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Portsmouth Hospitals NHS
NHS Trust

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Surrogate Pregnancies –Guideline

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Version Tracking

Version	Date Ratified	Brief Summary of Changes	Author
3	15th May 2014	Updated guidance	Lead Public Health Midwife

CONTENTS

QUICK REFERENCE GUIDE

Surrogacy care pathway.

1. The legal mother of the baby is the mother carrying the child (birth mother)

2. The intended parents need to be given a Parental Order (if one or both are genetically linked to the baby) or Adoption Order (if neither of the intended parents are genetically linked to the baby) before they are the legal parents

3. The birth mother carries full legal rights for the fetus and for decisions made during the pregnancy

4. The duty of care is to the birth mother

5. When the baby is born the birth mother remains the legal parent of the baby until she gives her permission for the intended parents to have responsibility for consent to treatment of the baby

6. Please ensure that both the surrogate and the IPs are given a copy of Department of Health and Social Care (2018), The Surrogacy Pathway, Surrogacy and the legal process for intended parents and surrogates in England and Wales.

7. Open discussion of antenatal and intrapartum care should be encouraged but with due consideration for confidentiality

8. The birth mother and intended parents should create a PHT hospital birth plan at a pre-birth meeting at 34 weeks (earlier in the case of a multiple pregnancy) with a Clinical Lead Midwife. Please refer via a request for extra midwifery input via Maternity Outpatients.

9. Conflict may occur if either party changes their mind and all parties will need support and guidance

10. Birth registration is the responsibility of the birth mother. If the conception takes place in a licenced clinic and the appropriate consent forms are completed, if the surrogate is not married, the IP that provided the sperm can be registered as the legal father on the birth certificate. This will give him shared parental responsibility with the surrogate. A parental order will still be necessary to transfer the legal parenthood of the second IP.

11. Contact telephone numbers if required:

    - PHT Legal Department 023 92286000 x 3482 or x 3479
    - PHT Safeguarding Children Office 023 922 86000 x 4533 or x 4581
    - Portsmouth MASH 02392 688793 / Out of hours 0300 555 1373
    - Hampshire Children's Social Care 0300 555 1384 / Out of hours 0300 555 1373

1. INTRODUCTION

Surrogacy in the UK is controlled by the Surrogacy Arrangement Act (1985), Human Fertilisation and Embryology Act (2008) and the Human Fertilisation and Embryology Act (1990).
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 themselves. (DOH 2018).

The midwife's role in caring for a surrogate mother is to respect her needs like that of any other pregnant woman (DOH 2018). The midwife should encourage the surrogate to be open about the arrangement so that the midwife is in a position to assist her in the planning of her maternity care (RCM 1997). The midwife's duty of care is to the surrogate mother and the baby when it is born.

2. PURPOSE

The purpose of this document is to clarify legal responsibilities in cases of surrogacy including the duty of care of the Maternity Services.

Whilst surrogacy is not prohibited by law there are complex legal and maternity care arrangements. It is unlikely but possible in some cases that either party may change their mind, in which case the legal arrangements need to be clear to ensure the welfare of the baby.

3. SCOPE

This document applies to midwives, doctors and maternity support workers and other members of staff who may provide care or services to women who are surrogates and the intended parents.

> *'In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, staff should take advice from their manager and all possible action must be taken to maintain ongoing patient and staff safety'*

4. KEY TERMINOLOGY

Intended Parents (IPs): These are couples or individuals who are considering surrogacy as a way to become parents. They may be a single person, heterosexual or same-sex couples in a marriage, civil partnership or living together/ cohabiting in an enduring relationship. To apply for a parenting order (which is the way that legal parenthood is transferred from the surrogate to the IPs) at least one of the parents must be a genetic parent of the child born to them through surrogacy. IPs generally prefer to be known as the parents of the baby (DOH 2018).

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

Straight surrogacy: Straight (also known as genetic, full or traditional) surrogacy is when the surrogate provides her own eggs to achieve the pregnancy. One of the IPs provides a sperm sample for conception through either self-insemination away from a licenced setting or artificial insemination with the help of a fertility clinic. Self-insemination does carry risks if the sperm has not been screened for infections. If either the surrogate or IP has fertility issues or prefers a more clinical environment, then embryos may also be created in vitro and transferred into the uterus of the surrogate.

Host Surrogacy: Host (also known as gestational or partial surrogacy) is when the surrogate doesn't provide her own egg to achieve the pregnancy. In such pregnancies, embryos are created in vitro and transferred into the uterus of the surrogate using the gametes of at least one IP, plus the gametes of the other IP or a donor, if required.

