Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Title of Guideline	**Surrogacy**
Contact Name and Job Title (Author)	[redacted] Community midwife
Division & Specialty	Surgery – Obstetrics
Guideline Number	**Obs 131**
Version Number	5
Date of Review	March 2026
Approving Committee(s)	Clinical Cabinet
Date of Approval	15th March 2023
Explicit definition of patient group to which it applies	Maternity patients
Abstract	
Statement of evidence base of the guideline Evidence Base (1-5)	

1a	Meta analysis of RCT
1b	At least 1 RCT
2a	At least 1 well designed controlled study without randomisation
2b	At least 1 other well designed quasi experimental study
3	Well –designed non-experimental descriptive studies (ie comparative / correlation and case studies)
4	Expert committee reports or opinions and / or clinical experiences of respected authorities
5	Recommended best practise based on the clinical experience of the guideline developer

Consultation Process	O&G Guideline Group
Target Audience	Maternity staff
This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date.	

Surrogacy

Written by [redacted], Supervisor of Midwives, July 2015, amended by [redacted] Named Midwife for Child Protection and Safeguarding Vulnerable Families October 2015, further amended by [redacted] and [redacted] October 2016. Updated by [redacted] and [redacted] March 2020 (v4). Reviewed March 2023 (v5)

Definition

The Surrogacy Arrangements Act (1985) defines a surrogate mother as:

"A woman who carries a child in pursuance of an arrangement –

a) Made before she began to carry the child, and

b) 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 reasonably practicable) by, another person or persons"

The intended parents (IPs) are those who wish to bring up the child after birth. They may be either one or both genetic parents or neither one genetically related.

Introduction

Surrogacy is the practice whereby one woman (the surrogate mother) becomes pregnant with the intention that the child should be handed over to the intended parents (IPs) after birth.

One in seven heterosexual couples is reported to experience problems with infertility in the UK (NICE, 2013). This may be overcome with treatment however common reasons why IPs may look to surrogacy include:

- Recurrent miscarriage in spite of all possible treatment
- Repeated failure of IVF treatment
- Premature menopause, often as a result of cancer treatment
- A hysterectomy or an absent or abnormal uterus.

Since April 2010 it has also been possible for same-sex couples to undertake surrogacy in the UK. This guidance will apply to all intended parents irrespective of sexuality.

There are many regulations governing surrogacy within the UK. These are set out in The Surrogacy Arrangements Act (1985), The Review of the Surrogacy Law (1998) and the amended Human Fertilisation and Embryology Act (1990). Surrogacy is legal in the UK however no third party should be involved on a commercial basis – that is, receive fees for 'brokering' a surrogacy relationship and the surrogate can only receive payment to cover the expenses that she has incurred in being pregnant for her IPs.

Types of Surrogacy

There are two types of surrogacy:

Straight / Partial (Traditional Surrogacy)

Straight surrogacy is the simplest and least expensive form of surrogacy and is also known as artificial insemination. The surrogate uses an insemination kit to become pregnant using the intended father's semen. The baby will therefore be conceived using the surrogate's egg.

Some people prefer to use a clinic for inseminations, but it can also happen at home conducted without the knowledge of any other agency. Whilst this type of surrogacy can seem a more natural and less 'medical' way of becoming pregnant than host surrogacy, Surrogacy UK warn that it can be harder emotionally for both the surrogate and the IPs.

Full / Host / Total (Gestational Surrogacy)

A 'full' surrogacy is when an embryo is created in vitro, usually using the IPs' egg and sperm, and is transferred to the surrogate mother's uterus. The surrogate therefore does not use her own eggs, and is genetically unrelated to the baby. As In Vitro Fertilisation (IVF) is involved, these arrangements are regulated by the Human Fertilisation and Embryology Authority (HFEA). It is a legal requirement that licensed clinics are used in these procedures.

There are three stages to this type of surrogacy:

- **Egg donation**: the female intended parent, or the egg donor, undergo special procedures to extract a number of eggs
- **Fertilisation:** the egg is fertilised with semen in the laboratory
- **Transfer:** the fertilised egg is transferred into the womb of the surrogate mother

The fertilised egg can be transferred to the surrogate either 'fresh' or after having been de-frosted from egg storage.

