The Dudley Group NHS Foundation Trust

Freedom of Information request 015816 – Surrogacy guidelines

16/8/21

Dear The Dudley Group NHS Foundation Trust

Do you have any clinical guidance regarding the maternity care of women involved in surrogacy and/or the intended parents?

If so, are you able to provide me with a copy, to see what aspects of care are covered?

Please see below

CARE FOR WOMEN INVOLVED IN SURROGACY GUIDELINE			
	DOCUMENT TITLE:	**CARE FOR WOMEN INVOLVED IN SURROGACY**	
	Name of Originator/Author /Designation & Specialty:	Specialist Midwife for substance misuse	
	Local / Trust wide	Trust Wide	
	Statement of Intent:	To provide guidance that ensures there is a consistent approach by all Health Care professionals when caring for women involved with surrogacy so there is appropriate care, referral and management of women within maternity services.	
	Target Audience:	Maternity and obstetrics	
	Version:	V1.0	
	Name of Review and Approval Group and Date when Recommended for Ratification	Virtual Policy Group	*Date* 3/8/21
	Name of Division/Group and Date of Final Ratification:	GAMe	*Date*
	Review Date:	August 2024	
	Contributors:	**Designation:**	
	The electronic version of this document is the definitive version		

CHANGE HISTORY

Version	Date	Reason
V1.0	July 2021	This is a new document

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

THE DUDLEY GROUP NHS FOUNDATION TRUST

CARE FOR WOMEN INVOLVED IN SURROGACY

1. GUIDELINE SUMMARY

Surrogacy is the act of a woman carrying a pregnancy and giving birth for a family who are unable to conceive or maintain a pregnancy themselves. There should be a holistic approach when providing care to families involved in a surrogacy arrangement and staff should be aware of the legal aspects involved. This should enable maternity services to provide those families with
a safe and high quality experience of birth for both the surrogate and intended parents with good outcomes for the child that takes into account the wishes of the surrogate and the intended parent/parents.

The below flowchart has been devised to act as an overview of the care that should be provided to the surrogate mother and intended parent/s throughout the journey of pregnancy, birth and the postnatal period.

Surrogacy flowchart

The Woman informs the Midwife during booking history that she is a surrogate. All antenatal care should be provided as per guideline. The midwife should refer to the Specialist Midwives for Vulnerable Women and for consultant led care.

The Surrogate mother should be seen alone where Domestic Abuse Routine Enquiry and Coercive Control Questions should be asked opportunistic and/or routine.

The Specialist Midwives for vulnerable women will arrange to meet with the Surrogate mother and if she consents, the Intended Parent/s to discuss details of the surrogacy arrangement. The wishes and feelings of both the Surrogate and Intended Parents need to be discussed and the Trust's ability to fulfil all reasonable requests.

Consent should be gained from the Intended Parent/s for the Midwife to make contact with the Community Midwife attached to their GP surgery in order to share information in relation to the Surrogacy arrangement and to arrange for a surrogacy assessment to be completed. Any concerns highlighted should be escalated appropriately.

A birth plan should be completed with the surrogate's and Intended Parents' wishes for birth and the postnatal period. A copy should be documented in the hospital antenatal care plan and woman's handheld maternity notes. The appropriate senior managers and lead midwives should have this information shared with them to confirm agreed arrangements and ensure that all staff are well-informed.

Every effort should be made to fulfil reasonable requests regarding postnatal care.

If the newborn is discharged separately to the Surrogate mother, consent should be gained from the surrogate mother and a copy of the consent form documented in the Surrogate's and newborn's records (See appendix).

Routine postnatal discharge to community care for the Surrogate mother and appropriate community midwifery care for the newborn.

As defined by the Surrogacy Act 1985, a ‘surrogate mother’ means a woman who carries a child in pursuance of an arrangement-

- Made before she began to carry the child, and
- Made with a view to any child carried in pursuance of it being handed over to, and the parental rights being exercised (so far as practicable) by, another person or other persons.

In January 2019 the Government made a change to legislation for The Human Fertilisation & Embryology Act 2008. This change now allows an individual applicant to obtain a parental order.
A parental order transfers legal parenthood to the Intended parent/s after a surrogacy arrangement.