5. DUTIES AND RESPONSIBILITIES

Who might use surrogacy?

Couples or individuals who cannot have a child themselves. This might be because of recurrent miscarriage, repeated failure of IVF, premature menopause, hysterectomy, absent or abnormal uterus, a serious risk to health that may result from pregnancy or same sex couples wanting to create a family.

The legal position

Altruistic surrogacy is an established and legal way of creating a family 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.

Are surrogacy arrangements legally enforceable?

Disputes in surrogacy are rare. Where the parties are being supported by one of the national altruistic surrogacy organisations, the organisation will usually offer assistance and support to help resolve any difficulties. Healthcare professionals should attempt to work with the surrogate and the IPs at all times. However in the event of an unresolvable dispute, the surrogates wishes must be respected, regardless of what is set out in any surrogacy agreement or consents that may have been previously provided.

If the surrogate changes her mind and wishes to keep the child herself or no longer wishes to transfer the child to the IPs, then staff must respect this and should ensure accurate notes of the circumstances are kept. If the IPs want to challenge this situation, then it will be a matter for the family courts to decide.

If the IPs change their mind and no longer want to keep the child, then parental responsibility remains with the surrogate as the legal parent of the child (and her partner if she has one). In the event that the surrogate is not prepared to take responsibility of the child, then social services should be contacted in the usual way.

If staff have any concerns about the welfare of the child, they should follow standard procedures for making a safeguarding referral. A welfare of the child assessment should have been carried out for any fertility treatment in line with the HFEA's Code of Practice. (DOH 2018)

The legal parenthood in surrogacy

The surrogate is the legal mother of the surrogate child from birth until legal parenthood is transferred to the 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.(DOH 2018). 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 straight forward and it is usual for a child to be cared for by the IPs from birth (with the surrogate's consent)

If the conception in a surrogacy arrangement takes place in a licenced clinic and the appropriate consent forms are completed, if the surrogate is not married, the IP who provides the sperm can be

registered as the legal father on the birth certificate. A parental order would still be necessary to transfer the legal parenthood of the second IP.
In order for the intended parents to become the legal parents of the child they must apply to adopt the child or apply for a parental order. This is the case even if they are the genetic parents of the child. If the intended parents change their mind about taking the child the surrogate mother and her partner are legally responsible for the child.

Parental order

A parental order makes the intended parents the child's legal parents. A parental order is obtainable through application to the courts (HFEA 2008). This is the same as adoption but allows a quicker route in cases of surrogacy.

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

- IPs must be over 18 years old
- IP couples must be married, in a civil partnership or living as partners in an enduring relationship.
- The surrogate and her partner if they are married or in a civil partnership, must give consent (no earlier than 6 weeks after the birth)
- The child must have been conceived artificially and be genetically related to one of the IPs
- The child must be living with the IPs
- IPs must apply within 6 months of the birth of the child
- At least one of the IPs must be domiciled in the UK.
- The surrogate should be paid no more than reasonable expenses, unless authorised by the court.

Adoption Order

If the intended parents are not genetically related to the baby an adoption order is required for parental responsibility.

Confidentiality

In surrogacy, it is common for the surrogate and the IPs to agree that any information sharing by healthcare staff should include both parties. The approach they have agreed will normally be set out in their surrogacy agreement. However, since the surrogate has a right to confidentiality. Great care should be taken to understand what information she has agreed may be shared with the IPs. If the parties have not included this point in their surrogacy agreement, they should be encouraged to discuss it and to record it in their agreement.

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 postpartum. 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. As part of this process, the adult safeguarding team should be involved and an assessment of need/support undertaken and action taken appropriately.
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 regard to adult and child safeguarding assessments. A multi-disciplinary team review is advised. In such rare situations, the

child will remain in the care of the surrogate until the IPs have had a clear assessment of their mental health. If the child cannot be cared for by the surrogate, children's social services will need to be involved and an interim arrangement facilitated.

Maternity Care Provision
Pre-birth

Ante natal care should be delivered in accordance with the relevant clinical guidance which is based on individual risk assessment, in the usual way.
Requests set out in the surrogacy agreement or agreed between the surrogate and the IPs should be discussed and accommodated wherever possible. If a written surrogacy agreement has not been prepared, or it does not adequately cover ante natal care then the surrogate and the IPs should be encouraged to create one. Staff should be satisfied that the surrogate consents to the sharing of data/medical information and/or attendance at appointments. All consents to share information should be recorded and confirm any point where confidentiality maybe an issue.
Best practice should be to give the surrogate opportunity to be seen on her own to be able to ask questions regarding social concerns i.e. Domestic abuse, physical and mental wellbeing.

