TRUST WIDE/DIVISIONAL DOCUMENT	
Delete as appropriate	**Clinical Guideline**
DOCUMENT TITLE:	**Surrogacy**
DOCUMENT NUMBER:	**G58 v3**
DOCUMENT REPLACES Which Version	**G58 v2.1**
LEAD EXECUTIVE DIRECTOR DGM	**Divisional General Manager**
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TARGET AUDIENCE:	**Medical Team, Nursing and Midwifery Team**
DOCUMENT PURPOSE:	Guidance for the care of surrogates and intended parents in surrogate births
To be read in conjunction with (identify which internal documents)	Capacity Confidentiality

SUPPORTING REFERENCES	Care in Surrogacy, Department of Health 2018 Screening Tests for You and Your Baby. Public Health England 2017 Human Fertilisation and Embryology Authority (HFEA) 2017 Code of Practice

CONSULTATION		
	Committee/Group	Date
Consultation		
Approval Committee	Womens and Newborn QSB	July 2019
Ratification date at WNQSB	11th July 2019	
NEXT REVIEW DATE:	July 2022	
AMENDMENTS:	Full review, no amendments December 2018 – extension July 2019 – full review	

Introduction

Purpose of Guideline

To support all staff when caring for surrogates and intended parents (IPS) during the antenatal, intrapartum and postnatal period.

Key terminology

Intended parents (IPS)

These are couples who are considering surrogacy as a way to become a parent. They may be heterosexual or same-sex couples in a marriage, civil partnership or living together/co-habiting in an enduring relationship. To apply for a parental order (which is the way that legal parenthood is transferred from the surrogate to the IPs) at least one of the IPs in a couple must be a genetic parent of the child born to them through surrogacy. IPs generally prefers to be referred to as the parents of the child.

Surrogate

This is the preferred term for women who are willing to help IPs to create families by carrying children for them. A surrogate may or may not have a genetic relationship to the child that she carries for a couple. Surrogates generally do not prefer to be referred to as the mother or parent of the child.

Straight surrogacy

Straight (also known as genetic, full or traditional) surrogacy is when the surrogate provides her own eggs to achieve the pregnancy. One of the IPs provides a sperm sample for conception through either self-insemination away from a licenced setting or artificial insemination with the help of a fertility clinic. Self-insemination does carry risks if the sperm has not been screened for infections. If either the surrogate or IP has fertility issues or prefers a more clinical environment, then embryos may also be created in vitro and transferred into the uterus of the surrogate.

Host surrogacy

Host (also known as gestational or partial surrogacy) is when the surrogate doesn't provide her own egg to achieve the pregnancy. In such pregnancies, embryos are created in vitro and transferred into the uterus of the surrogate using the gametes of at least one IP, plus the gametes of the other IP or a donor, if required.

Key principles

Altruistic surrogacy is a positive option for those seeking to start a family through assisted reproduction in the UK.

• The safety and health of the surrogate and child will always be of paramount importance.

• The vast majority of surrogacy cases are straightforward, positive and rewarding experiences; disputes between parties are very rare.

• The actions and attitudes of healthcare staff can have a significant impact on the experiences of surrogates and IPs. Surrogates can be stigmatised and IPs have often been through distressing experiences before turning to surrogacy, so compassion, dignity and sensitivity are important. Perceived negative attitudes can cause particular stress or distress.

• Surrogates and IPs should be treated in the same way as any other patients accessing healthcare during pregnancy and birth whilst recognising that there may be particular characteristics, such as LGBT+ status, that may require a more tailored approach.

• A co-ordinated, consistent but flexible approach is important.

• It is important to ensure the involvement of all parties in information-giving and decision-making wherever safe and practicable to do so, if this is something the parties have agreed to.

• Surrogacy should have comprehensive, trust-based agreements between the surrogate and IPs (known as surrogacy agreements), which cover most eventualities and desired outcomes; these should be reflected in birth plans and engagement with healthcare staff.