The Legal Position

Surrogacy is not prohibited by law. 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 or facilitate a surrogacy arrangement for another person. Any persons or organisations who organise or facilitate a surrogacy arrangement must do so on a non-commercial basis.

Surrogate mothers can however receive reasonable expenses from the IPs, such as for maternity clothing, insemination and IVF costs and costs of travelling to and from hospital. More examples can be found in '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 IPs) 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 for Safeguarding for further advice and guidance.

A surrogacy arrangement is not a legally binding contract and therefore, an arrangement between the surrogate mother and the IPs is not enforceable. Either party is therefore free to change their mind at any time.

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 where there is full surrogacy and the surrogate mother has no genetic link to the child. The legal mother has the right to keep the child. However, parenthood can be transferred by parental order or adoption.

UK law does not enforce contracts signed between surrogates and IPs even where IPs have paid expenses to the surrogate.

The Legal Father

- 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 parent will only gain parental responsibility for the child once he/she is named on the birth certificate. At this point he/she becomes a legal parent of the child. The General Register Office makes no distinction between births that have arisen by way of self-insemination or by IVF at a licensed clinic. Once named on the birth certificate, the intended father shares parental responsibility with the Surrogate mother.
- Where the sperm of the intended father, or an embryo created with his sperm, is used after his death, that man will not be treated as the father of the child.

Parental Orders

IPs must apply for a parental order if they want to become the legal parents of the child. This is true even if both of the IPs are the genetic parents of the baby.

For the purposes of a UK parental order, the surrogate mother must give her full and informed consent to hand over the child to the IPs.

This consent can only be given 6 weeks after the child is born and no earlier. It must be given in writing and must be notarised. Applications for parental orders must be made within 6 months of a child’s birth.

Until a parental order is granted the surrogate as the child's legal mother will remain legally responsible for ensuring that the proper arrangements are made for the care of her child whilst in the custody of the IPs.

To be able to apply for a parental order, IPs must be genetically related to a child i.e. the egg or sperm donor and in a relationship where they are either:

- Married
- Civil Partners
- Living as Partners

If neither Intended Parent is domiciled 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.

Due to the legal complexities of surrogacy all parties planning to enter into a surrogacy agreement should be advised to seek legal advice.

Confidentiality

The surrogate mother's confidentiality should be respected at all times. This means that no information about the surrogate mother or the unborn child should be shared with the IPs or any other third party without the consent of the surrogate mother.

Whilst a breach of patient confidentiality can be justified in certain circumstances, such circumstances are limited and are subject to strict criteria. As noted above, where staff become suspicious of a commercial arrangement, they should contact the Named Midwife for Safeguarding for further advice and guidance.

Care Management

Antenatal Care

Antenatal Screening Infectious Diseases

The British Medical Association in their paper "Considering Surrogacy? Your questions answered" (2007) highlight that parties should consider screening for HIV or hepatitis (or other applicable transmittable disease) prior to conception.

Where treatment has been provided in a licensed clinic, the eggs and the sperm to be used will be tested for HIV, hepatitis and other transmittable diseases. However, with self-insemination, there will be a risk of transmission of infection to the surrogate mother. It is therefore important that the surrogate mother is counselled of this risk and offered testing accordingly. The guidance also recommends that the intended father is tested prior to the insemination.

If the surrogate mother is identified as having a transmittable disease, staff are prohibited from sharing this information with the IPs 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 about 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.

Antenatal Screening for Fetal Abnormality

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 IPs 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 IPs or other third party without the consent of the surrogate mother.

Termination of Pregnancy

A surrogate mother has the right to a termination (provided her circumstances fall within the standard legal framework for abortion). The IPs have no right to prevent a termination taking place. The IPs should not be informed about a termination unless the surrogate mother has given her consent for this information to be shared.

Mental Capacity of the Surrogate mother to make decisions

Should staff have any concerns regarding the mental capacity of the surrogate mother to make decisions about her pregnancy, a formal assessment of capacity should be performed (staff are advised to follow Policy TW13-039 Mental Capacity Act 2005 (including Deprivation of Liberty Safeguards). In the event that the surrogate mother lacks capacity to make a particular decision, treatment should be administered, in accordance with trust policy, having given regard to the best interests of the surrogate mother and staff should seek advice if needed from the WWL Safeguarding Team, Trust solicitor and social care prior to administering non-emergency treatment in such circumstances.