2.1 TYPES OF SURROGACY

***Straight or traditional surrogacy*;** this is when the surrogate mother provides her own egg and the intended father provides a sperm sample. The egg is then fertilised with either naturally or by artificial insemination at home or through artificial insemination with the help of a fertility clinic.

***Gestational, Full or host surrogacy*:** this is when surrogate mother has no genetic link with the child but the embryos usually created from the eggs and sperm of the intended parents (IPs) (or where applicable, donor eggs or sperm). The embryos are created by in-vitro fertilisation in a fertility clinic.

2.2. SURROGACY AND THE LAW

Surrogacy is not prohibited by law. Altruistic surrogacy is a legal and an established way of creating a family in the UK. However, surrogacy through commercial arrangement is illegal (in accordance with section 2 Surrogacy Arrangements Act 1985) and therefore it is an offence for an individual or agency to act on a profit making basis to organise and facilitate a surrogacy arrangement for another person. Any persons or organisation that organise or facilitate a surrogacy arrangement must do so on a non-commercial basis.
Surrogate mothers can however receive reasonable expenses from the intended parents, such as for maternity clothing, insemination and IVF costs and costs of travelling to and from the hospital. More examples can be found in the ‘Surrogacy: review for Health Ministers of Current Arrangements for Payments and Regulation 1998’ available on the Department of Health website.
Staff should be alert to any third parties (i.e. parties outside of the Surrogate mother and Intended parent/s) who may be acting illegally on a profit making basis. Should staff become suspicious that the parties are involved in a commercial arrangement, they must ensure that they contact the Named Midwife for Safeguarding Children for support and advice.

2.3. SURROGACY ARRANGEMENTS AND THE LAW

The Courts have held that a surrogacy arrangement is not a legally binding contract and therefore, an arrangement between the Surrogate Mother and the intended parent/s is not enforceable. Either party are therefore free to change their mind at any time. The surrogate is the legal mother of the surrogate child until a parental order is granted to the intended parent/s, which has been made by a family court. The intended parent/s can begin the process to obtain a Parental order from when the child is six weeks until six months after the birth where certain criteria have been met. These include the surrogate gives consent, the child is being cared for by the intended parent/s and at least one of the intended parents being genetically related to the child.

Due to the legal complexities, health professionals should advise women involved in surrogacy arrangements that they may wish to seek the expert advice of a lawyer (DOH, 2018)

2.4. THE LEGAL STATUS AFTER BIRTH

The legal mother- The surrogate mother is the 'carrying' mother and therefore, in law is the legal mother of the child at birth. This even applies when there is a full surrogacy and the surrogate mother has no genetic link to the child.
The legal father-

- Where the surrogate mother is married- If the surrogate is married or in a relationship, then the surrogates partner will also assume legal parenthood status. This will assume once the baby is born until a parental order is made.
- Where the surrogate is not married, the IP who has provided the sperm can be registered as the legal father on the birth certificate and will gain parental responsibility for the child.

2.5. HOW THE INTENDED PARENTS BECOME THE LEGAL PARENTS

Heterosexual couples: In order for the intended parent/s to become the legal parents of the baby, they must either apply to adopt the baby or apply for a Parental Order. This is even if both the intended parents are the genetic parents of the baby.
It is important to realise that whilst a surrogate mother and/or the intended parent/s may wish responsibility for the child to pass to the intended parents at birth, the surrogate mother remains legally responsible for the baby until the baby has been legally adopted by the intended parent/s. The intended parents have no formal legal rights over the baby at this time.
Same sex couples*:* The Civil partnership Act 2004 set up the framework to allow same sex couples to achieve legal recognition of their relationship. Civil partners may apply to adopt the child, to apply for a Child Arrangement Order and/or a Parental Order.
Same sex couples could be those in Civil partnerships or those who are married under the marriage (same sex couples) Act 2013.
Foreign Intended Parents and British Surrogacy: if neither intended parent is a permanent resident in the UK, they will not be eligible to apply for a Parental Order. Adoption would therefore be the only available option to obtain legal parenthood.

