Surrogacy - Full Clinical Guideline

Reference No.: UHDB/Operational/07:23/O13

Contents

1. Introduction

Altruistic surrogacy is a positive option for those seeking to start a family through assisted reproduction in the UK. The Department of Health and social care published guidance for the care of surrogates and intended parents in surrogate birth in England and Wales (Updated 2021). The key principles outlined in this document are summarised below.

• 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 intended patients. Surrogates can be stigmatized 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 Intended Parents (IPs) should be treated in the same way as any other patients accessing healthcare during pregnancy and birth whilst recognizing that there may be particular characteristics, such as LGBTQIA status, that may require a more tailored approach.

• A coordinated, consistent but flexible approach is important.

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

• Surrogacy should have comprehensive, 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

2. Purpose and Outcomes

To offer clarity and guidance to health professionals involved in the planning of care for the surrogate mother, her baby and intended parents, during the antepartum, intra-partum and postnatal period

3. Key Terminology

Intended parents (IPs)
These are couples who are considering surrogacy as a way to become a parent. They may be couples of any gender or sexual orientation 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.

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.

Straight Surrogacy (also known as genetic, full or traditional)
This is when the surrogate provides her own eggs to achieve the pregnancy. One of the IPs, or the IP in case of an individual applicant, provides a sperm sample for conception through either self-insemination away from a licensed setting or artificial insemination with the help of a fertility clinic. 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 (also known as gestational or partial surrogacy)
This 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

4. Key Responsibilities and Duties

Following the booking, to ensure organisational and professional support is in place for the Surrogate and the intended parents, the named midwife should inform the Senior Midwife or Matron.

The Checklist for surrogacy documentation (Appendix A) is to be used and 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.

In accordance with guidance set out by the Department of Health and Social care (2019) there

is no need for routine referral to be made to social services simply because the child is being handed over to the IP(s) as part of a surrogacy agreement. Consent to complete routine background checks will be requested form both the surrogate and intended parents. If a surrogacy agency has been used and a surrogacy agreement is in place, these may already have taken place.

At consultant booking appointment it is the doctor's responsibility to ensure the following has been instigated;

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.
- If surrogacy arrangements have 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) in the antenatal stage.

5. Legal Implications

5.1 Legal position of surrogacy

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

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

5.2 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.
- 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 case of an individual applicant) being genetically related to the child.

If the surrogate is married or in a relationship:

- The partner of the surrogate will also assume legal parenthood status of the child from birth until the parental order is made

The IP who provides the sperm can be registered as the legal father on the birth certificate if:

- Conception takes place in a licensed clinic ***and***
- The appropriate consent forms are completed ***and***
- The surrogate is not married
- A parental order would still be necessary to transfer the legal parenthood of the second IP if there is one

5.3 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:

- conceive and manage the pregnancy and birth
- 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, COTS and Brilliant Beginnings – see Section 5).

6. Guidance for Healthcare Staff

All healthcare staff involved with providing care:

- Should understand that they have a duty of care, as when supporting any other pregnant woman, to the surrogate and should ensure that the surrogate has given her consent to any agreement regarding her care
- May wish to consider contacting the Lead for Safeguarding Children for further advice and guidance if they have any concerns.
- Best practice should be observed by providing the surrogate with 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
- Should understand that the surrogate has a right to confidentiality and great care should be taken to understand what information she has agreed may be shared with the IP(s) and consent to share any information should be recorded taking care to confirm at any point where confidentiality may be an issue
- Should not share any information about the surrogate or the unborn child with the IPs or any other third party without the express consent of the surrogate
- Surrogates have the right to accept or refuse any medical treatment so clinicians should ensure that the IPs are not seen to be coercing her
- Even if there is a plan in place the surrogate can change her mind at any time

In case of a dispute:

Disputes in surrogacy are rare. Where the parties are being supported by one of the national altruistic surrogacy organisations, the organization will usually offer assistance and support to help resolve any difficulties.

Healthcare professionals should attempt to work with the surrogate and the IPs at all times. In the event of an unresolvable dispute, the surrogate's wishes must be respected, regardless of what is set out in any surrogacy agreement or consents that may previously have been provided.

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

for the family courts to decide.

If the IPs change their minds and no longer want to keep the child, then parental responsibility remains with the surrogate as the legal parent of the child (and her partner if she has one).

In the event that the surrogate is not prepared to take responsibility for the child, then social services should be contacted in the usual way.

In case of any concerns about the welfare of the child:

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).

