Surrogacy

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1	New	July 2018	

Equality Impact

Bolton NHS Foundation Trust strives to ensure equality of opportunity for all service users, local people and the workforce. As an employer and a provider of healthcare Bolton NHS FT aims to ensure that none are placed at a disadvantage as a result of its policies and procedures. This document has therefore been equality impact assessed to ensure fairness and consistency for all those covered by it regardless of their individuality. The results are shown in the Equality Impact Assessment (EIA).

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1. Purpose

1.1 The purpose of this guidance is to provide a clear and legal framework within which midwives and the wider professional team can best support surrogate women whilst appreciating the position of the commissioning (intended) parents.

2. Content

2.1 This guidance does not override the individual responsibility of healthcare professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and /or carer. Healthcare professionals should be prepared to justify any deviation from this guidance.

2.2 Some couples may require the assistance of a surrogate in order to create a family. Surrogacy is when a woman carries a child for someone who is unable to conceive or carry a child for themselves.

2.3 This guidance is for use by the following staff groups:

2.4 This guidance applies to all healthcare professionals irrespective of grade, level, location or staff group.

3. Key Terminology

3.1 Intended Parents (IPs): These are couples who are considering surrogacy as a way to become a parent. They may be heterosexual or same-sex couples in a marriage, civil partnership or living together/co-habiting in an enduring relationship. To apply for a parental order (which is the way that legal parenthood is transferred from the surrogate to the IPs) at least one of the IPs in a couple must be a genetic parent of the child born to them through surrogacy. IPs generally prefer to be referred to as the parents of the child.

3.2 The Government announced its intention to introduce legislation to change the law so that a single person will also be able to apply for a parental order to transfer legal parenthood to them if they are an IP in respect of a surrogacy arrangement, provided they have a genetic link to the child. This change is expected in 2018.

3.3 Surrogate. This is the preferred term for women who are willing to help IPs to create families by carrying children for them. A surrogate may or may not have a genetic relationship to the child that she carries for a couple. Surrogates generally do not prefer to be referred to as the mother or parent of the child.

The Surrogacy Arrangement 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 is practicable) by another person or persons.”

3.4 The midwives duty is to the mother and child and this must come before the interests of any person on whose account the mother is bearing the child.

3.5 The duty of care to the baby remains paramount even following transfer to the IPs.

4. Types of Surrogacy

4.1 Traditional or straight surrogacy. This is where the surrogate uses her own egg, which is fertilised with the intended or commissioning father's sperm; this may be done by self-insemination using a syringe or done in an infertility clinic.

4.2 Gestational, full or host surrogacy. The surrogate carries the commissioning parent's genetic child conceived through in-vitro fertilisation an infertility clinic.

5. Legal position of surrogacy

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

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

6. Legal parenthood in surrogacy

6.1 The surrogate is the legal mother of the surrogate child from birth until legal parenthood is transferred to IPs through a parental order made by a family court. If the surrogate is married or in a relationship, her partner will also assume legal parenthood status of the child from birth until the parental order is made. IPs can start the process to obtain a parental order from six weeks until six months after the birth if certain criteria have been met, including the child being in their care, having the consent of the surrogate and at least one IP being genetically related to the child. The parental order process is normally straightforward and it is usual for a child to be cared for by the IPs from birth (with the surrogate's consent).

6.2 If the conception in a surrogacy arrangement takes place in a licenced clinic and the appropriate consent forms are completed, if the surrogate is not married, the IP who provides the sperm can be registered as the legal father on the birth certificate. A parental order would still be necessary to transfer the legal parenthood of the second IP.

7. Legal Aspects

7.1 In the United Kingdom the birth mother is the legal mother irrespective of the conception method and genetic make- up of the baby.

7.2 The surrogate's husband if married is considered the legal father and neither can surrender parental duties (Mason and Laurie 2006).

7.3 The courts have held that a surrogacy arrangement is not a legally binding contract and therefore an arrangement between the surrogate mother and the commissioning parents is not enforceable.

