Guideline Care of Surrogates
and intended parents in Surrogate Births.

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1.0 Introduction

Surrogacy is when a baby is carried and birthed by a surrogate for someone(s) else who is usually unable or does not wish to do so themselves. The surrogate is referred to as *the surrogate* and the parents to be as the *intended parents*. The intended parents may be of any sexual orientation and do not have to be married or in a civil partnership. A single person may also utilize the surrogacy process to enable them to parent (Department of Health (DOH), 2018).

Surrogacy is controlled by the Surrogacy Arrangements Act 1085 and the Human Fertilization and Embryology Acts 1990 and 2008. Surrogacy may be formal (through an agencies such as Surrogacy UK) or informal within family and friendship networks, medically achieved Artificial Reproduction Technology or performed socially (directly or indirectly) between individuals.

2.0 Objective

This guideline has been developed to provide all medical and midwifery staff within the maternity setting clear guidance to enable appropriate care for a surrogate in pregnancy and to appreciate the position of the commissioning (intended) parents.

3.0 Scope

This guideline applies all medical, midwifery and support staff working in the maternity services

4.0 Definitions

Straight Surrogacy: Also known as 'full' or 'traditional surrogacy'. The Surrogate Mother provides the egg. The egg is then fertilised (either naturally or through artificial insemination) by either the Intended Father or sperm donor.

Host Surrogacy: The Surrogate Mother has no genetic link with the child but gestates embryos usually created from the eggs and sperm of the Intended Parents or where applicable donor eggs and /or sperm.

5.0 The Law Relating to Surrogacy

In the UK surrogacy is regulated by the Surrogacy Arrangements Act 1985, The Human Fertilisation and Embryology Act 1990, and the Human Fertilisation and Embryology Act 2008. These permit such arrangements under tightly defined circumstances and prohibits commercial agencies organising surrogacy for profit. Reasonable expenses can however, be paid to the surrogate mother, which are required to be proven in court when a parental order is granted.

5.1 Agreement

Those participating in surrogacy must reach an agreement as to how the arrangements will proceed. However, regardless of whether the arrangement is in writing and whether expenses have been paid, The Human Fertilisation and Embryology Act 2008 renders surrogacy contracts unenforceable, therefore:

- If the surrogate wishes to keep the child she is entitled to do so
- If the Intended parents decide they do not want the child, the surrogate as its legal mother is responsible for its welfare

5.2 Legal Rights

The Legal Mother – The Surrogate Mother is the "carrying mother" and therefore, in law is the legal mother of the child at birth. This applies even when there is full surrogacy and the Surrogate Mother has no genetic link to the child.

5.3

The Legal Father – The law in relation to the Legal Father is complex:

- **Where the Surrogate Mother is married** – the husband is deemed to be the legal father of the child at birth unless he can prove he did not consent to the surrogacy process.

- **Where the Surrogate Mother is unmarried** – the Intended Father will only gain parental responsibility for the child once he is named on the birth certificate. At this point he becomes the legal father of the child. Once named on the birth certificate the intended father shares parental responsibility with the Surrogate Mother.

- **An intended father who donated the sperm** – An intended father who donated the sperm cannot be considered the legal father upon birth because the law states that sperm donors cannot be treated as the father of the child (s.41 HFEA 2008). An intended father who donated the sperm does not become the legal father unless and until a parental order is made or the adoption is approved.

- **An intended father who did not donate the sperm** – If the Intended Father did not donate the sperm he can be registered on the birth certificate **only** if he fulfils the relevant "fatherhood conditions", which are:
- The Surrogate Mother is not married
- The Surrogate Mother was treated in a UK licensed clinic
- Both the Surrogate Mother and the Intended Father gave written, signed consent to the Intended Father becoming the father, and the consent was not withdrawn

- The consent must be given at the time when the embryo or sperm and eggs are placed in the Surrogate Mother
- The sperm used to fertilise the egg was **not** from the Intended Father and
- The man was alive at the time.

