National Patient UTI Survey

Women's Lived Experiences of Urine Sample Collection and UTI Diagnosis

Analysis and Summary Report

Forte Medical, the specimen collection company, commissioned independent research business FemSights to conduct a national survey of women's lived experiences around Urinary Tract Infection, urine specimen collection methods and antibiotic prescribing. 303 women took part.

Responses demonstrate that Primary Care approaches to UTI are inconsistent, with a lack of protocol for midstream collection (MSU) as demanded by all global guidelines leading to inconsistent diagnosis and treatment for UTI.

Executive Summary

This report analyses a national patient survey exploring women's experiences of acute UTI diagnosis and treatment, with a specific focus on the urine sample collection process. The survey combined quantitative questions (pie-chart responses) with three open-ended qualitative questions, gathering over 450 individual comments across the three questions.

The findings show that whilst most women manage frequent or recurrent UTIs**, the urine sample collection is widely experienced as messy, undignified and technically uncertain.** Women are also concerned that antibiotic prescribing frequently proceeds without laboratory confirmation. Delays in access and results, inconsistent instruction on midstream collection, and experiences of being dismissed all compound to slow diagnosis and undermine targeted, effective prescribing.
Key findings

1. **Almost nobody collects a clean sample with current equipment — only 2%.**
   34% spilled on themselves, 31% caught some in the toilet first, 15% spilled on the toilet/floor, and 12% had overflow. Combined with 60% of women still using a plain screw-top bottle, this is the single most powerful stat for making the case that the standard collection device is the problem — and it's the most repeated concrete request in the qualitative data too.

2. **Nearly half of women (44%) were never told to collect midstream — despite it being essential in every global guideline.**
   This is a striking "gap between guidance and practice" stat: it's not that women are getting it wrong, it's that they're often not told the right method at all. Strong for messaging around inconsistent care and the case for built-in instruction/design that removes reliance on verbal instruction.

3. **3. 92% of women took antibiotics for a past UTI, but only 65% ever had a sample sent for lab culture.**
   This is the clearest stewardship/clinical-risk stat — prescribing is frequently happening on a bedside dipstick alone. It pairs powerfully with the qualitative theme of women wanting a "rapid test" or "the right antibiotic first time," and with the more serious accounts of dismissal and delayed diagnosis (e.g. the woman whose kidneys failed after being "fobbed off").

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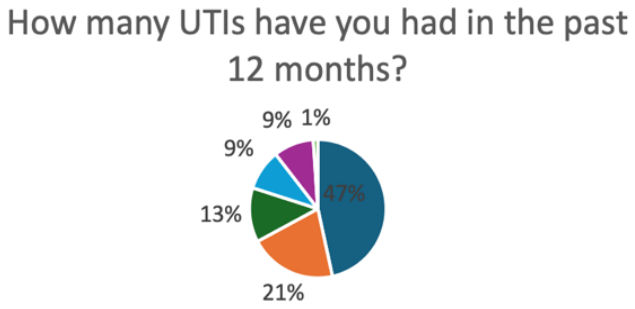
1. Quantitative Findings

Responses to the closed survey questions reveal a population managing frequent infections, collecting samples with inadequate equipment and instruction, and receiving antibiotics with limited microbiological confirmation.

47% had a UTI in the past 12 months	**44%** had 2+ UTIs in the past 12 months	**92%** took antibiotics for a past UTI	**65%** had a sample sent to a lab for culture

1.1 Frequency of infection



Nearly half of respondents (47%) had experienced a UTI in the past year, and a further 44% had experienced two or more — confirming this is largely a population managing recurrent infection, for whom the collection and diagnosis process is repeated frequently.

1.2 The collection device

60% of women collected their sample in a plain screw-top plastic bottle, and 18% had to decant urine from a home container into a collection pot. Only 10% were given a wider pot with a tube for staff to collect, and just 5% had a screw-top bottle with a funnel attached — meaning the large majority were given the least practical option for a clean midstream catch.

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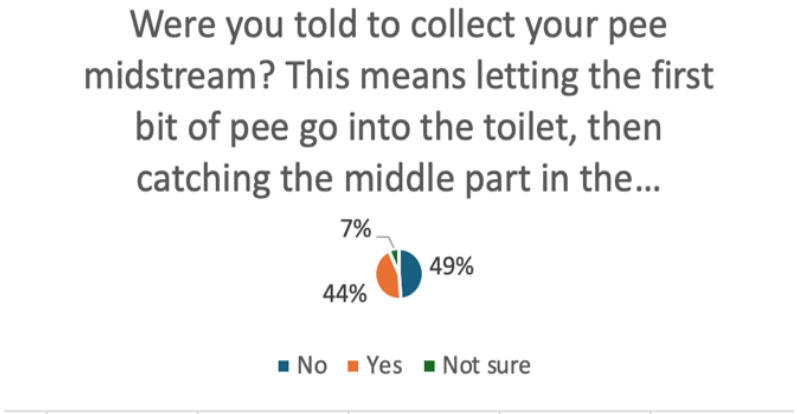
1.3 Midstream instruction



44% of respondents were not told to collect their sample midstream, and a further 7% were not sure whether they had been. Only 49% received clear instruction — despite midstream collection being cited in all guidelines as being essential for an uncontaminated, interpretable result.

