

Policy Regarding Management of Surrogacy

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Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2013094	March 2013	Linda Upton/ Jane Sumner	New format	

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Obstetricians/ Paediatricians/Children's Safeguarding Team		27/12/12

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction..... 4

2. Purpose 4

 2.1. Rationale 4

 2.2. Principles 4

 2.3. Scope..... 4

3. Definitions 4

4. Accountabilities and Responsibilities 5

 4.1. Midwives..... 5

 4.2. Medical Staff / Nursing and Midwifery 5

5. Surrogacy and the Law..... 6

6. Parental Responsibility: Who are the Child’s Legal Parents? 6

7. Payment Rules 7

8. Reasons for Surrogacy..... 8

9. Types of Surrogacy 8

10. Commissioning Issues 8

11. Procedures and Actions to Follow 9

12. Equality and Human Rights Statement 9

13. Training 9

14. Monitoring Compliance with the Document..... 10

15. References 11

Appendix A – Flowchart: Staff Responsibilities in Surrogacy..... 12

Appendix B – Staff Feedback Form 13

1. Introduction

Professionals need to be aware of the law regarding surrogacy and the rights of the parties involved. At birth the surrogate mother has parental responsibility (PR) which can only be transferred to the commissioning couple via the legal process. Only the surrogate mother can give consent until this process is completed.

2. Purpose

In the event of a request for surrogacy all staff should be aware of the legal requirements on the commissioning and surrogate parents.

2.1. Rationale

This guideline is an effort to explore the idea of surrogacy, taking into account the (2007) amendments to the Human Fertilisation and Embryology Act (HFEA) and the Surrogacy Arrangements Act of 1985. Whilst it would be impossible to cover all aspects of the surrogacy process, it aims to cover the main issues, current laws and advice to healthcare professionals.

2.2. Principles

- To offer care in a non-judgmental and supportive manner.
- Maintain accurate and contemporaneous records of discussions and decisions reached.
- Confidentiality is vital and disclosure should be made on a need to know basis. Any reference to the surrogacy arrangement in the medical notes should only be made after discussion with and permission from the surrogate mother.
- The needs of the surrogate mother should always be a priority and all (final) decisions rest with her.
- Information requested by the commissioning parents must be sanctioned by the surrogate mother and documented in the medical notes.

2.3. Scope

This guidance is relevant to obstetricians, gynaecologists, and paediatricians, IVF Practitioners, Midwives and Health Visitors.

3. Definitions

Commissioning couple

The commissioning couple are the people who wish to bring up the child after his or her birth. They may both be the genetic parents, or one of them may be, or neither of them may be genetically related to the child. The woman for whom the child is to be carried (the 'commissioning mother') may be the genetic mother in that she provides the egg. The genetic father may be the husband or partner of the commissioning mother, or even of the carrying (surrogate) mother; or he may be an anonymous donor. (DOH 1998)

Surrogacy

Surrogacy is the practice whereby one woman (the surrogate mother) becomes pregnant, carries and gives birth to a child for another person(s) (the commissioning couple) as the

result of an agreement prior to conception that the child should be handed over to that person after birth.

Surrogate mother

The woman who carries and gives birth to the child is the surrogate mother, or 'surrogate'. She may be the genetic mother ('partial' surrogacy) - *i.e.* using her own egg - or she may have an embryo - which may be provided by the commissioning couple - implanted in her womb using in-vitro fertilisation (IVF) techniques ('host' or 'full' surrogacy). Where the surrogacy is established using in vitro fertilisation (IVF) or anonymous donor insemination, this must (as with all uses of these techniques) take place in a clinic licensed by the Human Fertilisation and Embryology Authority (HFEA) under the terms of the Human Fertilisation and Embryology Act 1990. Such clinics are required to follow the provisions of the 1990 Act and the HFEA's Code of Practice, including a requirement to consider the welfare of any child born as a result of the treatment. Where IVF is not involved, the surrogate mother may attend a clinic to be inseminated or she may be inseminated artificially at home. If insemination occurs through sexual intercourse this may still constitute surrogacy.

4. Accountabilities and Responsibilities

Whilst the confidentiality of the commissioning and surrogate parents should be upheld there will need to be certain communications to ensure staff are not complicit in any illegal act and that all health staff, who need to know, are informed. Please see flowchart in Appendix A.

4.1. Midwives

The midwife should be informed of the status of the pregnancy and this should be recorded in the medical notes.

Details of the donor sperm and / or egg will need to be obtained by the midwife at booking if the surrogate mother wishes to have screening tests for chromosome abnormalities as the results are based on the ages of the parents at the time of conception, and any relevant family history.

