UK NEQAS
International Quality Expertise

UK NEQAS for
Immunocytochemistry & In-Situ Hybridisation

Participant's Manual

2020-2021

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DOWNLOAD LINK FOR THIS PARTICIPANT MANUAL AND THE PARTICIPANT QUICK GUIDE

This Participant Manual is a comprehensive reference guide to all aspects of the services offered and the procedures followed by UK NEQAS ICC & ISH.

We have also produced a user-friendly 'Quick Guide'.
It is a useful ready reference that contains answers to the most frequently asked questions.

Both documents can be downloaded from our website at: www.ukneqasiccish.org

1. Introduction

The origins of the **United Kingdom National External Quality Assessment Scheme for Immunocytochemistry and In-Situ Hybridisation** (UK NEQAS ICC & ISH) lie in an EQA scheme founded in 1985 by Gerry Reynolds, who at that time was a lead scientist working in the histopathology laboratories at Mount Vernon Hospital, London.

The UK Department of Health recognised the Scheme in 1988 and from that time, it became known as the UK National External Quality Assessment Scheme for Immunocytochemistry (UK NEQAS ICC) and subsequently, when *in-situ* hybridisation methodologies began to be assessed, UK NEQAS ICC & ISH.

General Structure

UK NEQAS ICC & ISH offers assessments of immunocytochemistry and *in-situ* hybridisation techniques. These assessments are carried out at evenly spaced intervals, approximately every three months throughout the EQA year, which runs from April to March.

Details of each module can be found in the pages that follow. Participants are encouraged to participate in those modules that are compatible with the range of immunocytochemistry performed in their laboratory.

Scheme Affiliations

UK NEQAS ICC & ISH is run on a strictly not-for-profit basis.

- The Scheme is a member of the UK National External Quality Assessment Service (UK NEQAS), a company limited by guarantee and a registered UK Charity.
- UK NEQAS ICC & ISH is accredited by UK Accreditation Services (UKAS) to ISO: 17043. Proficiency testing provider number: 7833.
- Hosting of the Scheme is provided by External Quality Assessment Services for Cancer Diagnostics (EQAS-CD), a Community Interest Company (EQAS-CD).

An Accredited EQA Scheme

UK NEQAS ICC & ISH is a UKAS accredited proficiency testing provider No. 7833. As a whole, and in all the individual assessment modules the Scheme operates to the internationally recognised standard [see Note]:

ISO 17043:2010 Conformity assessment - General requirements for proficiency testing

[Note 1. Pilot modules under development are not accredited. Accreditation of these is obtained prior to introducing them as full modules].

Benefits of Participation With UK NEQAS ICC & ISH

The Scheme's remit extends beyond the assessment of technical quality of the preparations submitted by its participants. A key goal of the Scheme is education to improve quality. Therefore, the list of benefits it provides is extensive:

- Compliance with ISO 15189:2012 regarding participation in an EQA scheme;
- Four assessment runs are carried out per year;
- Specific modules cater for the specialised areas of pathology;
- Two antigens are assessed per assessment run for all diagnostic biomarker modules;

- Assessment of UK NEQAS distributed material and participants' in-house samples;
- Web data entry and access to individual confidential reports;
- Constructive assessor feedback;
- Individual benchmarking graph to track performance over time;
- Frequency charts illustrating the distribution of participant scores for each run;
- Colour images showing optimal and sub-optimal demonstration of the antigens;
- Tables of the main antibodies and immunocytochemical reagents used by participants;
- Examples of 'Best Methods' and interactive searchable web 'Best Methods' database;
- An end of year certificate of participation (2 runs or more) along with an annual report;
- Other articles and reviews from the scheme;
- e-Journals, module reviews and articles.
- Participants 'Help-line' and details on obtaining advice;
- Participant user group scientific meetings and workshops.

An International EQA Scheme

The Scheme welcomes both UK and non-UK based laboratories. It currently has participants drawn from over 55 countries.

All submissions, irrespective of the participant's country of origin, are assessed in exactly the same manner at the same assessment sessions. Assessment of slides is carried out anonymously and assessors are blinded to all identifying features for all participant centres.

Educational Remit of the Scheme

One of the main aims of the service is to provide useful information on methods and reagents that allow for improved quality of immunocytochemistry. To this end, the main technical steps employed by participants at assessment are collated onto a database. The results of these analyses are subsequently provided as feedback to laboratories in the form of tabulated data showing information on pass rates, reagents, automation and detection system employed. Best methods are also provided along with images of good and poor examples of IHC and ISH staining.

Subcontracted Services

UK NEQAS ICC & ISH uses external suppliers including commercial and public-sector organisations from both the UK and overseas to:

- Provide EQA material, including formalin-fixed paraffin-embedded tissues and cell lines, and cytology preparations
- Provide section cutting services
- Provide stained samples for validation purposes and "gold standard" references

Where appropriate, accredited suppliers are used for the provision of these services. Regardless of this, UK NEQAS ICC & ISH assesses the competency of suppliers to provide the contracted service(s) prior to engaging them.

All EQA material is checked and validated by UK NEQAS ICC & ISH prior to dispatch to participants and the Scheme assumes responsibility to its participants for all subcontracted

work and services [Note 1].

[Note 1. Certain overseas participants will receive the EQA material through an authorised third-party distributor who receives the material directly from UK NEQAS ICC & ISH].

MODULES

Available Modules are shown in Table 1.

Module Code	Module Descriptor
1	General Pathology
2A	Breast Pathology (Hormonal Receptors – ER only)
2B	Breast Pathology (Hormonal Receptors – ER and PR)
3	Breast Pathology HER2 IHC
4	Lymphoid Pathology
5	Neuropathology
6	Cytology
7	Alimentary Tract Pathology (Gastro-Intestinal Stromal Tumour, GIST)
8	Gastric HER2 IHC
9	Breast HER2 ISH (Interpretive & Technical)
10	Non-Small Cell Lung carcinoma (NSCLC) ALK IHC
11	Non-Small Cell Lung carcinoma (NSCLC) PD-L1 IHC (Pilot)
12A	Non-Small Cell Lung carcinoma (NSCLC) ALK FISH (Pilot)
12B	Non-Small Cell Lung carcinoma (NSCLC) ROS1 FISH (Pilot)
13	Mismatch Repair (MMR) Proteins
14	Non-Small Cell Lung carcinoma (NSCLC) ROS1 IHC (pilot)

Table 1. Scheme Modules

2. REGISTRATION AND SUBSCRIPTION

Laboratories wishing to participate in one or more UK NEQAS ICC & ISH modules are recommended to read the detailed descriptions of each of the modules and elect to participate in those modules that cover the range of markers used routinely in their laboratory.

UK NEQAS ICC & ISH receives no financial support for the running of the Scheme, other than that generated from participants' subscription fees. These are set to cover the running costs of the scheme on a strictly non-profit basis. The annual subscription fees are provided to all currently subscribed members and can be sent out on request to prospective new participants.

- Subscription fees are payable prior to the start of the EQA financial year, which runs from April to March. They are collected by and made payable to our host organisation: External Quality Assessment Services for Cancer Diagnostics, which is a not-for-profit company;
- Fees are non-refundable;

- Participants enrolled in the current year's EQA service will automatically be sent subscription renewal forms. Non-return of subscription forms will be taken to mean that a participant no longer wishes to continue with their subscription;
- Participants must inform UK NEQAS ICC & ISH in writing if they wish to cease participating in any of its modules;
- Participants must inform UK NEQAS ICC & ISH in writing of any changes in contact details;
- New participants are expected to join at the beginning of the EQA year;
- Participation at all (usually four) Assessment Runs during the year is expected.

Subscription forms and further information about registration can be obtained by contacting the Scheme's Office Manager, Lin Rhodes.

Email: arhodes@ukneqasiccish.org; Telephone: +44(0)207 415 7065

3. Guidelines and Procedures

Slide Distribution and Placement of UK NEQAS and In-House Controls

Prior to each assessment run, participants receive:

- Two duplicate microscope slides, each bearing appropriate UK NEQAS ICC & ISH control materials
- An assessment run 'cover letter' providing comprehensive information and instructions (a copy is also sent to the participant laboratory's contact e-mail address). These instruction sheets can also be found on the UK NEQAS ICC & ISH website.

By convention, microscope slides distributed by the Scheme are separated into two areas (illustrated in Figure 1):

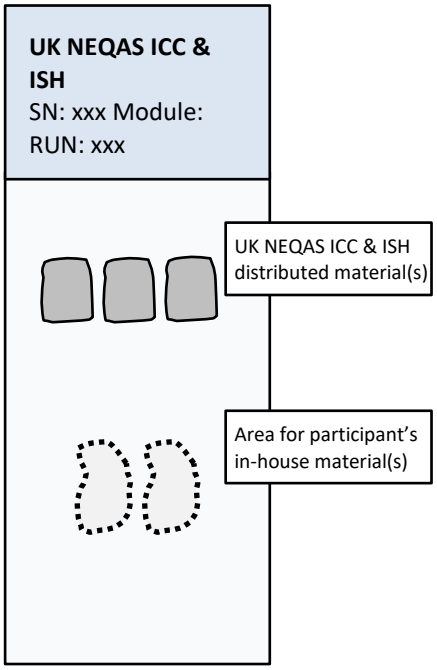

Figure 1. Distribution of samples on slide.