• It would be usual practice for the IPs to be treated as the parents of the child, subject to the agreement of the surrogate (and her partner, if she has one), and that the surrogate does not see herself as the mother.

1.Legal context and general guidance

1.1 Legal position of surrogacy

Altruistic surrogacy is an established and legal way of creating a family in the UK. Surrogacy agreements are not legally enforceable and the IPs need to apply for a parental order after their child is born in order to become the legal parents of the child. The legal framework allows for a surrogate to receive reasonable pregnancy-related expenses from IPs, as assessed by the family court.

Surrogacy through commercial means is illegal in the UK (Surrogacy Arrangements Act 1985). It is an offence for an individual or agency to act on a profit-making basis to organise or facilitate surrogacy for another person. Any persons or organisations that organise or facilitate surrogacy must do so on a non-commercial basis. Where staff have suspicions that there is a commercial arrangement, they should contact their Lead for Safeguarding Children for further advice and guidance.

1.2 Legal parenthood in surrogacy

The surrogate is the legal mother of the surrogate child from birth until legal parenthood is transferred to IPs through a parental order made by a family court. If the surrogate is married or in a relationship, her partner will also assume legal parenthood status of the child from birth until the parental order is made. IPs can start the process to obtain a parental order from six weeks until six months after the birth if certain criteria have been

met, including the child being in their care, having the consent of the surrogate and at least one IP being genetically related to the child. The parental order process is normally straightforward and it is usual for a child to be cared for by the IPs from birth (with the surrogate's consent).

If the conception in a surrogacy arrangement takes place in a licenced clinic and the appropriate consent forms are completed, if the surrogate is not married, the IP who provides the sperm can be registered as the legal father on the birth certificate. A parental order would still be necessary to transfer the legal parenthood of the second IP.

1.3 Role of surrogacy agreements

A surrogacy agreement is a document often drawn up by surrogates and IPs (prior to conception) that sets out how the parties intend to: i) conceive and manage the pregnancy and birth; and ii) care for the child post-partum. A comprehensive surrogacy agreement would cover all eventualities and decision-making events, for example how the termination of a pregnancy should be handled.
Whilst surrogacy agreements are not legally enforceable and do not override other legal obligations, they can be used by staff to guide the provision of healthcare to the surrogate and child. A surrogacy agreement may also contain information on non-healthcare related matters and so staff should handle the document with sensitivity and treat it as confidential patient information.

If a surrogacy agreement has not been drawn up then the parties should be encouraged by staff to prepare one and be advised that support is available, should they wish for it, from one of the national altruistic surrogacy organisations (Surrogacy UK, COTS and Brilliant Beginnings).
Healthcare staff have a duty of care, as when supporting any other pregnant woman, to the surrogate and they should ensure that she has given her consent to any agreement regarding her care. Staff may wish to consider contacting the Lead for Safeguarding Children for further advice and guidance if they have any concerns.

During care provision, best practice should be observed with the surrogate having an opportunity to be seen alone by a healthcare professional. This affords opportunity for routine and confidential discussion regarding social concerns (i.e. domestic abuse), physical or emotional well-being or any issues that may not otherwise be disclosed if accompanied.

1.4 Confidentiality

Staff should make sure that any consent to share information are recorded, and they should take care to confirm any point where confidentiality may be an issue. Staff should refer to ELHT Confidentiality Policy C077.

1.5 Disputes

Disputes in surrogacy are rare. Where the parties are being supported by one of the national altruistic surrogacy organisations, the organisation will usually offer assistance and support to help resolve any difficulties.
Healthcare professionals should attempt to work with the surrogate and the IPs at all times. In the event of an unresolvable dispute, the surrogate's wishes must be

respected, regardless of what is set out in any surrogacy agreement or consents that may previously have been provided.

If the surrogate changes her mind and wishes to keep the child herself or no longer wishes to transfer the child to the IPs, then staff must respect this and should ensure accurate notes of the circumstances are kept. If the IPs want to challenge this situation, then it will be a matter for the family courts to decide.