The midwife should establish whether the surrogate mother is married. If she is married then she and her husband hold parental responsibility until the legal process of transfer PR is complete.

If the surrogate mother is not married the midwife should establish that the (commissioning donor) father is registered on the baby's birth certificate when the baby is born. Only then will he hold parental responsibility.

The midwife should notify the health visitor and GP of the baby's status as above so that any consents required will be requested from the person holding parental responsibility. This is particularly important for the early immunisations which are due before the legal process may have been finalised or if the baby requires immediate/ early surgery or treatments.

It may be relevant for the midwife to complete an Additional Support Form.

4.2. Medical Staff / Nursing and Midwifery

When a baby is to be discharged and transferred to the commissioning parents who live in another part of the country, staff should ensure that the health staff in the new area

Policy Regarding Management of Surrogacy

are aware of the status of the baby and that there is full communication with the new area midwife and health visitor.

If any staff identify that the due legal process has not been followed they should notify the police.

If any staff have concerns for the safety or welfare of the baby they must follow the Sussex Safeguarding and Child Protection Procedures and make a referral to East Sussex Children's Social Care and notify the Safeguarding Children's Named Doctor/Nurse/Midwife.

5. Surrogacy and the Law

The legal framework for surrogacy is the Surrogacy Arrangements Act of 1985, amended in the Human Fertilisation and Embryology Bill of 2007. The intentions of the Surrogacy Arrangement Act of 1985 are summarized below:

1. Surrogacy is an agreement arranged before the pregnancy begins, with intent for another person to assume parental rights. Pregnancy is determined to begin at the time of insemination or embryo transfer.
2. No person with any commercial interest in the surrogacy arrangement may initiate or negotiate any part of the surrogacy proceedings.
3. It is illegal to advertise to seek or become a surrogate, through any form of the UK media.
4. Any person breaching (2) and (3) above is liable for punishment, either a fine or by imprisonment.

The 2007 amendments clarify that non-profit making organisations (such as the agencies which have a strong prevalence in many agreements today) are allowed to take part in the negotiations necessary for a successful surrogate pregnancy. Non-profit making organizations are allowed to advertise their services.

Surrogacy UK website provides detailed advice on all aspects of surrogacy:

<http://www.surrogacyuk.org/>

[http://www.surrogacyuk.org/Downloads/Guide to Surrogacy UK for Healthcare Professionals.pdf](http://www.surrogacyuk.org/Downloads/Guide%20to%20Surrogacy%20UK%20for%20Healthcare%20Professionals.pdf)

6. Parental Responsibility: Who are the Child's Legal Parents?

The Human Fertilisation and Embryology Act 1990 (2) section 27, states that the legal mother is always the surrogate mother regardless of genetic makeup and she is legally responsible for the child until such time as the intended parents adopt or seek a parental order.

There are two methods through which parental responsibility may be transferred.

- A parental order can be made if the case satisfies section 30 of the Human Fertilisation and Embryology Act. These are a set of criteria including a requirement that the parents are married to each other, aged over 18, domiciled in the UK and that the child is genetically related to one or both parents.
- An application may be made to adopt the child under the Adoption Act 1976.

Policy Regarding Management of Surrogacy

The baby should be assigned a legal Children's Guardian to act in the child's interests, until the legal responsibility is transferred, who has a responsibility to ensure that the criteria of section 30 of the Human Fertilisation and Embryology Act 1990 are fulfilled.

The process is allowed to take up to six months from the date of birth.

If, after the baby is born, the surrogate mother decides she does not want to hand the baby over at the end of the pregnancy, she cannot be forced to do so. The Brazier report estimates that in 4-5% of cases, a surrogate refuses to give the child to the commissioning couple, and in these cases the commissioning couple are almost certain to fail in any legal proceedings.

If, after the baby is born the commissioning parents do not want the baby, social services should be contacted and legal advice sought.

The Children's Guardian is also required to ensure that there are no contraindications to transfer of parental responsibility as set out in the Adoption Act. This process is often aided by specialist legal teams.

The Brazier Report, an independent government review in 1998, raises some issues regarding the legal transfer of parental responsibility. In the vast majority of cases the commissioning couple begin to take care of the baby from birth, hence are already looking after the baby by the time a Children's Guardian is assigned.

From a child welfare perspective it is very difficult to remove the baby from the commissioning parents unless the strongest of contraventions to the aforementioned acts is proven.

ESHT staff should ensure that if there is any cause for concern that they take advice from the Safeguarding children's named doctor or nurse / midwife. Midwives may also contact the Supervisor of Midwives (SOM) on call or their named SOM.

7. Payment Rules

To satisfy section 30 of the 1990 Human Fertilisation and Embryology Act the commissioning couple must ensure that "no money other than expenses has been paid in respect of the surrogacy arrangement unless authorised by the court".

