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SUPPORTING EVIDENCE REPORT

Evidence and Discussion Report from the Parliamentary Roundtable on Antimicrobial Resistance

Translating AMR Research into Parliamentary Action: A Multi-Stakeholder Roundtable

House of Commons, Westminster

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University of Hertfordshire

ESRC Impact Acceleration Account

Parliamentary Roundtable on Antimicrobial Resistance

Prepared by Dr Rasha Abdelsalam Elshenawy



Following a Parliamentary Roundtable on Antimicrobial Resistance, Westminster, 18 May 2026

UKRI Economic and Social Research Council

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Purpose of this report

This report provides the supporting evidence base for the policy brief developed after the Parliamentary Roundtable on Antimicrobial Resistance (AMR), held at the House of Commons on 18 May 2026. The Roundtable was convened through the Economic and Social Research Council (ESRC) Impact Acceleration Account at the University of Hertfordshire [ES/X004309/1]. It brought together parliamentarians, public health leaders, researchers, professional bodies, patient advocates and healthcare professionals to look at how to strengthen delivery of the UK National Action Plan on AMR.

The purpose of this report is to record the evidence, presentations, discussions and contributions that informed the five recommendations in the policy brief. It offers a transparent record of how AMR research was translated into parliamentary engagement and policy dialogue.

The report draws on several sources: the Public Accounts Committee inquiry on AMR (AR0005); the Westminster Health Forum conference (April 2026); the presentations given on the day; the facilitated discussion; reflections shared afterwards; and supporting reports and publications shared by participating organisations.

Prepared by Dr Rasha Abdelsalam Elshenawy, Principal Investigator, University of Hertfordshire.

Unlike the policy brief, which focuses on recommendations for policymakers, this document is an evidence and discussion record. It is intended for policymakers, researchers, healthcare professionals, public health agencies, professional bodies, patient organisations and anyone interested in antimicrobial stewardship, One Health, innovation, public engagement and research-to-policy translation. It also forms an evidence base for future dissemination and impact reporting linked to the ESRC-funded project. It is designed to support transparency, dissemination, policy follow-up, academic publication and impact reporting.

1. Background and policy context

Antimicrobial resistance (AMR) happens when bacteria, viruses, fungi and parasites stop responding to the medicines used to treat them. This makes common infections harder to treat and puts routine medical care at risk.

The UK has long been a leader on AMR. It has published successive National Action Plans, taken a One Health approach that joins up human, animal and environmental health and supported global action. The current plan, Confronting Antimicrobial Resistance 2024–2029, aims to reduce infections, improve how antibiotics are used, strengthen surveillance, support innovation and raise awareness.

Despite this progress, resistant infections still cause real harm. In 2025 the House of Commons Public Accounts Committee (PAC) examined progress in its inquiry Antimicrobial Resistance: Addressing the Risks, to which the University of Hertfordshire submitted written evidence (reference AR0005). Its main findings included:

- AMR is linked to an estimated 35,200 deaths a year in the UK.
- Only one of the five targets in the 2019–2024 plan was met (reducing antibiotic use in animals).
- About 20% of antibiotic prescriptions in primary care are still inappropriate.
- Progress on rolling out rapid diagnostics has been slow.
- There is roughly a 20% shortfall in consultant medical microbiologists.
- Weaknesses in wastewater management can help resistance spread.

In April 2026 the Westminster Health Forum conference, Next Steps for Tackling Antimicrobial Resistance in the UK, brought these issues together. It identified four strategic gaps: implementation infrastructure, diagnostic capacity, sustainable innovation pathways and the link between research and Parliament. Across the event there was cross-party agreement on a single message: the main problem is no longer a lack of evidence, but the need to deliver the tools we already have. This Roundtable was designed to respond to that message and turn it into practical recommendations for the next National Action Plan.

2. Roundtable methodology

The Roundtable was convened and led by Dr Rasha Abdelsalam Elshenawy under the ESRC Impact Acceleration Account at the University of Hertfordshire, in liaison with the secretariat of the All-Party Parliamentary Group (APPG) on Antimicrobial Resistance. It was held at the House of Commons on 18 May 2026, from 2:00pm to 4:00pm and brought together around 20 stakeholders.

The event ran under the Chatham House Rule. This means participants are free to use what was said, but not to reveal who said it. For that reason, this report records the points raised but does not attribute any view to a named individual.

The method had two simple parts. First, short evidence presentations set out the current picture from research, national agencies, professional bodies and patients. Second, a facilitated discussion turned that evidence into draft recommendations.

The work followed the AMR Translation Cycle: research and clinical evidence feed into institutional translation, then into engagement at Westminster, then into implementation in health systems and society, which in turn raises new questions for research. The Roundtable is one turn of that cycle.

Draft recommendations were checked against the APEASE criteria: acceptability, practicability, effectiveness and cost-effectiveness, affordability, safety (side-effects) and equity. This kept the recommendations realistic and fair, while leaving decisions on priorities and funding to Government.

3. Roundtable programme and presentations

The programme combined six short presentations with a facilitated discussion. The agenda is shown below.

Time	Session	Speaker
14:00–14:10	Welcome & scene setting	Professor Sam Salek (Chair)
14:10–14:20	Implementation science in AMS	Dr Rasha Abdelsalam Elshenawy
14:20–14:30	Public health & institutional strategy	Professor Zoe Aslanpour
14:30–14:42	National surveillance & prescribing	Dr Alicia Demirjian (UKHSA)
14:42–14:54	Stewardship in practice	Professor Andrew Seaton (BSAC)
14:54–15:02	The patient voice	Vanessa Carter
15:02–15:42	Parliamentary discussion & recommendation co-creation	All, chaired by Prof Sam Salek
15:42–15:50	Summary & next steps	Dr Rasha Abdelsalam Elshenawy

Presentation summaries

Welcome and scene setting, Professor Sam Salek (Chair). Set out the purpose of the event, placed it in the context of recent AMR findings and invited the parliamentary hosts to welcome participants.