If the IPs change their minds and no longer want to keep the child, then parental responsibility remains with the surrogate as the legal parent of the child (and her partner if she has one). In the event that the surrogate is not prepared to take responsibility for the child, then social services should be contacted in the usual way.

If staff have any concerns about the welfare of the child, they should follow standard procedures for making a risk assessment, involving other appropriate agencies and invoking child protection procedures (if applicable). A 'welfare of the child' assessment should have been carried out for any fertility treatment, in line with the HFEA's Code of Practice.

Staff may wish to consider contacting the Lead for Safeguarding Children for further advice and guidance if a dispute continues or a concern arises and refer to ELHT Safeguarding Children Policy CO38

1.6 Mental Capacity

Staff should refer to ELHT Mental Capacity Act Policy 2018 C082.

2 Pre-birth

2.1 Antenatal care

Antenatal care should be delivered in accordance with relevant clinical guidance which is based on individual risk assessment, in the usual way. Referral should be made for an consultation with an obstetrician. Requests set out in the surrogacy agreement or agreed between the surrogate and the IPs should be considered and accommodated, wherever possible.
Staff should be satisfied that the surrogate consents to the sharing of information and/or attendance at appointments.

2.2 Antenatal screening for infectious diseases

The Code of Practice guidance from the Human Fertilisation and Embryology Authority sets out the expectations for fertility clinic screening and outlines the requirements for testing for HIV and Hepatitis as well as other transmissible infections (https://www.hfea.gov.uk/code-of-practice/).

Where treatment has been provided in a licensed fertility clinic, the gamete providers will be tested for HIV, hepatitis and other transmittable infections. They will also be screened for blood karyotyping and cystic fibrosis, as well as other applicable genetic tests. The surrogate will also be tested for these infections, as part of the patients' screening requirements. Sperm is required to be quarantined for six months.

With self-insemination, however, there is a risk of transmission of infection to the surrogate and/or unborn child. It is therefore important that the surrogate (and her partner if she has one) is advised of this risk and offered testing accordingly, prior to or after conception. The IPs should be included in this counselling and decision-making if the surrogate has given her consent.

If the surrogacy is supported by one of the national altruistic surrogacy organisations and self-insemination is to be used, then parties are likely to have undertaken screening prior to joining. A risk could still exist at the point of conception, however, so this guidance recommends that the surrogate and intended father/donor be tested again prior to self-insemination.

Should the surrogate be identified as having a transmittable infection, then the usual counselling should be given regarding the risks of vertical transmission of infection and any recommended steps at birth to minimise the risk. Where the surrogate has given her consent, the IPs should be included in this counselling. Where one or both of the IPs is identified as having a transmittable infection, then they should be informed and advised to seek medical advice and treatment.

2.3 Antenatal screening for fetal abnormailities

All applicable and routine antenatal screening tests for anomalies will be offered to the surrogate in the usual way. Should any anomalies be identified, staff should discuss this with the surrogate and, where the surrogate has given her consent, the IPs should be included in counselling, decision-making and information sharing.

2.4 Termination of pregnancy

Where a termination of pregnancy is being considered and the relevant legal conditions are met, the surrogate makes any final decision about a termination. If the surrogate discloses that she is considering termination, then she should be referred to a counsellor and the relevant healthcare professionals in accordance with the gestation period of the pregnancy. The IPs should be included in this counselling, information sharing and decision making if the surrogate has given her consent.

3 Birth planning

A surrogacy birth plan is normally prepared by the surrogate and IPs with the support of the health care professional. This sets out the many issues commonly found in birth plans, such as: preferred method of birth; who will be present at the birth; who will hold the baby after birth; infant feeding choice and who will make decisions about the child's welfare.
Every effort should be made to accommodate all reasonable requests, making sure that other existing policies and procedures do not have the unintended consequence of blocking the wishes of the surrogate and IPs. Effective communication (with the appropriate consent) may be necessary with other departments and services.