Birth Planning

A surrogate mother and the IPs will often sign up to a written agreement (for example, the organisation, COTS (Surrogacy in the UK), provide a template agreement and guidance on the issues this may include. This agreement usually sets out the preferred method of birth, who will hold the baby after birth 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 as opposed to a binding agreement.

In the absence of a pre-prepared written agreement, staff should work with the surrogate mother and, where possible, the IPs (in so far as the surrogate mother consents to their involvement) to develop an agreed birth plan. This will assist in ensuring a workable and clear plan is in place relating to e.g. the preferred method of delivery, attendance at delivery, who the baby will be passed to at birth, use of drugs during delivery etc. However, whilst it is clearly beneficial for

these discussions to take place with the IPs, final decisions about delivery must be made by the surrogate mother.

Where a birth plan is completed with the involvement of the community midwife it should be discussed with the Head of Midwifery. A copy of the birth plan should be placed copy in both the handheld notes and the orange notes and also scanned and attached to the Euroking record.

The surrogate mother, with the advice of healthcare professionals where appropriate, will make the final decisions both during and immediately after the pregnancy. Where, following birth, the surrogate mother delegates responsibility for the child to the IPs, this should be written clearly in the medical notes. Staff should request that the surrogate mother records in writing that she is delegating responsibility for the baby to the IPs. Whilst the surrogate mother cannot surrender or transfer any part of her responsibility to the IPs without the permission of the court, she can arrange for some or all of it to be met by one or more person acting on her behalf (i.e. the IPs). This arrangement is not however legally binding. Further details of how responsibility passes to the IPs can be found in section 6.2 of this Guidance.

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 mother can change her mind at any time.

Postnatal Care

As the surrogate mother is the legal mother at birth, the baby cannot be removed from the hospital by the IPs without her consent. Staff should ensure they have written consent from the surrogate mother before handing over the baby and that this is done, wherever practicable, in the presence of the surrogate mother and the IPs. Staff should consider informing children's social care, only if safeguarding concerns arise, to ensure that both the surrogate mother and the IPs are able to receive appropriate support and advice.

The intended parent should not be admitted as a patient of the Trust on the maternity IT system. If the surrogate mother requests that the intended parent be permitted to stay with her until the baby is discharged, this should be accommodated where possible and recorded in the notes. Where, following birth, the surrogate mother delegates responsibility for the child to the IPs, this should be written clearly in the medical notes. If this is the case, wherever possible, the intended parent may be accommodated separately with the baby in a side room on the postnatal ward. Parenting support and advice will then be provided to the intended parent until the baby is discharged. This arrangement must be recorded in the surrogate mothers notes and also the baby's notes, stating that this is the request of the surrogate mother.

If the baby is not fit for discharge and requires treatment, it should be labelled with one of the birth mother's name bands and also labelled as 'baby of mother x', then the baby's date and time of birth, in line with the drug board. On

discharge a label may be supplied saying ‘baby Y and date and time of birth. In this instance, a side room will be offered where available for the IPs, though this will be assessed on an individual basis and depend on availability. It should be stressed that most cases only one parent stays with the baby in normal circumstances. If the baby requires admission to Neonatal Unit then cares can be given by the IPs.

The surrogate mother will require a community midwife to visit. 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 surrogate mothers, Reame (1990) suggested that 75% experienced a degree of postnatal depression for 2-6 weeks following the birth. For this reason, access to a community midwife should be encouraged for 28 days.

The IPs and the baby will require a community midwife to visit and the baby’s discharge should be communicated to the community midwife, health visitor and GP in the normal way. This may be an out of area discharge, if so it is vital that during the antenatal period the IPs address, telephone number, local hospital and GP contact details are recorded in the antenatal records.

The immediate postnatal period is a time of great emotional upheaval, which may be compounded in a surrogacy arrangement. Great sensitivity is required in caring for both the surrogate and IPs. Where there is conflict the midwife must focus her care on the surrogate mother and the baby.

Changes In Arrangements

What happens if there is a dispute between the IPs and the surrogate mother?

The Trust should attempt to work with the surrogate mother and the IPs at all times. Should a dispute arise, the surrogate mother's wishes should be respected at all times and staff may wish to consider contacting the Named Midwife for Safeguarding for further advice and guidance.