Implementation science in AMS, Dr Rasha Abdelsalam Elshenawy. Framed the day around the four Westminster Health Forum gaps. Introduced the GUIDE Framework, a five-step tool for evidence-based antibiotic prescribing and the SMART-AMS Dashboard, which shows prescribing data at ward level and is aligned with the WHO AWaRe classification. Explained the AMR Translation Cycle and set the goal of producing a UK policy brief.

Public health and institutional strategy, Professor Zoe Aslanpour. Linked the University's teaching, research and impact work to national AMR strategy, drew lessons from the COVID-19 response and highlighted surveillance, early warning and public behaviour change.

National surveillance and prescribing, Dr Alicia Demirjian (UKHSA). Presented the national picture on resistance and prescribing, current antibiotic use in England, national targets and what these mean for policy.

The surveillance picture, drawn from the Second-Generation Surveillance System covering around 98% of hospital microbiology laboratories in England, showed mixed progress against the 2029 ambitions of no rise in key resistant infections, a 5% cut in antibiotic use and 70% of antibiotics from the WHO Access group. In 2024 there were just over 92,000 bloodstream infections caused by priority bacteria, around one in five resistant to common first-line antibiotics and roughly 400 each week, with much of the burden driven by Gram-negative bacteria such as E. coli and Klebsiella. Antibiotic use sits about 2% below 2019 levels and 63% of use is from the Access group. Resistant bloodstream infections in the most deprived populations widened from 29% higher than the least deprived in 2019 to 47% higher by 2024.

Stewardship in practice, Professor Andrew Seaton (BSAC). Set out BSAC's role in promoting stewardship, the clinical challenges, examples of successful interventions, the importance of training and the priorities of the APPG on AMR (for which BSAC provides the secretariat).

BSAC, with over 10,000 members (more than half overseas), works across the whole pathway from discovery to appropriate use and disposal under a One Health lens. Stewardship was framed as infrastructure (comparable to reducing carbon emissions or reversing type 2 diabetes) and as everyone's business, since most antibiotics are prescribed by non-specialists, including nurses and dentists with limited dedicated training. Examples of working models included the Scottish Antimicrobial Prescribing Group, an 18-year interdisciplinary programme that benchmarks data, tackles variation and amplifies best practice nationally; GAMSAS accreditation as a top-down driver of organisational stewardship; and the newly launched LEAP to BSI programme as a ground-up complement in north-west and north-east England. During COVID-19, Scotland's focused approach kept a lid on prescribing, whereas broader-spectrum prescribing became embedded elsewhere.

The patient voice, Vanessa Carter. Shared lived experience as an AMR survivor, the human impact of resistant infection, why patient voices matter in policy and a call to action for policymakers.

4. Discussion themes and stakeholder contributions

The facilitated discussion was organised around five themes. Each is set out below with the colleagues who led it. In line with the Chatham House Rule, points are recorded without attribution.

Theme 1: Embedding AMR stewardship as a routine practice

Planned lead Dr Danny Chambers MP sent apologies; opened by Dr Alicia Demirjian, with Professor Andrew Seaton and Dr Rasha Elshenawy. Focus: AWaRe-aligned competencies, stewardship implementation and rational antibiotic use.

The discussion converged on embedding stewardship in the curriculum of every prescribing profession (not only medicine, but pharmacy, nursing, dentistry, physiotherapy and podiatry) and on understanding as well as prescribing, captured in the phrase 'if we misuse them, we lose them'. As prescribing rights expand across professions, participants saw a national opportunity to embed competencies and build the capability to apply them through royal

colleges, regulators and post-registration CPD, rather than as an optional add-on. Translating curriculum into practice means making stewardship everybody's business, with peers influencing peers and education tailored to each specialty and training level. A recurring point was that stewardship cannot be designed for stable conditions alone; it needs a crisis-resilient model for disruption, workforce shortages and emergencies. Reframing 'stewardship' as patient safety (a cornerstone of clinical care) was seen as key to engagement. Participants distinguished competency from capability: competency provides the knowledge, skills and tools, while capability is the ability to apply them consistently in real clinical settings and achieve measurable outcomes. Both should therefore be addressed in education, governance, workforce development, audit and implementation support.

Theme 2: One Health stewardship

Led by Baroness Bennett of Manor Castle. Focus: joining up animal, plant, environmental and human health in the next National Action Plan.

This theme widened the lens from medicines to the whole environment. The discussion heard the case for removing unnecessary biocides from consumer products (distinct from medical and veterinary uses) to reduce the total environmental load, alongside concerns about factory farming, trade, imported food and the extreme resistance seen in conflict settings such as Ukraine. AMR was framed within the planetary-boundaries model as a system-level pressure. A detailed hospital example contrasted universal skin decontamination with targeted, test-led decolonisation: the evidence presented showed no added clinical benefit from treating every patient, while increasing biocide volumes and selecting for multidrug-resistant skin organisms, at significant cost. A survey of 120 NHS trusts found wide variation in practice, which will be reflected in the policy brief, with variation in intravenous-line flushing raised as a further example.

Theme 3: Digital stewardship and AI

Open to the room, with the SMART-AMS Dashboard as a worked example. Focus: dashboards, decision support, surveillance and the safe use and regulation of AI in prescribing.