For all Modules (except the Cytology Module in cases where cytospin preparations are requested):

- the area towards the label end of the slide contains UK NEQAS ICC & ISH provided EQA sample(s);
- the area at the lower end of the slide is used by participants to mount their own in-house samples/controls;
- Slides are distributed with the mounted sections 'unbaked'.
- Upon receipt, participants should mount their in-house control material onto the same slide that contains the UK NEQAS ICC & ISH section(s)
- After mounting their own control materials, participants should heat slides in a slide-drying oven at either 37°C overnight *or* 55-60°C for 1 hour to ensure adequate section adhesion.
- As soon as possible after the slide drying has been completed, participants should carry out their routine staining procedure

It is very important that participants prepare control samples which are appropriate for the antigen that is being assessed. Ideally, the control tissues chosen should fit within the designated area on the same slide that holds the UK NEQAS ICC & ISH section(s). If this is not possible, it is permissible for them to be mounted on a separate slide.

Cytology Module cytospins only: participants who request cytospin samples as their UK NEQAS distributed material are required to submit a separate slide for their in-house control sample; the in-house sample should ideally be a cytospin from a cytology preparation. And, the staining method carried out should be the same for both the UK NEQAS distributed and the in-house samples. Participants who request a cell block sample should place their in-house section on to the same slide as the UK NEQAS sample where possible.

Antibody Not Stocked

If a suitable antibody against the antigen chosen for assessment is not stocked by a participant, they MUST contact the UK NEQAS ICC & ISH offices to agree a suitable alternative.

Note: Prior to this been agreed, the UK NEQAS ICC & ISH team may refer to that year's antibody repertoire declaration made by the participant to confirm non-access to the antibody.

The data that UK NEQAS ICC & ISH collects annually via the antibody survey helps to determine which antigens will be chosen as the 'fixed antigens for the EQA year: The scheme tries to include mostly those antigens against which suitable antibodies are stocked by at least 95% of laboratories. Given this, it is expected that most laboratories will stock antibodies against most of the antigens listed. And the UK NEQAS office staff may question when a laboratory does not stock a particular marker. However, UK NEQAS does appreciate that there are several specialist centres, which may only stock and use markers within their area of expertise.

If an alternative antibody is provided, slide(s) will be treated and marked in the same way as the original antibody and will count towards a participant's performance record. It is therefore important that you contact the UK NEQAS ICC & ISH office to ask for an alternative, and do not choose your own alternative.

Web Based Data Entry System and Accessing Online Reports

Participants have access to the UK NEQAS ICC & ISH web data entry and report system, which provides:

- Comprehensive instructions for each assessment
- Individual participant-specific assessment reports
- Selected assessment images showing optimal staining results and common features of sub-standard staining
- Assessment run results presented Graphically and in Tabulated format
- The Scheme's e-Journal

Assessment Procedure

Typically, participants are asked to demonstrate two different antigens at each assessment run (except in the Predictive Biomarker Modules, where one antigen/gene is examined at each run).

Participants are asked to stain the UK NEQAS sections using their routine method and return the best one for assessment, along with their usual in-house control slide placed on the same slide as the UK NEQAS material(s).

For some Modules, we may request one of the antigens from one assessment to the next over the EQA year as a 'Gold Standard'. This allows participants to implement recommended changes if their quality of immunocytochemical staining is found to be suboptimal and to test improved technique at the next or subsequent assessments.

Participants are also requested to complete details of the antibody and method they have employed on the web-based data collection forms.

Returned slides are assessed for technical quality by a panel of expert assessors comprising a mixture of senior biomedical scientists, clinical scientists, consultant histopathologists and cytopathologists. All assessors are evaluated, approved and appropriately trained by the Scheme's management team prior to assessing participants EQA submissions.

4. Assessment Scoring and Interpretation

This section details the guidelines assessors use when scoring participants submissions.

General assessment guide

- Each one of the four assessors independently award a mark out of '5' using the guidelines shown in Table 2;
- Marks are added together to give a final score out of 20;
- An acceptable level of staining is indicated by a score of at least 13/20;
- A borderline acceptable score of 12/20 indicates that whilst the staining may show some clinical relevance, the staining is sub-optimal, and improvements are required;
- A score of 8/20 or less is given for a poor quality of immunocytochemistry, which is of no clinical relevance. Significant improvements are required.

INDIVIDUAL ASSESSOR SCORING GUIDE

Table 2, on the next page shows in summary the criteria our assessors use when allocating their marks.

Note that, where marks have been deducted the reason will usually be shown on individual participant reports. And, where scores of '3' or less are allocated, assessors are mandated to provide feed-back comments to explain the reason and to provide advice for corrective actions. In the case of in-house controls, marks may be deducted for the use of inappropriate and/or inadequate control materials.

INTER-ASSESSOR AGREEMENT

A variance of 1 mark is allowed between assessors when assessing any given submission e.g. a mix of 4's and '5's is acceptable. This permits more 'granularity' in the final score achieved and reflects the fact that to some extent the score given by any one assessor has inevitable element of subjective variability attached to it.

Assessor's Score	Interpretation
0	**No submission**
1	**Unreadable** Clinically uninterpretable. Staining has no utility. Improvement essential. No significant demonstration of requested antigen. Excessive non-specific and/or inappropriate staining. Significant morphological damage caused by excessive pretreatment. Very poor tissue or section quality. Excessive haematoxylin counterstain completely obscuring specific ICC staining.
2	**Sub-optimal preparation that is clinically unsafe** Clinically uninterpretable. Staining has no utility. Improvement essential. Very weak demonstration of requested antigen, significantly below the expected level. For quantitative biomarkers: staining that is stronger than the expected level. Excessive non-specific and/or inappropriate staining. Significant morphological damage caused by excessive pretreatment. Very poor tissue/section quality. Excessive or very weak/absent haematoxylin counterstain.
3	**Sub-optimal preparation that is clinically readable** Although clinically interpretable with immunostaining considered to be appropriate for the target in question, the staining quality is sub-optimal and improvement is essential. Weak demonstration of antigen, below the expected level. Non-specific and/or inappropriate staining is present but does not make the staining uninterpretable. Some morphological damage caused by excessive pretreatment. Poor tissue/section quality. Excessive or very weak haematoxylin counterstain.
4	**Good preparation that is clinically readable** Clinically interpretable with immunostaining appropriate for the target in question and of good quality. Minor improvements are possible. Demonstration of requested antigen, at the expected level of sensitivity. No non-specific and/or inappropriate staining. Good tissue and morphological preservation. Correct level of haematoxylin counterstain. Some minor aspect(s) of the preparation are not optimal.
5	**Excellent preparation that is clinically readable** Clinically interpretable with immunostaining appropriate for the target in question and of excellent quality. No improvements are required. Demonstration of requested antigen, at the expected level of sensitivity. No non-specific and/or inappropriate staining. Good tissue and morphological preservation. Correct level of haematoxylin counterstain.

Table 2. Individual assessor scores and their interpretation.

Scores between any two assessors which vary by >1 mark are not deemed to be sufficiently closely aligned e.g. a score of 3 and a score of 5. They are automatically 'flagged' by the assessment software in real-time. And, in those situations, assessors are required to agree on amended more closely aligned scores by a process of consensus review.

Distinction Between Individual Assessor Scores of '3' and '2'

An exception to the procedure of allowing a variance of 1 mark occurs when assessors are making the distinction between staining which is substantially sub-optimal, but still clinically readable (score = 3), and staining which is sub-optimal to the degree of being of no clinical value (score = 2). These two score categories are mutually exclusive, and we therefore require unanimous consensus amongst our assessors on one or other of them.

Consequently, combined assessment scores of '9', '10' and '11' are no longer allocated to participants submissions by the Scheme.

Combined Assessment Scores

Participants receive a combined assessment score as a final indication of staining quality. Table 3 gives an indication of how these scores should be interpreted and what actions, if any are required.

Final Score	Interpretation
0	**No submission.**
4 - 8	**UNACCEPTABLE** Unreadable/clinically uninterpretable. Staining has no utility. Improvement essential.
12	**BORDERLINE ACCEPTABLE** Although clinically interpretable with immunostaining considered to be appropriate for the target in question, the staining quality is sub-optimal, and improvement is essential.
13 - 15	**ACCEPTABLE** Clinically interpretable with immunostaining appropriate for the target in question and of good quality. Improvements are required.
16 - 20	**GOOD to EXCELLENT** Clinically interpretable with immunostaining appropriate for the target in question and of good to excellent quality. Minor improvements may be possible.

Table 3. Interpretation of final score, produced from the 4 assessor's combined scores.

Breast HER2 IHC Assessment Guide

The following procedures and criteria are used in this assessment:

- Assessors evaluate each of the UK NEQAS distributed samples, and provide an interpretation on the membrane staining;
- Each of the four assessors score independently using an adapted method initially devised by the Clinical Trials Assay where percentage positivity and membrane intensity are both considered;
- Assessors provide an overall score out of '5', with the four assessors' marks being added together to give a score out of '20';

- Cell line samples are usually distributed for the Breast HER2 IHC module;
- Due to the nature of the cell lines, they can show a cell viability range of between 30-90%. Therefore, the overall percentage staining criteria cannot be accurately applied to each cell line and for this reason, reference sections are prepared by staining every 50th to 53rd cut section using HER2 IHC standardised kits/assays (Agilent Dako HercepTest, Leica Oracle and Ventana Pathway 4B5). This provides a reference point to gauge the expected level of staining of participants' submitted slides.

Assessors examine each sample, looking for presence of expected cell membrane staining patterns. Assessors will mark down or fail a participant stain for the following reasons: Excessive cytoplasmic/background staining; excessive/insufficient haematoxylin staining; insufficient membrane staining; false positive/negative membrane staining; morphological damage; poor quality of in-house control tissue, poor/inadequate choice of control tissue, poor/inadequate fixation of in-house material.

