St Helens and Knowsley Teaching Hospitals NHS Trust

Guideline for the Management of a Surrogate Pregnancy

Version No: 2

Document Summary:
The purpose of this guideline is to ensure good planning for surrogate parents, the children of surrogate parents and intended parents. The roles and responsibilities of staff are described to facilitate the development of robust sensitive plans for the ante-natal, labour and the post-natal periods, taking into account the relevant legislation. This will ensure that if any safeguarding concerns arise as a result of the surrogacy, these can be responded to appropriately by the professionals providing care to all parties.

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Document Control

[Author to complete all sections apart from Section 4 & 5]

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Contents

1. Scope

This guideline applies to all health practitioners working for St Helens & Knowsley Teaching Hospitals NHS Trust who may be involved in surrogacy arrangements.

2. Introduction

This guidance was produced by the Department of Health and Social Care in partnership with representatives of Surrogacy UK, COTS, The Royal College of Midwives and the Royal College of Nursing. Contributions and comments were received from the British Fertility Society, Royal College of Obstetricians & Gynaecologists, the Human Fertilisation & Embryology Authority, The British Association of Social Worker's Project Group on Assisted Reproduction, CAFCASS and a number of individuals who sat on the project reference group.

This guidance does not override the individual responsibility of healthcare professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and /or carer. Healthcare professionals should be prepared to justify any deviation from this guidance.

Some couples may require the assistance of a surrogate in order to create a family. Surrogacy is when a woman carries a child for someone who is unable to conceive or carry a child for themselves.

3. Statement of Intent

The purpose of the guideline is to clarify roles and responsibilities of Hospital Midwives, Community Midwives, Health Visitors and Safeguarding Team when caring for surrogate mothers and/or intended parents, taking into account the relevant legislation. This will ensure that if any safeguarding concerns arise as a result of the surrogacy, these can be responded to appropriately by the professionals providing care to all parties.

4. Definitions

The Surrogacy Arrangements Act (1985) defines a surrogate mother as:

“A woman who carries a child in pursuance of an arrangement –

(a) Made before she began to carry the child, and

(b) Made with a view to any child carried in pursuance of it being handed over to, and the parental rights being exercised (so far as reasonably practicable) by, another person or persons”

The intended parents are those who wish to bring up the child after birth. They may be either one or both genetic parents or neither one genetically related.

5. Duties, Accountabilities and Responsibilities

5.1 Chief Executive

The Chief Executive has overall responsibility for the strategic and operational management of the Trust including and ensuring that this guideline complies with all legal, statutory and good practice guidance requirements and is implemented effectively and efficiently.

5.2 Director of Nursing, Midwifery and Governance

The Director of Nursing Midwifery and Governance is the Accountable Director for this Guideline.

5.3 Clinical Director and the Obstetrics Team

The Clinical Director and his/her team has primary responsibility for the care of high risk women attending Maternity Services, and will ensure that all aspects of the woman's care is effectively communicated to the woman, using this guideline if necessary. The team will also communicate with other specialities when there is a clinical indication which requires this.

5.4 Head of Midwifery

The Head of Midwifery is accountable to the Trust Board for assuring compliance with this guideline within maternity services.

5.5 Audit and Guideline Development Midwives

The Audit and Guideline Development Midwives are responsible for ensuring that the guideline/policy/standard operational procedure are reviewed and updated by the specified review dates. Where appropriate the documents will be circulated for comments within and outside of maternity services. The Drugs and Therapeutic Group will be asked for their approval where drugs are referred to in these documents.

5.6 Matrons

The Matrons within maternity services are responsible for ensuring clarity and compliance with training requirements for this guideline, supported by the Clinical Practice Educator.

5.7 Ward Manager/Clinical Manager

The ward manager is responsible for ensuring that all staff working in their clinical areas are fully aware of their responsibilities within this guideline and any specific pathways that are available.

5.8 All Staff

All staff are responsible for ensuring they are familiar with Trust procedural documents and local procedural documents. Staff are aware that up to date clinical guidelines are available on the intranet and in hard copy files in Delivery Suite only.