AI was treated as a double-edged tool. Clinician hesitancy was acknowledged (many do not yet use AI) but framing its use responsibly markedly increased willingness to adopt it as guidance. Safe use depends on digital infrastructure, a regulatory framework, ethical safeguards and protection of patient data. The clearest near-term value lies in surveillance (analysing trends and predicting emerging resistance) and in point-of-care decision support through simple tools that make stewardship part of everyday practice. Risks were named directly: automation bias, inequity, limited transparency and explainability, data-quality dependency and over-prescribing; AI should support, not replace, clinical judgement. Several observed that the deeper problem is fragmented digital infrastructure, with clinical systems that do not interoperate and no national record linkage. The advice was not to run before walking: AI can already ease surveillance, case-finding and administrative burden.

Theme 4: Sustained innovation and the regulatory pathway

Led by Professor Sam Salek with Dr Alicia Demirjian. Focus: surveillance, the subscription model, antifungals, phage therapy and the role of the MHRA.

Participants agreed the UK is too small a market to drive innovation alone and that international coordination and incentives are essential, because resistance is outpacing development and weak commercial returns are drawing talent away from the field, described as an existential risk to drug development. An accelerated, adaptive regulatory pathway, with post-approval commitments, was proposed to move new products through faster. The UK subscription model (paying for value rather than volume) was highlighted as a structural achievement with outsized international influence, informing EU legislation, the US PASTEUR Act and an emerging Australian model. The discussion stressed enabling access in low- and middle-income countries, which carry most of the burden and include viable markets such as India, with UK–India development partnerships a promising route. The HIV response was cited as a warning against withholding drugs from those who need them and the new African Medicines Agency welcomed as progress.

Theme 5: Research–policy interface and public engagement

Led by Dr Rasha Elshenawy with Vanessa Carter, Dr Emily Scott-Dearing (Fleming Initiative) and the British Dental Association. Focus: a standing channel working with parliamentary champions and with bodies such as the APPG, arts-based engagement and the patient voice.

This theme returned to communication as the foundation: people engage once they understand and emotional engagement, not facts alone, is the prerequisite for behaviour change. Participants called for investment in patient and public involvement capacity, including participatory training so patients can co-author research and for removing the practical and cost barriers that exclude non-scientists. Patient organisations were seen as essential partners for reaching communities. Creative, arts-based engagement such as Lifeline the Musical was commended, diversified across media to reach different audiences. The discussion urged moving beyond awareness to active involvement, citing plans for a public venue and interactive exhibition that feeds the public's views, fears and priorities back into research and policy as a continuous loop, not a broadcast. The guiding principle was 'nothing about us without us' (patients as genuine partners, not tokens) supported by a standing research-to-Parliament interface working with parliamentary champions and with bodies such as the APPG.

5. Development of the policy recommendations

The presentations and discussion were brought together into five recommendations. Each links back to the evidence and themes above and each was tested against the APEASE criteria. They are offered as evidence-informed options; decisions on priorities, funding and implementation are for Government.

1. **Make AMR stewardship a core practice and safeguard prescribing.** (From Theme 1.) Embed WHO AWaRe-aligned stewardship competencies and implementation capabilities across training for every prescribing profession and link them to revalidation, because most antibiotics are prescribed by non-specialists; and as pharmacist independent prescribing at registration begins in 2026, match it with safeguards: audit, feedback, diagnostic stewardship and formulary alignment.

2. **Operationalise One Health stewardship.** (From Theme 2.) Join up human, animal, food, plant and environmental surveillance, scale wastewater monitoring linked to existing systems and reduce environmental drivers such as unnecessary biocides in consumer products, with clear cross-sector accountability.
3. **Build diagnostics, interoperable data and responsible AI.** (From Theme 3.) Treat rapid diagnostics and interoperable data as the precondition for effective stewardship; use digital tools such as the SMART-AMS Dashboard as implementation tools; and deploy AI only with strong governance, data quality and clinical oversight, evaluated before wider use.
4. **Sustain innovation and the regulatory pathway.** (From Theme 4.) Protect and improve the UK subscription model, including for small and medium-sized enterprises; support adaptive regulation and the MHRA sandbox; advance alternatives such as phage therapy and antifungals with stewardship plans; and strengthen international coordination and access in high-burden countries.
5. **Establish a standing research–policy interface and public engagement.** (From Theme 5.) Create a permanent AMR research-to-Parliament interface working with parliamentary champions and with bodies such as the APPG, including professional bodies, that tracks recommendations and implementation; embed patient and public involvement on the principle of 'nothing about us without us'; and invest in creative, arts-based engagement and AMR in education.

These five recommendations map one-to-one onto the five discussion themes. The fifth, a standing research-to-Parliament interface, is the mechanism that keeps the other four aligned with delivery across the life of the National Action Plan.

Evidence-to-recommendation mapping

The table below maps each evidence source and discussion theme to its policy recommendation and a suggested implementation indicator, supporting transparency, follow-up and impact reporting.

Evidence source	Theme	Policy recommendation	Suggested implementation indicator
PAC inquiry (AR0005); UKHSA prescribing data; BSAC/SAPG; ~99% prescribed by non-specialists	1. Stewardship as practice	R1. Stewardship as core practice and safe prescribing	AWaRe-aligned competency and capability requirements in curricula, practice and revalidation; prescribing audit coverage
PAC concern on wastewater and data sharing; hospital decolonisation evidence; NAP 2024–2029; One Health Joint Plan	2. One Health stewardship	R2. Operationalise One Health stewardship	Linked cross-sector indicators; wastewater surveillance coverage
SMART-AMS Dashboard; discussion on fragmented infrastructure; Elshenawy et al. (2025)	3. Digital stewardship and AI	R3. Diagnostics, interoperable data and responsible AI	Diagnostic turnaround; system interoperability; governed AI deployments
UK subscription model; Westminster Health Forum priority; McKinney reflection	4. Sustained innovation	R4. Sustain innovation and the regulatory pathway	Subscription-model uptake (including SMEs); products through the adaptive pathway
Westminster Health Forum (fourth gap); Rogers and Seo reflections; PPI (Nature Communications, 2025)	5. Research–policy interface	R5. Standing research–policy interface and engagement	Interface convened; recommendations tracked; patient and public involvement embedded

6. Stakeholder reflections received following the Roundtable

After the event, participants were invited to share brief written reflections. These were voluntary and are used here to add context, not as formal research data. Unlike the discussion summarised in Section 4, which follows the Chatham House Rule, these are signed contributions submitted for the record and are therefore presented with attribution. They expand on points raised during the Roundtable and, in several cases, point to supporting publications.