It will be exceptional for the Intended Father to satisfy the above fatherhood conditions. If the conditions are not satisfied then the Intended Father does not become the legal father unless and until a parental order is made or the adoption is approved.

5.4

The Legal Parents -To be legally recognised as the child's parents the Intended Parents must apply for a Parental Order or an Adoption Order

5.5

Parental Order - A Parental Order is a form of expedited adoption and the application is made to the family courts but cannot be obtained until the child is at least six weeks old. To get a Parental Order the Intended Parents must satisfy the all following conditions:

- At least one of the parents must be genetically related to the baby (i.e. is either a sperm or egg donor)
- The Intended Parents must be married, civil partners or a couple living in a long-term stable relationship
- The Intended Parents must apply within six months of the child's birth for the order
- The child must be living with the Intended Parents at the time of the application.

If the child is not genetically related to either Intended Parents, then the couple must apply for adoption. Additionally, a single person cannot apply for a Parental Order but must adopt the child.

A Parental Order/adoption will transfer all legal rights over the child to the Intended Parents and extinguish the legal rights of the Surrogate Mother. The Intended Parents should seek independent legal advice from their own solicitor when seeking to obtain a Parental Order or to adopt the child.

6.0 Antenatal Period

It should be noted from the outset that the intended parents do not have the legal rights to the fetus or to make decisions about the care during pregnancy. All professionals involved in the care of the surrogate mother must be aware of this when discussions and decisions are made regarding the pregnancy.

The Community Midwife will commence the Surrogacy Checklist (Appendix 1) at booking and forward with maternity booking paperwork. If this is an out of area booking, Antenatal clinic staff will commence the Surrogacy Checklist and file it in the Maternity Notes at the first Booking/Scan appointment.

The Surrogate Mother's confidentiality should be respected at all times. This means that no information about the Surrogate Mother or unborn child should be shared with the Intended Parents or any other third party without the express consent of the Surrogate Mother.

The midwife should respect the needs of the Surrogate Mother and encourage her to express her views. An open and supportive relationship between the midwife and the Surrogate Mother will help to alleviate any potential conflicts.

In addition, the midwife should encourage the two parties to engage in discussion about any screening tests and to undertake counselling regarding these tests. Both parties will need to consider how they might react should an abnormality be detected and how it would affect the surrogacy arrangements.

Ideally, discussions regarding the needs and preferences of the Surrogate Mother and Intended Parent/s regarding antenatal care, labour and beyond will take place well in advance so as to avoid any conflict or misunderstanding. The Surrogate Mother and Intended Parent/s (if agreed by the Surrogate Mother) should be offered an opportunity to meet with the Maternity Matron to discuss their wishes and preferences and these will be documented in the maternity records. This should include the plan for labour, birth, and the post-natal care in hospital.

A copy of the birth planning meeting will be filed in the Surrogate mother's hospital records, and staff providing care should refer to this information.

Discussions around completing the Surrogacy Consent Form (Appendix 2) should also take place.

Surrogate Mothers have the right to accept or refuse any medical treatment during pregnancy so clinicians should ensure that the Intended Parents are not coercing her.

6.1 Antenatal Information Requirement

It is important to obtain the following information:

- Names and dates of birth of both the Surrogate and the Intended Parent(s) (with their consent). Address and telephone number of both the Surrogate and the Intended Parent(s)
- Enquire if the Intended Parents have any other children. This is in order to assess the potential level of support that may be required and to assist in any Social

Services checks should these be required. If clinically appropriated surrogacy itself is not as reason to commence obstetric risk.

- Screening decisions are made by the Surrogate. Information regarding conception is required for the planning of appropriate care and screening tests. It is accepted that where donor eggs/sperm have been used this information will not be known.

6.2 Antenatal Screening

The surrogate should be offered all applicable antenatal screening tests for abnormalities.

If conception has been provided by a licensed fertility clinic the gamete providers and Surrogate should have been tested for HIV, Hepatitis and other transmittable infections as well as blood karyotyping and cystic fibrosis (along with other genetic tests).

If the pregnancy was through self-insemination the local screening guideline should be followed.