5.9 Safeguarding Team

The safeguarding team have responsibility to ensure adherence to this guideline and oversee the safeguarding provision for women and children within the maternity services and for maternity patients and their babies across the Trust.

6. Management of a Surrogate Pregnancy

6.1 Key Terminology

6.1.1 Intended Parent(s) (IP(s))

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. An individual may also apply for a parental order to transfer legal parenthood if they are genetically related to the child. IP(s) generally prefer to be referred to as the parent(s) of the child.

6.1.2 Surrogate

This is the preferred term for women who are willing to help IP(s) 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.

6.1.3 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, or the IP in the case of an individual applicant, 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.

6.1.4 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, or the IP if an individual applicant, plus the gametes of the other IP or a donor, if required.
More information about the use of donor gametes is available from the Donor Conception Network (DCN) www.dcnetwork.org

6.1.5 Implications Counselling

The Human Fertilisation and Embryology Authority (HFEA) Code of Practice (2017) explains that all parties involved in the surrogacy arrangement should be offered counselling to discuss the implications and potential challenges faced by them when undergoing complex treatment cycles. The implications counselling should be provided by a suitably qualified counsellor affiliated with the treating clinic.
In the cases when the surrogacy arrangement has taken place without the aid of a fertility clinic, then counselling by a suitably qualified professional should be recommended to both surrogate and IP(s) (including the surrogate's partner if applicable) at the antenatal stage.
More information about implications counselling can be found from the British Infertility Counselling Association (BICA) www.bica.net

6.2 Key Principles

The following key principles underpin the development of this guidance and how people involved in surrogacy would hope to be treated.

• 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 IP(s). Surrogates can be stigmatised and IP(s) 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 IP(s) 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, where all staff are aware: i) that the pregnancy is being carried by a surrogate; and ii) of best practice in how to ensure their approach facilitates a safe, positive and rewarding experience for all.

• 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 IP(s) (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 IP(s) to be treated as the parent(s) 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.

6.3 Legal context and general guidance

6.3.1 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 IP(s) need to apply for a parental order after their child is born in order to become the legal parent(s) of the child. The legal framework allows for a surrogate to receive reasonable pregnancy-related expenses from IP(s), as assessed by the family court.

Surrogacy through commercial means, however, is illegal in the UK (Surrogacy Arrangements Act 1985) and therefore 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.

6.3.2 Legal parenthood in surrogacy

The surrogate is the legal mother of the surrogate child from birth until legal parenthood is transferred to IP(s) 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. IP(s) 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 or the IP, in the case of an individual applicant, 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 IP(s) 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, if there are two IPs.

6.3.3 Role of surrogacy agreements

A surrogacy agreement is a document often drawn up by surrogates and IP(s) (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, IP(s) 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.

The guidance in this document assumes that a comprehensive surrogacy agreement has been prepared by the surrogate and IP(s) and made available to staff. If this is not the case 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 https://www.surrogacyuk.org/

COTS http://www.surrogacy.org.uk/

Brilliant Beginnings http://www.brilliantbeginnings.co.uk/

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.

6.3.4 Confidentiality

In surrogacy, it is common for the surrogate and the IP(s) to agree that any information sharing by healthcare staff should include both parties. The approach that they have agreed will normally be set out in their surrogacy agreement. However, since the surrogate has a right to confidentiality, great care should be taken to understand what information she has agreed may be shared with the IP(s). If the parties have not included this point in their surrogacy agreement, they should be encouraged to discuss it and to record it in their agreement.

Staff should make sure that any consents to share information are recorded, and they should take care to confirm any point where confidentiality may be an issue.

Whilst a breach of patient confidentiality can be justified in certain circumstances such as in a medical emergency or when a healthcare professional has serious concerns regarding the welfare of the surrogate, intended parent or the child, such circumstances are very limited and are subject to strict criteria. For example, following the correct reporting and escalation processes applicable to your area of practice and your working environment, in most cases a senior member of staff or line manager should be the first person to whom a potential issue is escalated.

6.3.5 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 IP(s) at all times. However, 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 IP(s), then staff must respect this and should ensure accurate notes of the circumstances are kept. If the IP(s) want to challenge this situation, then it will be a matter for the family courts to decide.