Professor Karolin Hijazi, Professor & Honorary Consultant in Oral & Maxillofacial Medicine, University of Aberdeen

Professor Hijazi's reflection expanded on the hospital decolonisation example raised during the discussion, drawing on molecular antimicrobial-resistance research led by the University of Aberdeen and her accompanying policy brief, "Time for Biocide Stewardship". She set out the case for biocide stewardship: nose and whole-body skin decontamination with biocides was introduced at the height of the meticillin-resistant Staphylococcus aureus (MRSA) crisis in the early 2000s and helped to control bloodstream infection in critical care, but as MRSA rates have fallen to an all-time low, the clinical benefit and the unintended harms of continuing to treat every patient warrant re-examination.

Her work contrasts two approaches in intensive care: universal decolonisation, in which every admitted patient is disinfected and targeted decolonisation, in which patients are tested and only MRSA carriers are treated. A controlled study led by the University of Aberdeen (The Lancet Microbe, 2025) found no added clinical benefit from universal decolonisation, while the far larger biocide volumes involved were associated with the expansion of biocide-tolerant, multidrug-resistant Staphylococcus epidermidis, including a direct relationship between universal decolonisation, chlorhexidine exposure and bloodstream infection with pathogenic meticillin-resistant S. epidermidis (MRSE). Universal decolonisation is also laborious and costly, requiring medical prescribing and trained nursing time and carries an environmental load as well as risks such as toxicity and allergic reaction.

Freedom of Information requests to 120 NHS Trusts found that decolonisation practice is not standardised and that most hospitals still apply universal decolonisation; a follow-up survey indicated that nearly 70% of intensive care units in England continue to do so, with practice differing across the devolved nations. Professor Hijazi also noted earlier work showing wide variation in the flushing of intravenous antibiotic lines, a further example of unwarranted variation that stewardship guidance could address. She has confirmed that this work will be reflected in the policy brief.

Suggested recommendation. Biocides and topical antimicrobials used for whole-body decolonisation should be explicitly embedded within UK antimicrobial stewardship frameworks. In low-MRSA settings, the benefits of universal decolonisation should be weighed against the risk of selecting invasive MRSE lineages and updated national guidance should support harmonised, safe, cost-effective and sustainable, test-led decolonisation as part of a broader concept of biocide (disinfectant) stewardship.

References cited

Sharaf S, et al. Universal versus targeted chlorhexidine and mupirocin decolonisation and the clinical and molecular epidemiology of Staphylococcus epidermidis bloodstream infections in patients in intensive care in Scotland, UK: a controlled time-series and longitudinal genotypic study. The Lancet Microbe. 2025;6(8):101118.

Zamudio R, Oggioni MR, Gould IM, Hijazi K. Time for biocide stewardship? Nature Microbiology. 2019;4(5):732–733.

Hijazi K, et al. Susceptibility to chlorhexidine amongst multidrug-resistant clinical isolates of Staphylococcus epidermidis from bloodstream infections. International Journal of Antimicrobial Agents. 2016;48(1):86–90.

David McKinney, Co-Founder and Director, ARMoR (Alliance for Reducing Microbial Resistance)

Mr McKinney's remarks focused on antimicrobial innovation and the structures needed to sustain it. He made the following points.

- The UK antibiotic subscription model has been well received internationally and has clearly informed the voluntary EU subscription model created under the recently updated General Pharmaceutical Legislation, the proposed PASTEUR Act in the United States and related proposals in Switzerland and Australia.
- The UK model could be improved, particularly in how it includes small and medium-sized enterprises (SMEs), which are currently unlikely to meet the eligibility requirements.
- While the UK is a leader in funding and supporting antimicrobial R&D, more could be done to coordinate efforts across government, academia and the private sector to ensure focus on products with the highest potential public health value.
- Development of new products should focus on high unmet need globally, as the majority of the AMR burden falls on low- and middle-income countries (LMICs). Countries such as India and China may offer strategic partnerships for development as well as viable markets to support antimicrobial commercialisation.

Recommendations

- Continue international advocacy and outreach on the adoption of pull incentives.
- Improve coordination of the UK discovery and development ecosystem, potentially through establishing a national owner.
- Strengthen international partnerships for antibiotic R&D and consider the role emerging markets can play in providing stable commercialisation pathways for new antibiotics.

He noted that these ideas are developed further in the APPG on Antibiotics report Antimicrobial Discovery Report (April 2026) and suggested it would be worth ensuring continuity between that report and the outputs of this Roundtable.

Dr Shelicia Rogers, MD, MPH, Early-Career Health Policy Analyst, St George's University (alumna)

Dr Rogers reflected that the fourth strategic gap identified at the Westminster Health Forum (the link between research and Parliament) is a particularly important leverage point. In her view, the knowledge, frameworks and will to act are already in place, so the first three gaps are largely matters of execution. She suggested that a standing accountability mechanism between researchers and Parliament would make a real difference in keeping implementation moving.

