United Lincolnshire Hospitals NHS Trust

Care in Surrogacy

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Division & Specialty	Family Health, Obstetrics
Submission Date:	July 2024
Document Ref:	C–G–243 (Formerly ULHT-G/2018/039)
Explicit Definition of Patient Group which this Document Applies (e.g. Inclusion and Exclusion Criteria, Diagnosis)	Surrogates and intended parents in surrogate births
Version Number:	V8.0
If this version supersedes another guideline, protocol or SOP please be explicit about which document it replaces, including the version number:	V7.1
Does this Guideline, Protocol or SOP have an Overarching Policy? If so, which one?	No
Statement of the evidence base of the guideline – has the guideline been peer reviewed by colleagues, and if so, which colleagues or specific groups? Evidence base: (1-6)	Peer reviewed by colleagues 1. DoH&SC (2021) HFEA (2022)

1	NICE Guidance, Royal College guideline, SIGN (please state which source).
2a	Meta-analysis of randomised controlled trials
2b	At least one randomised controlled trial
3a	At least one well-designed controlled study without randomisation
3b	At least one other type of well-designed quasi-experimental study

4	Well-designed non-experimental descriptive studies (i.e. comparative/correlation and case studies)	
5	Expert committee reports or opinions and/or clinical experiences of respected authorities	
6	Recommended best practice based on the clinical experience of the guideline developer	
Approved By:		Maternity Guideline Group
Date Approved:		July 2024
Staff Target Audience:		All healthcare professionals involved in the care of surrogates and intended parents in surrogate births.
Review Date: This is to be Applied by the Corporate Policies Team. A review date of 3 years will be applied by the Trust, but divisions can choose to apply a shorter review date, however this must be managed and agreed through Specialty Governance processes.		August 2027

Document scope:	**Trust-wide**

Version History Log

Version	Date Published	Details of key changes
V6.0	July 2018	Guideline completely rewritten in line with new guidance
V7.0	March 2021	Page 13 – Completion of birth plan **34 weeks** and responsible staff for devising the plan. Page 14 - removal of using fax Page 17 – Removal of Supervisor/Supervisory Team
V7.1	April 2024	No changes.
V8.0	August 2024	Amendment to guidance if birth is in theatre to limit the number who may attend p.11

Contents

Equality, Diversity and Inclusion

Corporate Guideline/SOP Statement

The United Lincolnshire Hospitals NHS Trust is committed to promoting equality and diversity in all its activities to promote inclusive services, processes, practices and culture. This commitment is articulated in our equality objectives for 2022-2025 Our equality objectives - United Lincolnshire Hospitals (ulh.nhs.uk)

This Guideline/SOP reflects the Trust vision, values and behaviours and supports employees in working for the benefit of patient care. It takes account of the provisions outlined in the Equality Act 2010 to ensure no individual receives less favourable treatment on the grounds of age, disability, sex, race, gender reassignment, sexual orientation, religion and belief, marriage/civil partnership and pregnancy/maternity.

Alongside being committed to a proactive delivery of the Equality Act 2010, the Trust proudly seeks to embody the duties of the Public Sector Equality Duty (2011) in all its activity by:

1) Eliminating unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2) Advancing equality of opportunity between people who share a protected characteristic and those who do not.
3) Fostering good relations between people who share a protected characteristic and those who do not.

We recognise high quality NHS patient care benefits by having a diverse community of staff who value one another and realise the contribution they can make to achieving Outstanding Care, Personally Delivered.

1. Introduction

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.

This guidance is for use by the following staff groups:

This guidance applies to all healthcare professionals irrespective of grade, level, location or staff group.

This guidance document applies to England and Wales only. The legislation relating to surrogacy is UK-wide but there are different approaches to the court systems in Scotland and Northern Ireland.

2. Definitions

Intended Parents (IPs)

- These are couples who are considering surrogacy as a way to become a parent. They may be heterosexual or same-sex couples in a marriage, civil partnership or living together/co-habiting in an enduring relationship. To apply for a parental order (which is the way that legal parenthood is transferred from the surrogate to the IPs) at least one of the IPs in a couple must be a genetic parent of the child born to them through surrogacy. IPs generally prefer to be referred to as the parents of the child.
- The Government announced its intention to introduce legislation to change the law so that a single person will also be able to apply for a parental order to transfer legal parenthood to them if they are an IP in respect of a surrogacy arrangement, provided they have a genetic link to the child. This change is expected in 2018.