2.6. SURROGACY AGREEMENTS

A surrogate mother and the intended parent/s will often draw up a surrogacy agreement prior to conception. This agreement sets out the surrogate mother and the IP/s intentions which include:

- Considerations around conception and managing the pregnancy.
- Considerations around birth planning.
- Considerations around care of the baby postnatally.
- When a comprehensive surrogacy agreement has been drawn up, this should consider all eventualities and decision- making events.

It is important to note that surrogacy agreements are not legally binding and do not override any other legal obligations. The surrogacy agreement should be used as a guide as opposed to a binding agreement.

In the absence of a pre-prepared written agreement staff should encourage the IP/s and surrogate 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).

As a health care professional, all professionals have a duty of care to the surrogate mother, as when supporting any other pregnant woman. The surrogate mother, with the advice of healthcare professionals where appropriate, will make the final decision both during and immediately after the pregnancy. Where, following the birth, the surrogate mother delegate's responsibility for the child to the IP/s, this should be documented clearly in the notes.

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 surrogate and IP/s) the surrogate mother can change her mind at any time.

2.7. CONSENT/ CONFIDENTIALITY/ INFORMATION SHARING

In surrogacy, it can be common that the surrogate and the IP/s agree that any information sharing by health care professionals should include both parties. The agreement and the approach to this are usually detailed in the surrogacy agreement. The surrogate mother's confidentiality should be respected at all times. It is essential that health care professionals establish what information she agrees to being shared with the IP/s, and ensure clear documentation when sharing any information that the surrogate has consented to. Health professionals should ensure that the surrogate and intended parent/s are aware of what medical consent and informed consent are. Staff should take care to confirm any point where confidentiality may be an issue. When information sharing has not been formally discussed between the surrogate and IP/s, staff should encourage both parties to have a formal discussion and clearly document the outcome in the surrogacy agreement.

Whilst a breach of patient confidentiality can be justified in certain circumstances such as when a professional has serious safeguarding concerns around the welfare of the surrogate, IP/s or child, or in a medical emergency, such circumstances are limited and are subject to strict criteria. Where staff members have any concerns they should escalate appropriately.

2.8. DATA PROTECTION ACT 2018 (GENERAL DATA PROTECTION REGUALTION – GDPR) LEGISLATION

The Trust has a duty under the Data Protection Act (2018) to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. Where consent is required, this must be explicit, informed and documented.

2.9. 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 her child in the postnatal period. Should staff have any concerns regarding the mental capacity of the surrogate, then a formal assessment of capacity should be performed, staff members are advised to follow the trust's Assessing Mental Capacity policy. In the event that the surrogate lacks capacity to provide consent or to make a particular decision, then treatment should begin having regard to the best interest of the surrogate.
In some rare cases, health professionals may raise concerns around the mental capacity of the IP/s during the pregnancy or when the child is born. When this occurs, further advice will need to be sought with regards to adult and child safeguarding assessments. Staff should contact the Named Midwife for Safeguarding Children to seek further advice and follow the trusts polices for safeguarding Children and Adults.

PROCEDURES

2.10. ANTENATAL CARE

It is important to recognise that the trust has a duty of care to the surrogate mother to provide maternity services. Where possible the Trust will attempt to accommodate and consider any requests that are set out in the surrogacy agreement. If a surrogacy agreement has not been prepared, staff should encourage the surrogate and intended parent/s to create one.
All applicable antenatal care should be provided to the surrogate mother as per the antenatal care guidelines whereby the surrogate mother should be referred for consultant led care. If the surrogate mother has given consent, then it is important to make the intended parent/s feel part of the process to achieve a safe, rewarding and positive experience for both parties.
The surrogate mother has the right to make all decisions relating to her antenatal care. It is important to remember that the unborn is not recognised as a "person" until birth and therefore the rights of the mother should take precedence over the interests of the unborn child. No one else can make decisions on her behalf.
If a woman has informed a health professional that she is being a surrogate mother for the intended parent/s staff should ensure that the surrogate and intended Parent/s do not feel stigmatised or judged. Staff should ensure a co-ordinated, flexible and consistent approach.
The Community Midwife should arrange to meet with the surrogate and intended parent/s to discuss the expectations from the surrogate and the intended parent/s. This should detail the preferred terminology for both the surrogate and intended parent/s. Where possible the intended parents are offered the option to have contact from a Community Midwife and Health Visitor allocated to their GP surgery. It is considered good practice for an antenatal surrogacy social risk assessment (**Appendix B**) to be completed by the Community Midwife with the intended parent/s

to ensure that all risks are considered such as alcohol consumption, smoking, previous social services involvement and contact information. The preparing for your baby discussion that covers important key information such as safe sleeping, home environment and equipment should also be completed at this time either with both parties or separately.

