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Care of Families involved in Surrogacy

Introduction and Aim

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared tojustify any deviation from this guidance

This guideline has been developed to provide the multi-agency team with clear guidance to provide appropriate maternity care for women involved in surrogacy whilst maintaining awareness of the position of the intended parents (IPs). The safety and health of the surrogate and child will be of paramount importance.

Objectives

The purpose of this guideline is to reinforce the need for all staff to be aware of security and safety of babies whilst in under the care of Maternity Services, whilst ensuring the pregnancy and parenthood journey for involved parties is supported.

Scope

This procedure applies to all of our staff in all locations including those with honorary contracts

Equality Health ImpactAssessment	An Equality Health Impact Assessment (EHIA) has been completed. The Equality Impact Assessment completed for the policy found here to be a positive.
Documents to read alongside this Procedure	Safeguarding an unborn child: A guideline for practice
Approved by	Maternity Professional Forum

Accountable Executiveor Clinical Board Director	*Jason Roberts, Executive Nurse Director*
Author(s)	Sarah Spencer Deputy Head of Midwifery

Disclaimer
If the review date of this document has passed please ensure that the versionyou are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	Date of Review Approved	Date Published	Summary of Amendments
1		2016	New Document
2	10/07/2020	13/07/2020	Reviewed and amended by Sarah Spencer
3	25/01/2024	30/03/2024	Reviewed and amended by Alys Gower

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The words woman and women have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. We recognise maternity and gynaecological services will be accessed by women, gender diverse individuals and those whose gender identity does not align with the sex they were assigned at birth or have a non-binary identity. Therefore, we believe delivery of care must at all times be appropriate, inclusive and sensitive to the needs of everyone (RCOG 2022).

1. Introduction

A surrogate pregnancy is when a woman or birthing person (the surrogate/gestational carrier [GC]) helps intended parent(s) (IP/s) to create a family by carrying a child for them. A surrogate may or may not have a genetic relationship to the child that she carries. Surrogates generally do not want to be referred to as the mother or parent of the child (DHSC, 2021).

Commercial surrogacy is illegal in the United Kingdom. Instead, families and surrogates enter altruistic arrangements with reasonable expense costs covered.

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2. Types of Surrogacy

1) *Straight (genetic, full or traditional) surrogacy*. This is where the surrogate provides her own egg, which is fertilised with an intended father's sperm; this may be done by self-insemination or in a fertility clinic.

2) *Host (gestational or partial) surrogacy*. The surrogate does not provide her own egg to achieve the pregnancy. Embryos are created in vitro using the gametes of at least one IP.

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3. Legal Parenthood in Surrogacy

The surrogate is the legal mother of the child until legal parenthood is transferred to the IP(s) through a parental order or adoption, applied for after the child is born. If the surrogate is married or in a relationship, her partner will assume legal parenthood status of the child from birth until the parental order or adoption is complete. A parental order can be applied for from 6 weeks until six months after birth if certain criteria are met:

- The child must be in the care of the IP(s)
- The surrogate must give consent
- At least one of the IPs must be genetically related to the child

If the conception takes place in a licensed clinic and

- The surrogate is not married
- The appropriate consent forms are completed

Then the IP who provides the sperm can be registered on the birth certificate as the legal father. A parental order will still be necessary to transfer the legal parenthood of the second IP if there are two.

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4. General guidance

Healthcare professionals have a duty of care to the surrogate (as when supporting any other pregnant woman) and they should ensure that she has given her consent to any agreement regarding care.

Please be mindful and sensitive to the many reasons why IP(s) turn to surrogacy. These include:

- Recurrent miscarriage
- Repeat failure of IVF/fertility treatment
- Premature menopause, often as a result of cancer treatment
- A hysterectomy or an absent or abnormal uterus
- A serious risk to health that may result from pregnancy
- LGBT+ parent(s) wanting to create a family.

The multi-professional team should be non-judgmental to ensure a good relationship based on trust is established.

The surrogate should have the opportunity to be seen alone at least twice to ensure anyconfidential discussions can be had i.e. domestic abuse.

Confidentiality is important and staff need to ascertain what information can be shared with the IP(s) and this should be documented.