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

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

Host surrogacy

- Host (also known as gestational or partial surrogacy) is when the surrogate doesn't provide her own egg to achieve the pregnancy. In such pregnancies, embryos are created in vitro and transferred into the uterus of the surrogate using the gametes of at least one IP, plus the gametes of the other IP or a donor, if required.
- More information about the use of donor gametes is available from the Donor Conception Network (DCN) (see Section 5).

3. 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 IPs (including the surrogates partner if applicable) at the antenatal stage.

More information about implications counselling can be found from the British Infertility Counselling Association (BICA) (see section 5).

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 IPs. Surrogates can be stigmatised and IPs have often been through distressing experiences before turning to surrogacy, so compassion, dignity and sensitivity are important. Perceived negative attitudes can cause particular stress or distress.
- Surrogates and IPs should be treated in the same way as any other patients accessing healthcare during pregnancy and birth whilst recognising that there may be particular characteristics, such as LGBT+ status, that may require a more tailored approach.
- A co-ordinated, consistent but flexible approach is important, 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 IPs (known as surrogacy agreements), which cover most eventualities and desired outcomes; these should be reflected in birth plans and engagement with healthcare staff.
- It would be usual practice for the IPs to be treated as the parents of the child, subject to the agreement of the surrogate (and her partner, if she has one), and that the surrogate does not see herself as the mother.

4. Legal Context and General Guidance

4.1. Legal Position of Surrogacy

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

4.2. Legal Parenthood in Surrogacy

- The surrogate is the legal mother of the surrogate child from birth until legal parenthood is transferred to IPs through a parental order made by a family court. If the surrogate is married or in a relationship, her partner will also assume legal parenthood status of the child from birth until the parental order is made. IPs can start the process to obtain a parental order from six weeks until six months after the birth if certain criteria have been met, including the child being in their care, having the consent of the surrogate and at least one IP being genetically related to the child. The parental order process is normally straightforward and it is usual for a child to be cared for by the IPs from birth (with the surrogate's consent).
- If the conception in a surrogacy arrangement takes place in a licenced clinic and the appropriate consent forms are completed, if the surrogate is not married, the IP who provides the sperm can be registered as the legal father on the birth certificate. A parental order would still be necessary to transfer the legal parenthood of the second IP.

4.3. Role of Surrogacy Agreements

- A surrogacy agreement is a document often drawn up by surrogates and IPs (prior to conception) that sets out how the parties intend to: i) conceive and manage the pregnancy and birth; and ii) care for the child post-partum. A comprehensive surrogacy agreement would cover all eventualities and decision-making events, for example how the termination of a pregnancy should be handled.
- Whilst surrogacy agreements are not legally enforceable and do not override other legal obligations, they can be used by staff to guide the provision of healthcare to the surrogate, IPs 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 IPs 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, COTS and Brilliant Beginnings – see Section 5).
- 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.

4.4. Confidentiality

- In surrogacy, it is common for the surrogate and the IPs 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 IPs. 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 consent 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.

4.5. **Disputes**

- Disputes in surrogacy are rare. Where the parties are being supported by one of the national altruistic surrogacy organisations, the organisation will usually offer assistance and support to help resolve any difficulties. Healthcare professionals should attempt to work with the surrogate and the IPs at all times. 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 IPs, then staff must respect this and should ensure accurate notes of the circumstances are kept. If the IPs want to challenge this situation, then it will be a matter for the family courts to decide.
- If the IPs change their minds and no longer want to keep the child, then parental responsibility remains with the surrogate as the legal parent of the child (and her partner if she has one). In the event that the surrogate is not prepared to take responsibility for the child, then social services should be contacted in the usual way.
- If staff have any concerns about the welfare of the child, they should follow standard procedures for making a risk assessment, involving other appropriate agencies and invoking child protection procedures (if applicable). A welfare of the child assessment should have been carried out for any fertility treatment, in line with the HFEA's Code of Practice.
- Staff may wish to consider contacting the Lead for Safeguarding for further advice and guidance if a dispute continues or a concern arises.

4.6. **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 IPs 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 IPs. 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 IPs 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.

5. Pre-Birth

5.1. Antenatal Care

- Antenatal care should be delivered in accordance with relevant clinical guidance which is based on individual risk assessment, in the usual way. Requests set out in the surrogacy agreement or agreed between the surrogate and the IPs 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 IPs 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.

