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Guideline for the Care of Women involved in Surrogate Pregnancy

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 to justify 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 surrogate women 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 the Directorate of Women and Children's Health, thus increasing the effectiveness of the UHB Security Policy.

Scope

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

Equality Health Impact Assessment	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	
Approved by	Maternity Professional Forum and Q+S

Accountable Executive or Clinical Board Director	Title of post holder *Ruth Walker, Executive Nurse Director*
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Disclaimer If the review date of this document has passed please ensure that the version you 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 Spenser

1.1 Introduction

A surrogate pregnancy is when a woman (the surrogate) helps 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, 2019)

1.2 There are two types of surrogacy

1) ***Straight (genetic, full or traditional) surrogacy***. This is where the surrogate provides her own egg, which is fertilized 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 doesn't provide her own egg to achieve the pregnancy. Embryos are created in vitro using the gametes of at least one IP.

1.3 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 made by the family court. 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 is made. 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.

General guidance

Healthcare professionals 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 care.

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

The surrogate should have the opportunity to be seen alone to ensure any confidential 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 safe guarding concerns/a medical emergency, confidentiality can be broken if the correct procedures are followed. (Safeguarding an unborn child: A guideline for practice, 2018)

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

It is good practice to inform The Head of Midwifery (or Deputy) of a surrogate pregnancy so that the appropriate support can be provided for the midwife caring for the parties.

Annex A is a useful checklist throughout the journey to ensure care will be seamless.

1.3.1 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.

Every effort should be made to accommodate all reasonable requests. In the absence of a completed surrogacy birth plan staff should work with the surrogate and the IP(s) to develop one. If the surrogacy has been supported through an organisation they will have access to a template that will cover the points listed in Annex B. A copy of this plan should be filed in the notes.

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. A copy of which should be in the notes. Ideally this should be signed by the surrogate and the IP(s).

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.

1.3.2 Intrapartum care

The birth plan should outline whether the IP(s) will be in attendance during the birth 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. (Guideline for the Identification of Babies, 2020).

1.3.3 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 2017). 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 children's services

1.3.4 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.

Consent for vitamin K administration should be obtained from the surrogate following delivery.

The surrogate will need to provide written consent for Newborn screening. It is appropriate to obtain this prior to the surrogate leaving hospital.

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 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 as patients but should be regarded as parent(s) of the baby and accommodated in a single room as acuity allows.

Written consent of the surrogate should be provided if the child is to be discharged with the IP(s) independently of her. If the child and surrogate are discharged at different times transfer of the child to the IP(s) should happen in an appropriate place on the hospital premises.

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).

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Sources of advice and support

- Safeguarding Midwifery Advisor
- Senior Midwife
- Line Manager

1.3.5

References

The British Medical Association (BMA), 2008. Parental responsibility, Guidance from the British Medical Association. [Online] Available at: https://www.bma.org.uk/advice/employment/ethics/children-and-young-people/parentalresponsibility [Accessed 27 December 2017]

DHSC (2019) Care in Surrogacy. Guidance for the care of surrogates and intended parents in surrogate births in England and Wales.

The Human Fertilisation and Embryology Authority (HFEA), 2017. Code of Practice. [online] Available at: https://beta.hfea.gov.uk/code-of-practice/11#section-header [Accessed 25 September 2017]

Guideline for the Identification babies (2020) Cardiff and Vale UHB

Annex 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

Please ensure that the following information is collected, signed and dated and place within the surrogates notes.

	Signature	Date
Ensure that a birth plan is completed with the surrogate's (and IP(s)' if appropriate) wishes for the birth/postnatal period, which should include the surrogate's wishes for the IP(s) (for example, whether to be present at the birth/during postnatal inpatient stay).		
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 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 / fax / telephone numbers for the following: - Local maternity hospital; - Community midwives; - Health visitors; and - Local GP surgery.		

1.4 Intrapartum (see Annex B also)

- Ensure that the birth plan is discussed with the midwife caring for the surrogate and that all team members have had the opportunity to read the notes and are aware of the situation.
- 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).