UK NEQAS Cell Line	Expected Staining		Descriptive
A: SK-BR-3	3+		Cells show strong complete membrane staining.
B: MDA-MB-453	2+		Complete membrane staining in most cells, which is of weak to moderate intensity
C: MDA-MB-175	1+		Cells show only partial membranous staining
D: MDA-MB-231	0		**Cells are not stained**

Table 4. Expected staining patterns of the cell lines.

'U' Scores: assessors may also give a score of 'U', which indicates that the staining is 'uninterpretable'.

Once the membrane staining has been interpreted for each of the UK NEQAS samples, assessors then provide an overall score out of '5', based on the interpretability of the membrane staining and technical quality. The four assessor's scores are then combined to give a possible score out of '20' marks:

Final Score	Interpretation
0	**No submission.**
4 - 8	**UNACCEPTABLE** Unsuitable quality for clinical interpretation and technical improvements need to be made. Marks may have been deducted due to: • Weaker/stronger than the expected level of membrane staining • False positive/negative membrane staining • Excessive cytoplasmic staining • Excessive morphological damage • Excessive staining of normal glands
12	**BORDERLINE ACCEPTABLE** Overall the samples are borderline interpretable. Indicating, that while still being clinically relevant, technical improvements need to be made. Marks may have been deducted due to: • Weaker/stronger than expected membrane staining • Some cytoplasmic staining • Morphological damage
13 - 15	**ACCEPTABLE** Some slight technical issues noted by some of the assessors, but overall the staining is suitable for interpretation.
16 - 20	**GOOD to EXCELLENT** All assessors agree that, overall for the samples distributed, the staining is at the expected level for each of the distributed samples.

Table 5. Interpretation of final score, produced from the four assessor's combined scores.

GASTRIC HER2 IHC ASSESSMENT GUIDE

UK NEQAS ICC & ISH uses an EQA specific scoring criteria when scoring the tissue sections, so as to provide participants with additional technical feedback (see Table 6).

- The Gastric HER2 scoring system is based on the original guidelines set out by Hoffman and Ruschcoff for surgical resections. The updated guidelines (Bartley et al. 2017) made no changes to the assessment of HER2 in gastric carcinoma.
- Prior dispatch, and due to the heterogeneity of gastric tissue, reference sections are prepared and stained at approximately every 25th - 28th serial section using the currently available commercial kits. Samples are further validated by ISH.
- The UK NEQAS distributed Gastric HER2 slides include formalin-fixed paraffin-embedded gastric carcinoma samples with a varying range of HER2 protein expression levels. The samples do not necessarily always include (and do not necessarily run in the order of) a 3+, 2+, 1+ and 0 at each assessment run.
- During the assessment, samples are assessed independently around a multi-header microscope, with each of the 4 assessors providing their interpretation on the membrane staining.

Expected Staining	Assessment Criteria
3+	• 3+: staining is as expected • 3+/2+: 3+ membrane staining is present but also showing 2+ staining
2+	• 2+: staining is as expected • 2+/1+: 2+ membrane staining is present but also showing 1+ staining • 2+/3+: stronger than expected with membrane staining showing more 2+ compared to 3+
1+	• 1+: staining is as expected • 1+/0: staining is more towards the weaker end of 1+ staining but still acceptable
0	• 0: staining is as expected • 0/1+: cells are starting to show very weak membrane staining

Table 6. Expected staining patterns of the gastric control samples.

'U' Scores: assessors may also give a score of 'U', indicating the sample is uninterpretable and substantial improvements are required. Any membrane score outside the range for each of the expected scores as indicated in Table 6 is deemed to be unacceptable. When membrane interpretation for each of the 4 samples is complete, an individual score out of 5 is awarded, based on the interpretability of the membrane staining and the technical feedback. An overall mark is awarded by combining the four assessor's scores to give a score out of 20 (Table 7):

Final Score	Interpretation
0	**No submission.**
4 – 8	**UNACCEPTABLE** Unsuitable quality for clinical interpretation and technical improvements need to be made. Marks may have been deducted due to: • Weaker/stronger than the expected level of membrane staining • False positive/negative staining • Excessive non-specific staining • Excessive morphological damage
12	**BORDERLINE ACCEPTABLE** Overall the samples are borderline interpretable. Indicating, that while still being clinically relevant, technical improvements need to be made. Marks may have been deducted due to: • Weaker/stronger than expected membrane staining • Excessive non-specific staining • Morphological damage
13 – 15	**ACCEPTABLE** Some slight technical issues noted by some of the assessors, but overall the staining is suitable for interpretation.
16 – 20	**GOOD to EXCELLENT** All assessors agree that, overall for the samples distributed, the staining is at the expected level for each of the distributed samples.

Table 7. Interpretation of final score, produced from the four assessor's combined scores.

NSCLC ALK IHC Assessment Guide

The UK NEQAS distributed material may contain up to six samples at any given Assessment Run. It will usually include a mixture of cell lines, non-small cell lung cancer (NSCLC) tissue samples of known ALK IHC expression and appendix. Reference sections are prepared by staining every 25th – 28th cut sections using the Ventana ALK D5F3 companion diagnostic (CDx) assay. This provides a reference point to gauge the expected level of staining of participants submitted slides.

Assessments are carried out by four assessors scoring independently. Each assesses the UK NEQAS distributed samples and provide an interpretation on the staining intensity (scoring as 3+, 2+, 1+ or 0).

'U'/Uninterpretable Scores: Assessors may also give a score of 'U', which indicates that the cell lines / tissue sections are 'uninterpretable'.

Assessors will then also provide an overall score out of '5' with the four assessors' marks added together to give a possible score out of 20 as shown in Tables 6 and 7 above (same criteria as those used for the Gastric HER2 Module).

NSCLC PD-L1 IHC (pilot) Assessment Guide

The UK NEQAS distributed material may contain up to eight samples at any given Assessment Run It will usually include a mixture of cell lines, NSCLC tissue samples of known PD-L1 IHC expression and tonsil tissue. Reference sections are prepared by staining every 25th -28th cut sections using the Ventana/Roche and Dako/Agilent PD-L1 NSCLC IHC assays. This provides a reference point to gauge the expected level of staining of participants submitted slides.

- Assessments are carried out by assessors scoring independently out of '5', and then the average of the four assessors marks are provided as a total score out of 20. Each assesses the UK NEQAS distributed samples and provide an interpretation. The tonsil section is scored as Acceptable or Unacceptable, and the cell lines and lung tumour samples are interpreted on the percentage of tumour cells staining as 0 or <1% (negative), 1-4%, 5-9%, 10-24%, 25-49%, 50-79% and 80- 100%.
- 'U'/Uninterpretable Scores: assessors may also give a score of 'U' which indicates that the cell lines / tissue sections are 'uninterpretable'.

Breast HER2 ISH Interpretive assessment guide

At each assessment, laboratories are sent formalin-fixed paraffin processed samples of known HER2 ISH status

Participants should assess the materials for *HER2* gene amplification using either a dual probe assay (*HER2*/Cep17: ratio method) OR single probe assay (*HER2* copy) (in accordance with current HER2 ISH guidelines).

Participants are required to complete and return scores for each sample using the online data entry system. They are also requested to input their methodology data to provide brief details of the probe and method they have employed.

In this module, a different panel of breast cancer specimens will be sent at each assessment to ensure coverage of the critical diagnostic ranges.

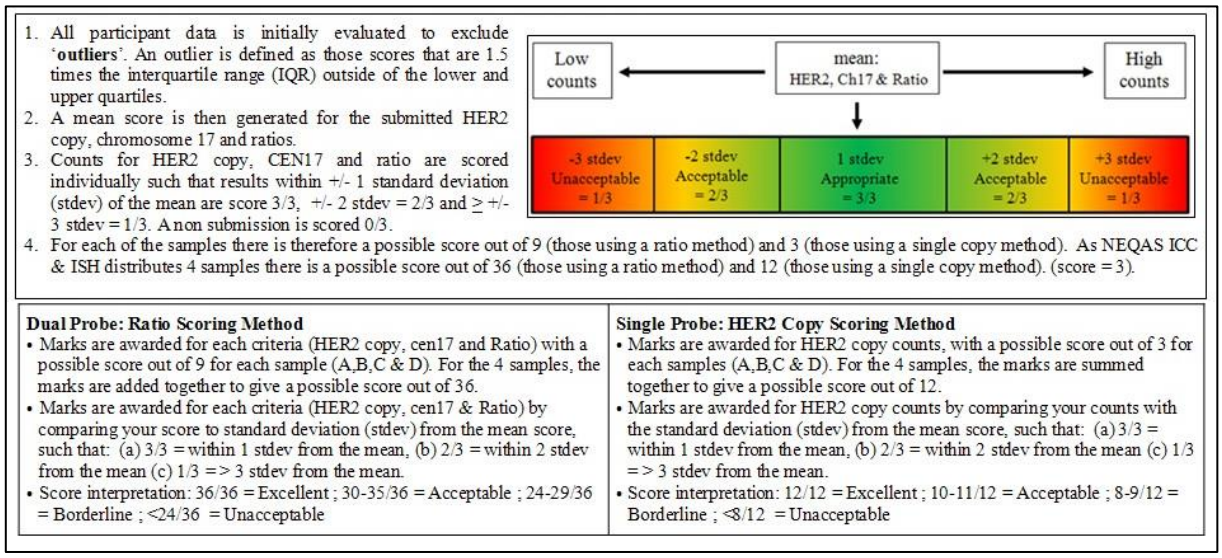

Figure 2. Statistical approach used in the ISH interpretive scoring system.