Dr Emily Scott-Dearing, Public Engagement & Involvement Lead, Fleming Initiative

Dr Scott-Dearing's reflection expanded on the role of public awareness and engagement, drawing on the work of the Fleming Initiative.

She emphasised the critical importance of increased public awareness. Like the climate emergency, AMR is not simply a technical problem with technical solutions; society needs to be brought along. This means building not only awareness of the facts but emotional engagement with the significance of the crisis, as a prerequisite for behaviour change. She advocated diverse means of communicating the challenge of AMR to the widest possible constituency (public and policymakers alike) with creative engagement that mobilises expertise from the arts, science communication and cultural sectors to win hearts as well as minds. She called for a rich, impactful ecosystem of emotionally engaging campaigns, alongside evidence-gathering on what works and commended Lifeline the Musical for revealing the personal impacts hidden behind anonymous AMR statistics and for mobilising stakeholders, from clinicians to policymakers, as changemakers. To reach the broadest audience, she argued, such approaches must be diversified: the Fleming Initiative has delivered high-visibility AMR content on billboards in Times Square and Piccadilly Circus, mobilised clinician content creators across social media and is developing an interactive exhibition. Its Keep Antibiotics in Play campaign, launched in June 2026 ahead of a summer of major sporting events and delivered with funding and support from GSK, illustrates the approach in practice. The Olympic and Commonwealth swimmer Becky Adlington OBE, the former England rugby international Matt Dawson MBE and the Paralympic and Commonwealth swimmer Alice Tai OBE each shared personal experiences of why effective antibiotics mattered to them, paired with an invitation to the public to help keep antibiotics in play. The campaign secured wide coverage across UK television, radio and newspapers.

She also stressed the importance of moving beyond awareness to actively involving the public, including patients, so that solutions are trusted and adopted. She referenced plans for the Fleming Centre (a UK AMR National Action Plan Outcome 2 case study), opening in 2028 at St Mary's Hospital, a century after Alexander Fleming discovered penicillin there and warned of the dangers of resistance. More than a research centre, it will co-locate researchers, clinicians, policy thinkers and the public. A free, interactive public exhibition there will:

- raise awareness of AMR's causes and solutions, especially among target audiences of young adults and families with secondary-school-aged children, the changemakers of the future;
- invite visitors to see themselves as part of the solution; and
- invite researchers and policymakers, working in the building and beyond, to treat the exhibition as an extension of their research and policy workspaces, bringing live research questions into the exhibition and events to explore, prioritise and address with the public.

She noted that the Fleming Initiative seeks to build a culture where public voice is valued by those working to tackle AMR and is embedding public and patient voice in its own work, including working with a Youth Panel to create the Fleming Centre exhibition, co-designing AMR education interventions with school pupils, co-designing research on AMR terminology and video explainers with the public, involving patients in the design of clinical research studies and convening a Public Advisory Group.

In post-meeting notes, she welcomed the Roundtable's recognition of the potential of embedding AMR in higher and professional education curricula to improve stewardship and added that embedding AMR in school curricula is equally important for raising public awareness. In response to United Nations General Assembly recommendations (paragraph 51), the Fleming Initiative has facilitated a global consensus on tackling AMR through education, setting out what children and adolescents need to know to act as agents of change (April 2026) and has published a first-of-its-kind global review of AMR education initiatives (April 2026) highlighting the opportunity to focus on behaviour change. On the poor name recognition of AMR raised in discussion, she noted the Initiative's behavioural science research with the Behavioural Insights Team, co-designed with the public, on AMR terminology. This supports a policy initiative for sustained, large-scale public discourse on AMR through multiple channels, including schools, professional education, community organisations, patient networks, broadcast media, digital platforms and the creative arts, with evaluation of reach and behaviour change.

Supporting publications cited

- Scott-Dearing, E., Carter, V., Corley, M. et al. Patient and public involvement and engagement to improve impact on antimicrobial resistance. Nat Commun 16, 1022 (2025). (co-authored by three organisations represented at the Roundtable)
- Global consensus on tackling AMR through education. Fleming Initiative, April 2026.
- Grailey, K., Diwanji, M., Murphy, C.O. et al. Shaping the future: Current landscape and potential impact of educating children and adolescents on antimicrobial resistance – a systematic review and narrative synthesis. Public Health, 253, (2026).
- Grailey, K., Finlayson, A., Stuijfzand, B. et al. Differing terminology used to describe antimicrobial resistance can influence comprehension and subsequent behavioural intent. Commun Med 5, 146 (2025).
- Keep Antibiotics in Play campaign. Fleming Initiative with funding and support from GSK, June 2026.

Dr Jegak Seo, Science & Research Manager / Co-Investigator, Royal College of Pharmacy and UCL Royal Free Hospital

Dr Seo provided a detailed reflection organised around the five discussion themes, drawing on his work at the Royal College of Pharmacy and UCL Royal Free Hospital, his doctoral research and his earlier work at the Royal Veterinary College and the United Nations Environment Programme (UNEP). Each theme is accompanied by a suggested recommendation.

1. Embedding AMR stewardship as a routine practice

Antimicrobial stewardship (AMS) should be treated as a routine component of professional practice, not as an optional or specialist activity. AMR policy will only translate into measurable impact when it changes prescribing behaviour, medicines optimisation, patient communication and local clinical governance. This is particularly important in pharmacy, where practitioners work across community, primary care, hospital, medicines optimisation, prescribing support, stewardship, patient counselling and, increasingly, independent prescribing. As prescribing responsibilities expand, stewardship safeguards need to expand with them.