5.2. 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 IPs should be included in this counselling and decision-making if the surrogate has given her consent.
- If the surrogacy is supported by one of the national altruistic surrogacy organisations and self-insemination is to be used, then parties are likely to have undertaken screening prior to joining. A risk could still exist at the point of conception, however, so this guidance recommends that the surrogate and intended father 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 IPs should be included in this counselling. Where one or both of the IPs is identified as having a transmittable infection, then they should be informed and advised to seek medical advice and treatment.

5.3. **Antenatal Screening for Foetal Abnormality** – 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 IPs should be included in counselling, decision-making and information sharing.

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

6. Birth Planning

A surrogacy birth plan is normally prepared by the surrogate and IPs, 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 IPs.

In the absence of a completed surrogacy birth plan, staff should work with the surrogate and the IPs (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 IPs will usually have access to a surrogate birth plan template that covers the points listed in Appendix 2.

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

When a vaginal birth is planned, the surrogate and the IPs should be supported by healthcare staff to outline in the surrogacy birth plan, if the surrogate wishes for the IPs to be in attendance. Early planning by healthcare staff should enable such preferences to be discussed and accommodated, with acceptance that it is equally important for the surrogate to be supported by her chosen birth partner as it is for the IPs to be present during the birth of their baby. Where possible, such requests should be accommodated to promote immediate bonding between the IPs and the baby, with skin-to-skin contact also being supported.

Due to limited capacity in theatre, when an elective caesarean birth is planned, or in the event of an intrapartum transfer to theatre (i.e. for an instrumental birth or emergency caesarean section), attendance at the birth will be limited to one person. The birth plan should outline who will be present at the birth and following discussions with healthcare staff, the appropriate place for IPs to remain during the procedure.

7. Post-Birth

7.1. **Postnatal Care**

- Postnatal care related to a surrogate birth will usually be very different to other births. Often the surrogate will consider her role to be finished after the birth and wish to be discharged independently of the child. Usually the child will be fully cared for by the IPs from birth and so parenting support, advice and decision making should be directed to them until they are discharged with the child. Whilst this is what often happens, it is not universal and it is very important to ensure that the parties agree (this is likely to have been agreed in advance and set out in the surrogacy agreement if there is one). In the event that staff have concerns about the welfare of the child, they should ensure that these are raised and actioned in accordance with the appropriate safeguarding policies. If a surrogacy agreement hasn’t yet been prepared or doesn’t cover the full range of issues, the surrogate and IPs should be encouraged to complete one.
- Every effort should be made to fulfil all reasonable requests regarding post-natal care, which may include a desire for the

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

- Since the surrogate remains the legal mother at birth, staff should ensure they are satisfied that she consents to the provisions within the surrogacy agreement and that the postnatal arrangements, including any delegations she has made to the IPs, are written clearly in the medical notes. Whilst it is often the case for a surrogate child to be transferred to the IPs at birth, the written consent of the surrogate should be provided if the child is to be discharged with the IPs and independently of her. If the child and surrogate are discharged at different times and the child is not already being cared for by the IPs, transfer of the child to the IPs should happen in an appropriate place on the hospital premises. In other words, the parties should not be forced to leave the premises in order to complete this transfer. Under no circumstances should the child be discharged with the IPs without the surrogate's consent. 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.

7.2. **Treatment of Sick Child**

- Where the surrogate has given her consent for IPs to care for the child and this has been included in the surrogacy arrangement, it is usual practice for the IPs' wishes to be considered by staff regarding the treatment of a sick child and for them to be included in any important decisions regarding the health of that child whilst recognising that the surrogate has the overall responsibility until a parental order has been issued (BMA 2008). The written consent of the surrogate should be provided which delegates treatment-related decision-making to the IPs and this should be clearly recorded in the medical notes again taking into consideration the legal framework for who can legally make those decisions.
- 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 IPs should be encouraged to complete one.

7.3. 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 IPs 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 IPs' 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.

7.4. 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 IPs 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 IPs 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 IPs live so

that care and support can be picked up locally in a seamless manner.

- IPs 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).

8. Source of Advice and Support

8.1. 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)

8.2. 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

Document Control

The Trust must be able to demonstrate that the documents are researched and based on best practice and that all guidelines are audited and reviewed therefore:

The following sections must be completed, with a clear statement of who will be responsible for the dissemination, implementation and review of the document.