Assessment of slides utilises a statistical method in order to provide concise information with regards to the inter-observer variability in enumerating *HER2* copy, chromosome 17 and overall ratios (see Figure 2 above).

Dual Probe		**Single Probe**	
Score	**Performance Descriptor**	**Score**	**Performance Descriptor**
36/36	Excellent	12/12	Excellent
30-35/36	Acceptable	10-11/12	Acceptable
24-29/36	Borderline	8-9/12	Borderline
<24/36	Unacceptable	<8/12	Unacceptable

Table 8. Interpretation of final score.

Breast HER2 ISH Technical assessment guide

Chromogenic *in-situ* hybridisation (CISH) slides are technically assessed around a multi-header microscope with each slide being assessed by four independent assessors. Each assessor provides a score out of '5', and then scores are added together to give a final score out of 20.

Fluorescent *in-situ* hybridisation (FISH) slides are technically assessed by a team of assessors at the same time, by incorporating a live-feed video from the fluorescence microscope with the image viewed on a large high definition monitor, allowing up to eight assessors to view and score the FISH slides at the same time, and then the consensus of the assessors' marks is provided as a total score out of 20.

Assessors examine the quality of the ISH staining but DO NOT carry out probe enumeration. This is evaluated during the HER2 ISH interpretive assessment. Technical evaluation scoring procedure and criteria for interpretation are shown in the guidelines given in Table 9.

Individual Assessor Scores (see Note 1)	**Overall Scores** (see Note 2)	**Score Interpretation**
0	0	**No submission**
1 and 2	4 - 8	**UNACCEPTABLE** The UK NEQAS distributed and/or in-house samples are uninterpretable. Potential features: • Excessive or very weak/absent nuclear (DAPI) staining; • Poor probe hybridisation; • Missing HER2 or CEP17 signals, leading to incorrect copy number evaluation; • Excessive background staining.
3	12	**BORDERLINE ACCEPTABLE** The UK NEQAS distributed and/or in-house samples are interpretable, but substantial improvements in quality of staining must be made. Potential features: • Weak nuclear counter-staining; • Weak HER2 and/or CEP17 signals; • Background staining.
3 and 4	13 - 15	**ACCEPTABLE** The UK NEQAS distributed and/or in-house samples show a good standard of staining and are suitable for interpretation. Minor non-critical defects are present.
4 and 5	16 - 20	**GOOD to EXCELLENT** The UK NEQAS distributed and/or in-house samples show a very good standard of staining and are optimal for interpretation.

Table 9. Individual and combined assessment scores and their interpretation.

Note 1: individual assessor's scores are applicable to the CISH assessment only, where each assessor awards a mark between 0 – 5. Note 2: combined assessment scores are produced for both the CISH and FISH assessments, with the range being 0 – 20.

Troubleshooting Interpretive and Technical module Results

Combining the results from the 'Interpretive' and 'Technical' HER2 ISH modules, allows laboratories to further troubleshoot their techniques as shown in Table 10 on the next page.

Technical Assessment Result	Interpretive Assessment Result	Interpretation and Recommended Actions
Acceptable	Appropriate or Acceptable	The UK NEQAS distributed samples show a good standard of staining and have been interpreted correctly. **No corrective action is required.**
Acceptable	Unacceptable	The UK NEQAS distributed samples show a good standard of staining BUT there is an issue with interpretation i.e. HER2 copy number and/or CEP17 incorrectly assessed. **Recommend that scoring/counting criteria are reviewed.**
Unacceptable	Appropriate or Acceptable	The technical staining quality of the UK NEQAS distributed samples is poor and therefore not suitable for interpretation. Although interpretation of these samples by the participant is correct their staining quality if present in clinical cases may lead to misinterpretation. **Recommend that technical method is optimised (or that a standardised kit/assay is used as per manufacturer's instructions).**
Unacceptable	Unacceptable	Overall the NEQAS samples are unacceptable for technical staining and interpretation. Reporting from such cases is very likely to lead to incorrect interpretation of clinical cases. **If there is persistent underperformance:** • Seek assistance from kit/assay manufacturer; • Seek assistance from UK NEQAS or colleagues; • Re-validate protocol (retrospectively and prospectively); • Review scoring criteria; • Consider sending out clinical cases to a referral centre to verify in-house results.

Table 10. Troubleshooting guidelines

5. In-house Control Tissue Requirements and Recommendations

- In-house samples should be placed onto UK NEQAS distributed slides as shown in Section 3 of this Manual.
- Appropriate controls must be used as outlined in the relevant Section below.
- Quality of the submitted in-house tissue is important. Tissues must be well fixed and processed with well-preserved morphology. Poor fixation, damage caused by excessive antigen retrieval, and inappropriately weak or strong counterstain will be taken into consideration when assessing quality. As will poor section quality and the use of excessively thick or thin sections.
- Online data sheets MUST be fully completed, indicating the tissue/tumour type, and where appropriate, which component has been used to control the staining (for example, in the breast module whether the *in-situ* carcinoma is to be assessed rather than the invasive component).
- We DO NOT require submission of unstained in-house controls for any of our Modules.

Suitable In-House Control Materials

For all modules, in-house tissue must include appropriate controls for the antigen requested. Marks will be deducted for inappropriate controls.

Module	Suitable In-House Control(s)
Alimentary Tract (GIST)	GIST and appendix *or* GIST with included normal mucosa.
Mismatch Repair Proteins	Tumour showing loss of expression (deficient) and appendix *or* tumour showing loss of expression (deficient) together with normal epithelium
Lymphoid Pathology	Lymphoma appropriate to the antigen assessed and tonsil.
NSCLC ALK IHC	ALK-positive and ALK-negative NSCLC and appendix are required.
NSCLC PD-L1 IHC (pilot):	PD-L1-positive and PD-L1-negative NSCLC together with tonsil.
Breast HER2 ISH	A single sample consisting of an invasive breast tumour.
Breast Hormonal Receptors (ER and PR)	Participants in-house control tissue MUST consist of composite breast tissue (see also Note 1 about use of cell lines): • >80% positive tumour with high intensity (Allred/Quick score 7-8) • 30-70% positive tumour with low or moderate intensity (Allred/Quick score 4-6) • negative tumour, ideally including normal glands (Allred/Quick score 0)
Breast HER2 IHC	In-house control material MUST include samples from 3+, 2+ and 1+/0 HER2 expressing invasive breast cancer cases (see Note 1 about use of cell lines). DCIS breast tissue showing differing levels of membrane staining is an acceptable alternative. However, laboratories must indicate which component they have scored, or the invasive component, if present, will be assessed. It is also acceptable to submit a heterogeneous in-house tumour control with areas of e.g. 3+ and 2+ membrane expression as long as the participant indicates the areas and expected levels of staining.
Gastric HER2 IHC	In-house control material MUST include 3+, 2+ and 1+/0 HER2 expressing cases preferably of gastric tumour, although breast tumour is also acceptable (see also Note 1 about use of cell lines). DCIS breast tissue showing differing levels of membrane staining is an acceptable alternative. Laboratories must indicate on their datasheet which component of the tumour they have scored, otherwise the invasive component, if present, will be assessed. It is also acceptable to submit a heterogeneous in-house tumour control with areas of e.g. 3+ and 2+ membrane expression as long as the participant indicates the areas and expected levels of staining.
ALK FISH (pilot):	ALK-positive and ALK-negative NSCLC
ROS1 FISH (pilot):	ROS-1-positive and ALK-negative NSCLC

Table 11. In-House Controls

IMPORTANT NOTE: cell lines are an acceptable substitute, but only when used alongside a piece of the participant's own in-house tissue. It is still a requirement to include the varying expression levels required, whether they are shown by the cell lines or a mixture of the cell lines and tissues. Cell lines included with commercial kit/assays are an acceptable substitute, but again a piece of the participant's own in-house tissue must also be included.

6. Participant Reports

At the end of each assessment, participants are sent notification via email that reports are available to view and download from the UK NEQAS ICC & ISH website.

Participants also have access to graphs, technical tables showing antibodies used, automation systems and retrieval methods, along with images showing optimal and poor examples of staining. Furthermore, 'Best Methods' are also generated from anonymised participant technical data.

Individual Participant Reports

All individual reports consist of:

- The individual assessors' scores out of 5 and total score out of 20;
- Assessor feedback when appropriate;
- A bench-marking graphical panel showing the results for the participant over the course of 10 assessments compared to the group average.

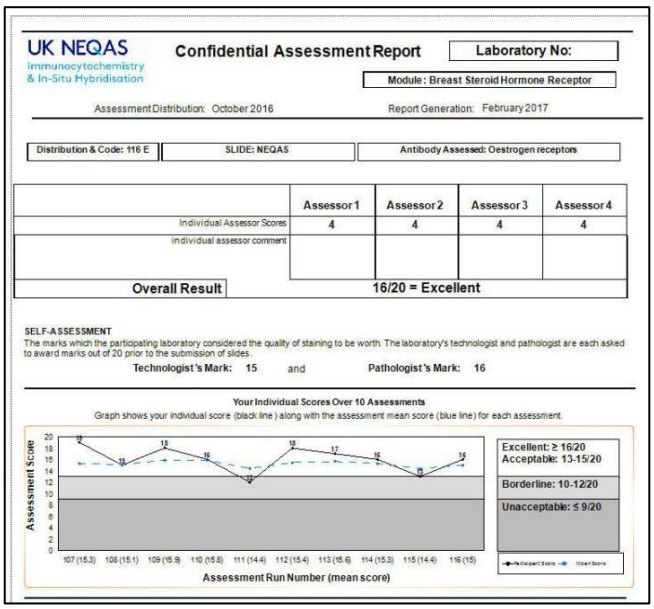

Figure 3. Participant report example from the breast hormonal receptor module.