2.11. ANTENATAL SCREENING

When treatment has been provided in a licensed fertility clinic, the egg and sperm 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 patient's 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 the unborn child. It is therefore important that the surrogate mother (and her partner if she has one) are counselled of the risk and offered testing accordingly, prior to or after conception. Guidance also recommends that the intended father is also tested prior to insemination.

2.12. IF A SURROGATE MOTHER TESTS POSITIVE FOR A TRANSMITTABLE DISEASE

Should the surrogate mother be identified as having a transmittable disease, staff are prohibited from sharing this information with the intended parent/s or other third party without the consent of the surrogate mother. To do so would be a breach of patient confidentiality.
The surrogate mother should however be counselled of the risks of transmission of infection to the child and any recommended steps at birth to minimise the risk of transmission, in the usual way. If the surrogate mother has given consent, then the IP/s should be included in this counselling.
If one or both of the IPs are identified as having a transmittable disease, they should be advised to seek medical attention and treatment.

2.13. ANTENATAL SCREENING

The surrogate mother should be offered all applicable antenatal screening tests for abnormalities. Staff should only perform tests that the surrogate mother has consented to. The intended parent/s have no authority to demand testing that the surrogate mother does not consent to.
Should an abnormality be identified in the unborn child, staff should not share this information with the intended parent/s or third party without the consent of the surrogate mother. Where a termination of pregnancy is being considered, the surrogate mother has the right to a termination (provided her circumstances fall within the standard legal framework for termination) and should be referred to the relevant health care professionals.

2.14. BIRTH PLANNING

As part of the surrogacy agreement, the surrogate and IP/s will often have prepared a birth plan. Within the birth plan, this sets out the preferred method of delivery and who will be present, who will hold the baby after delivery and who will make decisions about the child's welfare etc. Staff should be aware that these agreements are not legally binding and should be used as a guide only.

In the absence of a completed surrogacy birth plan, staff should work with the surrogate and where possible the IP/s to develop an agreed birth plan. For surrogacy supported through the national altruistic surrogacy organisations (Surrogacy UK, COTS and brilliant beginnings) the surrogate and intended parent/s will usually have access to a template for a surrogacy birth plan. This will assist in ensuring a workable and clear plan is in place. Whilst it is clearly beneficial for discussions to take place with the intended parent/s, final decisions about birth must be made by the surrogate mother.

Once a birth plan has been agreed, if the surrogate provides consent, a copy of the completed birth plan should be filed in;

- The surrogate mothers hospital care plan and handheld notes.

The information should then, with consent, be shared with;

- The safeguarding team are made aware to provide advice and support.
- The appropriate senior managers such as the Inpatient Matron

Regardless of the planned birth outcome, the surrogate and the IP/s should be supported by healthcare staff to outline in the birth plan if the surrogate wishes for the IP/s to be present. Health professionals that are involved in providing care should ensure that they have read the notes and are aware of the situation; this should ensure that the surrogate and intended parent/s do not feel they need to continuously explain their situation.

POSTNATAL CARE

2.18. POSTNATAL CARE FOR BABY

The Midwife should ensure a clear handover of care to the Midwife, and again ensure that they are fully aware of the surrogate arrangement and the surrogate and IP/s's wishes. As the mother is the legal mother at birth, the baby cannot be removed from the hospital by the Intended Parent/s without the consent from the surrogate. It is important that staff members are aware that although the Intended Parent/s will often take of the care of the child, they should not be admitted as a patient at the hospital. Often the surrogate will consider her role to be finished following birth and wish to be discharged independently to the baby. The surrogate should sign a copy of the consent form for neonatal discharge (**appendix A**) and ensure that a copy is attached to the surrogates and child's hospital records and a copy shared with the Community Midwives.
Routine postnatal care should be provided to the surrogate mother, and where possible staff members are to facilitate reasonable requests that are detailed in the birth plan. Staff should be aware of the surrogate mothers psychological well-being and if staff have any concerns to follow the trusts 'Maternal mental health guideline'.