The document: Surrogacy: Review for Health Ministers of current arrangements for Payments and Regulation, 1988 gives a definition of acceptable expenses:

- Maternity clothing
- Counselling fees
- Healthy food
- Legal fees
- Domestic help
- Life and disability insurance
- Travel to and from hospital/clinic
- Medical expenses
- Telephone and postal expenses
- Ovulation and pregnancy tests
- Overnight accommodation
- Insemination and IVF costs
- Child care to attend hospital/clinic

Policy Regarding Management of Surrogacy

- Medicines and vitamins
- Any time taken off work by the surrogate mother (if employed at the time of insemination/embryo transfer) should be taken in accordance with medical advice and statutory requirements.

8. Reasons for Surrogacy

The route by which a commissioning couple comes to require a surrogate varies widely, depending largely on the medical reasons as to why a surrogate pregnancy is required.

The reasons why surrogacy is 'an acceptable method of last resort' vary, but include:

- After hysterectomy for cancer
- Congenital absence of the uterus
- Hysterectomy for postpartum haemorrhage
- Repeated failure of in vitro fertilisation treatment
- Recurrent abortion
- Hysterectomy for menorrhagia
- Severe medical conditions incompatible with pregnancy

9. Types of Surrogacy

Traditional or 'straight' surrogacy, using the surrogate mother's own genetic material may be carried out by artificial insemination with minimal or no medical assistance.

NB: sexual intercourse to achieve conception is a contravention of the 1985 Surrogacy Act.

Those couples planning to use IVF for conception (whether using their own or donor gametes) must be referred to a licensed centre by a Consultant Gynaecologist or General Practitioner.

As stated earlier, it is illegal for a commissioning couple to advertise for the services of a surrogate, hence they are legally required to find their own host.

At the initial appointment for IVF a full medical history and examination are required to ensure that the host is suitable for pregnancy

Counselling for surrogacy is usually carried out by an independent fertility counsellor, frequently in the home of the commissioning couple, and issues relating to surrogacy are explored over several visits.

10. Commissioning Issues

Before IVF takes place there should be consideration regarding whether the Clinical Commissioning Group (CCG) is prepared to fund the procedure.

Surrogacy UK, one of the two non-profit surrogacy agencies in the UK, estimates the cost of a cycle of IVF surrogacy is in excess of £6000 and IVF may not be successful at first attempt.

There may be circumstances where the CCG that agrees to fund the surrogacy arrangement might be liable for claims for damages for personal injuries arising from the surrogacy process. (South Essex Health Authority addressed these issues in a Health Authority Board paper and suggested that unwanted multiple births, a less than perfect baby being rejected

by both mothers/couples, the surrogate having a termination of pregnancy, the surrogate refusing to give up the baby to the commissioning couple or the surrogate mother suffering complications of pregnancy leaving her unable to return to work as potential issues).

11. Procedures and Actions to Follow

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 commissioning parents. Where there is conflict the midwife must focus her care on the surrogate mother and baby.

A child born to a surrogate mother must be registered as her child.

The commissioning parents, even if they have taken the child, have no legal relationship with it and no rights in law until a parental order has been made or unless the commissioning father is named on the birth certificate.

The HFEA advises that, until the parental order comes into force, strictly speaking it is the legal mother who should give consent for screening of the newborn.

Commissioning or intended parents will apply for a parental order (if the genetic makeup of the baby comes from either or both of them) or an adoption order where gametes from either of the commissioning parents have not been used. Until this time (6 weeks – 6 months) the legal mother is the surrogate mother.

Handing over the baby will take place following discussion and agreement with the surrogate mother. The outcome of this discussion and agreement must be documented in the maternal and neonatal records.

The handover should take place outside of the maternity unit and no maternity staff should be involved with the handover, other than providing follow up care to the mother and baby after they return home.

The surrogate mother is cared for as per routine postnatal care guidelines. Her G.P. is notified of her discharge home.

The commissioning mother and baby are notified to the appropriate community midwife, health visitor and G.P.

12. Equality and Human Rights Statement

The Trust recognises the diversity of the local community and those in its employment. Our aim is, therefore, to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriate to their need.

13. Training

No specific training is required for the implementation of this guideline.