If there are safeguarding concerns/a medical emergency, confidentiality can be broken if the correct procedures are followed (Working Together to Safeguarding Children 2023).

Details of the surrogacy agreement should only be documented in the health care records if the surrogate consents.

The Consultant Midwife team should be informed so that care can be facilitated.

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5. Safeguarding Considerations

If the fertility treatment has been undertaken by a licensed clinic, midwives and professionals can be assured that the treatment will have been in accordance with the Code of Practice (HFEA 2019). It is advised that written evidence from the fertility clinic is obtained. The IP(s) should have written confirmation from the licensed centre of the genetic relationship to the child and the fact that their treatment involved the surrogate. It is preferable that as far as possible this information is obtained by the people involved.

If the IP(s) change their minds about caring for the child, the surrogate (and her partner) will be legally responsible for the child. In the event that the surrogate also refuses to take on the responsibility, a referral should be made to Social Services.

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6. Antenatal Care

Antenatal care should be delivered in accordance with relevant clinical guidance which is based on an individual risk assessment. Requests set out within a surrogacy agreement should be considered and accommodated wherever possible. If a surrogacy agreement has not been written or is not comprehensive the surrogate and the IP(s) should be encouraged to write one. Staff should be aware that any contracts or agreements signed/entered into before the child is born are not legally binding and should only be used as a guidance.

Please ensure referral to a Consultant Midwife at an early stage in the pregnancy to support the families and facilitate care. Every effort should be made to accommodate all reasonable requests. The Consultant Midwife overseeing care will work with the surrogate and IP(s) to develop a comprehensive birth plan including considerations for intrapartum and postnatal care, which will be made available to involved parties and the multidisciplinary team and attached to the surrogate's electronic maternity record (see appendices).

Arrangements for baby care following birth should be discussed with the surrogate and IP(s) between 34-36 weeks' gestation and ensure that this is clearly documented in the birth plan.

Communication with the Health Visitor(s)/midwife(s) who will care for the surrogate and intended parents should occur during the antenatal period and be documented.

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7. Intrapartum Care

The birth plan (see Appendix B) should outline whether the IP(s) will be in attendance during thebirth and every effort should be made to accommodate these wishes noting clinical care needs will be prioritised.

Computerised records should be completed as normal and with consent it should be noted that this is a surrogate birth. The baby should be registered in the hospital PMS system as normal.

The baby and surrogate should be identified following usual hospital procedures. Additional ID bands for baby that match the IP can be created in addition to but not in place of the baby and surrogate ID bands.

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8. Postnatal Care

Clinically appropriate postnatal care should be provided to the surrogate and the baby. Consent for medication/screening of the baby must be obtained from the surrogate, even if the baby is in the care of the intended parents. Please see Appendix C for template consent form. Copies should be filed in surrogate's maternal notes, neonatal notes and copies to remain with IP(s) and baby following discharge home.

Please ensure prolactin inhibitor medication (e.g. Cabergoline) has been offered to the surrogate and lacto-suppressant expectation/management discussed, if required.

Consent for immediate Vitamin K administration should be confirmed with the surrogate following delivery.

The surrogate will need to provide written consent for new-born screening (e.g. bloodspot screening) if this is to be performed in the community setting following discharge. It is appropriate to obtain this prior to the surrogate leaving hospital (Appendix C).

If the surrogate has given her consent for the IP(s) to care for the child, it is best practice for their wishes to be considered by staff when caring for a sick child, and to include them in any decision making whilst recognising that the surrogate has overall responsibility until a parental order has been issued (BMA 2008).

The IP(s) should be supported to care for the baby. They are not admitted to the hospital as patients but should be regarded as the parent(s) of the baby and accommodated in a private room as acuity allows.

The community midwife, GP and Health Visitor for the IP(s) should be informed of the birth and arrangements for the baby as soon as practicable.

Transfer to the Health Visitor should ensure continued seamless care for the surrogate, the baby and the IP(s). This may be to an area outside of Cardiff and Vale University Health Board.