2.19. WHEN A CHILD BECOMES ILL AND IS IN NEED OF TREATMENT

In most circumstances the surrogate mother will hand over responsibility to the intended parent/s, this is usually included in the surrogacy agreement and staff are to confirm that this is the approach both parties wish to adopt and ensure they clearly document this discussion. A copy of the written consent should be filed into the hospital notes. If the surrogate mother has consented to the intended parent/s taking

over the care of the child, it is usual practice that health care professionals are to consider the wishes of the intended parent/s regarding treatment of the sick child and ensure that they are included in any discussions regarding the child's health.

The surrogate mother remains legally responsible for the baby until a Parental Order has been issued or the child has legally been adopted by the Intended Parent/s. The surrogate mother has the legal right to consent/refuse treatment on behalf of the child. The Intended Parent/s have no legal rights over the baby until an order is issued.
Whilst the surrogate mother cannot surrender or transfer any part of her responsibility to the intended parent/s without the permission of the court, she can arrange for some or all of it to be met by one or more persons acting on her behalf (i.e. the intended parent/s). This arrangement however is not legally binding.
Therefore, as a matter of law, even when the surrogate mother has delegated the care of the baby to the intended parent/s, this does not mean that she relinquishes all legal rights or responsibilities to the child or that the intended parent/s automatically assumes the legal right to make a decision about the baby.

2.20. DISPUTE BETWEEN THE SURROGATE AND THE INTENDED PARENT/S

Where there is a dispute between the surrogate and the intended parent/s the trust should attempt to work with the surrogate mother and the intended parent/s at all times. Although in surrogacy disputes are rare, if unresolved, the surrogate mother's wishes should be respected at all times, regardless of the surrogacy agreement or consent forms that may have previously been signed. The surrogate mother has parental responsibility in law to consent/refuse treatment on behalf of the child (subject to the usual test of best interests). Staff should seek advice and support from the Named Midwife for Safeguarding Children.
If the intended parent/s attempt to remove the baby from trust premises against the surrogate mothers wishes, staff should consider informing the police, subject to the consent of the surrogate mother.
Should staff have any concerns about the welfare of the child, staff should follow standard procedures in terms of risk assessment and involvement of other appropriate agencies.

2.21. IF THE INTENDED PARENT/S CHANGES THEIR MINDS

If the intended parent/s change their mind about taking the child, for example, if their circumstances have changed and they feel unable to take on responsibility for the child, the surrogate mother (and her partner if she has one) will be legally responsible for the child.
In the event that the surrogate mother also refuses to take on the responsibility of the child, children's services should be contacted.

2.22. IF THE SURROGATE MOTHER CHANGES HER MIND

If the surrogate mother changes her mind and wishes to keep the child, the trust must respect these wishes. In this situation the intended parent/s can apply to the Family Courts where the courts will make a decision based on the best interest of the child, irrespective of the surrogacy agreement.
If there is a disagreement between the surrogate mother and the intended parent/s, staff should contact the Named Midwife for Safeguarding Children.

2.23. COMMUNITY SUPPORT

The usual discharge process should be followed for both the surrogate mother and the child. The Community Midwife should offer routine visits to the surrogate mother. Staff should be aware of the surrogate mothers psychological well-being and if staff members have any concerns to follow the trusts guideline on maternal mental health. As the intended parent/s and child are discharged to another address separately of the surrogate mother, all usual discharge information should be clarified and sent to the Community Midwife, GP and Health visitor. A copy of the consent form for Neonatal screening that has been signed by the surrogate should be documented in the child's notes and a copy provided to the intended parent/s. The Community Midwife should follow the usual hand over of care to the Health visitor and GP.

1. DEFINITIONS/ABBREVIATIONS (IF APPLICABLE)

Intended Parent/s (IP) – These are couples who are considering surrogacy as a way of becoming parents. This could be from a heterosexual or same sex couple in a marriage, co-habiting/living together in an enduring relationship or couples in a civil partnership. In order for intended parents to apply for a parental order, at least one of the IPs must be a genetic parent of the child who is born to them through surrogacy.