7.4 The Parental Orders (Human Fertilisation and Embryology) Regulations 1994 came into effect in November 1994 which brought into effect section 30 of the Human Fertilisation and Embryology Act 1990, also known as Parental Orders. This allows commissioning (intended) parents the opportunity to become the child's legal parents. Under English law, one the Parental Order is granted the commissioning/intended parents will receive a new birth certificate stating they are the legal parents of the child.

7.5 A Parental Order is issued by the Family Proceedings Court in the applicant's home area and the following criteria must be met:

- Over 18 years of age
- The commissioning parent must be resident in the United Kingdom
- At least one of the applicants must be genetically related to the child
- The application can be made after 6 weeks of the birth and before 6 months
- The surrogate parents must consent to the making of the order
- No money other than expenses must have been paid in respect of the surrogacy arrangement
- The child must reside with the IP.

7.6 In accordance with Section 2, Surrogacy Arrangements Act 1985 surrogacy through a commercial arrangement is illegal and it is therefore an offence for an individual or agency to act on a profit-making basis to organise or facilitate a surrogacy arrangement for another person.

7.7 Surrogate mothers can however review reasonable expenses from the intended parents, such as maternity clothing, insemination, and IVF costs and costs of travelling to and from hospital. Staff should be alert to any third parties (ie parties outside the Surrogate mother and Intended parents who may be acting illegally on a profit making basis. Should staff become suspicious that the parties involved in a commercial arrangement, they should contact the Lead Safeguarding Midwife for Children.

8. General Guidance

8.1 Mental capacity. It is essential that the surrogate has the mental capacity to consent to surrogacy and to make decisions about her care and that of the child post-partum. Should staff have any concerns regarding the mental capacity of the surrogate, then a formal assessment of capacity should be performed (staff are advised to follow the Trust's consent policy). In the event that the surrogate lacks

capacity to provide her consent or to make a particular decision, then treatment should be given having regard to the best interests of the surrogate. However, staff are advised to consult the Trust's Lead on Mental Capacity, taking into account the Mental Capacity Act 2005, prior to administering non-emergency treatment in such circumstances. As part of this process, the adult safeguarding team should be involved and an assessment of need/support undertaken and action taken accordingly.

8.2 The surrogacy agreement should be clear as to whether the surrogate agrees to IPs being the sole decision makers for the care of the child from birth. In rare cases, healthcare staff may have concerns regarding the mental capacity of the IPs. This may arise during the pregnancy or when the child is born. In this situation, further advice will need to be sought with regards to adult and child safeguarding assessments. The lead midwife, obstetrician and named nurse/midwife for safeguarding must be informed and a multi-disciplinary team review is advised, taking into consideration guidance and potential for deprivation of liberties. In such rare situations, the child will remain in the care of the surrogate until the IPs have been counselled and seen by a clinic's counsellor (or a psychologist), social worker and members of the mental health team to make a clear assessment of their mental capacity. If the child cannot be cared for by the surrogate, children's services will need to be involved and an interim arrangement facilitated.

8.3 Health care professionals have a legal duty of care to the surrogate mother and the baby once born. The wishes of the surrogate are paramount and the IPs will only become involved with her direct consent or until such time as the IPs seek a parental order or adopt.

8.4 The multi-professional team should be non-judgmental and encourage the surrogate to be open and honest about the arrangements to ensure a good relationship based on trust.

8.5 Record keeping details of the surrogacy agreement should only be documented in the health care records with the surrogates consent.

8.6 The confidentiality of the surrogate mother should be respected at all times. Information should only be shared with the IPs with the consent of the surrogate mother and only on a need to know basis.

8.7 The Head of Midwifery should be informed of all surrogate pregnancies and may wish to meet with the surrogate and the commissioning couple.

8.8 The Local Authority needs to make enquiries when it is made aware that a baby has been or is about to be born as a result of surrogacy so as to be satisfied that the baby is not, or will not be at risk as a result of the arrangement.