1.4 The collection experience

Asked directly what happened when they collected their sample, only 2% caught all their urine cleanly from start to finish. 34% spilled some on their hands, legs or clothes; 31% had some go into the toilet before catching the middle part; 15% spilled on the toilet or floor; and 12% had the container overflow.

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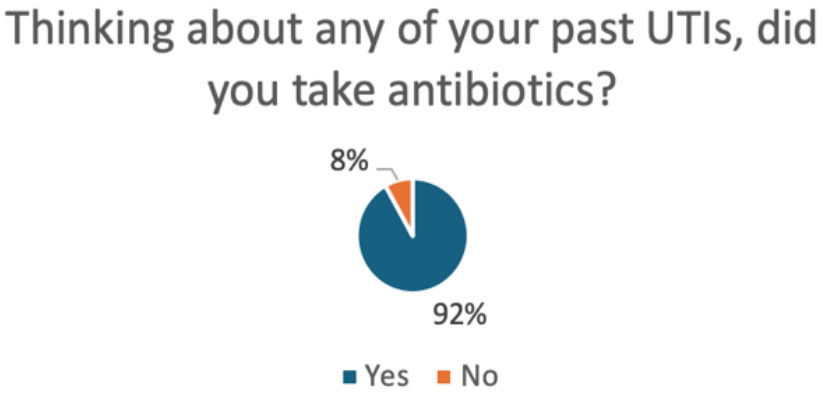
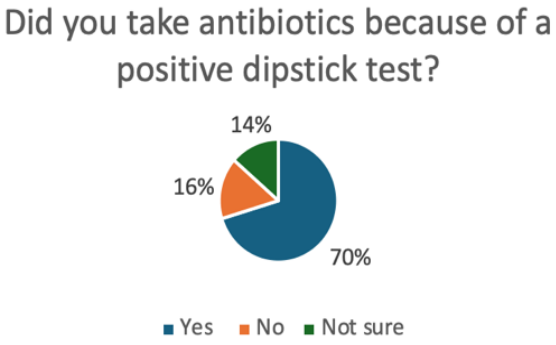
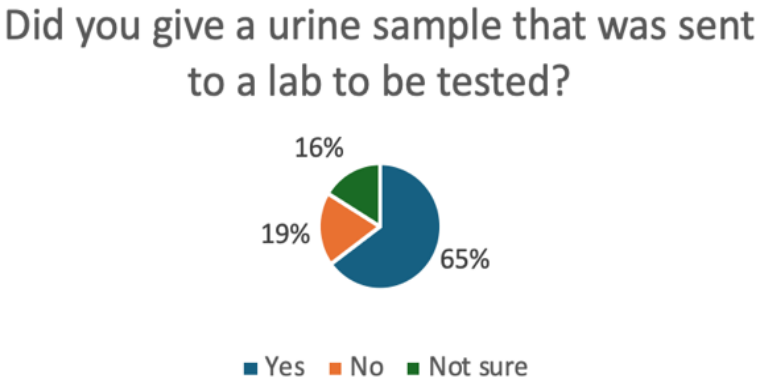
1.5 From sample to prescription







92% of respondents had taken antibiotics for a past UTI. Of those, 70% did so following a positive dipstick test, 16% said no and 14% were not sure. Only 65% ever gave a sample that was sent to a lab for culture, with 19% saying no and a further 16% unsure. Taken together, prescribing is frequently proceeding on the basis of a bedside dipstick alone, with lab confirmation either absent, delayed, or unclear to the patient.

2. Qualitative Findings

Three open-ended questions were analysed thematically: (1) the hardest part of managing UTIs, (2) the single change that would make the biggest difference, and (3) anything else respondents wanted to share. Recurring themes are summarised below with illustrative, consented quotes.

2.1 Sample collection: mess, dignity and uncertainty

Across all three questions, collection equipment and process was one of the most consistently raised issues. Respondents described narrow tubes and "vacuum" pots that are difficult to operate — particularly for older or unwell patients — decanting urine from a home container, and a general sense that the process is outdated and undignified.

> *"No one should be expected to pee into a narrow plastic tube without another vessel to catch the urine first."*
>
> *"I have used a Peezy device before and it was brilliant and clean!"*
>
> *"Embarrassed when I handed sample to receptionist and she held it at arm-length and pulled a disapproving face."*
>
> *"Urine collection into a 25mL universal pot is always interesting!"*

2.2 Access to timely care and testing

Many respondents described difficulty securing a GP appointment, being redirected between pharmacy and GP services, lack of weekend/out-of-hours access, and the burden of travelling while acutely symptomatic just to obtain a pot or hand in a sample.