If the IP(s) 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.

6.3.6 Mental Capacity

It is essential that the surrogate has the mental capacity to consent to surrogacy and to make decisions about her care and that of the child post-partum. Should staff have any concerns regarding the mental capacity of the surrogate, then a formal assessment of capacity should be performed (staff are advised to follow the Trust's consent policy). In the event that the surrogate lacks capacity to provide her consent or to make a particular decision, then treatment should be

given having regard to the best interests of the surrogate. However, staff are advised to consult the Trust's Lead on Mental Capacity, taking into account the Mental Capacity Act 2005, prior to administering non-emergency treatment in such circumstances. As part of this process, the adult safeguarding team should be involved and an assessment of need/support undertaken and action taken accordingly.

The surrogacy agreement should be clear as to whether the surrogate agrees to IP(s) being the sole decision makers for the care of the child from birth. In rare cases, healthcare staff may have concerns regarding the mental capacity of the IP(s). This may arise during the pregnancy or when the child is born. In this situation, further advice will need to be sought with regards to adult and child safeguarding assessments. The lead midwife, obstetrician and named nurse/midwife for safeguarding must be informed and a multi-disciplinary team review is advised, taking into consideration guidance and potential for deprivation of liberties. In such rare situations, the child will remain in the care of the surrogate until the IP(s) have been counselled and seen by a clinic's counsellor (or a psychologist), social worker and members of the mental health team to make a clear assessment of their mental capacity. If the child cannot be cared for by the surrogate, children's services will need to be involved and an interim arrangement facilitated.

6.4 Pre-birth

6.4.1 Antenatal Care

Please refer to the Standard Operational Procedure for the Management of a Surrogate Pregnancy in Appendix 1

Antenatal care should be delivered in accordance with relevant clinical guidance which is based on individual risk assessment, in the usual way. Requests set out in the surrogacy agreement or agreed between the surrogate and the IP(s) should be considered and accommodated, wherever possible (i.e. who will be present during consultations).

If a written surrogacy agreement has not yet been prepared, or if it does not adequately cover antenatal care, then the surrogate and IP(s) should be encouraged to create one. Staff should be satisfied that the surrogate consents to the sharing of data/medical information and /or attendance at appointments.

6.4.2 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/). Guidance for this screening has also been produced by The American Society for Reproductive Medicine and highlights that parties should consider screening for transmissible infections prior to conception (ASRM 2016).

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 IP(s) 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 be tested again prior to self-insemination, if that is the method used.

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

6.4.3 Antenatal screening for fetal anomaly

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

6.4.4 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 IP(s) should be included in this counselling, information sharing and decision making if the surrogate has given her consent.

6.5 Birth planning

Please refer to the Standard Operational Procedure for the Management of a Surrogate Pregnancy in Appendix 1

A surrogacy birth plan is normally prepared by the surrogate and IP(s), often as part of the surrogacy agreement. 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 IP(s).

In the absence of a completed surrogacy birth plan, staff should work with the surrogate and the IP(s) (if the surrogate has given her consent) to develop one. For surrogacy supported through the national altruistic surrogacy organisations (Surrogacy UK, COTS and Brilliant Beginnings), surrogates and IP(s) will usually have access to a surrogate birth plan template that covers the points listed in Appendix 4.

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. A copy should also be kept in the bleep holder file. 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 IP(s) should be supported by healthcare staff to outline, in the surrogacy birth plan, if the surrogate wishes for the IP(s) 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 IP(s) to be present during the birth of their baby. Where possible, such requests should be accommodated to promote immediate bonding between the IP(s) and the baby, with skin-to-skin contact also being supported.

The birth plan should also outline the wishes of the surrogate and the IP(s) 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.

6.6 Post birth

6.6.1 Postnatal care

Please refer to the Standard Operational Procedure for the Management of a Surrogate Pregnancy in Appendix 1

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 IP(s) 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 IP(s) 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 IP(s) (with child) to be accommodated separately, but with access to each other after the birth. Wherever possible, it may be advantageous for surrogates and IP(s) 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 IP(s), for example: the need for the child to be cared for by one or both IP(s), if there are two 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).