In the event of a termination of pregnancy is being considered (and the relevant legal conditions are met) the Surrogate makes the final decision.

6.3 Antenatal Care

The Surrogate should be offered care in line with local antenatal guidance

6.4 Parent Education

Intended Parent(s) may choose to attend parenting classes within the Surrogate's area or attend a ward tour which is appropriate and should be encouraged if requested. Intended Parents should be made aware of information regarding bonding, attachment, skin to skin and feeding in preparation for parenthood. Intended Parents should be treated as the future parents of the baby.

6.5 Discussion Points at the Birth Plan Visit (34-36weeks)

Consideration should be given that the birth plan will often be prepared and agreed as part of the Surrogacy Agreement. If this has not occurred, is not sufficiently detailed or details have changed since it was agreed it should be revisited and agreed (if possible) at this stage.

The Surrogates wishes will always take priority and a discussion will hopefully have already taken place between the Surrogate and the Intended Parent(s).

The Intended Parent(s) may be present at this visit if the Surrogate wishes and this should be accommodated.

Discussions should be sensitive and supportive to all those involved.

- Ensure the Intended Parent(s) are aware they will not be able to provide consent for any care (including emergency care) or procedure regarding the Surrogate or baby during the labour or birth. The baby has no legal rights until birth thus all decisions taken prior to the birth must be based upon the consent of the Surrogate. In the event the Surrogate lacks capacity decisions must be made in the surrogate's best interests.
- Discuss the completion of the Surrogacy Consent Form (Appendix 2) This delegated parental authority agreements allows the Intended Parent(s) to make decisions in relation to the treatment and/or care of the baby on behalf of the Surrogate. This is not legally binding until a parental order is agreed in court and parental responsibility then legally passes to the Intended Parent(s).
  This can not be applied for by the Intended Parent(s) at the family court until the baby is at least 6 weeks old.

7.0 Intrapartum

A decision about the presence of the Intended Parents at the birth should be made beforehand, and clearly documented in the hospital records. In the event of any conflict, the midwives should ensure that their duty always lies in supporting the Surrogate Mother. Staff providing care should refer to the Birth Planning meeting in the Surrogate Mother's hospital records.

It is important to remember that even where a birth plan has been agreed in advance (either within the unit or a formal written agreement drawn up independently by the parties) the Surrogate can change her mind at any time.

Decisions about feeding and caring for the baby should be made in advance by the Surrogate Mother and the Intended Parents and documented on the birth plan.

The Surrogate should receive intrapartum care in line with local intrapartum care guideline

8.0 Postnatal period

The immediate postnatal period can be an emotional time which may be compounded in a surrogacy arrangement and sensitivity is required in communications with the Surrogate Mother and Intended Parents. Where there is conflict, the midwife must focus her care on the Surrogate Mother and baby.

The Surrogate Mother remains the legal guardian of the baby until a Parental Order has been granted. Therefore, consent for any treatment such as medication and screening of the baby must be obtained from the Surrogate Mother even if the baby is handed over at birth. Staff should refer to the completed Surrogacy Consent Form (Appendix 2).

The Surrogate and baby should receive postnatal care in line with local postnatal care guideline

Every effort should be made to fulfil all reasonable requests made by Intended Parents and Surrogate Mother regarding postnatal care in hospital. From the birth of the baby, as long as there are no disputes regarding the surrogacy agreement, the Intended Parent(s) should be offered support as parents in accordance with the agreed birth plan and should be offered a private room for bonding.

In the event of the baby having an abnormality and/or being rejected by the Intended Parent(s) the staff must provide support for the Surrogate and contact the Senior Midwifery team/ Safeguarding team or Trust Legal team for advice.

8.1 Unwell baby

In the event that the baby is unwell or requires admission to the Neonatal Unit, wherever possible decisions about the baby's treatment should be made jointly by the Surrogate Mother and Intended Parents in conjunction with health professionals.