> *"It is difficult to get to the surgery when you are feeling unwell and have an urgency to pee... This is also difficult if it happens over a weekend."*
>
> *"Referred to Pharmacist for antibiotics and then being referred back to the GP!"*

2.3 Diagnostic accuracy and "the right antibiotic first time"

A strong and recurring request was for reliable testing — point-of-care culture and susceptibility testing in particular — to avoid trial-and-error prescribing, short ineffective courses, and broad-spectrum guesses.

> *"A rapid test for the type of organism... and whether it is resistant... based on the rapid result."*
>
> *"Doing a quick diagnostic test at the GP... will stop the use of general antibiotics and prescribe the correct ones."*
>
> *"Not all UTIs come up in tests... three days [of an antibiotic] is not always enough."*

2.4 Turnaround time and uncertainty while waiting

Waiting several days for culture results while symptomatic was a significant source of anxiety, and several respondents noted that starting antibiotics before the culture returned made the result uninterpretable:

> *"Faster lab results. It takes 4 days currently and I take antibiotics while I wait, but it's not ideal."*
>
> *"Sometimes urine test was done after I started antibiotics and so was clean; sometimes nothing was picked up in the test either way."*

2.5 Not being believed, and missed or delayed diagnoses

A substantial number of respondents described feeling dismissed, particularly when symptoms persisted despite a negative dipstick or culture. In several cases this delay was linked to serious escalation, including kidney infection, sepsis, and one case where a tumour was later identified:

> *"My previous GP surgery kept fobbing me off... Three months later my kidneys failed and I ended up in a coma."*
>
> *"I understand that the UTI test is very outdated and unreliable but feel doctors doubt me."*
>
> *"Stop disbelieving women. We know our bodies and know when something isn't right."*

2.6 Prescribing: course length, side effects and stewardship

Respondents raised inconsistency in course length (3 vs 7 vs 10 days), difficulty switching when a first-line antibiotic was unsuitable or previously caused side effects, and a wish for accompanying advice on probiotics to offset effects such as thrush:

> *"Prescriptions for 3 days... leaflet states 7 days but GP states NICE recommend only 3 days."*
>
> *"The most annoying thing is that no doctor will state... take probiotics to replenish the microbiome."*

2.7 Prevention, recurrence and life-stage factors

Recurrence was a major long-term burden, with many respondents seeking non-antibiotic strategies (D-mannose, probiotics, Methenamine Hippurate) and better recognition of triggers including sex, catheterisation, and the menopause transition.

> *"Since being prescribed Methenamine Hippurate one year ago I haven't had a single infection."*
>
> *"Women need to understand that UTIs are a part of peri menopause and menopause for many women."*

3. Conclusions: What Needs to Change

Read together, the quantitative and qualitative findings point to the same underlying problem: the sample collection process and the diagnostic pathway around it are not currently designed to reliably deliver a clean, timely, confirmed result — which pushes clinicians toward empirical, non-targeted prescribing, undermines antimicrobial stewardship, and in a minority of cases delays diagnosis of serious complications. The following actions follow directly from the evidence gathered:

1. Redesign the collection device. Replace plain screw-top bottles with a wider-mouthed, funnel or midstream-designed device as standard. This is the single most repeated, concrete request in the survey and directly targets the near-universal spillage and contamination problems reported (only 2% caught a completely clean sample).
2. Make midstream instruction mandatory and consistent. With 44% of respondents not told to collect midstream, clear verbal and written instructions should be provided every time a sample is requested, not assumed as prior knowledge.
3. Close the confirmation gap. Only 65% of samples reached lab culture, yet 92% of respondents received antibiotics. Wider deployment of point-of-care culture/susceptibility testing would let clinicians prescribe quickly without defaulting to unconfirmed, broad-spectrum treatment.
4. Reduce lab turnaround time and improve communication of results, since delay is both a driver of patient distress and a cause of empirical prescribing ahead of confirmation.
5. Build a clear pathway for symptomatic-but-negative results. Rather than dismissal, negative dipstick or culture results in the presence of ongoing symptoms should trigger a defined next step (repeat testing, further investigation, or specialist referral), given the accounts of delayed diagnosis and escalation to sepsis or kidney failure.
6. Reduce logistical friction around sampling. Same-visit provision of pot and instructions (rather than a separate appointment), discreet drop-off points, and phone-based result delivery would address repeated access complaints.
7. Standardise prescribing guidance and pair it with stewardship advice, including consistent course-length guidance and routine advice on probiotics/side-effect management, to improve both effectiveness and patient trust.
8. Address the trust and communication gap. Training and consultation practices that ensure women's symptom reports are taken seriously (particularly where dismissiveness was linked to gender dynamics) would reduce delayed care-seeking and repeat presentations.

Together, these changes target the two outcomes this survey was designed to inform: making UTI diagnosis more prompt (through better devices, instructions, access and turnaround) and more accurate (through consistent confirmation, point-of-care testing, and clearer pathways for atypical or negative-but-symptomatic cases) — enabling truly targeted, rather than empirical, antibiotic prescribing.

AI was used in the analysis of survey data