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 IP(s), are written clearly in the medical notes. Whilst it is often the case for a surrogate child to be transferred to the IP(s) at birth, the written consent of the surrogate should be provided if the child is to be discharged with the IP(s) and independently of her (Appendix 3 Consent to delegate responsibility and to remove baby from hospital) . If the child and surrogate are discharged at different times and the child is not already being cared for by the IP(s), transfer of the child to the IP(s) 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 IP(s) without the surrogate's consent. However, 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.

6.6.2 Treatment of a sick child

Where the surrogate has given her consent for IP(s) to care for the child and this has been included in the surrogacy arrangement, it is usual practice for the IP(s)' 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 (BMA 2008). The written consent of the surrogate should be provided which delegates treatment-related decision-making to the IP(s) and this should be clearly recorded in the medical notes again taking into consideration the legal framework for who can legally make those decisions (Appendix 3 Consent to delegate responsibility and to remove baby from hospital).

Burrel and O'Connor (2013) explore the issues and difficulties surrounding consent in their study into the ethical and medico-legal issues in modern surrogacy, and the difficulties that surrogates, IP's and healthcare professionals face.

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 IP(s) should be encouraged to complete one.

6.6.3 Community support

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 community midwife, GP or hospital team. When discharged from hospital this should be communicated to the Community Midwife, GP and Health Visitor in the normal way. Whilst there is no conclusive data on the incidence of postnatal depression in surrogates, The Royal College of Psychiatrists (2017) suggests that of all postnatal women, there may be an increased risk of a degree of postnatal depression from 1–2 months following the birth. For this reason, access to a community midwife should be encouraged for 28 days or more if required for the surrogate and health visiting staff made aware.

The IP(s) and child will require a community midwife to visit them and the child's discharge should be communicated to the Community Midwife, Health Visitor and GP in the normal way. If this is an out-of-area discharge then the IP(s)' address and telephone number along with names and contact details of their local hospital, Community Midwives, Health Visitors and GP details should be recorded in the antenatal records.

6.6.4 Follow on care

The Health Visitor and team will continue to monitor the child's progress as is routine for any child born in the UK. They will also assist and offer advice to the IP(s) with regards to postnatal depression (as above) and how the new family is coping and settling in. There is no reason to consider that families formed following surrogacy arrangements would be at increased risk of developing problems with coping (they are often seen as low risk), but routine support and advice will also be required even in low risk cases.

It would be for the GP to consider monitoring the surrogate with regards to post-natal depression and offer support and advice if required. A systematic review covering 8 studies looking at the outcomes of surrogates, children and the resulting families carried out in 2015 stated that 'no serious psychopathology among the surrogate mothers was noted' and for the IPs, 'no major differences in the parents' psychological state were observed' (Soderstrom et al 2016).

Both the surrogate and IP(s) may also receive ongoing support and advice from the national altruistic surrogacy organisations, if they are members and choose to do so.

Hospital staff should ensure the timely transfer of information about the child to the community healthcare team where the IP(s) live so that care and support can be picked up locally in a seamless manner.
IP(s) should be encouraged to apply for a parental order. More detail is given in `The Surrogacy Pathway' document on gov.uk and from CAFCASS for England & Wales

(https://www.cafcass.gov.uk/grown-ups/surrogacy.aspx).

6.7 Record Keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per St Helens & Knowsley Teaching Hospitals NHS Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the **date and time** together with **signature, printed name and designation.**

6.8 Safeguarding

The CMW should follow processes set out in SOP Appendix1, this will ensure that information is shared with all relevant professional including children's social care. A referral should be made when the details of the surrogacy are disclosed, this will enable the Local Authority to complete screening checks and establish whether further assessments are required. A referral should be made to the area where the surrogate mother and the intended parents reside (this will be two referrals if they live in different areas). A Maternity Information Sharing Form (MISF) should also be completed which will be shared with the safeguarding team, G.P for the surrogate and Health visiting teams for both parties.