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9. Sources of advice and support

- Consultant Midwife lead for surrogacy
- Safeguarding Lead Midwife
- Senior Midwifery Team
- Operational Lead

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10. References

The British Medical Association (BMA) 2008. Parental responsibility, Guidance from the British Medical Association [online] Available: Parental responsibility (bma.org.uk) [Accessed 25 Jan 2024]

Dept. Health and Social Care (2021) Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales [online] Available: Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales - GOV.UK (www.gov.uk) [Accessed 25 Jan 2024]

HM Government (2023) Working Together to Safeguard Children 2023 [Online] Available: Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk) [Accessed 25 Jan 2024]

The Human Fertilisation and Embryology Authority (HFEA), 2019. Code of Practice. [online] Available: Read the Code of Practice | HFEA [Accessed 25 Jan 2024

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11. Appendix A: Checklist for surrogacy care

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

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12. Antenatal period

Please ensure that the following information is collected, signed and datedand place within the surrogate's notes.

	Signature	Date
Refer to Consultant Midwifery team for discussion and planning for intrapartum and postnatal care of involved IP(s), baby and surrogate.		
Ensure that preferred terminology is agreed with both the surrogate and IP(s) and clearly documented in the maternity notes.		
Ensure that all parties are aware of how medical consent and informed consent works.		
Clearly document all aspects of surrogacy including what the surrogate and IP(s) have agreed in terms of participation and decision-making.		
Clearly document any consents that the surrogate has given, e.g. consent to share information with the IP(s) and parenthood consents.		
Ensure that full contact details for the IP(s) are recorded: • Names, contact numbers, home address • Address / telephone numbers for the following: - Local maternity hospital - Community midwives - Health visitors - GP surgery		

13. Intrapartum (see Appendix B)

- The Consultant Midwife overseeing care will discuss and support creation of a birth plan (see appendix B) which will be made available to IP(s), surrogate and relevant team members.
- The birth plan will ensure that the surrogate's wishes for the IP(s) are clear (for example, whether to be present at the birth/during postnatal inpatient stay)

14. Early post-natal period

	Signature	Date
Ensure that the postnatal ward staff are clear of the surrogate's wishes relating to the IP(s) and a realistic expectation regarding plans for accommodating the surrogate's wishes, and those of the IP(s) is achieved.		
Ensure that the agreement between the surrogate and IP(s) regarding the care of the child is clearly documented in the maternity notes and neonatal notes, and clearly record any necessary consent by the surrogate for the IP(s) 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). Please refer to Appendix C.		
Check discharge details for the IP(s): ❖ Names, contact numbers, home address ❖ Local maternity hospital; ❖ Community midwives ❖ Health visitors ❖ GP surgery		
To ensure that both the surrogate and child receive follow-up care in the community - Communicate the surrogate's details to her Community Midwife and GP; - Communicate the baby's discharge detailsto the Community Midwife and GP of the IP(s).		

15. Appendix B: Birth Plan template **(GC = Gestational Carrier/Surrogate)**

<table>
<tr><td>Surrogate/Gestational Carrier (GC) Details

Name:

DOB:

Hospital Number:

Address:

Telephone number:

GP:

Birth partner:

Relationship:</td><td>Intended Parent/s (IP) details

Name/s:

DOB:

DOB:

Address:

Telephone number/s:

GP:</td><td>EDD:</td></tr>
<tr><td>Midwife:</td><td colspan="2">Health Visitor:</td></tr>
<tr><td>Surrogate Medical History:

Surrogate Obstetric history:</td><td colspan="2">Intended Parent’s Medical History:

Is GC genetic parent to child: YES/NO</td></tr>
<tr><td colspan="3">Birth planning meeting

Date:
Present:</td></tr>
<tr><td colspan="3">Antenatal:

Booked under MLC/CLC
Senior management team have agreed that GC, birth partner and both IPs should be facilitated to attend antenatal appointments and scans together. Please make every effort to accommodate this

Consultant:

Intended birth mode:

There are going to be written and signed consent documents available in maternity notes ahead of the birth, to detail handover of care of baby, vitamin K, any medical tests, admission to NNU and NBS Please ensure copies are filed in maternity notes and neonatal notes.</td></tr>
<tr><td colspan="3">Birth: (see additional birth plan for more detail)