Surrogate - This is the preferred term for a woman who consents to help the intended parent/s by carrying children for them to create families for the IP/s.

2. TRAINING/SUPPORT (IF APPLICABLE)

Training to be included within vulnerable women's study day but more support is available as needed. Please see below for available resources.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843891/Care_in_surrogacy_-_guidance_for_the_care_of_surrogates.pdf

3. REFERENCES

- Brazier. M, Vincent Campbell. A and Golombok, S. (1998) Surrogacy: review for the UK Health Ministers of current arrangements for payments and regulation.
- Civil Partnership Act (2004), [online] Available at: http://www.legislation.gov.uk/ukpga/2004/33/contents [Accessed on 06th March 2020]
- Data Protection Act (2018), [online] Available at: https://www.legislation.gov.uk
- Department of Health (2018) Care in Surrogacy: Guidance for the care of surrogates and Intended parents in surrogate birth in England and Wales.
- Human Fertilisation and Embryology Act 2008 [online] Available at: https://www.legislation.gov.uk [Accessed on the 6th March 2020]
- Management of women with perinatal mental health attending for maternity care guideline (20017), Birmingham Women's and Children's NHS Foundation Trust.
- Surrogacy Arrangements Act 91985), Section 2 [online] Available at: http://www.legislation.gov.uk [Accessed on 06th March 2020]

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APPENDIX A

Consent form to be signed by the surrogate mother when baby is being discharged with the intended parents independently from the surrogate mother.

Consent to be gained during the antenatal period:

I understand that (Baby)…… can be discharged independently of me and I confirm my explicit consent for (Baby)……..... to be discharged to the care of:
IP Names: …… and ……..
In accordance with the terms of the surrogacy agreement dated……..
Signature of surrogate…….

Consent to be obtained once the baby is medically fit for discharge:
I confirm my explicit consent to the discharge of (Baby)……..
(D.O.B)…….
To the care of: IP Names: ……
and ……..

And independent to me, in accordance with the terms of the surrogacy agreement
(Date)…….

Neonatal screening will be discussed prior to the discharge of the baby. I (the surrogate)…… give advanced consent for baby…….. to have the neonatal screening, by way of a heel prick test, performed by the Midwife caring for baby whilst resident with the intended parents.
Signature of surrogate…….

A copy of the agreement should be filed in the patients notes and must be completed prior to the discharge of the baby from hospital. Copy to be shared with the Community Midwife. Please note that this is not a legal document and parental responsibility remains with the surrogate mother until a parental order is gained.

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APPENDIX B

SURROGACY RISK ASSESSMENT FOR INTENDED PARENTS

Your details: intended parent (IP 1)
Name:
D.O.B:
Address:
GP:

Your details: intended parent (IP 2)
Name:
D.O.B:
Address:
GP:

Social Assessment	
Difficulty understanding English:	Yes / No
Difficulties reading/writing:	Yes / No

Social Assessment	
Difficulty understanding English:	Yes / No
Difficulties reading/writing:	Yes / No

Tobacco use	
Are you a smoker?	Yes / No
Have you ever smoked tobacco?	Yes / No
Was this in the last 12 months?	Yes / No
When did you stop?	Yes / No
Anyone else at home smoke?	Yes / No

Tobacco use	
Are you a smoker?	Yes / No
Have you ever smoked tobacco?	Yes / No
Was this in the last 12 months?	Yes / No
When did you stop?	Yes / No
Anyone else at home smoke?	Yes / No

Drug Use	
Have you ever used street drugs, cannabis, or psychoactive substances (legal highs)?	Yes / No
Have you ever injected drugs?	Yes / No
Have you ever shared drug Paraphernalia?	Yes / No
Are you receiving treatment?	Yes /No
Any drug or alcohol concerns at Home?	Yes / No

Drug Use	
Have you ever used street drugs, cannabis, or psychoactive substances (legal highs)?	Yes / No
Have you ever injected drugs?	Yes / No
Have you ever shared drug Paraphernalia?	Yes / No
Are you receiving treatment?	Yes /No
Any drug or alcohol concerns at Home?	Yes / No

Alcohol use	
Do you drink Alcohol?	Yes / No
Alcohol units?	_____

Alcohol use	
Do you drink Alcohol?	Yes / No
Alcohol units?	_____

Previously or currently known to Children Social Care?	Yes / No
Details:	
Referral to relevant agencies?	Yes / No
Referrals shared with?	