6.9 Sources of advice and support

6.9.1 Sources within the healthcare system

- Lead Nurse/ Midwife for Safeguarding Children
- Senior Midwife
- Line Manager
- Surrogacy Coordinator at the licensed centre where the conception took place (if applicable)

6.9.2 External sources

- Donor Conception Network www.dcnetwork.org
- British Infertility Counselling Association www.bica.net
- Surrogacy UK (SUK):

- Website: https://www.surrogacyuk.org/
- Facebook: https://www.facebook.com/SurrogacyUK.org/
- Twitter: @SurrogacyUKorg

- Childlessness Overcome Through Surrogacy (COTS):
  - Website: http://www.surrogacy.org.uk/
  - Facebook: https://www.facebook.com/groups/480648862111229/

- Brilliant Beginnings (BB):
  - Website: http://www.brilliantbeginnings.co.uk/
  - Facebook: http://facebook.com/Brilliant-Beginnings
  - Twitter: @BrillBeginnings

7. Training, Equipment / Medication Requirements

No specific training requirements.

8. Monitoring Compliance

8.1 Key Performance Indicators (KPIs) of the Policy

No	Key Performance Indicators (KPIs) Expected Outcomes
1	Compliance with the guideline

8.2 Performance Management of the Policy

Minimum Requirement to be Monitored	Lead(s)	Tool	Frequency	Reporting Arrangements	Lead(s) for acting on Recommendations
Adherence to the SOP (Appendix 1) and required referrals made.	Safeguarding Team	Data collection tool to reflect the minimum requirement to be monitored	Tri-annual	O&G Clinical Governance Quality and Safety Group	Safeguarding Team

9. References

No	Reference
1	The Surrogacy Arrangements Act (1985) Available at: http://www.legislation.gov.uk/ukpga/1985/49
2	The Mental Capacity Act 2005. [online] Available at: https://www.legislation.gov.uk/ukpga/2005/9/contents
3	The American Society of Reproductive Medicine (ASRM), 2016. Recommendations for practices utilizing gestational carriers: A committee opinion. [pdf] Available at: http://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/practice-guidelines/for-non-members/recommended_practices_for_utilizing_gestational_carriers-pdfnoprint.pdf
4	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/parental-responsibility
4	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
5	Burrell , C and O'Connor H., 2013 Surrogate pregnancy: ethical and medico-legal issues in modern obstetrics. The Obstetrician and Gynaecologist [e-journal] 10.1111/tog.12010. Available through: Wiley online library website

	http://onlinelibrary.wiley.com/doi/10.1111/tog.12010/abstract
6	Antilla Soderstrom V, Wennerholm UB, Loft A, Pinborg A, Aitomaki K, Romundstad LB, Bergh C., 2016. Surrogacy: Outcomes for surrogate mothers, children and the resulting families – a systematic review. Human Reproduction Update, [e-journal] 22(2), pp. 260-276. https://doi.org/10.1093/humupd/dmv046
7	The Adoption & Children Act 2002 Available at: http://www.legislation.gov.uk/ukpga/2002/38/contents
8	DCN, 2017. The Donor Conception Network, Supporting families through donor conception. [online] Available at: https://www.dcnetwork.org/about
9	The Royal College of Psychiatrists, 2015. Postnatal depression [online] Available at: http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx [Accessed 27 December 2017]
10	COTS Surragacy in the UK www.surrogacy.org.uk
11	Care in Surrogacy: Guidance for the care of surrogates and intended parents in surrogate births in England and Wales. Department of Health & Social Care Nov 2019

10. Related Trust Documents

No	Related Document
1.	S011 SOP Safeguarding Maternity
2.	
3.	
4.	
5.	
6.	

11. Equality Analysis Form

The screening assessment must be carried out on all policies, procedures, organisational changes, service changes, cost improvement programmes and transformation projects at the earliest stage in the planning process to ascertain whether a full equality analysis is required. This assessment must be attached to all procedural documents prior to their submission to the appropriate approving body. A separate copy of the assessment must be forwarded to the Patient Inclusion and Experience Lead for monitoring purposes. Cheryl.farmer@sthk.nhs.uk. If this screening assessment indicates that discrimination could potentially be introduced then seek advice from the Patient Inclusion and Experience Lead. A full equality analysis must be considered on any cost improvement schemes, organisational changes or service changes which could have an impact on patients or staff.

