telephone, and persons with documented infection were promptly treated.

Outcomes/Impact During the first six months of operation (19 June 2020 – 18 Jan 2021), the clinic provided 383 STI screenings to 347 unique individuals (mean age 27.9 years [IQR 21.0–32.0]) and a total of 864 self-collected specimens were tested. GC was detected in 13/184 (7.0%) males vs. 4/163 (2.5%) females ($p = 0.47$). CT was detected in 30/184 males (16.3%) vs. 17/163 (10.4%) females ($p = 0.11$). A total of 4 persons were co-infected with GC and CT. Overall positivity with either GC or CT was 5.8%. Sample site positivity was highest for self-collected rectal specimens (6/46, 13.0%), followed by genital (55/664, 8.3%) and pharyngeal (5/88, 5.7%) specimens.

Innovation and Significance Findings demonstrate the ongoing need for sexual health services during the COVID crisis, and the feasibility of no-exam, drop-off testing of self-collected specimens. Gonococcal and chlamydial positivity rates exceeded that of standard pre-COVID clinic operations, supporting wider expansion of the Quick Test Clinic model. Future innovations may include text messaging and web-based applications for results notification and treatment referral.

017.4 FIRST CLINICAL EVALUATION OF A 30-MINUTE POINT-OF-CARE-TEST FOR CHLAMYDIA TRACHOMATIS AND NEISSERIA GONORRHOEAE INFECTION IN UK SEXUAL HEALTH CLINICS

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Background As part of a programme of work seeking to facilitate adoption of multi-STI POCTs in English sexual health services (SHS), we implemented an approach to facilitate adoption of the binx health io CT/NG Assay ('binx POCT'). This included supporting analysis and interpretation of data following clinical validation and routine use of the binx POCT as implemented into clinical care, prior to SHS adoption decisions.

Methods Binx POCT diagnostic accuracy was compared to locally-used laboratory-based nucleic acid amplification tests (NAATs) and expressed as positive (PPA) and negative percentage agreement (NPA), with 95% confidence intervals (95% CI). Individual SHS reported turnaround time (TAT) from sample collection to patient receipt of results, before and after binx POCT implementation.

Results Three SHS participated, and were a mix of high, medium and low-throughput in south England. Of N=417 patients across all services, n=396 (195 women and 201 men) were successfully tested with both the binx POCT and SHS routine NAATs. CT: male PPA 92.5% (79.6–98.4), NPA 99.4% (96.6–100.0); female PPA 82.1% (63.1–94.0), NPA 98.2 (94.8–99.6). NG: male PPA 91.7% (61.5–99.8), NPA 100% (98.1–100.0); female PPA 90.9% (58.7–99.8), NPA 100% (2.0–100.0). Median TAT decreased from 5 days (IQR 3–7.25) pre-implementation, to 1 day

(1=same-day (IQR 1–2)) during implementation; $p < 0.000001$.

Conclusion Binx POCT PPA and NPA, as compared to participating SHS routine NAATs, were largely within expected ranges of the diagnostic evaluation conducted in the United States for FDA approval, and there was significant decrease in TAT time across all services. The binx POCT was not available for purchase directly following the programme's end, however, local data gave confidence to SHS to use the test in routine care, and all indicated interest in adoption. Providing services the ability to test new POCTs in local settings prior to purchase could help facilitate their wider implementation.

017.5 BLOOD BORNE VIRUSES SCREENING (BBVS) FOR TEMPORARILY HOUSED ROUGH SLEEPERS IN BRIGHTON & HOVE DURING THE COVID-19 PANDEMIC

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Background At the start of the Coronavirus pandemic the UK Government pledged to house all rough-sleepers in temporary accommodation. This provided healthcare workers with a unique opportunity to access this 'hard-to-find' group, offer blood borne viruses screening (BBVS) and link clients testing positive into individualised treatment.

Approach A collaborative working group (HIV clinicians, HIV prevention specialists, hepatitis C outreach nurses and rough-sleepers health-engagement workers) established comprehensive risk-assessments, PPE supplies and dried blood spot procurement. Two experienced outreach workers worked along-side trusted homeless key-workers to offer BBVS (HIV, hepatitis B&C) in hotels, a hostel and student halls over 13-weeks (Jun-Sep 2020). Clients were offered £5 food-voucher for participating.

Outcomes 270 clients were housed during this time, 256 (95%) were offered BBVS; 192 (72%) tested. 148 (77%) tested 'mainly due to the incentive'. Of the 192 testers the median age (range) was 40y (18–69). Clients were mainly male 161 (83%); white-British 164 (85%) and heterosexual 179 (93%). 54 (28%) stated previous IVU; 39 (20%) other drug use and 92 (48%) prison as risk-factors. 70 (36%) had not previously tested. 31 (16%) were hepatitis C antibody positive; 13 (7%) RNA positive. To date 4 have started treatment; 5 deferred; 3 did not engage with services despite being aware of the diagnosis; 1 left the area. No new HIV diagnoses (two clients re-engaged with care). Most clients considered the service good or excellent, and would recommend (99%). Challenges included lab delays due to competing Covid-19 testing and engaging disenfranchised clients.

Innovation and Significance This project brought together a multidisciplinary collaboration, drawing on specialist knowledge to meet complex needs. Despite challenges during a pandemic, we obtained a useful snap-shot of BBV rates. Offering an incentive to a cohort sensitised to BBVS was important. New outreach testing opportunities were identified which will be progressed in 2021.