If the IPs attempt to remove the baby from Trust premises against the surrogate mother's wishes, staff should inform the Police.

Should staff have any concerns about the welfare of the baby, staff should follow standard procedures in terms of risk assessment, involvement of other appropriate agencies as well as invoking child protection procedures (if applicable).

What if the IPs change their minds?

If the IPs change their minds about taking the child, for example, if their circumstances have changed or if the child is born physically or mentally disabled and they feel unable to take on the responsibility, 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, social services should be contacted in the usual way.

What if the Surrogate Mother changes her mind?

If the surrogate mother changes her mind and wishes to keep the baby, the Trust must respect her wishes. In this situation, the Courts will usually allow her to keep the baby. If there is disagreement between the surrogate mother and the IPs, the Named Midwife for Safeguarding should be contacted.

Consent

Consent for immunisations and any medical procedures

In most circumstances, the surrogate mother will hand over responsibility to the IPs on an informal basis, at birth. However, the surrogate mother remains legally responsible for the baby until a Parental Order has been confirmed or the baby has been legally adopted by the IPs. The IPs have no legal rights over the baby until this time.

Those conducting the Examination of the Newborn as part of the National Screening programme need to gain consent from the surrogate mother prior to commencing the examination.

In order to complete the NIPE screening, information will be needed from the surrogate mother and IPs to identify risk factors that may impact on the screening elements of the exam; particularly if the surrogate's own genetic material is used. The red child health record book can to be given to the IPs along with discharge information.

The Parental Order giving the IPs parental responsibility will not usually be awarded until the baby is around 6 months old. This can cause problems where consent is required and most frequently arises in the case of immunisations.

If the surrogate mother can attend with the IPs for immunisations there is no problem but this is often not practical. The surrogate mother can authorise the IPs to exercise parental responsibility on her behalf. If the surrogate mother signs a letter giving consent for the baby to have the standard immunisation programme, this is usually sufficient as this is in the best interests of the child.

In the event of a dispute between the surrogate mother and the IPs, it is the surrogate mother who has parental responsibility in law to consent/refuse treatment on behalf of the child (subject to the usual test of best interests).

Should a dispute between the surrogate mother and the IPs arise, staff are advised to contact the Named Midwife for Safeguarding for further advice.

Birth Registration

Where the Surrogate Mother is married

If 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

If the surrogate mother is unmarried and the intended father is present when the birth is registered, he may be named as the father on the birth certificate and thus obtain parental responsibility. This is true whether the birth came about by self-insemination or by IVF at a licensed clinic. The IPs will need to obtain a Parental Order to become the legal parents. The birth can then be re-registered to show the IPs as the parents of the child. In both cases the baby can be given the IPs surname.

Record Keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Wrightington, Wigan & Leigh NHS Foundation Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the **date and time** together with **signature, printed name and designation.**

Human Rights Act

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

Procedure

	Action	Rationale
1.	The Trust is not legally obliged to provide any special treatment of either the surrogate or the IPs. However, we aim to meet their needs.	To uphold the good name of the Trust and facilitate streamlined care.
2.	The Head of Midwifery and hospital inpatient Matron/ward manager should be informed.	To aid care planning and service provision for maternity, birth and the postnatal period.
3.	The relevant Social Care Children's Duty Team for the surrogate, her partner and the IPs, should be contacted, **only** if any safeguarding concerns are identified by the booking in midwife to perform a safeguarding check on the surrogate/her partner and the IPs. **Surrogacy itself is not a safeguarding concern.** (Be mindful in these circumstances to acquire full names/dates of birth/addresses of all parties involved including previous children names/dates of birth/addresses from both families and inform them that this is taking place). The Named Midwife for Child Protection and Safeguarding Vulnerable families (01942 822821) should be informed only if safeguarding concerns are identified.	To ensure that safeguarding concerns are acted on appropriately if needed to safeguarding the unborn And to ensure effective liaison between all agencies and services involved.