Equality Analysis			
Title of Document/proposal /service/cost improvement plan etc:	**Guideline for the Management of a Surrogate Pregnancy**		
Date of Assessment	05/05/2021	**Name of Person completing assessment /job title:**	Ann Finch
Lead Executive Director	Director of Nursing, Midwifery & Governance		Audit and Guideline Midwife

	Does the proposal, service or document affect one group more or less favourably than other group(s) on the basis of their:	**Yes / No**	**Justification/evidence and data source**
1	Age	NO	
2	Disability (including learning disability, physical, sensory or mental impairment)	NO	
3	Gender reassignment	NO	
4	Marriage or civil partnership	NO	
5	Pregnancy or maternity	NO	Maternity Guideline
6	Race	NO	
7	Religion or belief	NO	
8	Sex	NO	Maternity Guideline
9	Sexual Orientation	NO	
	Human Rights – are there any issues which might affect a person's human rights?	**Yes / No**	**Justification/evidence and data source**
1	Right to life	NO	
2	Right to freedom from degrading or humiliating treatment	NO	
3	Right to privacy or family life	NO	
4	Any other of the human rights?	NO	

Lead of Service Review & Approval	
Service Manager completing review & approval Job Title:	Jacqui Kourellias
	Quality and Safety Matron

12. Appendix 1- Standard Operational Procedure for the Management of a Surrogate Pregnancy

	Action	Rationale
1	**At booking appointment** a routine enquiry should be made by the community midwife as to whether the pregnancy is as a result of a surrogacy arrangement. This includes establishing the type of surrogacy and whether the woman has been a surrogate previously. This information should be clearly recorded on the Maternity IT system Medway as part of the record of booking assessment. The midwife should inform her team leader and the named midwife for safeguarding.	To ensure that health professionals are aware of surrogacy arrangements from the early stages of pregnancy to enable appropriate assessments and care planning to take place. And ensure appropriate support is in place for both the surrogate and midwife.
2	If a surrogacy arrangement is disclosed the midwife should collect/record additional information at booking appointment: • Names, date of birth, address and GP of the intended parents. • Details of any previous children of intended parents • Were the intended parents presents present at the booking appointment? • Details of any surrogacy arrangement in place including name of agency (if any) involved with the surrogacy.	Good record keeping practice is essential to ensure that midwife has full details of surrogacy arrangement as a basis for effective communication between all involved with assessments and care planning in relation to the surrogate pregnancy.
3	If a surrogacy arrangement is disclosed by the pregnant woman the midwife will inform the surrogate (and intended parents if present) about the organisations surrogacy guideline which she will follow. This includes the provision of routine antenatal care with additional measures to ensure that the surrogate mother's birth plan is	To ensure that surrogate mothers and intended parents are well informed regarding what they should expect from St Helens & Knowsley Teaching Hospitals NHS Trust Maternity Services in both the ante-natal and post-natal periods. To enable Children's Social Care (CSC) to undertake screening assessments of the surrogacy arrangement in relation to both

	Action	Rationale
	appropriate to safeguard all parties and to ensure that the welfare of the baby remains paramount. The surrogate/intended parents will also be informed about the referral that will be made routinely to Children's Social Care departments in both the borough in which the surrogate mother resides and the borough in which the intended parents reside (if different).	the surrogate mother and the intended parents to establish whether a more detailed social care assessment is appropriate.
4	As soon as the midwife becomes aware of the surrogacy she should make a referral to Children's Social Care in the borough where the surrogate mother and the intended parents reside (this is likely to mean that referrals to two different local authorities are required).This referral should provide full details of the surrogacy arrangement. This referral should be signed by the surrogate/birth mother.	Referral is required to enable the local authority to complete screening checks to establish whether an assessment by CSC in relation to the proposed surrogacy is appropriate to ensure that the baby's welfare is paramount and that the baby is safeguarded.
5	The community midwife will send a copy of the Children's social care referral to: • The Head of Midwifery at the hospital where surrogate mother has chosen to deliver • The Named Midwife for Safeguarding • The Named Nurse for Safeguarding	To ensure effective communication between practitioners involved in the care of the surrogate mother and the unborn baby.
6	A midwifery Cause for Concern form will be completed and a copy sent to the following practitioners: • Midwifery Team Leader • The Head of Midwifery at the hospital where the surrogate mother has chosen to deliver • Consultant Obstetrician • GP for both surrogate mother and intended parents • Health Visitor for both surrogate	To ensure good communication between all parties involved in providing care to the surrogate woman and her unborn