Note: The report shown is taken from an Assessment Run prior to the implementation of consensus scoring for '2'/'3', and hence Borderline is shown as 10-12/20 and Unacceptable as ≤9/20.

Graphical Data

Graphs are provided showing the distribution of pass rates for a particular run on both the UK NEQAS ICC and in-house samples.

This allows individual participants to gauge their performance against the rest of the participants. An example is shown below.

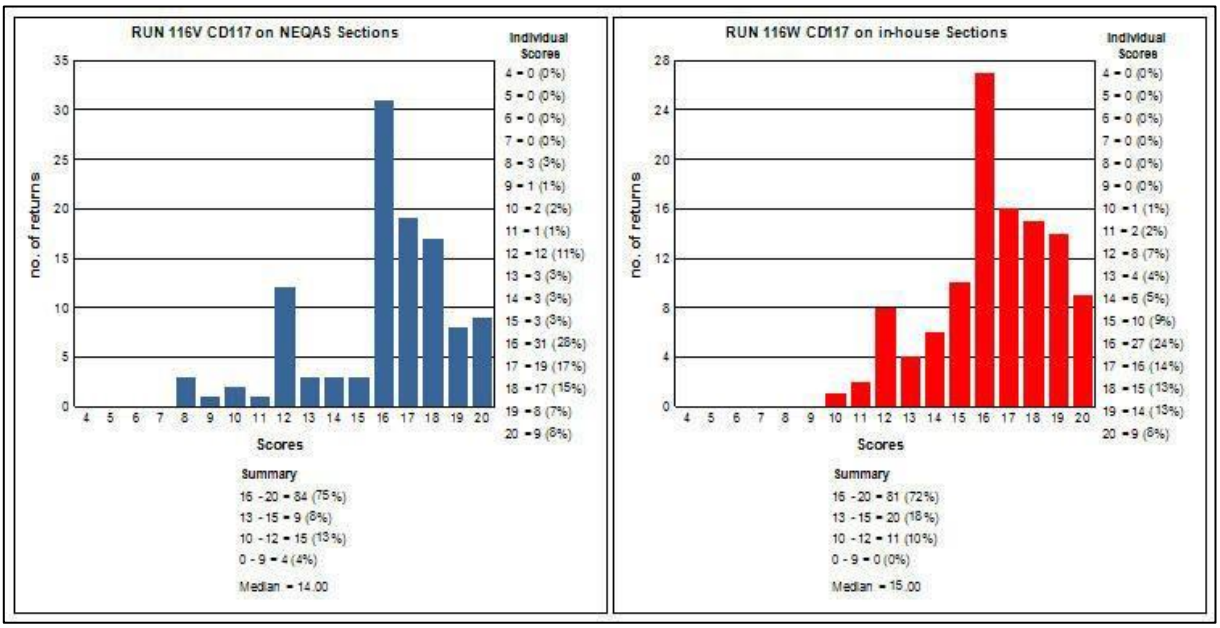

Figure 4. Example of the graphical reports from the Alimentary Tract module.

Note: The charts depicted are taken from an Assessment Run prior to the implementation of consensus scoring for '2'/'3', and hence do show scores of 9, 10 and 11 and categories of 0-9 and 10-12.

Technical Data

Technical tables, showing participant choice of antibodies, automation systems, and retrieval methods are also provided. The data show the number of participants using a particular method (N) along with the percentage (%) that have achieved an acceptable score using the selected parameters (score≥12/20 in the case of most modules).

Neuropathology Run: 116

Primary Antibody : Glial Fibrillary Acidic Protein(GFAP)

Antibody Details	N	%
Dako M0761 (6F2)	12	83
Dako Z0334 (R Poly)	26	96
Immunon 490740RB	1	100
Novocastra NCL-GFAP-GA5 (GA5)	2	50
Sigma G3895 (GA5)	2	50
ZymedInvitrogen 08-1021 (ZCG29)	1	100
Dako IR524 (R Poly)	2	50
Novocastra PA0026 RTU (GA5)	4	100
Ventana 760-4345 (EP672Y)	6	100
Cell Marque (EP672Y) 258R	2	100
Dako Omnis GA524 (R Poly)	3	100

Neuropathology Run: 116

Automation	Glial Fibrillary Acidic Protein (GFAP) N	%	Tau Protein N	%
Dako Autostainer Link 48	6	67	7	86
Dako Autostainer Plus Link	1	0	0	0
Dako Omnis	5	100	1	100
Leica Bond Max	6	100	4	50
Leica Bond -III	13	85	11	91
None (Manual)	3	100	7	100
Ventana Benchmark ULTRA	20	100	13	92
Ventana Benchmark XT	7	86	8	88

Figure 5. Example of the technical reports from the Neuropathology module

Selected 'Best Methods' in Reports

Best methods are selected from a variety of the most popular methods from participants that have scored well in the assessments on both the UK NEQAS and in-house slides.

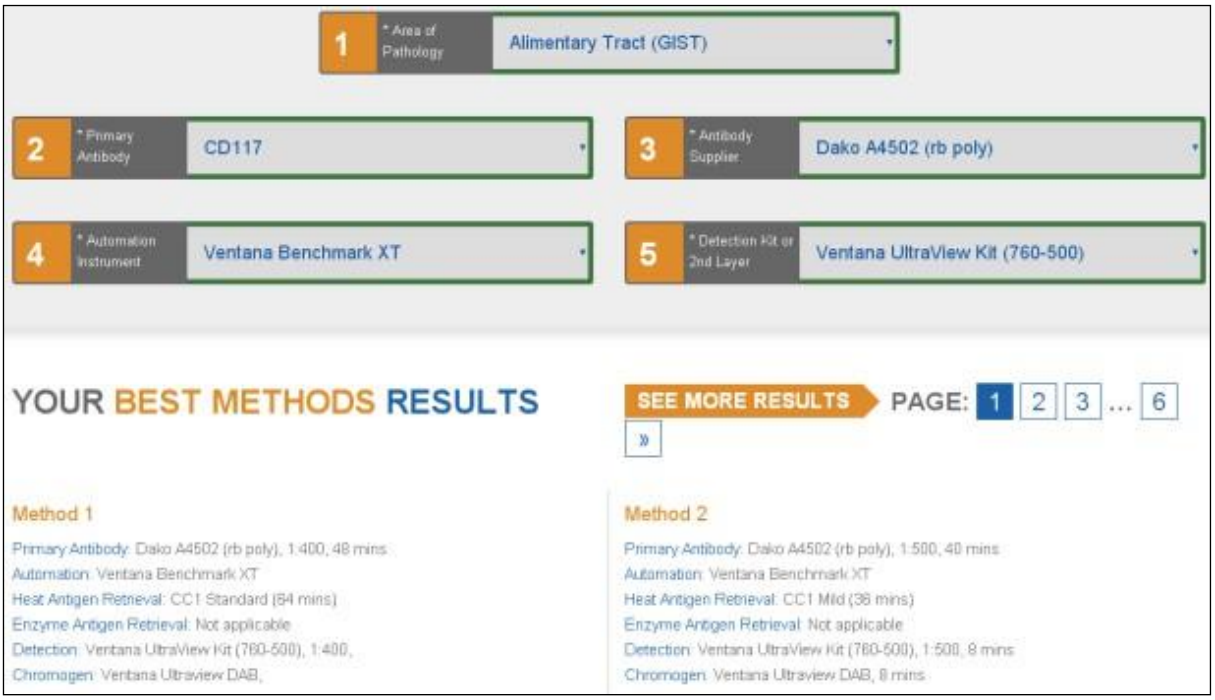

Figure 6. Example from the Alimentary Tract (GIST) module.

Web-based 'Best Methods' are available through our Immunohistochemistry Best Methods Database (www.ukneqasiccish.org/best-methods/), which contains a collection of several thousand anonymised methodologies collated from methods submitted by participants to UK NEQAS ICC & ISH that are associated with excellent staining results.

Photographic Examples: Acceptable and Unacceptable Staining

Images are taken after each assessment illustrating the level of staining that is both acceptable and unacceptable, allowing participants to make a direct comparison with their own submitted assessment slides.