Please remember that even if an informal agreement has been made regarding responsibility between the Surrogate Mother and the Intended Parents the Surrogate Mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted. The Intended Parents have no legal rights over the baby until this time and the Surrogate Mother has the legal right to consent/ refuse treatment on behalf of her child.

Decisions made to provide or withhold care and treatment should always be made in the best interests of the baby. In the event of a dispute between (any of) the Surrogate, the Intended Parent(s) and the treating team that is not capable of resolution through discussion, legal advice should be sought through the Trust legal team. Where the baby's life is in immediate danger then treatment should be provided to preserve life and avoid serious harm in the best interests of the baby.

9.0 Discharge from Hospital

An early discharge from hospital should be facilitated if both mother and baby are fit and well.

As the Surrogate Mother is the legal mother at birth, the baby cannot be removed from the hospital by the Intended Parents without her consent. Written consent from the Surrogate Mother should be provided (Appendix 2) if the baby is to be discharged with the Intended Parent's and independently of her. A photocopy of this should be filed in the medical records and the original copy should be given to the Intended Parent.

Social Care do not need to be notified of the birth and discharge from hospital unless indicated to do so in the hospital records by the Named Midwife Safeguarding Children or if new safeguarding concerns arise.

Written consent is required for the discharge of the baby if the Surrogate is no longer in contact i.e.: if the Surrogate has been discharged and the baby is still in hospital. If the baby is admitted to NNU – written consent is also required from the Surrogate in order for the baby to be discharged to the Intended Parent(s).

Ensure the appropriate documentation is given to the Surrogate and the baby at discharge for the postnatal period. Discharge is at a mutually agreed point when the surrogate and the baby are fit and well. The surrogate may go home before the baby if they wish as long as the appropriate screening consent has been given and appendix 1 is signed , copies obtained by all parties and filed in both the Surrogate and baby's records.

If the Surrogate and the Intended Parent(s) live in the same area covered by the maternity unit the 2 different midwives should be allocated to deliver ongoing postnatal care, one for the Surrogate and another for the baby and Intended Parent(s). Special attention should be given to monitor the emotional and mental wellbeing of the Surrogate in the postnatal period especially once the baby has moved away with the Intended Parent(s). Continuity of carer should be provided as practically possible.

The intended discharge address and GP details of both the Surrogate Mother and the baby should be confirmed by staff in order to arrange appropriate postnatal care.

Ensure good communication is in place should the baby require any follow up from another department such as Audiology. If required ensure the new address for baby is communicated and appropriate transfer of care occurs.

9.1 Out of Area Discharge

In the event the Intended Parent(s) live in an area covered by a different maternity unit , inform the relevant maternity unit of the discharge so that continued postnatal care can be given.

There is no requirement to share the Surrogates details with the receiving area, share only the details of the Intended Parent(s) address and telephone number. If the receiving area needs to contact the Surrogate for example in the event of requiring consent whilst awaiting the Parental Order they can obtain this information from Barnsley maternity unit.

9.2 Health Visitor

If the baby is more than 10 days old at the point of discharge the appropriate Health Visiting team needs to be informed. The Health Visitor and Child Health for the area the baby was born in will have to be informed if the baby has been discharged out of area.

10.0 Birth Registration

The Law requires a birth to be registered within 6 weeks.

- **Where the Surrogate Mother is married** she and her husband will be named on the birth certificate as the parents. If the husband of the Surrogate Mother writes a letter stating that he did not give permission for the arrangement, the Intended Father can be named as the father.

- **Where the Surrogate Mother is unmarried** the Intended Father is usually the legal father, and he can be named as such on the birth certificate. However, because he is not married to the child's legal mother, he will have to attend the birth registration in order to be named on the birth certificate.

In both cases the baby can be given the Intended Parents' surname.

After a parental order is granted the Intended Parents are issued with a new birth certificate, which replaces the original birth certificate. This names both Intended Parents on the birth certificate.

UK birth certificates issued to fathers and mothers in same sex relationships following the granting of a parental order record both as parents.

11.0 Special Considerations

Conflicts may occur should either the Surrogate or Intended Parent(s) change their minds.