4.	In surrogacy, it is common for the surrogate and the IP(s) 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 IP(s). If the parties have not included this point in their surrogacy agreement, they should be encouraged to discuss it and to record it in their agreement. Staff should make sure that any consent to share information is recorded, and they should take care to confirm any point where confidentiality may be an issue.	Care in Surrogacy. Guidance for the care of surrogates and IPs in surrogate births in England and Wales - DOH 2019.
5.	The surrogate and the Intended parents should both be offered mainstream services, e.g. Parenthood, and an antenatal home visit considered wherever service provision allows, (This may be in a different hospital if the woman chooses to book/deliver out of area, so it is the responsibility of the booking in midwife assigned to that hospital to liaise with all agencies - especially community midwives in the area where the surrogate/IPs live, to format a plan for antenatal classes applicable for that hospital/place of birth and to take the lead)	To ensure equality and knowledge for the safety of the baby and to ensure effective communication and a clear plan is in place for all concerned

6.	A detailed birth plan, which forms part of the agreement should be devised and agreed by all parties, in the prior to conception. This is generally thoroughly carried out by Surrogacy UK and a copy of the agreements can be sought via any of the involved parties. Sensitive areas such as analgesia in labour, cutting of the umbilical cord or skin to skin at birth, should be clearly outlined and documented on the birth plan and a copy placed in the hand held notes and the orange notes and also scanned and attached to the Euroking record. (See Appendix 1 for surrogacy birth plan).	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. Surrogacy should have comprehensive, trust-based agreements between the surrogate and IP(s) (known as surrogacy agreements), which cover most eventualities and desired outcomes; these should be reflected in birth plans and engagement with healthcare staff.
7.	Intended parents should be invited to attend scans and health appointments. Any decisions regarding the antenatal period or the birth, should however, always be in the favour of the surrogate and in line with her wishes. If an anomaly is found or treatment is necessary antenatally, this should not be shared with the IPs until consent is gained from the surrogate.	As per the legal requirements.
8.	Where service provision allows for it, the Trust policies around attendants at birth should be relaxed to allow both couples to be present at the birth. Prior discussion with the maternity inpatient matron/ward manager should take place to facilitate this.	To ensure that a robust plan is in place in preparation for the birth.
9.	Skin to skin with the intended parents should be encouraged.	To provide equality and encourage bonding.

10.	In the event of a caesarean section, elective or emergency, it should be noted that normally only one other person may be present in theatre and recovery with the surrogate. The surrogate and IPs should be made aware of this in the antenatal period. One additional IP may be able to be present but this requires the agreement of the whole surgical team.	To ensure that all Trust Health & Safety arrangements are upheld. If all the team agree and there is space in the theatre health and safety will not be compromised
11.	Should service provision allow it, and the birth mother has delegated responsibility to the IPs, a side room can be allocated to allow the Intended Parents to stay with the baby immediately after birth and provide cares. Basic baby cares should be demonstrated to the IPs, as per any other new parents. IPs may provide cares in the Neonatal Unit with written consent for treatment from the birth mother.	To provide equality.

12.	Taking the baby home and hospital discharge. Discharge from hospital should be mutually agreed between healthcare staff, the surrogate and IP(s), recognising that it will be the IP(s) who will be the main caregivers to the child. There is no reason why the 'hand over' of the baby to the IP(s) should take place outside hospital premises and hospital staff should not suggest this. In the absence of other concerns or factors, there is also no need for a referral to be made to social services simply because the child is being handed over to the IP(s) as part of a surrogacy arrangement.	

References

1. COTS Surrogacy in the UK www.surrogacy.org.uk
2. Human Fertility & Embryology Authority www.hfea.gov.uk
3. Department of Health (2008) email dhmail@dh.gsi.gov.uk
4. The Adoption & Children Act 2002
5. The Surrogacy Arrangements Act chapter 49 (1985)
6. A Guide to Surrogacy for Health Professionals, Surrogacy UK (2010)
7. Rights for Surrogate Mothers, GOV.UK
8. Reame, NE & Parker, PJ (1990) Surrogate Pregnancy: Clinical features of 44 cases. American Journal of Obstetrics and Gynaecology 16(2): 1220 - 1225
9. Considering Surrogacy? Your questions answered (2007) The British Medical Association
10. Brazier, M., Campbell, A. and Golombok, S. (1998) Surrogacy: Review for health ministers of current arrangements for payments and regulation. Report of the review team (online).
11. National Institute for Health and Care Excellence (2013 updated 2015) Fertility problems: assessment and treatment.
12. Care in Surrogacy: Guidance for the care of surrogates and intended parents in surrogate births in England and Wales Department of Health & Social Care Feb 2018

Process for audit

There are no specific audit criteria for this guideline but it will be audited as required dependent on clinical indications.