All ante natal screening for infectious diseases and fetal abnormality will be offered to the surrogate in the usual way. Should any abnormalities be identified staff should discuss this with the surrogate and where the surrogate has given her consent, the IPs should be included in counselling, decision making and information sharing.

Where a termination of pregnancy is being considered and the relevant legal conditions are met, the surrogate makes any final decision about a termination.

Birth planning

A surrogacy birth plan is normally prepared by the surrogate and IPs, often as part of the surrogacy agreement. A meeting should be held with a Clinical Lead Midwife at 34 weeks, earlier in the case of a multiple pregnancy, to formulate a hospital birth plan, taking into account the wishes expressed in the surrogacy birth plan. This meeting should include the surrogate, her partner if applicable, the IPs and the named midwife. The purpose of the meeting is to discuss the surrogate's and IPs wishes for the birth and immediate postnatal period, ensuring every effort is made to accommodate all reasonable requests. The Birth plan should be filed in the surrogates notes and a copy put in the complex needs file. A pop up should be created on Protos which highlights on admission that the surrogate has a complex birth plan. The surrogate should be advised when calling labour line or the bleep to arrange admission that she is a Surrogate, this will enable the assigned midwife to access the birth plan and be prepared for the admission and that there may be more than the regular amount of birth partners present at the birth.
The Birth plan should outline the wishes of the surrogate and the IPs and include if transfer to the operating theatre becomes necessary who will go with her if a birth partner is able to.
Where possible requests that promote immediate bonding of the baby to the IPs should be supported.
Information with regard to the post natal discharge address and GP for the IPs and the baby should be obtained and the community midwives in the receiving area notified re the IPs plans to return home with the baby. The IPs should also notify their GP of their plans and ensure the baby will be registered and cared for following discharge.

Postnatal care

Post natal care related to the surrogate birth will usually be very different to other births. Often the surrogate will consider her role finished after the birth and wish to be discharged home independently of the child. Usually the child will be fully cared for by the IPs from birth and therefore parenting support, advice and decision making should be directed to them.

It must be noted that the intended parents do not have the legal rights to the fetus or for decisions made during the pregnancy. All professionals involved should be aware of this when discussions and decisions are made with regard to the pregnancy.

All professionals involved in the care of a surrogate mother and the intended parents should facilitate non-judgemental care.
In the event of any concerns being raised with regard to the welfare of the child, they should ensure that these are raised and actioned in accordance with local safeguarding policies.
Every effort should be made to fulfil all reasonable requests regarding post natal care, which may include a desire for the surrogate and the IPs with the baby to be accommodated separately, but with access to each other after the birth. This should be where possible in adjoining single rooms to ensure confidentiality.
The discharge of the surrogate and the baby with the IPs should be arranged and scanned separately to the relevant post natal nhs.net account, ensuring that the IPs GP and HV have a copy of the baby's discharge summary.

It will be useful to have written consent from the surrogate to the IPs confirming any specific screening tests which she has given consent for the baby to have. The IPs need to have a copy of this when they are discharged home particularly if they live in another area. For anything else the IPs need to obtain a letter or signed consent order confirming that the surrogate has consented to the IPs making decisions about the child's care. Delegated parental responsibility is sufficient for most general purposes for example dealing with immunisations and screening. For more serious issues, for example if a child required hospitalisation and ongoing medical treatment it is within the IPs power to apply to the family court to acquire parental responsibility via a child arrangements order so they have the legal authority to make decisions.
Under no circumstances should the baby be discharged home with the IPs without the surrogates consent.

Birth Registration

This is the responsibility of the surrogate mother (and that of her partner or person treated as the father). The intended parents who take the child have no legal relationship/no right in law until a parental order has been made (Human Fertilisation and Embryology Act 2008, Braude and Muhammed 2003). If the surrogate is single and has no partner in law then one of the intended parents, if they are biologically related to the baby, can be registered on the birth certificate and this will give them shared parental responsibility.

A child born to a surrogate mother will be registered as her child and that of the legal father. Where a parental order has been granted a separate entry will be made in the Parental Orders Register. It is not however, possible to abolish the original birth registration, and at the age of 18 the child will be able to obtain a certified copy of the original birth certificate

Safeguarding Children and Young people

Everybody who works or has contact with children, parents/carers or expectant parents/carers should be able to recognise, and know how to act upon evidence that a child's health or development (or that of the unborn baby) is, or may be being impaired and especially when they are suffering or at risk of suffering significant harm.

If hospital staff become aware a baby about to be, or just born is the product of commissioning and have grounds to doubt commissioners' identity/suitability to provide care/or degree of voluntarism (payment beyond reasonable expenses is unlawful), they should contact the Safeguarding Children Office and Children's Services (Social Care).