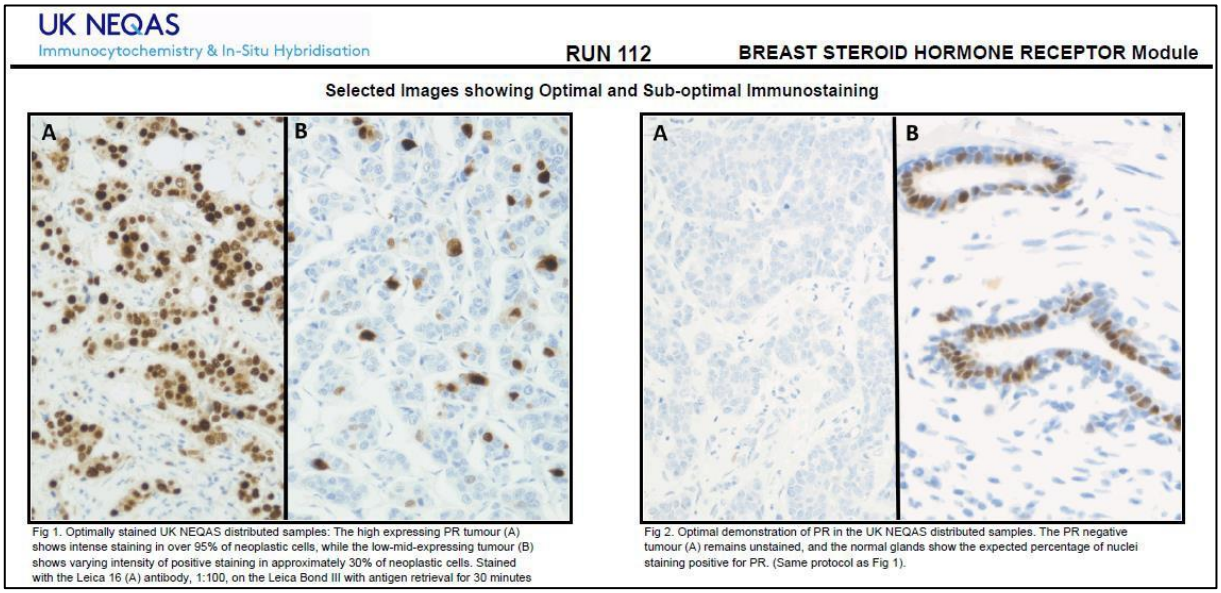
UK NEQAS
Immunocytochemistry & In-Situ Hybridisation
RUN 112
BREAST STEROID HORMONE RECEPTOR Module
Selected Images showing Optimal and Sub-optimal Immunostaining
A
B
A
B
Fig 1. Optimally stained UK NEQAS distributed samples: The high expressing PR tumour (A) shows intense staining in over 95% of neoplastic cells, while the low-mid-expressing tumour (B) shows varying intensity of positive staining in approximately 30% of neoplastic cells. Stained with the Leica 16 (A) antibody, 1:100, on the Leica Bond III with antigen retrieval for 30 minutes
Fig 2. Optimal demonstration of PR in the UK NEQAS distributed samples. The PR negative tumour (A) remains unstained, and the normal glands show the expected percentage of nuclei staining positive for PR. (Same protocol as Fig 1).

Figure 7. Example of the image report from the Breast Hormone module

IMMUNOCYTOCHEMISTRY E-JOURNAL

Data is combined into a single E-Journal and is available to download after assessment completions. All E-Journals are also freely available to download from: www.ukneqasiccish.org/journals/

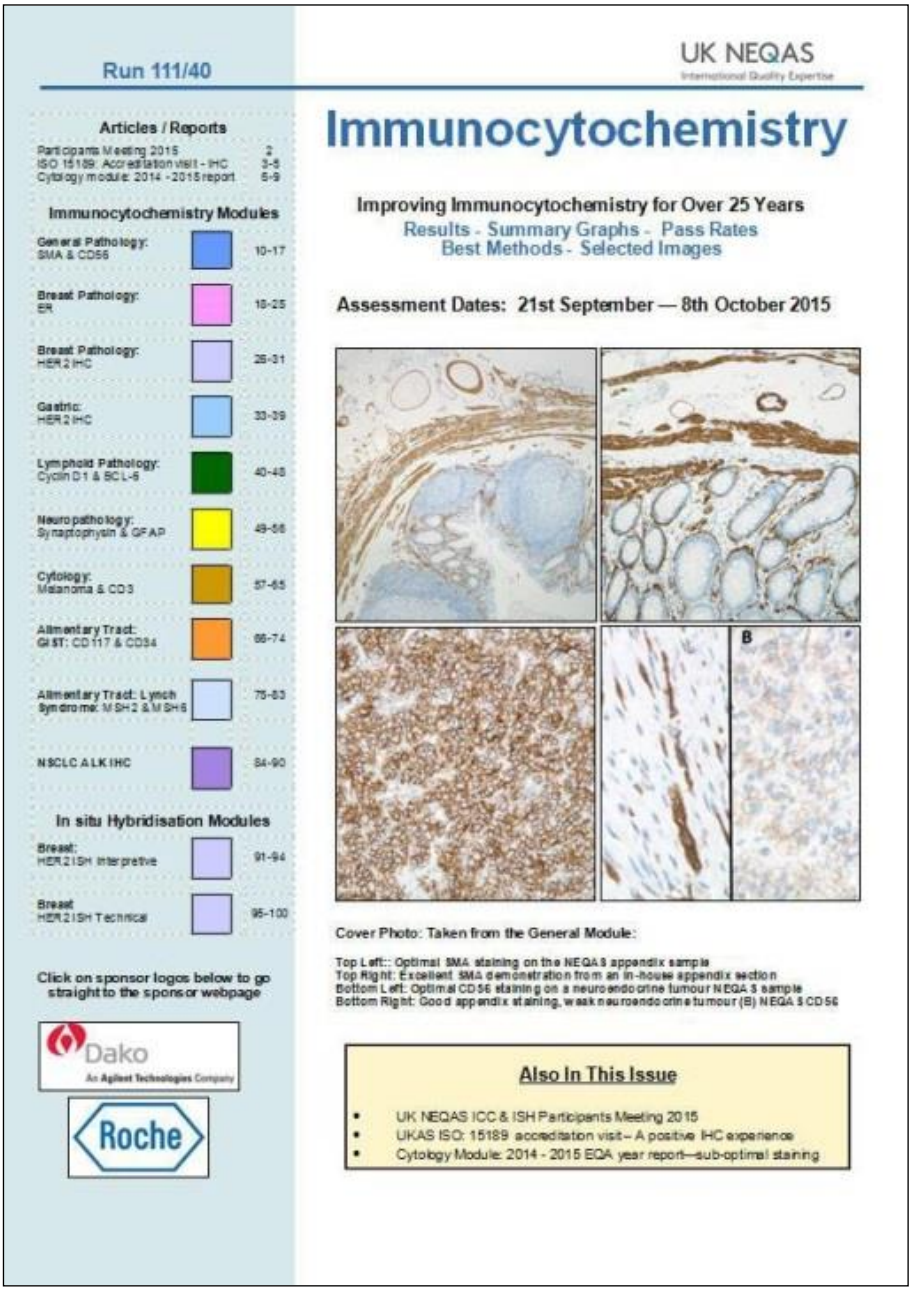

Figure 8. An example of the front-cover from one of our e-Journals.

7. Poor Performance Monitoring (UK Clinical Laboratories Only)

All UK NEQAS schemes are required by their accrediting body, UKAS (ISO/IEC 17043:2010), to have in place a formal system whereby performance of their UK clinical laboratory-based participants is monitored.

UK NEQAS ICC & ISH is required to notify the appropriate Royal College of Pathologist National Quality Assurance Advisory Panel (RCPath NQAAP) of all instances of persistent substandard performance from participating UK clinical laboratories.

The Joint Working Group for Quality Assurance, which is the RCPath body with overall responsibility for clinical quality assurance, has instituted a 'traffic light' system for the grading of UK clinical laboratory-based participants' performance:

Colour Code	Descriptor
GREEN	Participant has no issues with poor performance.
AMBER	Issues with poor performance, managed locally between the Scheme and the participant.
RED	Poor performance issues remain unresolved; participant is designated as a persistent poor performer and referred to NQAAP

Table 12. Traffic Light system used for grading sub-optimal performance

The UK NEQAS ICC & ISH Poor Performance monitoring covers the five most recent runs following the upload of reports after each assessment.

Each Module is treated as a separate entity; low scores from one Module **are not** combined with low scores from another to produce a poor performance.

It is important that a laboratory which has underperformed continues to participate at subsequent Assessment Runs in order that their continuing performance can be correctly judged (please note that un-sanctioned non-submission counts towards poor performance).

Although in-house sections are not part of the front-line poor performance monitoring procedure, the importance of good in-house staining is to be emphasised and laboratories may be contacted if their in- house controls are suboptimal, or their choice of in-house control material is not appropriate. It will not be acceptable to perform well on UK NEQAS ICC & ISH material alone. Laboratories with persistent suboptimal staining of their in-house material will be contacted, and their EQA results discussed with a view to further action being taken if the situation continues.

Offer of Assistance Letters

When a participant has received one score (in Predictive Biomarker Modules) or two scores (in Diagnostic Modules) indicative of underperformance(s), the scheme will contact the participant with an 'Offer of Assistance' letter. Although participants are not obliged to contact UK NEQAS ICC & ISH at this point, they may still wish to do so for advice and feedback to improve on future assessment results. Performance status remains **GREEN** at this stage.

Non-submission of Slides

This will result in a score of zero (0), and will be included in poor performance monitoring, unless the laboratory has informed UK NEQAS ICC & ISH of a valid reason for the non-submission.

NQAAP has stated that submission rates should be **100%** for all UK Clinical laboratories. If a laboratory has not submitted for a run, then the EQA provider (UK NEQAS ICC & ISH) should be given/sent a valid explanation or reason why; e.g. antibody not stocked (and an alternative could not be provided), not clinically testing or testing being outsourced.

Retrospective explanations following the production of results, and subsequent poor performance reports, may not be acceptable.