8.9 The community midwife must ensure early liaison with the relevant Social Services in the area where the surrogate mother and the commissioning parents reside.

9. Antenatal Care

9.1 Planning of care during pregnancy is vital so that the midwife ensures that the surrogate mother receives the care she requests which may include involvement of the commissioning parents (Appendix 1).

9.2 Arrangements to meet the surrogate alone with the team leader or matron should be made to ensure her choices for birth are not influenced by the commissioning parents; and then a further meeting with both the surrogate and the commissioning parents to discuss and record the plan for birth.

9.3 Attention should be paid to care planning relating to the following as they may influence the surrogacy agreement:

- Screening tests and the plan of care if an abnormality is detected and forward planning relating to the potential for termination of pregnancy.
- Place of birth: - If the surrogate agrees it may be appropriate for the intended parent to be present.
- Management of labour and birth including pain management and support should also be discussed and a clear plan documented in the maternity records.
- Surrogate mothers wishes relating to the care of the baby in the case of her being unable to communicate this if she is unwell.
- Method of feeding and immediate care of the baby. Consideration of the Trusts position relating to the commissioning mother staying in hospital to provide care and potentially initiation of breast feeding.

10. Intrapartum

10.1 If the surrogate mother agrees, the IPs may be present at the birth.

10.2 Health care professionals should ensure that the wishes of the surrogate remain paramount.

11. Postnatal

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

11.2 If an early discharge for either surrogate mother or baby is not possible various options can be explored dependant on the surrogate mother and the IPs wishes:

- Baby to stay in hospital with surrogate mother (if either mother or baby are unable to be discharged)
- Baby to be discharged with IPs.

- Surrogate mother to be discharged and baby stay in hospital with the IP..

11.3 In ALL cases the surrogate MUST 'hand over' the baby outside the unit even if this requires her to return to the unit.

11.4 The commissioning parents who take the baby have no legal relationship with it and no rights in law until a parental order has been made (Appendix 2)

11.5 Routine postnatal care should be provided to the surrogate mother. Particular care should be paid to her psychological state and additional support offered. Additional postnatal visits may be required and should be decided on an individual basis.

11.6 Consent for medication/screening of the baby **MUST** be obtained from the surrogate mother even if the baby is handed over at birth.

11.7 The baby requires routine postnatal care. If the IPs are providing this care it may be appropriate to admit the surrogate and the intended parent where they can stay together and provide care to the baby.

11.8 Early postnatal communication with the Health Visitor for the IPs is advised.

11.9 Transfer to the Health Visitor should ensure continued care for the surrogate mother as well as the baby and the commissioning couple particularly if they live in different areas.

11.10 To ensure that both the surrogate and child receive follow-up care in the community

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

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

12. What If The Baby Becomes Ill And Needs Treatment?

12.1 Where possible decisions about the baby's treatment should be made jointly by the surrogate mother and the IPs on an informal basis at birth. However the surrogate mother remains legally responsible for the baby until a parental order has been granted or the baby has been legally adopted by the IPs.

12.2 The BMA in their 'Considering Surrogacy' guidance, state that provided the baby has been 'passed' to the commissioning (intended) parents by the surrogate mother responsibility for decision making should pass to them.

12.3 Where a surrogate mother informs staff that she has handed over responsibility for the baby to the IPs, staff should consult with the IPs in respect of decision-making and seek their consent to procedure accordingly. Staff should request that the surrogate mother records in writing (Appendix 2) that she is delegating responsibility to the intended parents. Whilst the 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 persons acting on her behalf. This arrangement is not legally binding. As a matter of law the surrogate mother has parental responsibility at birth and therefore has the legal right to consent/refuse treatment on behalf of her baby. This is the position until the IPs have obtained a parental order or adoption proceedings are finalised.

13. Information needed for surrogacy documentation

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

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

- A birth plan is completed with the surrogate's (and IPs' if appropriate) wishes for the birth/postnatal period, which should include the surrogate's wishes for the IPs (for example, whether to be present at the birth/during postnatal inpatient stay).
- That preferred terminology is agreed with both the surrogate and IPs and clearly documented in the maternity notes.
- All parties are aware of how medical consent and informed consent works.