Referrals to Children's Services (Social Care) should be made if the cumulative impact of the circumstances indicates that the unborn baby is in need or that s/he is suffering or is at risk of suffering significant harm. Children's Services (Social Care) responses should be a proportionate one and legal advice will probably be required.

Whenever practitioners are concerned about the welfare or safety of a child (including an unborn child) they should follow Working Together to Safeguard Children a guide to interagency working (2018) and Safeguarding Children and Young People Practice/Operational Policy (2018)

6. PROCESS

Antenatal Booking Visit

- Arrangements for antenatal care should be discussed with the surrogate including the involvement of the intended parents
- The surrogate mother must be able to make decisions about her antenatal care
- The surrogate mother and intended parents should discuss screening tests
- To ensure confidentiality the surrogate mother should only inform the relevant health professionals and any reference to the arrangement in medical notes should only be made with the consent of the surrogate mother.
- Referral pathways for identified risk factors should be followed

Antenatal Care

- If the intended parents are to accompany the surrogate mother to antenatal appointments and screening tests, consideration for special arrangements may be required in order to maintain confidentiality
- The named midwife should meet the surrogate mother and intended parents in early pregnancy to provide information and thereafter be available to the surrogate mother acting as an advocate as required.
- The midwife must ensure relevant information is available to facilitate choice
- The intended parents should be involved in care as per pre-birth and booking discussions with the surrogate mother
- Parent education must be offered to the surrogate and/or intended parents
- If screening tests reveal an abnormality, the obstetrician and named midwife need to facilitate decision making between surrogate and intended parents with consideration to the legal position on surrogacy
- If the surrogacy agreement is terminated by the intended parents during the antenatal period the surrogate mother should be advised to seek legal advice and be referred to Children Services (Social Care) (see Special Considerations).
- If the surrogate mother terminates the surrogacy agreement she is to be supported by the maternity services. The intended parents are not receiving care from the service.

- Portsmouth Hospitals NHS Trust will seek legal advice if any concerns are raised throughout the surrogate mothers episode of care.

Pre-birth meeting

At approximately 34 weeks of pregnancy a meeting should be held to include the surrogate mother, her partner if relevant, the intended parents and the clinical lead for Public health. This meeting should be facilitated by a Clinical Lead midwife.
The aims of the meeting are:

1. To formulate a plan to include management of labour and pain relief, immediate postnatal care of the mother and baby and method of infant feeding.
2. To discuss the presence of one or both the intended parents at birth
3. To support the surrogate mother and intended parents and prevent potential conflicts.

Care during labour

The pre-birth meeting should have identified a birth plan and whether the intended parents are to be present or not. Midwives should make every effort to accommodate the mutually agreed wishes of both parties (DOH 2018). However, if there is a situation of conflict the midwife must remember that her duty of care is to the surrogate mother and s/he must ensure that the surrogate mother's needs are met, and that any decision regarding care in labour rests with her and not the intended parents.

In the case of the child having an abnormality and/or being rejected by the intended parents at birth, the staff must provide support for the surrogate mother and contact the trust safeguarding children's team and the Trust Legal Department for advice.

Postnatal Care

- Plans for the postnatal period should have been discussed at the pre-birth meeting, in agreement with both the surrogate and intended parents. Having plans in place should avoid any conflicts/problems occurring during the postnatal period
- The surrogate mother requires both postnatal care and support and should be offered care for 28 days post birth (RCM 1997)
- Single rooms should be allocated if possible for reasons of confidentiality.
- The intended parents must be offered support in the postnatal period, including postnatal care for the baby. Every effort should be made to accommodate one of the intended parents on the postnatal ward should the baby be required to stay. At present there are no facilities to accommodate both of the intended parents. The surrogate mother remains the legal parent and will be required to give consent for any treatment for the baby.
- In the community the surrogate mother, the intended parents and the baby may wish to be seen together and where possible this should be accommodated.
- If the intended parents or the surrogate mother are transferring to a different area after the birth transfer arrangements should be made for postnatal care in that area.

7. TRAINING REQUIREMENTS

There are no specific training requirements.

8. REFERENCES AND ASSOCIATED DOCUMENTATION

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Surrogacy Arrangement Act 1985 (c.49) The UK Statute Law Database
The Royal College of Midwives (1997) Position Paper No 18: Surrogacy Defining Motherhood. London. RCM
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9. MONITORING COMPLIANCE WITH, AND THE EFFECTIVENESS OF, PROCEDURAL DOCUMENTS

Each case will be reviewed