With the agreement of the surrogate, a copy of the completed birth plan should be filed in the hospital records and brought to the attention of the Head of Midwifery. It is also good practice to request a copy of the treatment summary if the conception took place in a fertility centre.

Whether a vaginal birth or a caesarean section birth is planned, the surrogate and the IPs should be supported by healthcare staff to outline, in the surrogacy birth plan, if the surrogate wishes for the IPs to be in attendance. Early planning by healthcare staff should enable such preferences to be discussed and accommodated, with acceptance that it is equally important for the surrogate to be supported by her chosen birth partner as it is for the IPs to be present during the birth of their baby. Where possible, such requests should be accommodated to promote immediate bonding between the IPs and the baby, with skin-to-skin contact also being supported.
The birth plan should also outline the wishes of the surrogate and the IPs should transfer to the operating theatre be necessary (i.e. if an instrumental delivery or an emergency caesarean section is required). Ultimately, under these circumstances, it should be accepted that the health professionals will make the decision with regards to who can be in attendance in accordance with clinical care needs being prioritised.

Consideration in the birth plan should be given to the points listed in Appendix A.

4 Post-birth

4.1 Immediate postnatal care

Postnatal care related to a surrogate birth will usually be very different to other births. Often the surrogate will consider her role to be finished after the birth and wish to be discharged independently of the child. Usually the child will be fully cared for by the IPs from birth and so parenting support, advice and decision making should be directed to them until they are discharged with the child. Whilst this is what often happens, it is not universal and it is very important to ensure that the parties agree (this is likely to have been agreed in advance and set out in the surrogacy agreement if there is one).

In the event that staff have concerns about the welfare of the child, they should ensure that these are raised and actioned in accordance with the appropriate safeguarding policies. If a surrogacy agreement hasn't yet been prepared or doesn't cover the full range of issues, the surrogate and IPs should be encouraged to complete one.

Every effort should be made to fulfil all reasonable requests regarding post-natal care, which may include a desire for the surrogate and IPs (with child) to be accommodated separately, but with access to each other after the birth. Wherever possible, it may be advantageous for surrogates and IPs to be accommodated away from the other mothers on the post-natal ward to maintain privacy at a sensitive time. Attention should be given to ensuring that other existing policies and procedures don't have the unintended consequence of blocking the wishes of the surrogate and IPs, for example: the need for the child to be cared for by one or both IPs should not be limited by normal visiting hours or restrictions on overnight stays (previously this has been found to be an issue for male, same-sex IPs). However, consideration for the needs of other patients must be considered sensitively.

Since the surrogate remains the legal mother at birth, staff should ensure they are satisfied that she consents to the provisions within the surrogacy agreement and that the postnatal arrangements, including any delegations she has made to the IPs, are written clearly in the medical notes.

Whilst it is often the case for a surrogate child to be transferred to the IPs at birth, the written consent of the surrogate should be obtained if the child is to be discharged with the IPs and independently of her (Appendix B).

If the child and surrogate are discharged at different times and the child is not already being cared for by the IPs, transfer of the child to the IPs should happen in an appropriate place on the hospital premises. In other words, the parties should not be forced to leave the premises in order to complete this transfer. Under no circumstances should the child be discharged with the IPs without the surrogate's consent. There is no need to inform a social worker or lead for safeguarding unless staff determine that either party may be experiencing difficulty or there is some other reason that staff consider a social worker should be contacted.

4.2 Treatment of sick or preterm neonate

Where the surrogate has given her consent for IPs to care for the child and this has been included in the surrogacy arrangement, it is usual practice for the IPs' wishes to be considered by staff regarding the treatment of a sick child and for them to be included in any important decisions regarding the health of that child whilst recognising that the surrogate has the overall responsibility until a parental order has been issued. The written consent of the surrogate should be provided which delegates treatment-related decision-making to the IPs and this should be clearly recorded in the medical notes again taking into consideration the legal framework for who can legally make those decisions.

