Department
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Social Care

Care in Surrogacy

Guidance for the care of surrogates and intended parents in surrogate births in England and Wales

February 2018

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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.

Key terminology

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.

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).

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.

1. Legal context and general guidance

1.1 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.

1.2 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.

1.3 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.

1.4 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 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.

1.5 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 Children for further advice and guidance if a dispute continues or a concern arises.

1.6 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.

2. Pre-birth

2.1 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.

2.2 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.

2.3 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.

2.4 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.

3. 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 Annex B.

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.

Whether a vaginal birth or a caesarean section 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.

The birth plan should also outline the wishes of the surrogate and the IPs 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.

4. Post-birth

4.1 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.

4.2 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.

4.3 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.

4.4 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).

5. Sources of advice and support

5.1 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)

5.2 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/
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Annex A: Checklist for surrogacy documentation

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

Antenatal period

Please ensure that the following information is collected and documented in the pregnancy records during the antenatal period:

- Ensure that a birth plan is completed with the surrogate's (and IPs' if appropriate) wishes 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).
- 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:

- Fax the surrogate's details to her Community Midwife and GP; and
- Fax the child's discharge details to the Community Midwife and GP of the 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.

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

Aim: to ensure that maternity care is appropriate for both the surrogate, as the woman receiving care, and 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 caesarian section
  - Emergency caesarian section, epidural

    - Emergency caesarian 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
- 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
- IPs' local maternity hospital, community midwives, health visitors and local 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.

Credits:

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