14. Monitoring Compliance with the Document

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Adherence to the process	Obstetrics and Gynaecology	Compliance will be monitored by the Safeguarding Leads through staff interviews by external and internal auditors such as Care Quality Commission, incident reporting, clinical audit and child protection supervision	As required	Maternity Risk Group via incident reporting	Maternity Services/ Paediatric Services	Children's Safeguarding Team [inc midwives]

15. References

Brazier Report: Surrogacy: Review For Health Ministers Of Current Arrangements For Payments And Regulation. DH 1998

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014373.pdf

Human Fertilisation and Embryology Authority. Code of Practice

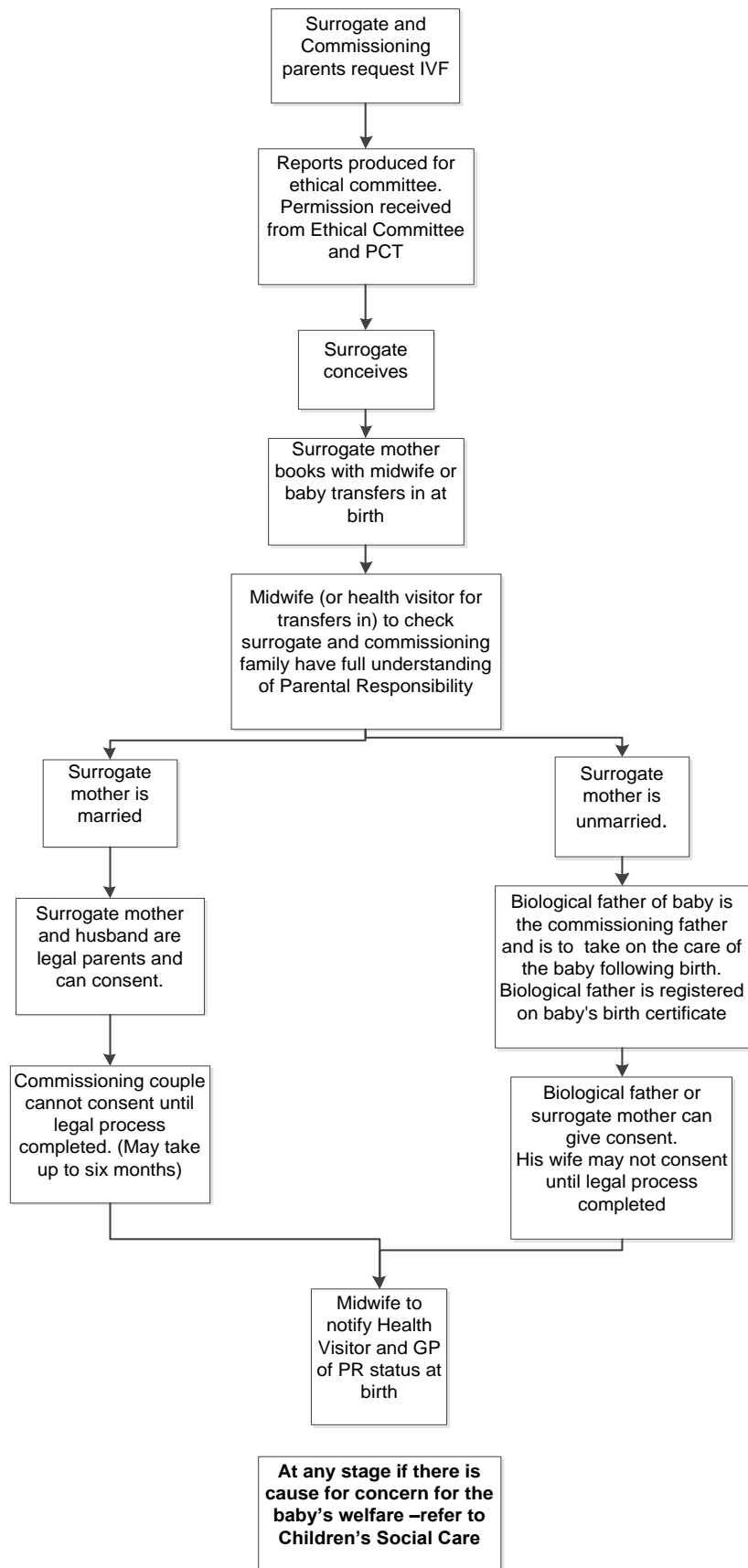
<http://www.hfea.gov.uk/code.html>

Surrogacy UK

<http://www.surrogacyuk.org/>

http://www.surrogacyuk.org/Downloads/Guide_to_Surrogacy_UK_for_Healthcare_Professionals.pdf

Appendix A – Flowchart: Staff Responsibilities in Surrogacy



Appendix B – Staff Feedback Form

Please complete this form if you would like to make a comment on the procedural document you have just read. Your feedback will be held by the Assurance Manager and your views will be taken into account at the next review date of the document.

Title of the procedural document:	
Date of next review:	
Your name (optional):	
Date today:	
Your comments:	

Thank-you for your feedback

Please forward this form to: **Assurance Manager (NHSLA)**