Auditable Standards and Frequency

Audits will be considered based on occurrence due to the infrequent cases within the Trust

Implementation Strategy

- Added to SharePoint
- Inform staff at Clinical Governance Meetings
- Give to the Ward managers
- Disseminate through ward meetings
- Email to all staff

Appendix 1 – 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 wishes by 34 weeks gestation (and IPs' if appropriate) for the birth/postnatal period, which should include the surrogate's wishes for the IPs (for example, whether to be present at the birth/during postnatal inpatient stay). The Community Midwife and Community Midwifery Manager are responsible for devising the plan and should liaise with managers from inpatient areas to ensure all are in agreement.

• Ensure that preferred terminology is agreed with both the surrogate and IPs 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 IPs 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 IPs and parenthood consents.

• Ensure that full contact details for the IPs 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.

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 IPs are clear (for example, whether to be present at the birth/during postnatal inpatient stay).

Post-natal period

• Ensure that the postnatal ward staff are clear of the surrogate's wishes relating to the IPs and a realistic expectation regarding plans for accommodating the surrogate's wishes, and those of the IPs is achieved.

• Ensure that the agreement between the surrogate and IPs regarding the care of the child is clearly documented in the maternity notes and the new-born notes and

clearly record any necessary consent by the surrogate for the IPs to make decisions about the baby (note that the existence of a surrogacy agreement does not override any subsequent decision by the surrogate who remains the child's legal mother until parenthood is transferred).

• Check discharge details for the IPs:

• Names, contact numbers, home address

- Address / fax / telephone numbers for the following:

- Local maternity hospital;

- Community midwives;

- Health visitors; and

- Local GP surgery.

To ensure that both the surrogate and child receive follow-up care in the community, please:

•Provide surrogate's details to her Community Midwife and GP; and

• Provide child's discharge details to the Community Midwife and GP of the IPs.

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

Appendix 2 – 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 IPs and to ensure that communication between them and the multi-professional maternity team is facilitated.

Where the surrogate and IPs 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

• IPs' 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 IPs

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 IPs request one)

• Guest/family visiting rights

• Discharge of surrogate, IPs 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)

• IPs' 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, IPs 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 IPs and child following birth)

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

• IPs' 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

• 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

• IPs' local maternity hospital, community midwives, health visitors and GP surgery

• 'Child health' information to include IPs' 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 IPs, for neonatal screening tests and for decision making for treatment

Equality and Health Inequality Impact Assessment Tool

This tool has been developed by the Equality, Diversity and Inclusion Leads for use in the NHS Provider organisations in Lincolnshire. The tool is designed to ensure due regard is demonstrated to the Equality Act 2010, the Public Sector Equality Duty and potential health inequalities are also identified and addressed (as outlined in the Health and Social Care Act). Please complete all sections below. Instructions are in ***italics***. Support can be found at http://ulhintranet/equality-and-diversity,

A. Service or Workforce Activity Details	
1. Description of activity	To provide guidance for staff on the care and management of surrogates and intended surrogate parents, based on national Guidance and best available evidence.
2. Type of change	Adjust Existing
3. Form completed by	Sharon Hannam, Specialist Midwife for Audit and Guidelines
4. Date decision discussed & proposed	July 2024
5. Who is this likely to affect?	Service users x Staff x Wider Community x If you have ticked one or more of the above, please detail in section B1, in what manner you believe they will be affected.
B. Equality Impact Assessment	
Complete the following to show equality impact assessment considerations of the decision making to ensure equity of access and to eliminate harm or discrimination for any of the protected characteristics: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Further, please consider other population groups which are at risk of health inequality and can include, but not be limited to, people who are; living in poverty / deprivation, geographically isolated (e.g. rural), carers, agricultural workers, armed forces, migrants, homeless, asylum seekers/refugees, surviving abuse, in stigmatised occupations (e.g. sex workers), use substances etc. Please ensure you consider the connections (intersectionality) between the protected characteristics and population groups at risk of health inequality (e.g. it is recognised that older men from a BAME background, with one or more comorbidities and living in deprivation are more at risk of a poorer outcome if they contract CV-19).	
1. How does this activity / decision impact on protected or vulnerable groups? (e. g. their ability to access services / employment and understand any changes?) Please ensure you capture expected positive and negative impacts.	**Age** – It is recognised that the majority of service users accessing the service are of a younger age our services are designed to meet the needs of service users for all ages. See mitigation below. **Disability** – There are a range of disabilities which could be negatively impacted, e.g. understanding due to learning difficulties, communication as a result of sensory impairments or/and additional support required due to any mental health problems, see below for mitigations. **Gender reassignment** – It is recognised that people under this characteristic may present with a pregnancy, although this guideline is relevant to patients who identify as women it is also applicable for those who identify as non-binary and trans men, see mitigations below. There is no known impact on **marriage and civil partnership** as a person's marriage / civil partnership status has no bearing on the implementation of this guideline **Pregnancy and maternity** – a positive impact is envisaged as this guideline provides evidence based quality care for pregnant and postnatal service users. **Race** – The trust cares for patients from many different racial and ethnic backgrounds and therefore there is a potential vulnerability in terms of language barriers, see mitigation below. Pregnant Patients from BAME group are identified as having a disproportionate risk of death in childbirth compared to white women. See mitigations below. **Religion or belief** – there is a neutral impact under this characteristic as it has no bearing on the implementation of this guideline however for patients who may