1.5 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 the new-born 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).		
Check discharge details for the IP(s): ❖ Names, contact numbers, home address ❖ Address / fax / telephone numbers for the - Local maternity hospital; - Community midwives - Health visitors - Local GP surgery		
To ensure that both the surrogate and child receive follow-up care in the community, please: • Fax the surrogate's details to her Community Midwife and GP; and • Fax the child's discharge details to the Community Midwife and GP of the IP(s).		

Staff should ensure that correct protocols are followed as explained in the guidance if any concerns arise with regards to the surrogate, IP(s) or child.

2 Annex B: Checklist of information to be included in surrogacy birth plan

Aim: to ensure that maternity care is appropriate for both the surrogate, as the woman receiving care, and IP(s) and to ensure that communication between them and the multi-professional maternity team is facilitated.

Where the surrogate and IP(s) are supported by a national altruistic surrogacy organisation, their documentation for birth planning can be used. Parties are encouraged to seek support and guidance from their organisation as needed.

2.1 Names and contact details

- Surrogate name, date of birth and contact details
- IP(s)' name(s), date(s) of birth and contact details
- Where the surrogate has a spouse/partner, name and contact details
- Details of community midwife/midwives supporting surrogate and IP(s)

2.2 Birth-planning meeting

- Date of surrogacy birth-planning meeting
- Who attended birth-planning meeting
- Which healthcare professional(s) the plan was created and agreed with

2.3 Surrogate pregnancy details

- Surrogacy organisation used (if any)
- Form of surrogacy – straight or host
- Expected delivery date for child
- Summary of fertility treatment from clinic (if available)

2.4 Antenatal care

- Confirm that all routine antenatal care has been/will be received
- Who will attend scans and appointments with the surrogate

2.5 The birth

- Where the surrogate would like to give birth
- Who will be the surrogate's birth partner?
- Who will attend the birth, if:
    - Vaginal
    - Planned caesarean section
    - Emergency caesarean section, epidural
    - Emergency caesarean section, general anaesthetic
- Pain-relief options
- Who will make decisions for surrogate if she can't speak during birth
- Handling of child at birth (cord cutting including intentions for delayed cord clamping, skin-to-skin, holding the baby thereafter)

2.6 Post-partum care

- Who will care for child following birth, and when and where will transfer of care take place
- Who will make medical decisions about care/treatment for child
- Feeding method (surrogate breast milk through expressed feeds, intended parent breast milk, donated breast milk, formula)
- Name bands (what name appears on child's name band and can IP(s) request one)
- Guest/family visiting rights
- Discharge of surrogate, IP(s) and child, including surrogate's wishes regarding early discharge if delivery uncomplicated
- Who the child will be discharged with
- Surrogate postnatal healthcare needs (assessment and care should include physical, emotional and mental health)
- IP(s)' and baby's postnatal healthcare needs (for example, midwifery support with care of baby; assessment of, and support for, IP's emotional well-being and mental health).
- Where surrogate, IP(s) and child will stay after birth, both in the immediate postpartum period and if longer stay is required

(including possibility of amenity room for IP(s) and child following birth)

2.7 Communication and consents

- Confirm that the following professionals have been informed of the pregnancy and impending arrival of the child. Provide their names and contact details.
- Surrogate's GP and community midwives
- IP(s)' GP, community midwives and health visitors
- Confirm birth plan has been communicated with / made available to the following people, and provide their names and contact details:
- Head of Midwifery at surrogate's local hospital
- Maternity Unit at surrogate's local hospital (if not Cardiff and Vale)
- Confirm that the appropriate professionals will be informed of the discharge of the surrogate and child following birth and relevant documentation sent to ensure appropriate and seamless care is provided to all:
- Surrogate's community midwives, health visitors and GP
- IP(s)' local maternity hospital, community midwives, health visitors and local GP surgery
- 'Child health' information to include IP(s)' and their local GP's address and contact details to ensure information, e.g. vaccination appointments, etc. is addressed appropriately
- Appropriate written consents from the surrogate for transfer of care for the child to the IP(s), for neonatal screening tests and for decision making for treatment