This is becoming urgent because pharmacist independent prescribing is moving from a specialist post-registration qualification towards a much larger workforce model. Under the General Pharmaceutical Council's 2021 reforms, all trainee pharmacists will, once the reforms are implemented in full, become independent prescribers at the point of registration, with the first full cohort expected to enter the register in summer 2026; many already-registered pharmacists will not automatically receive the annotation and will need to complete an accredited course. This is a major opportunity, but it also raises a governance question: independent prescribing should be used as an opportunity to embed stewardship into pharmacy education, prescribing governance, audit and feedback, revalidation, diagnostic pathways and patient communication. Foundations already exist (the UKHSA/DHSC Antimicrobial Prescribing and Stewardship competency framework and NHS England's AMR/AMS pharmacy undergraduate competency framework) but competency frameworks alone do not guarantee capability, safe practice or measurable prescribing outcomes in daily care. The approach could be strengthened by explicit operational safeguards: prescribing audit, AWaRe-based metrics, access to relevant clinical records, diagnostic stewardship, local formulary alignment, safety-netting, referral thresholds and regular feedback on prescribing patterns.

Suggested recommendation. AWaRe-aligned antimicrobial stewardship competencies and implementation capabilities should be embedded across pharmacy, medical, dental, nursing and veterinary education, prescribing governance and professional revalidation, supported by audit, feedback, clinical record access, diagnostic stewardship, local formulary alignment and measurable implementation indicators.

2. One Health stewardship

Dr Seo's doctoral research at UCL focused on multidisciplinary One Health AMR: the exposure pathways through which antimicrobial residues, food contamination, gastrointestinal exposure, microbiology, infectious disease, epidemiology, modelling and real-world data intersect. On this view, One Health AMR is not only a high-level relationship between human, animal and environmental sectors but a practical exposure and implementation problem: how antimicrobial use in one part of the system influences residues, microbial ecology, human exposure, environmental contamination, prescribing behaviour and downstream resistance risk. His work at the Royal Veterinary College developed pharmacokinetic exposure modelling to estimate antimicrobial concentrations in bile and gastrointestinal compartments arising from veterinary drug residues in meat, connecting food systems, bioavailability and AMR-relevant interpretation. His UNEP work under the Quadripartite framework underlined the importance of linking AMR action plans to measurable indicators, country-level implementation, environmental interventions, surveillance design, data sharing and cross-sector accountability. One Health policy should be judged not only by whether sectors are represented, but by whether their data, responsibilities and implementation pathways are genuinely connected.

Suggested recommendation. The UK should strengthen One Health AMR implementation by linking human prescribing data, veterinary antimicrobial use, food-chain exposure, environmental surveillance and wastewater monitoring into an integrated framework with clear accountability and professional implementation routes.

3. Digital stewardship and AI

Digital stewardship is a major opportunity, but only if data are translated into decisions. Dashboards, AI tools and surveillance platforms add value when they change clinical

behaviour at the point of care. Dr Seo's UCL/Royal Free work using NHS real-world data and risk-prediction modelling has shown that data infrastructure alone is not sufficient: data must be connected to interpretation, clinical workflows, prescribing review, medicines optimisation and accountability. In pharmacy practice this means digital tools should support antimicrobial review, dose optimisation, de-escalation, duration review, patient safety and referral decisions. There is a risk that AI and dashboards become passive monitoring tools rather than active stewardship mechanisms; to avoid this, digital stewardship should be designed around real clinical workflows and should include pharmacy teams as key users, interpreters and implementers of prescribing intelligence.

Suggested recommendation. Digital AMR stewardship tools should be designed as implementation tools, not only surveillance tools. Dashboards and AI-supported decision systems should be linked to prescribing review, pharmacy-led medicines optimisation, audit and feedback, diagnostic stewardship and local accountability mechanisms.

4. Sustained innovation and the regulatory pathway

New antimicrobial innovation is essential (including new antibiotics, antifungals, phage therapy and other emerging modalities) but innovation alone will not solve AMR unless it is linked to responsible use. From a pharmacy and medicines-optimisation perspective, the regulatory and innovation pathway should include stewardship planning from the start, with clear guidance on patient selection, prescribing criteria, monitoring, supply, safety, resistance risk, real-world evaluation and de-escalation. The UK subscription model is an important structural achievement, but its long-term value depends on whether new antimicrobials are introduced into a system that can protect their effectiveness, in which pharmacy has a central role through medicines governance, formulary implementation, antimicrobial review, safety monitoring and patient communication. The AMR challenge is not only the development of new antimicrobials, but how antimicrobial exposure is created, distributed, monitored and controlled across human, animal, food and environmental systems.

Suggested recommendation. AMR innovation funding and regulatory pathways should include mandatory stewardship and implementation plans, covering prescribing governance, pharmacy involvement, patient selection, monitoring, real-world evaluation, environmental considerations and responsible-use safeguards.

5. A permanent AMR Research–Policy–Practice Interface

Dr Seo strongly supported the proposal for a permanent AMR research-to-Parliament channel, suggesting it should function as a Research–Policy–Practice Interface. The route from evidence to impact often runs through professional standards, education, guidance, training, clinical governance and workforce behaviour, so a permanent interface should include not only researchers, parliamentarians, UKHSA, NHS England and patient advocates, but also the professional bodies representing pharmacy, medicine, dentistry, nursing, veterinary practice, public health, microbiology and infection specialists. His work at the Royal College of Pharmacy (translating evidence into briefings, consultation responses and professional-facing outputs) has shown that effective translation requires clear ownership, structured outputs, implementation pathways, measurable recommendations and follow-up mechanisms; without these, policy discussions risk producing repeated diagnosis rather than sustained implementation.