As with all other aspects of surrogacy care, however, the surrogacy agreement should be reviewed to confirm that this is the approach the parties wish to adopt. If a surrogacy agreement has not yet been prepared or does not cover the full range of issues, then the surrogate and IPs should be encouraged to complete one.

4.3 Community support following discharge

The surrogate should be provided with all discharge information relating to her aftercare. This includes information about follow-up care and appointments which may be via the team midwife, GP or hospital team. When discharged from hospital this should be communicated to the team midwife, GP and Health Visitor in the normal way.

The IPs and child will require a midwife to visit them and the child's discharge should be communicated to the midwife, health visitor and GP in the normal way. If this is an out-of-area discharge then the IPs' address and telephone number along with names and contact details of their local hospital, Midwives, Health Visitors and GP details should be recorded in the antenatal records. Documentary evidence should be in the neonates notes relating to consent to routine screening and care in the post-natal period.

East Lancashire Hospitals NHS Trust

Appendix A

Checklist for Surrogacy Documentation

The following checklist should be adhered to for all surrogate births. A thorough risk assessment should be carried out, and any reasons or potential problems that may deviate from the usual surrogacy pathway should be documented clearly.

Antenatal period

A senior midwife in antenatal clinic should be located to ensure all documentation is completed and is the named contact for the parties involved.

	Signed	Date	Comments
A birth plan is completed with the surrogate's (and IPs' if appropriate) wishes for the birth/postnatal period, which should include the surrogate's wishes for the IPs (for example, whether to be present at the birth/during postnatal inpatient stay).			
The preferred terminology is agreed with both the surrogate and IPs and clearly documented in the maternity notes.			
All parties are aware of how medical consent and informed consent works.			
Clearly document within the birth plan all aspects of surrogacy including what the surrogate and IPs have agreed in terms of participation and decision-making.			
Full contact details for the IPs are recorded in the medical notes			
Names, contact numbers, home address in medical notes			
Address / fax / telephone numbers for the following: - Local maternity hospital; - Community midwives - Health visitors; - Local GP surgery documented in medical notes			
Lead midwives in clinical areas notified of plan for sharing with relevant staff			

Intrapartum

• The midwife caring for the surrogate and all team members must have had the opportunity to read the notes and are aware of the situation.
• Ensure that the surrogate's wishes for the IPs are clear (for example, whether to be present at the birth/during postnatal inpatient stay).

Post-natal period

• The postnatal ward staff are clear of the surrogate's wishes relating to the IPs and a realistic expectation regarding plans for accommodating the surrogate's wishes, and those of the IPs is achieved.
• The agreement between the surrogate and IPs regarding the care of the child is clearly documented in the maternity notes and the new-born notes including the recording of any necessary consent by the surrogate for the IPs to make decisions about the baby (note that the existence of a surrogacy agreement does not override any subsequent decision by the surrogate who remains the child's legal mother until parenthood is transferred).
• Check discharge details for the IPs:
• Names, contact numbers, home address - Address / fax / telephone numbers for the following:
- Local maternity hospital;
- Community midwives;
- Health visitors; and
- Local GP surgery.

To ensure that both the surrogate and child receive follow-up care in the community, please:
• handover the surrogate's details to her Community Midwife and GP; and
• handover the child's discharge details to the Community Midwife and GP of the IPs.

Once completed this should be documented in the medical notes.

Staff should ensure that correct protocols are followed if any concerns arise with regards to the surrogate, IPs or child.

Appendix B

Surrogacy Arrangements – Handover of Baby Form

Hospital Number .....DOB.....

First Name .....M / F.....

Last Name .....

I ……
(print name)

place the care of my baby, born on…….

in the care of……

Address: .....
.....

Contact number: .....

GP: .....

Signed:……

Witnessed by:…….

Date: .....

Handover of baby form – to be filed in mother's hospital records