13.3 Clearly document all aspects of surrogacy including what the surrogate and IPs have agreed in terms of participation and decision-making.

- Clearly document any consents that the surrogate has given, e.g. consent to share information with the IPs and parenthood consents.
- Ensure that full contact details for the IPs are recorded:
- Names, contact numbers, home address
- Address / fax / telephone numbers for the following:

  - Local maternity hospital
  - Community midwives
  - Health visitors
  - Local GP surgery

13.4 Intrapartum. Please ensure the following:

- The birth plan is discussed with the midwife caring for the surrogate and that all team members have had the opportunity to read the notes and are aware of the situation.
- The surrogate's wishes for the IPs are clear (for example, whether to be present at the birth/during postnatal inpatient stay).

13.5 Post-natal period. Please ensure the following:

- Postnatal ward staff are clear of the surrogate's wishes relating to the IPs and a realistic expectation regarding plans for accommodating the surrogate's wishes, and those of the IPs is achieved.
- The agreement between the surrogate and IPs regarding the care of the child is clearly documented in the maternity notes and the new-born notes and Midwife and GP of the IPs.
- Staff should ensure that correct protocols are followed as explained in the guidance.

14. Information to be included in surrogacy birth plan

Aim: to ensure that maternity care is appropriate for both the surrogate, as the woman receiving care, and IPs and to ensure that communication between them and the multi-professional maternity team is facilitated.

Where the surrogate and IPs are supported by a national altruistic surrogacy organisation, their documentation for birth planning can be used. Parties are encouraged to seek support and guidance from their organisation as needed.

14.1 Names and contact details

- Surrogate name, date of birth and contact details
- IPs' name(s), date(s) of birth and contact details
- Where the surrogate has a spouse/partner, name and contact details
- Details of community midwife/midwives supporting surrogate and IPs

14.2 Birth-planning meeting

- Date of surrogacy birth-planning meeting
- Who attended birth-planning meeting
- Which healthcare professional(s) the plan was created and agreed with

14.3 Surrogate pregnancy details

- Surrogacy organisation used (if any)
- Form of surrogacy – straight or host
- Expected delivery date for child
- Summary of fertility treatment from clinic (if available)

14.4 Antenatal care

- Confirm that all routine antenatal care has been/will be received
- Who will attend scans and appointments with the surrogate

14.5 The birth

- Where the surrogate would like to give birth
- The surrogate's birth partner
- Who will attend the birth, if: - Vaginal
  - Planned caesarean section
  - Emergency caesarean section, epidural
  - Emergency caesarean section, general anaesthetic

- Pain-relief options
- Who will make decisions for surrogate if she can't speak during birth
- Handling of child at birth (cord cutting including intentions for delayed cord clamping, skin-to-skin, holding the baby thereafter)

14.6 Post-partum care

- Who will care for child following birth, and when and where will transfer of care take place
- Who will make medical decisions about care/treatment for child
- Feeding method (surrogate breast milk through expressed feeds, intended parent breast milk, donated breast milk, formula)
- Name bands (what name appears on child's name band and can IPs request one)

- Guest/family visiting rights
- Discharge of surrogate, IPs and child, including surrogate's wishes regarding early discharge if delivery uncomplicated
- Who the child will be discharged with
- Surrogate postnatal healthcare needs (assessment and care should include physical, emotional and mental health)
- IPs' and baby's postnatal healthcare needs (for example, midwifery support with care of baby; assessment of, and support for, IP's emotional well-being and mental health).
- Where surrogate, IPs and child will stay after birth, both in the immediate post-partum period and if longer stay is required (including possibility of amenity room for IPs and child following birth)

