIDE Framework and the SMART-AMS Dashboard, what problem they solve, where they are being deployed, and how they fit into AWaRe-aligned prescribing?

The GUIDE Framework and the SMART-AMS Dashboard are the two implementation tools developed to operationalise the crisis-resilient AMS framework I published. They address two different layers of the same problem.

The GUIDE Framework is a five-step, evidence-based approach to antibiotic selection at the point of prescription. It is structured, teachable, and embeddable in undergraduate and postgraduate clinical training. It directly addresses the workforce education gap that the PAC inquiry identified as among the most urgent. I have applied it most recently in real-time during a meningococcal outbreak in Kent, UK, earlier this year, which I have written up. The Kent paper proposed four NAP-aligned reforms: AMS metrics in outbreak response, MenB vaccination expansion, risk-stratified chemoprophylaxis, and antibiotic supply chain preparedness.

The SMART-AMS Dashboard is the digital infrastructure layer. It provides clinicians with real-time prescribing data at the ward level, aligned with the WHO AWaRe classification.

It is essentially the audit-and-feedback loop that the pandemic dismantled, rebuilt as standing digital infrastructure. The PAC's own evidence confirmed that where electronic dashboards displaying antimicrobial use were maintained during COVID-19, prescribing oversight measurably improved. SMART-AMS is the operationalisation of that finding.

Both tools sit explicitly within the WHO AWaRe framework. AWaRe classifies antibiotics into access, watch, and reserve categories, and provides a globally standardised, evidence-based framework for antibiotic selection. The GUIDE Framework operationalises AWaRe at the bedside. SMART-AMS operationalises it at the system level. Together, they address the implementation gap and the digital infrastructure gap simultaneously. Both are AI-enabled where appropriate, which is what brings them into the wider conversation about regulatory frameworks for AI in antimicrobial prescribing.

Q4. The Westminster Health Forum identified four strategic gaps: implementation, diagnostics, sustained innovation, and research-to-parliament infrastructure. Which is most underserved by current UK policy?

All four are real and structural. But the fourth, research-to-parliament infrastructure, is the one that determines whether the others ever close. Without a standing channel between AMR researchers and parliamentarians, the first three gaps are continuously rediscovered rather than progressively closed.

The PAC inquiry received 26 written submissions from researchers, clinicians, and patient advocates. It cited several, including ours. But there is no standing infrastructure for that conversation to continue. No formal mechanism through which AMR researchers and parliamentarians regularly exchange evidence, track implementation, and hold each other accountable. The result is a cycle in which each new inquiry, action plan, or forum produces the same diagnosis and the same broad recommendations, with limited progress between iterations.

This is precisely what the 18 May Roundtable is designed to address. The methodology I have built, the AMR Translation Cycle, is a continuous, documented loop. Academic and clinical research feeds institutional translation; institutional translation reaches Westminster; Westminster engagement drives implementation in health systems and society; and implementation generates new questions and new data that return to research. Each turn is aligned with national and global AMR priorities, and with the standards of research excellence and impact the UK system requires.

Q5. Why does the patient voice, AMR survivor, sit at the centre of an agenda that parliamentarians usually hear as a numbers story?

Because antimicrobial resistance is a silent, slow pandemic, and slow pandemics lose political attention without human anchors. The numbers matter. Thirty-five thousand AMR-attributable deaths a year in the UK. Twenty per cent of inappropriate prescribing. Twenty per cent shortfall in consultant medical microbiologists. These are figures the

PAC, UKHSA, and BSAC have all confirmed. But figures alone do not sustain parliamentary urgency over the multi-year cycle required to deliver structural reform.

The AMR patient voice sits at the centre of the agenda because lived experience is the evidence that the system has gaps the numbers do not always reveal. AMR patient advocacy has done critical work to centre that experience in global policy conversations, and the contribution to this Roundtable comes directly from that community. When parliamentarians hear, directly, what it means to live with antimicrobial resistance, the diagnostic uncertainty, the surgical complications, the cumulative cost to a life, the policy questions reorganise themselves. Workforce competencies become urgent. Diagnostic infrastructure becomes essential. The subscription model becomes a question of human consequence, not just procurement architecture.

There is also a methodological reason. A research-to-parliament pipeline that produces policy briefs without the patient voice is incomplete. It reproduces the asymmetry between technical expertise and lived experience that the PAC itself flagged. The methodology I have built insists that patient advocacy is a substantive input to the policy brief, not a closing slide. Vanessa's role at the Roundtable, and the wider arts-based and narrative engagement work we are integrating through interdisciplinary attendees, including the Fleming Initiative and the British Dental Association, is what makes the methodology defensible as well as effective.

AMR is a slow pandemic, and parliamentary attention is a finite resource. Patient voice is what sustains the urgency between data points.

Q6. What does success for the 18 May Roundtable look like 6 months on, the policy brief, the methodology paper, and the case for a standing AMR research-policy interface?

Success has four documented outputs and one structural shift, and we should be judged on all five.

First, a policy brief, which will carry specific recommendations on four interconnected priorities: AWaRe-aligned competencies in postgraduate revalidation; AI and digital infrastructure for stewardship; the innovation pipeline and alternatives to antibiotics; and the regulatory science framework that must accompany them.

Second, a peer-reviewed methodology paper documenting the AMR Translation Cycle as a replicable model. This is the paper that establishes the methodology as a citable, adoptable framework for other AMR research communities. It is also what positions this work for research excellence as a documented research-to-policy translation methodology.

Third, the ESRC Impact Acceleration Award final report, which captures the methodology's full evidence base from written evidence through to parliamentary outputs.

Fourth, a public engagement roadmap for AMR research communities, distributed via national and global conferences, so the methodology is genuinely replicable rather than locked to my team alone.

AMR research should be judged not only by its citations but by the changes it makes to patients' lives and to national preparedness. The 18 May Roundtable is designed to deliver that response.

If, 6 months from now, the policy brief is on the national reading list, the methodology paper is published, the Interface has a steering group meeting in the diary, and a follow-up Roundtable is in preparation, then the methodology will have demonstrated what it set out to. AMR research will have reached Parliament through a documented, replicable pipeline, and Parliament will have responded with the structural commitments the next phase requires.