Diagnostic Biomarker modules

These include:

- General Pathology
- Cytology
- Neuropathology
- Lymphoid Pathology
- Alimentary Tract (GIST)
- Mismatch Repair (MMR) Proteins

Action	Trigger Point	Monitoring Procedure
Offer of Assistance Letter	**Two** unacceptable scores (≤8/20) over 5 runs on UK NEQAS Gold or second antibody assessments.	Participant nominated contact is notified of repeated underperformance. Participant will be offered assistance to improve.
AMBER STATUS	**Three** unacceptable scores (≤8/20) over 5 runs on UK NEQAS Gold or second antibody assessments.	Participant nominated contact and Head of Department are notified of repeated underperformance. A 'Warning letter' is issued indicating that they are close to being deemed a poor performer.
RED STATUS	**Four** unacceptable scores (≤8/20) over 5 runs on UK NEQAS Gold or second antibody assessments.	Participant nominated contact and Head of Department are notified of repeated underperformance. A 'Red letter' is issued indicating that they are deemed to be a poor performer and are required to contact the Scheme Director. NQAAP is informed.

Table 13. Sub-optimal performance action for Modules assessing non-biomarkers.

Although in-house sections are not part of poor performance monitoring, they may be used to gauge overall performance in cases of poor performance. Participants should make every effort to submit appropriate control material for the antigen requested.

Predictive Biomarker Modules

Because of the direct impact that the results of assays for predictive biomarkers have on patient management, more stringent performance monitoring mechanisms are employed.

Modules designated as assessing biomarker include:

- Breast Pathology Hormone Receptors (ER and PR)
- Breast Pathology HER2 IHC
- Breast Pathology HER2 ISH
- Gastric Pathology HER2 IHC
- NSCLC ALK IHC

Note that the NSCLC PD-L1 IHC, NSCLC ALK ISH, and ROS1 IHC and ISH are all predictive biomarker Modules, but they are currently in Pilot and therefore are not performance assessed.

Action	Trigger Point	Monitoring Procedure
Offer of Assistance Letter	**Two** unacceptable scores (≤8/20) over 5 runs on UK NEQAS Gold or second antibody assessments.	Participant nominated contact is notified of repeated underperformance. Participant will be offered assistance to improve.
AMBER STATUS	**Three** unacceptable scores (≤8/20) over 5 runs on UK NEQAS Gold or second antibody assessments.	Participant nominated contact and Head of Department are notified of repeated underperformance. A 'Warning letter' is issued indicating that they are close to being deemed a poor performer.
RED STATUS	**Four** unacceptable scores (≤8/20) over 5 runs on UK NEQAS Gold or second antibody assessments.	Participant nominated contact and Head of Department are notified of repeated underperformance. A 'Red letter' is issued indicating that they are deemed to be a poor performer and are required to contact the Scheme Director. NQAAP is informed.

Table 13. Sub-optimal performance action for Modules assessing biomarkers.

Although in-house sections are not part of the poor performance monitoring system, they may also be used to gauge overall performance status in cases of poor performance. Participants should make every effort to submit appropriate control material for the antigen requested.

Poor performance monitoring is carried out over a rolling five-assessment period 5. Participants may receive a letter to confirm their current status or continuing (e.g. Amber or Red) even if this may have been triggered at a previous Assessment Run.

If a laboratory's status changes following an appeal (reassessment), a revised letter will be sent

to confirm the new status.

8. Poor Performance Monitoring of Non-UK Participants

UK NEQAS ICC & ISH does not have a mandate to report poor performance of non-UK based participants. But in order serve those participants as well as is possible, the Scheme will contact them at Amber and Red trigger points to offer help and assistance on a voluntary basis.

9. End of Year Performance Record / Certificate of Participation

At the end of each EQA year, the Scheme provides all participants with a printed 'certificate of participation', listing all modules participated in. For each module, laboratories must have submitted at least twice during the EQA year. Participants also receive a summary of the results they achieved over the preceding year (annual report).

10. Meetings and Practical Workshops

Participant and scientific meetings, and practical workshops are organised throughout the year, details of which are distributed to all UK NEQAS ICC & ISH subscribers.

These meetings provide the opportunity for participants to discuss immunocytochemistry, *in-situ* hybridisation and EQA related topics with other participants, the Scheme's assessors, and UK NEQAS ICC & ISH personnel.

11. The Scheme's Scope

For a full list of antigens (examined using ICC) and genes (examined using ISH) that are able to be assessed by UK NEQAS ICC & ISH (its Scope), please refer to the Scheme's accrediting body's website:

www.ukas.com/wp-content/uploads/schedule_uploads/00013/7833Proficiency%20Testing%20Multiple.pdf

12. The Scheme's Modules: General Remarks

Laboratories are welcome to participate in any of the Modules, depending on their service commitments and specialised areas of interest. All modules offer **four** Assessment Runs per year. Participants are assessed on both the UK NEQAS distributed materials and participant's own in-house controls.

Participation in all Assessment Runs during the EQA year is expected.

The Scheme will make every effort to ensure that, where specified the stipulated requested markers and are assessed as stated but reserves the right to change them for suitable alternatives where circumstances require it to be done.

13. MODULE 1: GENERAL PATHOLOGY

REQUESTED ANTIGENS

- P63
- Chromogranin
- SMA
- GATA-3
- TTF-1
- E-Cadherin
- EMA
- AMACR/PIN-cocktail (Alternative PSA)

14. MODULE 2: BREAST PATHOLOGY HORMONAL RECEPTORS (ER AND PR)

REQUESTED ANTIGENS

- Oestrogen Receptor (ER)
- Progesterone Receptor (PR)

15. MODULE 3: BREAST PATHOLOGY HER2 IHC

Formalin fixed and paraffin processed cell lines showing the full range of HER2 IHC expression (3+, 2+, 1+ and 0) are generally used as the UK NEQAS assessment samples.

16. MODULE 4: LYMPHOID PATHOLOGY

REQUESTED ANTIGENS

- BCL2
- CD5
- MUM-1
- CD23
- CD79a
- PAX-5
- Kappa
- TdT

17. MODULE 5: NEUROPATHOLOGY

REQUESTED ANTIGENS

- ATRX
- Ki-67
- Synaptophysin
- Tau
- Prolactin
- IDH1
- FSH
- CD34

18. MODULE 6: CYTOPATHOLOGY

REQUESTED ANTIGENS

- ER
- PAN CK
- Melanoma Marker
- CD3
- PAN CK
- WT-1
- CD45
- TTF-1

Cytospin preparations or cell block sections are distributed by the Scheme dependent on the indicated participant preference.

Participants' in-house controls should preferably consist of complimentary preparations depending on the requested choice of sample for assessment, i.e. if you request a cytospin from us we will expect to see a cytospin in-house control, and similarly for cell block preparations.

19. MODULE 7: ALIMENTARY TRACT PATHOLOGY (GIST)

GOLD STANDARD AND SECOND ANTIGENS

The Gold Standard antigen will be:

- CD117 (c-KIT)

The second antibody/antigens (in assessment order) are shown below:

DOG-1
Desmin
CD34

20. MODULE 8: GASTRIC HER2 IHC

UK NEQAS distributed samples will consist of formalin-fixed paraffin-embedded gastric cancer tissue from excision samples showing varying levels of HER2 membrane protein expression.

21. MODULE 9: BREAST HER2 ISH (TECHNICAL AND INTERPRETIVE)

UK NEQAS distributed samples will consist of formalin-fixed paraffin-embedded breast tumour samples

22. MODULE 10: NSCLC ALK IHC

UK NEQAS distributed samples will consist of formalin-fixed paraffin-embedded lung tumour tissue from excision samples, and also cell lines with varying levels of ALK IHC expression. UK NEQAS samples will also include an appendix.

23. MODULE 11: NSCLC PD-L1 (PILOT)

UK NEQAS distributed samples will consist of formalin-fixed paraffin-embedded lung tumour

tissue from excision samples, and also cell lines with varying levels of PD-L1 IHC expression. NEQAS samples will also include a tonsil sample.

24. MODULE 12: NSCLC ALK/ROS1 FISH (PILOT)

UK NEQAS distributed samples will consist of formalin-fixed paraffin-embedded cell lines and/or lung tumour samples of known gene status.

25. MODULE 13: MISMATCH REPAIR PROTEINS

GOLD STANDARD

The Gold Standard antigens will be:

- MLH1 and PMS2
- MSH2 and MSH6

The antigen pairs will be requested at alternate Assessment Runs.

26. UK NEQAS ICC & ISH Contact Details and Personnel

Contact

Address all correspondence to the UK NEQAS ICC & ISH office:

UK NEQAS ICC & ISH,
Office 127, Finsbury Business Centre,40
Bowling Green Lane,
London EC1 0NE UK.
Telephone: (+44) (0)207 415 7065.
Email: info@ukneqasiccish.org

Alternatively, email or call the appropriate UK NEQAS ICC & ISH staff member using the contact details given in the Table below.

Name	Position	Telephone	Email
Andrew Dodson	Scheme Director	0207 415 7065	adodson@ukneqasiccish.org
Suzanne Parry	Scheme Manager	020 7415 7038	sparry@ukneqasiccish.org
Ai Lin Rhodes	Office Manager	020 7415 7065	arhodes@ukneqasiccish.org
Chris-Jude Quaye	Quality Manager	020 7415 7038	cjquaye@ukneqasiccish.org
Sumera Khalid	Scientist	0207 415 7181	sskhalid@ukneqasiccish.org
Nicholas Warrick	Scientist	0207 415 7181	nwarwick@ukneqasiccish.org
Marie Stoddart	Administrative Assistant	0207 415 7065	mstoddart@ukneqasiccish.org
Wendy Fernandes	Administrative Assistant	020 7415 7065	wfernandes@ukneqasiccish.org

Table 1: UK NEQAS ICC & ISH Personnel and their contact details.

27. UK NEQAS ICC & ISH Assessors

UK NEQAS ICC & ISH assessments are a team effort, our assessors are a key part of that team.