DISCUSSED

Preparing for your baby:

Parent education: ☐
Home environment:
Safe sleeping: ☐
Equipment:
Vitamin K: ☐

Newborn physical examination: ☐
Newborn blood spot test:
Newborn hearing screen: ☐

Respondi ng t o your bab y' s needs: ☐

Importance of comfort and love to;
Help brain development:
Recognising feeding cues: ☐

Preparing for your new baby: ☐

Safe sleeping:

Sudden Infant Death Syndrome (SIDS) which is commonly referred to as cot death is a sudden and unexpected death of a baby where no cause is found. While SIDS is rare, it can still happen and there are steps parents can take to reduce the risks of it happening. These include;

- Placing your baby on their back to sleep in a "feet to foot" position, in a cot, Moses basket or bedside crib in the same room as you for the first 6 months.
- The cot/crib that baby is sleeping in should be clear which means no cot bumpers, soft toys, loose bedding, pillows, duvets or sleep positioners.
- Not smoking in pregnancy or letting anyone smoke in the same room as your baby.
- It is important not to share a bed with your baby if you have been drinking alcohol, are under the influence of drugs or if you are a smoker.
- Never sleep with your baby on a sofa or armchair.
- Making sure baby is a comfortable temperature where s/he is not too hot or too cold and the room temperature is 16-20°C.

- It is recommended that you follow this advice for all sleeps that your baby has and not just for night time sleeps.
  For further information: www.lullabytrust.org.uk

Equipment:

Every new parent needs some essentials for their new baby. In the early days, you will need clothes, nappies and feeding equipment. You need something for your baby to sleep in such as a cot or a Moses basket. If you have a car or will be travelling in one, you must have a car seat that your baby will travel in for every journey. Think about other ways of carrying your baby when you are out, such as baby carriers/ slings or prams/ pushchairs.

Newborn screening:

After birth, your baby will be offered some screening tests. The blood spot test is designed to identify those few babies who may be affected by PKU, cystic fibrosis, congenital hypothyroidism, MCADD, MSUD, HCU, IVA, GA1 and haemoglobinopathy disorders. Two detailed examinations of the baby will be performed, one within 72 hours of the birth and one when your baby is 6-8 weeks old. These check your baby's eyes, heart and lungs, nervous system, abdomen, hips and testes (in boys). The hearing test is designed to find babies who have a hearing loss. Your midwife will give you a leaflet explaining these screening tests. For further information visit: www.screening.nhs.uk/annbpublications

Vitamin K:

We need vitamin K to make our blood clot properly so we do not bleed easily. To reduce the risk of a bleeding disorder, your baby should be offered vitamin K after birth. The most effective way of giving this is by an injection (Oral doses may be an option).

Greeting your baby for the first time:

Holding your baby in skin to skin contact soon after birth is the perfect way to say hello. Skin contact will help you both to feel calm, give you time to rest, keep warm and get to know each other. As your baby recognises your voice and smell, they will begin to feel safe and secure. Take time to notice different stages your baby goes through to get ready for their first feed.

Respondi ng t o your bab y' s needs:

New babies have a strong desire to be close to their parents as this helps them to feel secure and loved. When babies feel secure they release a hormone called oxytocin which helps their brain to grow and develop. If you choose to bottle feed, your baby will enjoy being held close, and fed by you and your partner rather than by lots of different people.

Feeding your baby:

When you use formula milk to feed your baby, your midwife will give you information about how to hold your baby for feeding and how to make up feeds safely.

Appendix C

Surrogacy arrangement birth plan.