	experience a pregnancy loss ULHT have a chaplaincy service available for spiritual support. **Sex** - There is no impact under this protected characteristic as this has no bearing on the implementation of this guideline. **Sexual Orientation** – There is no impact under this characteristic as this has no bearing on the implementation of this guideline. **Living in poverty/deprivation** – It is recognised that there may be patients who present in pregnancy who are living in deprived areas/poverty, see mitigation below. **Homeless** – Pregnant patients may present at booking who are homeless/sofa surfing, see mitigation below. **Migrants and Asylum seekers** - will be identified at the booking process, see mitigations below. **Substance Misuse** – pregnant patients may disclose substance misuse at booking/during pregnancy, see mitigations below. **Domestic Abuse** - Pregnant patients who experience domestic abuse may be at an increased risk of preterm birth and may disclose domestic abuse during their pregnancy, see mitigations below.
2. What data has been/ do you need to consider as part of this assessment? What is this showing/ telling you?	*The MBRRACE report (2018) reported that black women were 5 times more likely to die due to childbirth related causes.* *And Asian women twice as likely (compared to white women). The causes for this are unknown and require further research* *MBRRACE (2021) reports Eight percent of the women who died during or up to a year after pregnancy in the UK in 2016-18 were at severe and multiple disadvantage. The main elements of multiple disadvantage were a mental health diagnosis, substance misuse and domestic abuse highlighting the need for maternity pathways into appropriate Specialist services*
C. Risks and Mitigations	
1. What actions can be taken to reduce / mitigate any negative impacts? (If none, please state.)	**Patients** **Age** - ULHT have a local guideline based on national guidance to support teenage pregnancy. **Disability** - For services users dealing with learning difficulties, the NHS in Lincolnshire provides Learning Disability Specialist Liaison Nurses, both in the hospitals and the Community to support service users. For people living with sensory impairment, the trust provides a full range of sensory impairment translation services (e.g., British Sign Language). There is a Perinatal Mental Health Midwife and Perinatal Mental Health Team available to support mothers with mental health illness. **Gender reassignment** – all patients will be treated with the same dignity and respect. Transgender patients who present in pregnancy are also offered additional care by a Consultant Midwife to develop an individualised plan of care. **Race** - Interpretation services are used to provide information to parents on an individual basis where a need is identified. In addition there are some written materials available in other languages, and requests can be made for leaflets to be translated for individuals as necessary. ULHT Maternity has guidelines that highlight the potential health inequalities for the BAME community and recommends additional appointments for these patients and their families. There are support groups within the community (Just Lincolnshire). 'Dad Pads' are delivered to the Traveller communities for expectant/new fathers in an easy to read format. The wider implementation of continuity of carer within ULHT will include a caseload where there are increased population of ethnic