We rely very heavily on their expert help and advice and are very grateful to them.

The list shows names and locations of our current assessors (correct at the time this Manual was published).

United Kingdom
Mr C Abbott, Bristol
Mr D Allen, London
Dr M Arends, Edinburgh
Dr M Ashton-Key, Southampton
Mr D Blythe, Leeds
Dr C Cardozo, Lancashire
Dr L Carson, Aberdeen
Mrs A Clayton, Preston
Ms M Domingo-Arada, London
Mrs G Donald, Maidstone
Mr I Downie, Glasgow
Dr L Farmkiss, Portsmouth
Mr R Fincham, Cambridge
Mr D Fish, Southampton
Mrs S Forrest, Liverpool
Mr S Forrest, Liverpool
Dr I Frayling, Cardiff
Dr C Gillett, London
Mrs L Govan, Lanarkshire
Dr L Gudur, Preston
Dr J Gupta, Maidstone
Dr A Haragan, Liverpool
Mr J Hughes, London
Prof R Hunt, Stockport
Dr N Johnson, Cambridge
Ms S Jordan, London
Dr J Joseph, Preston
Mrs L Kane, Glasgow
Ms K Kennedy, Belfast
Mrs S Saleem Khalid, London
Dr G King, Aberdeen
Mr J Linares, London
Ms A Long, Newcastle
Mrs J MacMillan, Glasgow
Mr Colin Marsh, Newcastle
Dr B Mahler-Araujo, Cambridge
Dr P Maxwell, Belfast
Ms H McBride, Belfast
Mr J McGloin, London
Dr A Merve, London
Dr A Miremadi, Cambridge
Ms A Newman, Brighton
Dr G Orchard, London
Dr D Pandit, Lancashire
Dr A Paton, Glasgow
Ms A Patterson, Belfast
Prof S Pinder, London
Dr M Pitt, Preston
Mrs J Pritchard, Birmingham
Dr E Provenzano, Cambridge
Mr C Quaye, London
Mrs F Rae, Edinburgh
Dr A Riley, Stirling
Mr G Rock, Birmingham
Ms R Sardinha, London
Ms P Singh, Cambridge
Mrs L Skaetes, Cambridge
Dr J Starczynski, Birmingham
Dr P Taniere, Birmingham
Mrs J Terry, Halifax
Mrs C Thomas, Preston
Mrs K Thwaites, London
Ms G Valentine, London
Dr R Vaziri, Birmingham
Mr N Warrick, London
Mr P Wells-Jordan, Leicester
Dr P Wencyk, Nottingham
Mrs H White, London
Ms M Whitney, Nottingham
Mrs J Williams, Portsmouth
Brazil
Dr N Pinheiro, Salvador
Germany
Dr Iris Nagelmeier, Kassel
Republic of Ireland
Mr K McAllister, Dublin
Ms D McMahon, Dubl
Dr T O'Grady, Dublin
Netherland
Dr E Erik Thunnissen, Amsterdam
Portugal
Dr J Cabecadas, Lisbon
Mr A Ferro, Lisbon
Mrs T Pereira, Lisbon
Mr R Roque, Lisbon
Mr J Matos, Lisbon
Ms S Moliveira, Lisbon
Slovenia
Mrs S Gabric, Ljubljana
Mrs I Kirbis, Ljubljana
Mr D Vidovic, Maribor
South Africa
Mrs R Van Wijk, Cape town
Switzerland
Dr Pierre-Andre Diener, St Gallen
Dr L Tornillo, Basel
Saudi Arabia
Dr T Khan, Saudi Arabia

29. Replacement slides

Replacement slides for those which arrive broken may be obtained by contacting Marie Stoddart or Wendy Fernandes in the UK NEQAS ICC & ISH office. Please include your Participant Code and the reason why you are requesting replacements.

Email: info@ukneqasiccish.org; Telephone: +44(0)20 7415 7065

30. Appeals and Help

Participants who are not satisfied with their scores can appeal, and have their slides reassessed.

Reassessments take place at the first assessors meeting after receipt of the request. If the reassessment scores are different from the original ones, the score sheets and database are amended accordingly and the participant is sent amended scores and a letter of explanation.

An appeal can only be made from the most recently completed run.

Only originally submitted slides will be reassessed. We are unable to reallocate or update marks on newly stained slides.

A Reassessment form can be found on the UK NEQAS ICC & ISH website.

Participants experiencing technical difficulties or requiring information about a particular antibody or reagent are encouraged to contact the Scheme

UK NEQAS ICC & ISH is always ready to assist with advice and troubleshooting.

Participants are welcome to send in slides asking for feedback and advice at any time (a Referral Request form can be downloaded from our website). Do not use the UK NEQAS ICC & ISH reassessment forms for this service.

Ideally, all laboratories experiencing difficulties should contact the scheme for advice well before poor performance monitoring mechanisms are triggered.

31. Complaints Procedure

Formal complaints about the service (**not an appeal against your score**) offered by UK NEQAS ICC & ISH must be addressed to the Scheme's Director, Mr Andrew Dodson; please use the official complaint form which also has the scheme Director's contact details. The document is available from our website. (Do not use this form if requesting a reassessment).

32. Confidentiality Policy

UK NEQAS ICC & ISH maintains the confidentiality of a participants' performance results at all times; except where the scheme is obliged to inform regulatory bodies (NQAAP) of UK clinical laboratories that are persistent poor performers; this is to ensure that patient safety is not endangered.

During assessments, and at any subsequent use of data for educational purposes, the participants' identity is never disclosed

Linkage of the unique participation code with the identity of the centres is only available for selected UK NEQAS ICC & ISH staff members.

Where a third party or an interested party enquires about the use of an individual participants' data, this will only be disclosed if the participant waives its right to confidentiality. UK NEQAS ICC & ISH may provide anonymised data to third parties that have a direct involvement in UK NEQAS ICC & ISH.

If UK NEQAS ICC & ISH is legally obliged to provide data, to a regulatory body or another organisation, the participants will be informed in all such instances.

33. Associated Schemes

Cellular Pathology Techniques

Participants are assessed for the quality of their staining preparations in both Haematoxylin and Eosin stained sections and special staining methods. For further information please contact the Scheme's using its general contact email address: cpt@ukneqas.org.uk or contact the Scheme Manager: Mrs Chantell Hodgson; chantel.hodgson@ghnt.nhs.uk

Molecular Pathology

GenQA provides an EQA service for a variety of molecular tests on a range of diseases. Test are carried out on the patient tumour samples providing an EQA service for a variety of molecular tests, including, Non-small cell lung cancer, Colorectal cancer, Melanoma, and Gastrointestinal Stromal Cancer. For further information please contact Dr Sandi Deans (Scheme Director); sandi.deans@ed.ac.uk

34. Steering Committee for Technical EQA Schemes in Cellular Pathology

Chairperson: Mr Alex Javed
Service Manager. Laboratories and Radiology, NHS Highland, Inverness, Scotland
Email: alex.javed@nhs.net

35. General Terms and Conditions

An active participant (laboratory, organisation or individual) subscribed to our services, agrees to, and acknowledges the following:

- Inform UK NEQAS ICC & ISH of any change of personnel or contact details
- Always quote your unique participants' code whenever contacting UK NEQAS ICC & ISH
- Ensure slides are securely packaged to prevent breakages and possible non-assessment, and returned in the correct labelled slide boxes to aid sorting
- Ensure slides are clearly labelled, and concealing your site's identity where appropriate
- Adhere to submission deadlines – late submissions will be logged by the scheme
- Prompt payment of subscription fees, your account may be suspended if payment is not received
- Antibody repertoires, non-declaration of this may lead to a non-submission (0 score) and possible poor performance issues
- Follow specific staining requirements for each of the subscribed modules
- Complete entry of methodology protocols
- Declares that the methodology submitted is the same method used in the routine

setting of the laboratory

- Producing local procedures for EQA, including the handling and interpretation of results
- Respect the anonymity and confidentiality aspect of EQA when corresponding with other laboratories
- Suspected collusion and/or falsification of results, data or manipulation of EQA slides will result in the participant/s being suspended from UK NEQAS ICC & ISH
- UK NEQAS ICC & ISH requests as wide a range of markers for each module as possible but cannot cover all antigens or tissue types. Participants should have their own alternative performance assessment activities to cover their repertoire
- Provided assessment results, although confidential to each participant, may be used by the participant as they see fit (e.g. printed, placed on website etc). However, under no circumstances

If individual reports are used in any form then the accompanying statement should be included:

"Participation in UK NEQAS ICC & ISH is not an indication of the overall performance of the participant (laboratory, organisation or individual), and as such is not an endorsement of the overall quality of staining produced".

36. Selected References

Recent Publications from the Scheme

- Dodson A, Parry S, Ibrahim M, et al. (2018). Breast cancer biomarkers in clinical testing: analysis of a UK national external quality assessment scheme for immunocytochemistry and in situ hybridisation database containing results from 199 300 patients. J Pathol Clin Res. 2018 Oct;4(4):262-273.
- Dodson A, Parry S, Lissenberg-Witte B, et al. (2019). External quality assessment demonstrates that PD-L1 22C3 and SP263 assays are systematically different [published online ahead of print, 2019 Dec 17]. J Pathol Clin Res. 2019;10.1002/cjp2.153. doi:10.1002/cjp2.153

The host organisation of the UK National External Quality Assessment Scheme for Immunocytochemistry and In-Situ Hybridisation is External Quality Assessment Services for Cancer Diagnostics.

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