Appendix 1

Surrogacy Birth Plan

Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

Surrogacy Birth Plan

Name

Surrogate Mother and Intended Parents agreement

Date

EDD:

Plan Developed with:

Arrangements and agreement as to who will be attending and supporting the surrogate mother for Birth	
In the event of an elective section	
Birth Partners?	
	Commissioning Parents **Both IPs will attend as birthing partners (usually only 1 birthing partner for caesarean section)** **In total agreed 3 birth partners**
Ensure plans are in place for community midwife to undertake home visit to Intended parents' home. **Community Midwife Contact numbers for commissioning parents:**	Ensure offer of parent education is offered to Intended parents **Complete – referred to CMW**
Midwife to inform the following when . . . . . presents in the hospital	
Named Midwife for Safeguarding **Community Matron** **Hospital Matron**	
Intrapartum care, including pain relief	
Preferred mobility?	Involvement of Students? N/A
Method of analgesia?	Use of fetal monitoring? If required
Use of ARM?	Use of oxytocics?

Preferred positions for birth -	Use of episiotomy N/A
Who will baby be handed to immediately post-delivery?	Cutting of nuchal cord:
Management of the third stage	Planned caesarean section.
Placental disposal	Use of Vitamin K
Infant feeding choice and skin to skin	Special request following delivery
Emergency Situations	
Obstetric Haemorrhage	Need for emergency caesarean section
Companions roles in such situations.	If baby is required to go to SCBU the Midwife providing care would be responsible for communicating the surrogacy arrangements and plan to SCBU staff. Parental responsibility remains with the surrogate mother. . . . . will sign an agreement stating that the commissioning parents can give consent for treatment.
Postnatal Care	
Length of stay agreed by both surrogate and Intended parents? Comments: **In the event that . . . . . 's discharge is delayed but baby is fit for home, ... can hand the baby over to Intended parents for discharge.** **Where there is a single room available, this should be offered to Intended parents. If there is not a room available, the parents will be able to access extended visiting.**	Method of Feeding **Intended parents address:** **Maternity Hospital** **Labour Ward:** **Community Midwives office:**
Have Health Visiting Services for Intended parents been informed?	Details of Health Visiting Services notified:
Has Child Health Department been notified?	Have Intended parents been advised to inform their GP?

<table>
<tr><td>Have Intended parents been offered parent education?</td><td>Have visiting times and security issues been discussed with Intended parents?

Intended parents - tour around Midwifery Led Unit Suite</td></tr>
<tr><td>Has surrogate provided consent for new-born screening and treatment if required?
YES/NO</td><td></td></tr>
<tr><td colspan="2"><u>Detail of plans agreed for handover of the baby</u>

• . . . . will be discharged from Wigan Hospital to the care of . . . . .Maternity Services. It is recommended that the Community Midwife provide extended visits up to 28 days.

• Trust staff are not permitted to hand the baby to the Intended parents. This must be done by the surrogate mother. The names and address and GP details of the Intended parents must be clearly documented on the baby's discharge summary

• . . . . 's discharge information is to be communicated to . . . . .Maternity services.

• The baby's discharge information is to be communicated to:
Community Midwives office:
Health Visitors:
G.P. of Intended Parents:
Entered correctly on hospital systems:

• Intended parents must be made aware when and how to register the baby.

• This birth plan once agreed to be shared with the following:-
Named Midwife Safeguarding
(Community Midwife)
copy in hand held records
Copy within hospital notes/Maternity Bleep Folder
Copy SCBU/Theatre</td></tr>
<tr><td>Has surrogate agreed plans for parental order?
YES/NO

Comments:</td><td>Notification to midwives / health visitors / safeguarding leads / GP in area of surrogate and commissioning parents residence
YES/NO
Has confidentiality of information including the potential for media interest been discussed?
YES/NO</td></tr>
<tr><td colspan="2">Is there the likelihood of media interest? YES/NO
Comments from commissioning parents: As stated in Surrogacy UK agreement in notes.</td></tr>
<tr><td colspan="2">Signed:

Surrogate mother . . . .

Intended parents . . . .</td></tr>
</table>