On public engagement, he suggested combining direct AMR communication with passive norm-shaping through social norms, environments and everyday cues. The COVID-19 pandemic offers an example: hygiene behaviours became partly embedded as social norms rather than only formal instructions. AMR engagement should similarly aim to normalise behaviours that reduce inappropriate antimicrobial demand and infection transmission, including self-care for viral infections, greater acceptance of delayed antibiotic use, better public understanding of when antibiotics are not needed, hygiene behaviours in schools and workplaces and supportive rather than judgemental pharmacy-based conversations.

Suggested recommendation. A permanent AMR Research–Policy–Practice Interface should include professional bodies and public engagement expertise, with a clear mechanism for tracking recommendations, implementation progress and accountability. Public engagement should combine direct AMR communication with passive norm-shaping approaches that make responsible antimicrobial use, infection prevention and appropriate healthcare-seeking behaviour part of everyday social practice.

References cited

- General Pharmaceutical Council (2021) Revising the education and training requirements for pharmacist independent prescribers: analysis report.
- General Pharmaceutical Council (January 2025) Standards for the education and training of pharmacist independent prescribers: guidance to support implementation.
- Department of Health and Social Care; UK Health Security Agency (updated 6 August 2025) Antimicrobial prescribing and stewardship competency framework.
- NHS England (11 March 2024) Antimicrobial resistance and antimicrobial stewardship: pharmacy undergraduate competency framework.
- General Pharmaceutical Council (updated April 2025) In practice: guidance for pharmacist prescribers.

7. Supporting evidence and publications

Parliamentary and policy documents

- HM Government (2024) Confronting Antimicrobial Resistance 2024–2029: UK National Action Plan. London: DHSC.
- House of Commons Committee of Public Accounts (2025) Antimicrobial Resistance: Addressing the Risks. 30th Report of Session 2024–25.
- Elshenawy, R.A., Aslanpour, Z. and Umaru, N. (2025) Written evidence to the Public Accounts Committee inquiry on AMR (AR0005). UK Parliament.
- Westminster Health Forum (2026) Next Steps for Tackling Antimicrobial Resistance in the UK, 21 April 2026.

UK surveillance and data

- UK Health Security Agency (2024) English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Report. London: UKHSA.

Peer-reviewed publications and frameworks

- Elshenawy, R.A. (2025) UK Parliament's antimicrobial resistance inquiry: translating evidence into crisis-resilient action. JAC-Antimicrobial Resistance, 7(6), dlaf218.

- Elshenawy, R.A. et al. (2025) WHO AWaRe classification in UK NHS secondary care. Frontiers in Microbiology.
- Elshenawy, R.A. et al. (2024) COVID-19 impact on Start Smart Then Focus.
- GUIDE Framework for evidence-based antibiotic prescribing (WHO collaboration).
- Murray, C.J.L. et al. (2022) Global burden of bacterial antimicrobial resistance in 2019: a systematic analysis. The Lancet, 399(10325), 629–655.
- O'Neill, J. (2016) Tackling Drug-Resistant Infections Globally: Final Report and Recommendations. Review on Antimicrobial Resistance.

International frameworks

- World Health Organization (2021) Global Action Plan on Antimicrobial Resistance. Geneva: WHO.
- World Health Organization (2023) Global Antimicrobial Resistance and Use Surveillance System (GLASS) Report. Geneva: WHO.
- World Health Organization. AWaRe (Access, Watch, Reserve) classification of antibiotics.
- European Commission (2017) A European One Health Action Plan against Antimicrobial Resistance. Brussels: EC.

Briefings and related outputs

- Elshenawy, R.A. (2026) The next steps for tackling AMR in the UK are translation, not repetition. Westminster Health Forum post-conference briefing.
- Elshenawy, R.A. (2026) Slow pandemic, fast politics: from the Westminster Health Forum to Westminster itself. University of Hertfordshire.
- Elshenawy, R.A. (2025) GUIDE Framework: a five-step tool to combat AMR through evidence-based prescribing and stewardship. South Centre News on AMR, December 2025.

8. Next steps and dissemination strategy

The Roundtable feeds into a clear set of outputs:

- **Policy dissemination.** APPG on AMR, the Department of Health and Social Care, the Health and Social Care Select Committee, UKHSA, NHS England and the Parliamentary Office of Science and Technology (POST), with a follow-up briefing.
- **Academic dissemination.** A peer-reviewed methodology paper (intended for JAC-Antimicrobial Resistance), conference presentations (BSAC and UKHSA) and a university impact case study toward REF 2029.
- **Professional dissemination.** BSAC and the pharmacy, medical, dental, nursing and veterinary networks, including royal colleges and professional regulators.
- **Public engagement and communications.** Patient organisations, The AMR Narrative and the Fleming Initiative, alongside school and public education, arts-based engagement, opinion-editorial opportunities and wider spokesperson activity. Communications amplification should be considered particularly around World AMR Awareness Week in November 2026, with preparatory engagement beginning in October.

Impact will be tracked using process and outcome indicators: downloads and requests for the brief; meetings with parliamentarians, the APPG or the Department of Health and Social Care; references in Parliamentary Questions, debates, committee reports or consultations; uptake of recommendations by professional bodies; citations in policy documents; stakeholder follow-up actions; media reach, public engagement and educational outputs; and contribution to the planned REF 2029 impact case study.

9. Publication readiness, accessibility and institutional review

The University Marketing and Communications review recommended light-touch institutional branding, including use of the approved University of Hertfordshire logo on the cover, together with confirmation of the relevant ESRC and Impact Acceleration Account identity guidance. The review identified no reputational or institutional concerns, noting that the materials are grounded in the research and address a real-world problem. Before public release, the University Research Office should confirm the accessibility pathway. The publication workflow should include an accessible source document and a tagged PDF with logical reading order, meaningful alternative text for informative images, sufficient colour contrast, descriptive hyperlinks, properly structured headings and tables and a final accessibility check. Communications amplification may include opinion-editorial articles and wider spokesperson opportunities, particularly around World AMR Awareness Week in November 2026.