	Action	Rationale
	• mother and intended parents • The Named Midwife for Safeguarding in both the surrogate mother's and intended parents' locality. • The Named Nurse for Safeguarding in both the surrogate mother's and intended parents' locality.	
7	**At the routine 16 week ante natal appointment** the midwife should check all the information is still correct – if any changes disseminate via updated information sharing/cause for concern to all practitioners previously informed as outlined in (6).	To ensure good communication and record keeping to ensure safe and effective care.
8	**At 16 weeks (if not done previously)** The midwife should make a written referral to Children's Social Care providing full details of the surrogacy arrangement. This referral should be signed by the surrogate/birth mother. Copies should be sent to head of midwifery and safeguarding nursing team as per action 5.	To ensure that local authority are aware of surrogacy arrangement in timely manner to enable them to initiate appropriate assessments well in advance of baby's arrival.
9	**At 20 - 30 weeks ante natal appointment** • It is the responsibility of the Hospital Head of Midwifery to arrange a meeting with the surrogate mother and the commissioning parents to discuss the pre- birth check list and the birth plan. • The community midwife should be invited to and attend the pre-birth meeting detailed above. • The community midwife should liaise with CSC departments to confirm the outcome of the referral(s) made and update the	To ensure that the necessary preparations are in place pre-birth.

	Action	Rationale
	• hospital midwife with this information. • Documentation recording the outcome of the referral and the screening checks completed should be available for the pre-birth meeting. • The Head of Midwifery should provide the community midwife with a copy of the pre-birth check list and birth plan which should include plans for the baby's discharge from hospital. • The midwife can advise the intended parents to attend parent craft sessions in their local area. The community midwife should discuss the case with the Named Midwife and the Named Nurse for Safeguarding.	To provide support to the community midwife and maintain management oversight of the case.
10	**At 28 weeks ante natal** the community midwife will liaise with CSC departments to establish whether assessments have been completed in relation to both the surrogate mother and the intended parents and the outcome of these assessments (if not already in receipt of this information). A record of the discussion should be made in the Health Record. The community midwife should update practitioners identified in (6) by completion of an updated cause for concern/information sharing form.	To ensure good communication between agencies
11	**At 32 weeks ante natal** the community midwife should contact the Named Midwife for Safeguarding to ensure that all parties are clear regarding the birth plan. This should also be communicated to the hospital midwives. If the outcome of the CSC assessment remains outstanding further contact with CSC is appropriate to clarify the	To ensure good communication between health providers and local authority.

	Action	Rationale
	reasons for the delay and the expected outcome of assessment. Community midwife to update all parties identified in action 6 via updated cause for concern.	
12	**Before 34 weeks ante natal** the community midwife should confirm that the birth / discharge planning meeting has been held and a copy of the plan obtained. This should clearly indicate whether there is any on-going role for CSC, plans for baby's discharge from hospital and arrangements regarding consent for the baby. If by this stage of the pregnancy there is no clear outcome of the CSC referral or no meeting has been held to agree birth plan concerns, this is to be escalated to the Named Midwife / Nurse for Safeguarding who will escalate on the midwife's behalf to the principal manager in the local authority and the Head of Midwifery at the hospital where the baby is due to be born.	To ensure good communication and safe and effective care.
13	**Birth** The hospital midwife should inform the Named Midwife / Nurse for Safeguarding of the outcome of the birth and whether there are any safeguarding concerns.	To ensure that information is shared appropriately with relevant health professionals.
14	In the event of a maternal death, Children's Social Care should be notified before the baby is discharged. This is the responsibility of the hospital staff. The surrogate mother's partner will remain the legal parent.	It may be possible for the legal father of the baby to confer parental responsibility rights for the child onto the intended parents.
15	If following the birth of the baby neither the surrogate nor the commissioning parents agree to accommodate the baby then CSC must be notified immediately.	To ensure the baby is safeguarded
16	**Post-natal visit.** Post-natal care should	There needs to be consideration given to the