14.7 Communication and consents

- Confirm that the following professionals have been informed of the pregnancy and impending arrival of the child. Provide their names and contact details.
- Surrogate's GP and community midwives
- IPs' GP, community midwives and health visitors
- Confirm birth plan has been communicated with / made available to the following people, and provide their names and contact details:
- Head of Midwifery at surrogate's local hospital
- Supervisor / supervisory team at surrogate's local hospital
- Maternity Unit at surrogate's local hospital
- Confirm that the appropriate professionals will be informed of the discharge of the surrogate and child following birth and relevant documentation sent to ensure appropriate and seamless care is provided to all:
- Surrogate's community midwives, health visitors and GP
- IPs' local maternity hospital, community midwives, health visitors and local GP surgery
- 'Child health' information to include IPs' and their local GP's address and contact details to ensure information, e.g. vaccination appointments, etc. is addressed appropriately
- Appropriate written consents from the surrogate for transfer of care for the child to the IPs, for neonatal screening tests and for decision making for treatment.
- clearly record any necessary consent by the surrogate for the IPs to make decisions about the baby (note that the existence of a surrogacy agreement does not override any subsequent decision by the surrogate who remains the child's legal mother until parenthood is transferred).
- Check discharge details for the IPs:
- Names, contact numbers, home address - Address / fax / telephone numbers for the following:
    - Local maternity hospital;
    - Community midwives;
    - Health visitors; and
    - Local GP surgery.

15. Monitoring Compliance

Area to be monitored	methodology	Who	Reported to	frequency
Documentation all present in notes and fully completed	Audit of notes	Matrons/midwives	WQF	As required

Appendix 1: Surrogacy Plan

Plan for NAME DOB and RMC

Information giving

Arrangements for delivery

Staying in hospital

Following Delivery

If mother goes home first

If baby goes home first

Discharge

Intended parents contact details:

Appendix 2: Form for documenting the arrangement that birth mother has requested for commissioning couple to act on her behalf in caring for baby and making decisions in the baby's best interest.

"*A person who has parental responsibility for a child may not surrender or transfer any part of that responsibility to another but may arrange for some or all of it to be met by one or more persons acting on his behalf*" Section 2(9) of the Children Act 1989

I …… (print name)

place the care of my baby, born on…….

in the care of…… (print name)

Address:

Contact number:

Signed:……

Witnessed by……..

Date……..

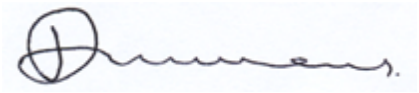
5 Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the document/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender (including gender reassignment)	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are there any valid exceptions, legal and/or justifiable?**	No	
4.	**Is the impact of the document/guidance likely to be negative?**	No	
5.	**If so, can the impact be avoided?**		
6.	**What alternative is there to achieving the document/guidance without the impact?**		
7.	**Can we reduce the impact by taking different action?**		

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Co-ordinator, together with any suggestions as to the action required to avoid/reduce this impact.

3 Document Development Checklist

Type of document	Clinical Guideline
Lead author:	Jayne Mulligan
Is this new or does it replace an existing document?	NEW
What is the rationale/ Primary purpose for the document	**To support midwives when involved with surrogacy and to ensure care is appropriate for both the surrogate and the commissioning couple.**
What evidence/standard is the document based on?	Best practice.
Is this document being used anywhere else, locally or nationally?	No
Who will use the document?	Midwives and the wider professional team
Has a pilot run of the document taken place (optional)	No
Has an evaluation taken place? What are the results (optional)	
What is the implementation and dissemination plan? [How will this be shared?]	Quality forum, matrons and ward managers.
How will the document be reviewed? [When, how and who will be responsible?]	By Named Midwife Jayne Mulligan
Are there any service implications? [How will any change to services be met? Resource implications?]	No
Staff/Stakeholders Consulted:	
All documents with a pharmacy impact should be reviewed and signed by a nominated member of the pharmacy team to validate that consideration has been given to pharmacy impact	N/A
Signed and dated By Chair of Validating Committee or Group	 …10th July 2018……
Signed and dated By Chair of Ratifying Committee	……

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