Staff may wish to consider contacting the Lead for Safeguarding and Vulnerable peoples team for further advice and guidance if a dispute continues or a concern arises

In case of mental capacity concerns (surrogate):

- Escalate to the senior midwife, Lead obstetrician and named midwife for safeguarding to support with a formal assessment of capacity
- If the surrogate lacks capacity to provide her consent or to make a particular decision:
  - Consult the Trust lead on Mental Capacity prior to non-emergency treatment
  - Treatment should be given having regard to the best interest of the surrogate

In case of mental capacity concerns (IPs):

- Escalate to:
  - Lead midwife
  - Lead obstetrician
  - Named midwife for safeguarding
- The child will remain in the care of the surrogate until the IPs have had a clear assessment of their mental capacity

6.1 Specific to care in the antenatal period

- Discussions regarding the needs and preferences of the surrogate and IPs regarding antenatal care, labour and beyond should take place well in advance to avoid any conflict or misunderstanding and to provide support. These should be documented (see Appendix A).

- Details of commissioning parent(s) address, GP, local maternity services / hospital should be obtained and documented within the maternity records, obstetric notes and safeguarding information page on Electronic Maternity pages

- Meet with surrogate and commissioning parent(s) antenatally, if requested, to identify their plans / wishes re birth plan, birth partners, infant feeding, immediate care of baby, postnatal visiting etc. Documentation of this discussion should be made in the Surrogate mother's health records (see Appendix A)

Antenatal screening for infectious diseases

- 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 6 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 2 IPs, is identified as having a transmittable infection, then they should be informed and advised to seek medical advice and treatment.

Antenatal screening for fetal abnormalities

- All applicable and routine screening tests should be offered to the surrogate in the usual way. Both parties will need to consider how they might react should an abnormality be detected and how it would affect the surrogacy arrangements.
- 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

Termination of pregnancy

- Where a termination of pregnancy is considered and the relevant legal conditions are met, the surrogate makes any final decision.

6.2 Specific to birth planning and Intrapartum care

It is important to ensure that all parties have had the opportunity to contribute to the development of a birth plan and a copy of this should be placed within the surrogate's pregnancy records. UHDB maternity services aims to support the requests of the surrogate and IP(s) where feasible and safe to do so.

- Consideration should be given to the intended parents and the possible supportive role they have in relation to the surrogate mother during labour
- An individual birth plan should be made available and discussed with the Midwife providing care during labour in order to support the wishes of both surrogate and intended parents. It is important that arrangements for labour setting, birth attendants during routine and potential emergency situations and identification bands/security for baby following the birth have been discussed and recorded.
- In the event of any issues the midwives should ensure that their duty always lies in supporting the Surrogate and to escalate to the senior Midwife in charge if not resolved.

6.3 Specific to the postnatal period

- Ensure that the parties have agreed on the IP(s) caring for the child from birth
- If parties have agreed, parenting support, advice and decision making should be directed to the IP(s) until they are discharged with the child
- 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
- Every effort should be made to fulfil all reasonable requests regarding post natal care which may include the desire for the surrogate and IP(s) with child to be accommodated separately but with access to each other after the birth
- Every effort should be made to maintain privacy
- 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 clearly documented in the medical notes and in the hand held records - to include consent for Newborn Screening tests.
- The written consent of the surrogate should be provided if the child is to be discharged

with the IP(s) and independently of her
- The parties should not be forced to leave the premises in order to complete transfer of the child
- Under no circumstances should the child be discharged with the IP(s) without the surrogate's consent
- There is no need to inform a social worker or lead for safeguarding unless staff determine that either party may be experiencing difficulty or there is some other reason that staff consider a social worker should be contacted.
- On transfer to community the surrogate and baby are separately notified to the appropriate community midwifery teams for their place of residence
- Postnatal care as per routine guidelines
- The details of IP(s) address, GP and telephone number should be written within the maternity records and obstetric paper notes.
- The staff generating the Newborn screening purposes must ensure the correct details are on the system re which address the baby will be discharged to.

7. Home Birth

The role of the attending midwives is to care for the surrogate mother if she chooses to have her baby at home. The needs of the surrogate mother are always given priority and all final decisions rest with her.

Midwives attending surrogate home births will have access to a Midwifery manager to receive support and advice.

The immediate postnatal period is a time of great emotional upheaval and the midwife must always support the surrogate mother and remains the main focus of care.

In the event of surrogate mother and/or the baby requiring transfer into hospital following birth, the midwife will be responsible for ensuring safe transfer of care of both mother and baby.

Midwives responsibilities remain the same, as with any transfer into hospital from home birth. (i.e. responsibility is to the care of birth mother and baby)

8. BBA

In the event a surrogate mother delivers at home unexpectedly and without the commissioning parents present the midwife must contact the Social care duty officer immediately if the mother declines contact or care for the baby

9. What if the Surrogate or IP(s) changes her/their mind?

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
- should ensure accurate notes of circumstances are kept
- should contact the lead for Safeguarding and Vulnerable peoples team
- inform IP(s) if challenged that if they want to challenge this situation 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)
- if the surrogate is not prepared to take responsibility for the child, social services should be contacted in the usual way

10. What if the child becomes ill and is in need of treatment?

- 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.