Review status. Professor Sam Salek's substantive and editorial comments have been incorporated, including recommendations concerning professional competency and capability, stewardship as routine practice, large-scale public discourse, and consistent use of British English. The required ESRC funding acknowledgement has been retained. Vicky Trendall's institutional communications review has also been incorporated. Final advice regarding accessibility and logo placement was obtained from the University of Hertfordshire News and Communications team and has been implemented in the published version.

Appendices

Appendix A, Participants

The Roundtable convened a cross-sector group of around 20 senior stakeholders, under the Chatham House Rule. Participants are listed with consent. In line with the Chatham House Rule, no comments, positions or recommendations are attributed to any individual participant.

Name	Role / Position	Organisation
Parliamentary hosts and roundtable convenors		
Andrew Lewin MP	Event host	House of Commons (Welwyn Hatfield)
Dr Danny Chambers MP	Event host; Secretary, APPG on AMR	House of Commons (Winchester)
Baroness Bennett of Manor Castle	Treasurer, APPG on AMR	House of Lords
Rhian Foley	APPG on AMR Secretariat	BSAC
Academic chairs & convening team, University of Hertfordshire		

Name	Role / Position	Organisation
Professor Sam Salek	Chair; Emeritus Professor of Pharmacoepidemiology & Regulatory Science	University of Hertfordshire
Dr Rasha Abdelsalam Elshenawy	Senior Lecturer & Principal Investigator (roundtable lead)	University of Hertfordshire
Professor Zoe Aslanpour	Professor of Public Health & Patient Safety; Head of Department	University of Hertfordshire
Leisha O'Brien	Policy & Community Engagement, Office of the Vice-Chancellor	University of Hertfordshire
Government & national agencies		
Dr Alicia Demirjian	Head of the AMR & Prescribing Team	UK Health Security Agency (UKHSA)
Professional & clinical bodies		
Professor Andrew Seaton	President, BSAC; Chair, Scottish Antimicrobial Prescribing Group	BSAC
Dr Rajeev Shah	Clinical Director; member, DHSC SPRHAI	East London NHS Foundation Trust
Dr Jegak Seo	Science & Research Manager / Co-Investigator	Royal College of Pharmacy / UCL Royal Free Hospital
Mr Nicholas Marshall	Board Member; UKRI PEOPLE AMR Network advisory board	British Dental Association (BDA)
Patient voice & public engagement		
Vanessa Carter	AMR survivor & Founder	The AMR Narrative
Emily Scott-Dearing	Public Engagement & Involvement Lead	Fleming Initiative
AMR researchers		
Professor Karolin Hijazi	Professor & Honorary Consultant in Oral & Maxillofacial Medicine	University of Aberdeen
David Richard McKinney	Founder, Alliance for Reducing Microbial Resistance (ARMoR)	ARMoR / Institute of Development Studies
Early-career researchers		
Maureen Eloho Okorodudu	Graduate	University of Hertfordshire
Dr Shelicia Rogers	MD, MPH; Early-Career Health Policy Analyst	St George's University

Appendix B, Programme

Time	Session	Speaker
14:00–14:10	Welcome & scene setting	Professor Sam Salek (Chair)
14:10–14:20	Implementation science in AMS	Dr Rasha Abdelsalam Elshenawy
14:20–14:30	Public health & institutional strategy	Professor Zoe Aslanpour
14:30–14:42	National surveillance & prescribing	Dr Alicia Demirjian (UKHSA)

Time	Session	Speaker
14:42–14:54	Stewardship in practice	Professor Andrew Seaton (BSAC)
14:54–15:02	The patient voice	Vanessa Carter
15:02–15:42	Parliamentary discussion & recommendation co-creation	All, chaired by Prof Sam Salek
15:42–15:50	Summary & next steps	Dr Rasha Abdelsalam Elshenawy

Appendix C, Methodology note

- Chatham House Rule: participants may use the information shared, but not the identity or affiliation of who said it.
- APEASE criteria used to test recommendations: acceptability, practicability, effectiveness and cost-effectiveness, affordability, safety (side-effects) and equity.
- AMR Translation Cycle: research and clinical evidence → institutional translation → Westminster engagement → implementation in health systems and society → back into research.
- Theme selection: the five themes were derived from the four Westminster Health Forum priorities and the Public Accounts Committee inquiry findings, refined by the convening team and confirmed in the session programme.
- Capturing contributions: speaker presentations and a facilitated discussion were recorded contemporaneously by the convening team, with points logged without attribution under the Chatham House Rule.
- Synthesis: discussion points were grouped by theme and synthesised into five draft recommendations, each traceable to the evidence and discussion.
- Post-event reflections: participants were invited to submit voluntary written reflections, presented with attribution as signed contributions and used to add context, not as formal research data.
- Feasibility and policy relevance: draft recommendations were checked for feasibility, deliverability and policy relevance and aligned one-to-one with the five themes.

Appendix D, Photographs and attendance

A selection of photographs from the Roundtable is shown below. The signed attendance list is held on file by the convening team and is available on request.



The Roundtable convenes at the House of Commons under the banner ‘Translating AMR Research into Parliamentary Action’.



Evidence presentations during the first session.



Parliamentary discussion and recommendation co-creation, second session.



Roundtable participants, House of Commons, 18 May 2026.

Suggested citation and licence

Suggested citation. Elshenawy, R.A. (2026) Evidence and Discussion Report from the Parliamentary Roundtable on Antimicrobial Resistance: Translating AMR Research into Parliamentary Action—A Multi-Stakeholder Roundtable. Supporting Evidence Report. Hatfield: University of Hertfordshire.

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