- A surrogate may change their mind after giving birth: even if they are not genetically related to the baby they will retain legal parenthood unless or until a parental order is made changing the legal position.
- The Intended Parent(s) may change their minds and refuse to take the baby home.
- In these situations all parties will need support and advice: support should be sort from the Trusts legal team.
- Should the Intended Parent(s) change their mind then the Surrogate is legally responsible for the baby. Should the surrogate also decide they do not wish to care for the baby the Children's Social Care will need to be informed - refer to Relinquishment Guideline

12.0 Mental Capacity for the Surrogate to make decisions

Should staff have any concerns regarding the mental capacity of the Surrogate to make any decisions about her pregnancy, labour and birth then a formal assessment of capacity should be performed.

Follow local guidance on Mental Capacity – see Appendix 3 (Mental Capacity Assessment Form)

13.0 Safeguarding

Surrogacy in itself is not and unborn child safeguarding concern and does not require an automatic safeguarding referral. However, if the member of staff has any safeguarding concerns that relates to:

- A surrogacy arrangement which appears unplanned and only comes to the attention of the maternity services late in pregnancy, in labour or the postnatal period
- The ability of the Intended Parent(s) to care for the baby
- Conflict between the adults in the surrogacy agreement e.g. the Surrogate appears under pressure to relinquish the baby against her will
- Concerns surrounding the amount of expenses being paid or the degree of voluntarism involved

An unborn/newborn baby in these circumstances could be at risk of physical and emotional abuse and/or neglect. It is the responsibility of the member of staff witnessing these to safeguard and promote the welfare of the baby (unborn or newborn) and a referral to Children's social care

Staff should be alert to any third parties (i.e. parties outside of the Surrogate Mother and Intended Parents) who may be acting illegally on a profit-making basis. Should staff

become suspicious that the parties are involved in a commercial arrangement they should contact the Named Midwife Safeguarding Children for further advice and guidance.

In the event of the Surrogate leaving the baby in hospital without informing staff of her intention, this may be considered as abandonment and a referral to children's social care made if there is no one else with legal parenthood. The Intended Parent(s) can make an application foe a parental order without the agreement of the Surrogate if she can not be found or is incapable of giving agreement.

14.0 Legal Parenthood prior to the grant of a Parental or Adoption Order

- If the Surrogate was married to, or in a civil partnership with another person at the time of the treatment then there is a presumption that that person will be the legal father or parent of the baby unless it can be shown that they did not consent to the treatment or were judicially separated at the time of treatment
- If there is no father or other parent then the Intended father can be the legal father at common law if their sperm was used (i.e. if they are the biological father of the baby), with the agreement of the Surrogate
- If there is no father or other parent then one (and only one) of the Intended Parent(s) may have legal parenthood if:
    - They are the Intended father whose sperm was not used
    - They are the Intended Mother whether their eggs were used or not

  And all the following are satisfied
- Treatment was performed by a licenced healthcare professional
- Both the Intended Parent and Surrogate have given (and have not withdrawn) the appropriate consent
- The Intended Parent and the surrogate are not within the prohibited degrees of a relationship
- As a husband or civil partner will supersede a biological parent, it is important to confirm the status of the Surrogate, highlighting with her the importance of the issue, prior to recording legal parenthood on the birth certificate

If there is any confusion to the above staff should direct the Intended Parent(s) and the surrogate to the HFEA website:

https://www.hfea.gov.uk/about-us/how-we-regulate/consent-forms/

These forms contain guidance as to who should complete them, how to do so and the reasons for why it's necessary.

14.1 Parental responsibility Agreement (Section 4 (1) (b) or Section 4ZA (1) (b) Children Act 1989)

Once the baby is born the surrogate may sign a Parental Responsibility Agreement with either of the Intended Parent(s). This allows the Intended Parent(s) equal rights with the Surrogate to make decisions about the baby even though the don't have yet legal Parenthood until a Parental Order has been issued.