Name (sticker)……	**Intended Parent/s:**
Hospital No……	Name……..
DOB……..…	DOB……
Contact No……..	Name……
	DOB……
	Address……..
	……
	Contact No……

Pre-birth plan (tick when complete) **N.B if the mother already has a pre-written agreement/ plan this should be used and filed in the records.**	**Tick**	**Name and Signature**
Inform the specialist Midwives Team		
Meet both surrogate and Intended Parent/s to discuss their wishes and feelings		
Guideline discussed/ Shared with both parties		
Advise on their legal responsibilities (refer to Guideline)		
Develop birth plan with the surrogate mother and Intended Parent/s and inform management of wishes for birth and the postnatal period		
File birth plan in the hospital records		
Advised to seek legal advice or/and contact COTS Tel 01549 402777 info@surrogacy.org.uk		
Responsibility for decision making in respect of the baby signed by surrogate mother and a copy filed in the records		
Place of birth:		
Preferred method of delivery and pain relief		
Birth partners		

Post Birth plan		
Immediately following birth, the baby to be passed to…..		
Postnatal stay for the surrogate mother:		
Postnatal stay for Intended Parent/s and the Child:		
Feeding arrangements for the Child		
Who will make decisions for the Child's welfare?		
Registration of birth discussed (this can also be done pre-birth)		
Discharge arrangements for the Surrogate Mother		
Discharge arrangements for the Child		
Community Midwife/ GP services		
Other		

Name:	Address:	Contact Number:

Name:	Address:	Contact Number:

Signature of the Surrogate mother:		

Print:		Date:

Agreed delegation of responsibility for the welfare decisions for the child
As the surrogate mother, I wish to delegate the responsibility of the making decisions about the welfare of the child to …….

The Dudley Group NHS Foundation Trust

Guideline Consultation Form

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Please ensure that you receive either a confirmation or comments from a stakeholder (via an email) before you add their details to the consultation section on the procedural document

What is the title of the procedural document:			
CARE FOR WOMEN INVOLVED IN SURROGACY			
Date of Submission:		**Author**	
Is there a similar/same document already in existence / if so will this document replace this one or is it in addition?			
No – new guideline			
In addition to the central HUB page for procedural documents will it need to be linked to any other pages? Please list below			
N/A			
Consultation: Please list the stakeholders who have been consulted in the development of this document and the date they confirmed agreement of its content. This is any member of staff/groups who will be part of or affected by this. If this was a group please list attendees:			
Name	**Designation**	**Date Confirmed Agreement**	
SPECIALISTS / GROUP/S (if no Specialists / Groups consultation identify the reason why)			
	Lead Midwife	18/10/20	
	SPMW for screening	26/6/21	
	SPMW substance misuse	02/08/21	

	Consultant Obstetrician	26/6/21
DIVISIONAL MANAGEMENT CONSULTATION (if no Management consultation identify the reason why)		
	Matron OPD	28/07/21
	Deputy Matron and interim governance lead	29/07/20
	Interim Clinical Director	28/6/21
PHARMACY CONSULTATION (if medication referred to in guideline, pharmacy must be consulted)		
OTHER		
	Midwife	2/7/21

Check List

(This page to be deleted from the document prior to adding to HUB Trust Central document page)

Prior to submission of the Guideline for ratification please ensure you can answer yes or N/A to all of the questions below.

	Yes/No
1. Title	
Is the title clear and unambiguous?	Y
2. Front Sheet Completion	
Is the colour banding strip green?	Y
Is the Author identified (name and designation)?	Y
Does the statement of intent clearly identify what the document intention is?	Y
Is the target audience identified?	Y
Is the document version controlled?	Y
Have the people contributing to the document been identified on the Front cover Sheet as per designation and not individual names?	Y
Has the change history been fully completed?	Y
Is there evidence that appropriate consultation has taken place? Refer to consultation document which should be submitted with the document?	Y
3. Body of the document	
Does the document follow a logical, succinct, clear format for the main body?	Y
Is there a footer on each page recording; document title, date of issue, version number, page number and number of pages?	Y
Is the document written in Arial 12pt font?	Y

Does the document contain individual designations and NOT names?	Y
Are procedural documents relating/supporting this document linked?	Y
Does the numbering run in sequence?	Y
4. Definitions / Abbreviations (If Applicable)	
The meaning for any definitions or abbreviations used are clearly stated?	Y
5. Training / support (If Applicable)	
If there is identified training or support this is clearly cited?	Y
6. Evidence Base(If Applicable)	
Are references cited in full?	Y