- 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.

11. Monitoring Compliance and Effectiveness

Monitoring requirement	Review of practice against local guidelines
Monitoring method	Retrospective case note review
Report prepared by	Auditor
Monitoring report sent to:	Maternity Development
Frequency of report	3 yearly

12. References

Department of Health & Social care. Care in Surrogacy. Guidance for the care of the surrogates and intended parents in surrogate births in England and Wales. November 2019

NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

Surrogacy checklist

Place surrogate hospital sticker

Antenatal period		
Ensure that the following information is collected and documented in the pregnancy records during the antenatal period	**Date**	**Initials**
Full contact details for the IP(s) are recorded (names, contact numbers, home address)		
For the IP(s), the addresses / fax / telephone numbers are recorded for the following: • Local maternity hospital • Community midwives • Health visitors • Local GP surgery		
Preferred terminology is agreed with both the surrogate and IP(s) and clearly documented in the notes		
Establish if there is a formal surrogacy agreement in place.		
All aspects of surrogacy including what the surrogate and IP(s) have agreed in terms of participation and decision making		
Any consent that the surrogate has given, e.g. consent to share information with the IP(s) and parenthood consents		
A birth plan is completed with the surrogate's (and IP(s)' if appropriate) wishes for the birth and postnatal period, which should include the surrogate's wishes for the IP (s) (for example, whether to be present at the birth and/or during postnatal inpatient stay)		

Intra-partum		
Ensure that the following is documented in the pregnancy records as part of the admission in labour documentation	**Date**	**Initials**
The birth plan is discussed with the midwife caring for the surrogate and all team members have had the opportunity to read the notes and are aware of the situation		
The surrogate's wishes for her care in labour are clear e.g. pain relief etc		

Post-natal period		
Ensure that the following is documented in the pregnancy records as part of the post-natal documentation	**Date**	**Initials**
Staff caring for family following birth 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) has been recorded and communicated. A separate birth plan detailing the preferences of the surrogate and (IP(s) should be made available to staff caring for the family.		
Ensure that the Surrogate and IP(s) are aware of hospital security arrangements following the birth e.g. name band identification will be that of the Surrogate		
The agreement between the surrogate and the IP(s) regarding the care of the child is clearly documented in the maternity notes as well as in the baby notes, with clear record of any necessary consent by the surrogate for the IP(s) to make decisions about the baby (**note that the existence of a surrogacy agreement does not override any subsequent decision by the surrogate who remains the child's legal mother until parenthood is transferred)**		

Check discharge details for the IP(s):
• Names, contact numbers, home address
• Address / fax / telephone numbers for the following:
  • Local maternity hospital
  • Community midwives
  • Health visitors
  • Local GP surgery		

To ensure that both the surrogate and child receive follow-up care in community: • Ensure surrogate's community midwife and GP are informed of the birth details and discharge • Ensure the community midwife and GP of the IP(s) are informed of the discharge details for the baby • If the baby is moving out of area with IP(s) ensure that any investigation / screening test results will be directed to the appropriate GP/ Midwife/Health visiting team		

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

Appendix B

NOTIFICATION – SURROGATE PREGNANCY

Surrogate / Pregnant Woman	Intended Parents
Name: Hospital Number: EDD:	Name(s):
Address: Telephone:	Address: Telephone:
Additional Information:	Additional Information:
GP Name: Address: Telephone:	GP Name: Address: Telephone:
Community Midwife:	Community Midwife / Midwifery Office: Telephone:
	Local Maternity Hospital address: Telephone:

Documentation Control

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	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
	1	2005	Sheena Appleby. HOM	New local guidance
	2	July 2011	Maternity Guideline Group Nicola Evans-Legal Advisor	Review & update of local guideline
	3	June 2016	Carolyn Langrick – Matron Inpatient Services	Review and update of guideline
WC/NP/99	**Burton trust prior to merged document:**			
Original 2014	2	Jan 2018		Review – no change
Version control for UHDB merged document:				
	1	Feb 2020	Lorraine Purcell – Head of Midwifery	Review and update of the guideline
	2	June 2023	Pam Herod - Named midwife for safeguarding, Rebecca Robinson - Obstetric consultant, Karen McIlwrath - Community Matron	Review and update
Intended Recipients: All staff with responsibility for caring for pregnant women in a surrogate pregnancy				
Dissemination: Cascaded through lead midwives/doctors, Published on Intranet, NHS mail circulation list. Article in BU newsletter				
To be read in conjunction with:				
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