14.2 Parental responsibility Agreement (Section 4 (1) (b) or Section 4ZA (1) (b) Children Act 1989)

A parental order is obtained through the application to the courts and makes the Intended Parent(s) the baby's legal parents. Parental Orders can be made by one or two applicants. This is the same as adoption but allows a quicker route in cases of Surrogacy.

In order to apply for a parental order the following criteria must be met:

- The baby must be genetically related to the Intended Parent or one-person applicant or one or both of the Intended Parents for a two-person applicant
- The Intended Parent(s) must be over 18 years of age
- Where there are two applicants, they must be married, civil partners or two persons living as partners in an enduring relationship and are not within the prohibited degrees of relationships
- The legal mother and father (i.e. the surrogate and her partner if she has one) must consent to the making of the order. Where the application is for one parent, consent must be obtained from any other person who is a parent of the baby but is not the applicant (by virtue of agreeing the 'parenthood conditions' i.e. through the 'appropriate consents' mentioned above or the biological father if he has been recorded on the birth certificate); this consent can not be given until 6 weeks after birth
- No money, other than reasonable expenses can be paid for the surrogacy arrangement
- The baby must be living with the Intended Parent(s) and one or both should be living in the UK
- The application must be made within 6 months of the birth of the baby
- There must not have been any previous parental orders relating to the baby (for an application made by one or two applicants under that part of the Human and Embryology Act 2008)

15.0 Roles and responsibilities

Midwives

- Are responsible for providing care and support to the Surrogate Mother, baby and where applicable the Intended Parents during the antenatal period, labour, birth and the postnatal period.

Named Midwife Safeguarding Children

- Will ensure that where a referral has been made to social care, any action or feedback is recorded in the hospital records prior to the birth
- Any new concerns will be actioned appropriately.

Professional Midwifery Advocates (PMAs)

- Can help support midwives to advocate for the surrogate

16.0 Associated documents and references

Department of Health, 2018, The Surrogacy Pathway: Surrogacy and the legal process for intended parents and surrogates in England and Wales, Department of Health, UK.

The Adoption & Children Act 2006.

Surrogacy UK. Information support community. Surrogacy Law in the UK. [online] Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales - GOV.UK (www.gov.uk)

17.0 Training and resources

Training will be given as documented in the Maternity Training Needs Analysis. This is updated on an annual basis.

18.0 Monitoring and audit

Any adverse incidents relating to the care of Surrogates and Intended Parents will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety. The guideline for the Care of surrogates and intended parents in Surrogate births will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be

reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

19.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

19.1 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Surrogacy Checklist

Antenatal checklist	date	signed	comments
At booking ensure full contact details for the Intended Parents (IPs) and the Surrogate Mother (SM) are recorded on the family assessment form: • Names • Contact details • Home addresses • Local hospital of the IPs if different to Barnsley			
At booking agree with the SM and the IPs a preferred terminology i.e. the IPs to be referred to as the *actual parents,* or the SM may wish to be identified as the *birth mother*. Clearly document this in the hospital records.			
At booking discuss and document how medical and informed consent works.			
After the 20 week scan e-mail the Health Visitors to inform of the surrogacy arrangement in the locality of the SM. This is to ensure that antenatal visit is not undertaken.			
At the 28 week appointment make contact with the IPs local Health Visitor (can be done via the IPs GP). Arrange a home visit from the Health Visitor to the IP's.			

From 28 weeks onwards, a birth plan is completed with the SM (and IPs if appropriate). The wishes for the birth and the postnatal period should be recorded and filed in the hospital notes. This should be done no later than 32 weeks.			
Inform the Lead Midwives in all areas of the planned birth wishes. Also inform the Paediatric team of consent arrangements and birth plan			

This checklist is not exhaustive and is tailored to each individual situation.

At the earliest opportunity following the birth ensure the *Surrogacy Consent Form* (Appendix 2) is completed. The original copy of this must go to the IPs and a copy must be placed in the SMs notes and if required into the Baby's notes. Ensure all staff are aware of this form and what it means.			
Whilst the baby's name bands must be in the name of the Surrogate Mother whilst in hospital, it is acceptable to offer a further set with the IPs surname on as a keepsake.			