	Action	Rationale
	be provided by the community midwife to the surrogate mother. This should be responsive to need and should be offered for up to 28 days postnatal.	psychological health of the surrogate mother and her wider family in the post-natal period. Up to 75% of surrogate mothers experience a degree of post-natal depression for 2-6 weeks following the birth (Raeme 1990)
17	**Discharge of baby** is the responsibility of the hospital midwife who should ensure that the correct information is provided to community midwifery/HV teams in the borough in which the child will be living. The hospital should not release the baby into the custody of any person where there are concerns that the baby may be at risk. If the baby is placed with the intended parents but living within the same geographical area as the surrogate mother, the community midwife will support all parties. The midwife will need to establish who has parental responsibility (PR) for the baby to ensure that either the intended father has PR or the surrogate mother has authorised the intended parents to exercise PR on her behalf.	To ensure the babies discharge from hospital is supported by good communication which includes clarity regarding the baby's location and correct address for both the surrogate mother and the intended parents.
18	**Day 5 Post-natal visit** to undertake newborn blood spot screening at the intended parents' home if the baby is living within the boundary of St Helens & Knowsley. Consent for screening should have been obtained prior to the procedure as part of the birth/post-natal plan. The community midwife should complete a routine health visitor liaison form and make contact with the health visitor to ensure that they are in receipt of all appropriate information prior to completing the birth visit.	To ensure good communication between health practitioners and seamless care for baby and parents
19	The community midwife should advise the surrogate mother to register the birth before 42 days.	A child born to a surrogate mother must be registered as her child. Unless the intended father is genetically related and named on

	Action	Rationale
		the birth certificate the intended parents who take the child have no legal relationship with the child or rights in law until a Parental Order has been made.

13. Appendix 2 - 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 and documented in the pregnancy records during the antenatal period.

- 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 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;
    - Local GP surgery

Intrapartum

- 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).

Postnatal period

- 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 / telephone numbers for the following
    - Local maternity hospital
    - Community Midwives
    - Health Visitors
    - Local GP surgery

To ensure surrogate mother and baby receive follow up care in the community please:

- Give the surrogate mother's details to the community midwife and GP
- Remember to give the baby'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.

14. Appendix 3 - Consent to delegate responsibility and to remove baby from hospital.

The Surrogate Mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the Intended Parents.

The Intended Parents have no legal rights over the baby until this time.

I …….. ……

(insert full name of surrogate mother, date of birth)

Delegate informally responsibility for decisions made regarding

……..... ……

(insert name and date of birth of the child)

to the intended parents detailed below.

I ……. ……

(insert full name of surrogate mother)

consent for

…… ……**(name of child)**

to leave hospital with the intended parents detailed below.

Intended Parents details

Parent 1……

Parent 2……

(insert full names of both intended parents including date of birth)

Signed by – Surrogate Mother……..Dated:……. ……

Signed by - Intended Parent 1 ……. ……Dated: ……

Signed by - Intended Parent 2 ……..Dated: ……

Witnessed by –

Registered Midwife……Dated: ……

Confirmed by –

Coordinator/Matron……Dated:……

Copies to:
Baby's record
Surrogate mothers record
Intended parent

15. Appendix 4 – 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.

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)

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

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)

Antenatal care

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

The birth

- Where the surrogate would like to give birth
- 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)

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 post-partum period and if longer stay is required (including possibility of amenity room for IP(s) and child following birth)

Communication and consent

- 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
- Supervisor / supervisory team at surrogate's local hospital
- Maternity Unit at surrogate's local hospital
- 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.