	minority groups. ULHT in collaboration with the CCG, Better Births are developing personalised care plans for all women which will include being available in the top 3 non-English languages for Lincolnshire. **Living in poverty/deprivation** – A risk assessment is undertaken at booking to identify women who may be living in poverty/deprivation. An early help assessment is completed for all women assessed as vulnerable to identify any agencies that can be involved with the patient. Early Help workers located in children's centres can be assigned to patients to help with budgeting/benefits/housing etc. The continuity of carer National initiative to ensure safer care antenatal/intrapartum/postnatal care based on a relationship between women and their midwives, has been implemented within ULHT maternity with areas of Social Deprivation prioritised as the initial areas. **Homeless** - People identified as homeless would be sign-posted to the local authority or may be able to access housing through a referral to Social Care. **Migrants & Asylum seekers/refugees** – Midwives will complete an early help assessment for these vulnerable patients and any needs would be identified and managed through the TAC process within Social Care. Community support services would be identified through Social Care. ULHT Maternity is developing a SOP for the care of recent Afghan pregnant refugees placed within Lincolnshire. **Substance Misuse** – ULHT Maternity has a Substance Misuse guideline which provides a pathway of support for patients experiencing substance misuse. **Domestic Abuse** – Risk assessments at each antenatal contact screens patients for domestic abuse, ULHT Maternity also has a Domestic Abuse guideline to provide a pathway for patients who disclose domestic abuse. **Staff** For staff living with disabilities who require the policy in an alternative format this will be provided upon request.
2. What data / information do you have to monitor the impact of the decision?	Impact on these affected characteristics can be monitored through Staff debriefs, Personal Midwifery Advocates and staff feedback, or through the DATIX systems, patient surveys/friends and family tests, Maternity Voices Partnership, Local audits as per the maternity Forward Audit Plan.
D. Decision/Accountable Persons	
1. Agreement to proceed proposed?	Yes
2. Any further actions required?	No further actions required.
3. Name & job title accountable decision makers	Sharon Hannam, Specialist Midwife for Audit and Guidelines
4. Date of decision	July 2024
5. Date for review	August 2027

Purpose of the Equality and Health Inequality Assessment tool

- The NHS in Lincolnshire has a legal duties under the Equality Act 2010, Public Sector Equality Duty 2011 and the Health and Social Care Act 2012 to demonstrate due regard in all decision making, for example, when making

changes to services or workforce practices, to ensure access to services and workforce opportunities are equitable and to avoid harm and eliminate discrimination for each of the protected characteristics and other groups at risk of inequality.

- Within the guidance toolkit there are also some examples of decisions this tool has been used on in other organisations and the impacts they have identified.

Checklist

- Is the purpose of the policy change/decision clearly set out? x□
- Have those affected by the policy/decision been involved? x□
- Have potential positive and negative impacts been identified? x□
- Are there plans to alleviate any negative impact? x□
- Are there plans to monitor the actual impact of the proposal? x□

This form is based on a template produced by Cambridge University Hospitals NHS Trust and used with their kind permission. FINAL Trust Leadership Team approved for use 01.04.2021

Referenced Documents and Metadata

References

- Department of Health and Social Care 2021 Care in Surrogacy Guidance for the care of surrogates and intended parents in surrogate births in England and Wales Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales - GOV.UK (www.gov.uk)
- The Surrogacy Arrangements Act 1985, Section 2 [online] Available at: http://www.legislation.gov.uk/ukpga/1985/49
- The Mental Capacity Act 2005. Available at: Mental Capacity Act 2005 (legislation.gov.uk)
- Practice Committee of the American Society for Reproductive Medicine and Practice Committee of the Society for Assisted Reproductive Technology. Electronic address: asrm@asrm.org (2022). Recommendations for practices using gestational carriers: a 2 committee opinion. Fertility and sterility, 118(1), 65–74. Available from: Recommendations for practices using gestational carriers: a committee opinion - Fertility and Sterility (fertstert.org)
- Gov.UK. Surrogacy: legal rights of parents and surrogates. Surrogacy: legal rights of parents and surrogates: Overview - GOV.UK (www.gov.uk) Accessed 20/7/2024
- The Human Fertilisation and Embryology Authority (HFEA), 2022. Code of Practice. [online] Available at: Read the Code of Practice | HFEA
- 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
- 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
- The Adoption & Children Act 2002. [online] Available at: http://www.legislation.gov.uk/ukpga/2002/38/contents
- DCN, 2017. The Donor Conception Network, Supporting families through donor conception. [online] Available at: https://www.dcnetwork.org/about
- The Royal College of Psychiatrists, 2015. Postnatal depression [online] Available at: http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx

Other Documents – None.

Metadata (Maximum of 255 Characters including Spaces) – Surrogacy, Surrogate

Signature Sheet

Names of people consulted about this document:

Name	Job title	Department

Author(s) confirm that they have collected all the signatures, as listed above, email Corporate Governance at corporate.policies@ulh.nhs.uk	**YES**

Names of committees which have approved the document	Approved on
Maternity Guideline Group	July 2024