When discharging: • Check IPs discharge address/telephone number • Ensure the discharge is forwarded to the IPs local maternity unit to ensure appropriate visits and support occur. • Photocopy the baby's section of the postnatal documentation for the IPs to take home for community midwife. • Check the SMs discharge address/telephone number • Ensure that details of the SMs discharge are forwarded to the appropriate community services for postnatal follow up			
Telephone 0-19 health visitors in Barnsley (01226 774411) to confirm the birth of the baby and discharge address/Intended parent's details. Inform that **no birth visit** is needed for SM.			

Appendix 2

Surrogacy Consent Form

I …… hereby give my consent to (Surrogate)
…….. and

……. (Names) who are the intended parents of

……. (Name of baby) to take care of him/her under a gestational surrogacy arrangement pending a joint application for a Parental Order (S54 Human Fertilisation and Embryology Act 2008).

I also confirm that I authorise them to give consent to any treatment that the baby might need between its birth and the making of a Parental Order and that the baby can be discharged from hospital with them.

Printed…….

Signed ……. (Surrogate)
Dated ……

Printed…….

Signed ……. (Intended Parents)
Dated ……

Printed…….

Witness ……
Dated ……

To be signed after the birth of the baby.

A copy is required to be given to the surrogate and copies must be placed in the surrogate and the baby hospital records. The original is given to the Intended Parents.

Appendix 3

Mental Capacity Assessment Form

Name: **DOB:**

Ward / Team: **Date of Assessment:**

Form completed by: **Job title:**

What reasonable adjustments have you made to enable the person to participate in the assessment? e.g. aids to communication, translator, time place and people present, written or pictorial information
Specify anyone who has been consulted to assist in this assessment e.g. someone who knows the person well (friend or family), a Speech and Language Therapist, a clinical specialist, Learning Disability Liaison Nurse
What pertinent information was provided and in what form e.g. verbal, written, easy read
Stage1
Does the person have an impairment of, or disturbance in the functioning of the mind or brain? If 'yes' give specific details, if 'no' then the Mental Capacity Act does not apply.
Details of decision to be made
Stage 2
1. Has the person understood the decision to be made and the consequences? **YES / NO** Give specific details showing your evidence to support your findings.
2. Is the person able to retain the information long enough to make a decision? **YES / NO** Give specific details showing your evidence to support your findings.

3. Has the person understood and weighed up the options before making a decision? **YES / NO** Give specific details showing your evidence to support your findings
4. Has the person communicated his / her decision? **YES / NO** Give specific details of how this was done, including the communication methods used

ASSESSMENT OUTCOME

If the answer to any question in stage 2 above is 'no' then the person lacks capacity to make decision.

Does the person have capacity to make the decision? Please put a cross in the appropriate box below		
Yes		The person makes their own decision even if it is considered by others to be an unwise one
No		**Proceed to a best interest decision**

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Document type (policy, clinical guideline or procedure)	Guideline
Document title	Guideline for the Care of surrogates and intended parents in Surrogate births
Document author (Job title and team)	Safeguarding/ Maternity Matron (inpatients)
New or reviewed document	New
List staff groups/departments consulted with during document development	Maternity, safeguarding, paediatrics.
Approval recommended by (meeting and dates):	Women's Business and Governance 15.03.24
Date of next review (maximum 3 years)	March 2027
Key words for search criteria on intranet (max 10 words)	Fertilisation, Embryology, Pathway, Donor, consent
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	**Name:** **Designation:**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): **Date approved:** **Date Clinical Governance Administrator informed of approval:** **Date uploaded to Trust Approved Documents page:**

Version	Date	Comments	Author
1	25/2/24		Maternity guideline group
2			Maternity guideline group
3			Maternity guideline group

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	14/05/2020
Reviewed at Women's Business and Governance meeting	22/05/2020
Approved by CBU 3 overarching Governance	26/08/2020
Approved at NICE and Clinical Guidelines Group	12/11/2020
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