- GC would like to be supported by <birth partner> for the duration of the birth, or in the event of a Caesarean birth.
- If goes spontaneously labours, GC would like to be supported by <birth partner> and involvement with IPs at all stages</td></tr>
</table>

- *Please be mindful of GCs dignity during labour and birth. As per what she feels comfortable with. IPs to be supported to be at GC's head. IPs happy to step out of room if required for examination/suturing.*
- *It has been agreed by service leads and senior midwifery team that IPs will be supported to be at the birth (Caesarean birth)*

If Caesarean birth required:

IPs and Birth Partner must be in theatre scrub attire (scrubs and hat) if attending theatre at any time. IPs will be supported to be present in theatre with a dedicated staff member (i.e. the Maternity Unit Manager)

GC to be advised that the risk of infection from microbial contamination increases with a higher number of people present in theatre. Minimal foot traffic is preferred in theatre cases.

All Caesarean birth plans as described below are flexible and will depend on the individual clinical needs of each theatre case. GC's birth partner and IPs are aware that if any concerns arise during the operation that they may be asked to leave theatre immediately.

1. *In the case of Planned Caesarean Birth (T2 theatre)*
   - *Both IPs and birth partner can be facilitated to be present*
   - *GC and birth partner will go into theatre initially for spinal anaesthetic, catheter, drapes and WHO check list*
   - *Once the team and GC are happy following analgesia establishment and catheterisation, IPs will be supported to enter T2 theatre and to remain by the neonatal resuscitative area to meet their baby*
   - *Please leave extra length of cord so that IPs can trim on resuscitaire*
   - *IPs will then leave theatre with their baby, if they wish, to their allocated room*
   - *GC is aware that space in recovery area is limited and that there may not be enough space for everyone at the bedside*

1. In the case of Unplanned Caesarean Birth (all Obstetric theatres; 1, 2 and T2 – please use larger theatre, if able)
- *Category 1 (with or without GA); expectation of neonatal or maternal compromise: IPs to remain in the Birthing Room to meet their baby*
- *Category 2; if expecting neonatal compromise, IPs to be supported to enter theatre after baby has been born and stabilised by the Neonatal Team*
- *Category 2; if not expecting neonatal compromise (e.g. if delay in the first or second stage of labour): IPs to be supported to enter theatre following analgesia establishment and catheterisation, and before knife to skin.*
- *Category 3 and 4: to be treated as Planned Caesarean Birth, as much is reasonably able. T2 theatre to be used when possible.*

When baby is born:

- *Sex to be announced/discovered by ……….*
- *Skin to skin*
- *Cord to be cut by*
- *The baby will have ID bands as per usual protocol*
- *Recovery arrangements*
- *IPs will then be supported to have a room with their baby on the MLU if baby has no additional medical needs, or on First Floor if baby needs any additional support.*
- *It has been agreed by the senior team that second parent can stay overnight.*

Feeding:

- *Baby to have formula*

- *To prescribe breast milk suppressant to GC if required*

Postnatal care:

- *Side room/private room once initial post-operative observations are complete (where available)*
- *Time spent together and meeting baby*
- *Discharge of GC when she is ready*
- *Visiting of IPs if remaining in hospital with baby*
- *New baby ID bands to be written in addition, once in the care of parents.*

Unexpected Neonatal Stay:

- *If baby needs any admission to NNU, IPs will be present to make any decisions and receive updates*
- *GC visiting*

Signed:	Date	

16. Appendix C: Consent for Neonatal Care

Neonatal Consent Following Surrogacy

To whom it may concern,

I, ……………………………………………………… am acting as gestational carrier/surrogate for intended parent(s): ...…………………………………… ………………………………………………………………………………………

I would like to give full written consent for the following in respect of the baby:
- The baby is to be cared for by the intended parent(s) during the hospital stay and during any additional admissions.
- The baby is to be discharged to the home of above parent(s) where they will care for the baby.
- The baby is to have the hearing screening.
- The baby is to have the new born infant physical examination.
- The baby is to have new born blood spot screening.
- The baby is to have any relevant vaccinations.
- The baby is to receive recommended treatment as per the intended parent(s)' wishes.

Discharge address:

Signed :

Date: