Clinical Management Information Template Form

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Clinical Policy (must do) ☐
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Title of document : Surrogacy Guideline Maternity.
Specialty : Maternity and Neonatal.

1. Indications

1.1 Background

- Whilst surrogacy arrangements remain relatively rare, there is some evidence to suggest that such arrangements are becoming more frequent.
- Midwives are inextricably involved in surrogacy as they will be called upon to provide care and support for both the surrogate mother and the Intended Parents.

1.2 Aim/purpose

- The aim of this guideline is to provide the multi-professional team with clear guidance to be able to give appropriate care and support to surrogate women, to support the Intended Parents and include them in the care as appropriate.

1.3 Definitions

- The Surrogacy Arrangement Act 1985 (amended 1990) defines a surrogate mother as;
  A woman who carries a child in pursuance of an arrangement:
- Made before she is carrying the child and
- Made with a view that any child carried in pursuance of it being handed over to, and parental rights being exercised by another person or persons.

There are 2 types of surrogacy:

- Traditional or straight surrogacy – This is where the surrogate uses her own egg which is fertilised with the intended father's sperm. This is often done at home without medical involvement.

- Gestational, full or host surrogacy – This is when the surrogate carries the Intended Parents' genetic child conceived through IVF.

1.4 Legal aspects of surrogacy

Surrogacy is not prohibited by law as long as there is a non-profit-making arrangement.
Surrogate mothers however can receive reasonable expenses to cover, travelling, IVF treatment, maternity clothing.

A person recognised as the legal parent of a child may not automatically have parental responsibility. Legal parenthood gives a lifelong connection between a parent and a child, and affects things like nationality, inheritance and financial responsibility. A person with parental responsibility has the authority to decide about the care of the child while the latter is young, for example for medical treatment and education.

A child's legal mother automatically has parental responsibility. The position of the father or other parent depends on factors including their marital status, what is recorded on the birth certificate, and whether the family court has made an order.

In the United Kingdom the birth mother is the legal mother irrespective of the conception method and genetic make-up of the baby. If the surrogate is married at the time of insemination, the surrogate's husband is considered the legal father of the child unless they were judicially separated or her husband/civil partner did not consent to the placing of the eggs/sperm/embryos they will both have parental responsibility.

A Surrogacy agreement is not a legally binding contract and therefore an arrangement between the Surrogate mother and the Intended Parents is not enforceable and either party are free to change their mind at any time.

Section 30 of the Human Fertilisation and Embryology Act 1990, also known as Parental Orders, allows intended parents the opportunity to become the child's legal parents. The following criteria must be met in order to apply for a parental order:

- Over 18
- Intended parent resident in the UK

- At least one of the applicants must be genetically related to the child
- Apply 6 weeks after birth and before 6 months
- The surrogate mother/parents must consent to the making of the order
- The child must reside with the intended parents.

If neither parent is the biological parent of the baby then they must apply to adopt the baby in order to become the legal parents of the child.

2. Clinical Management

Antenatal Care.

Antenatal Screening.

Where treatment has been provided in a clinic the eggs and the sperm will be tested for HIV, Hepatitis and other transmittable diseases. However with self-insemination there will be a risk of transmission.
Should the surrogate women be identified as having a transmittable disease, staffs are prohibited from sharing this information with the intended parents without the consent of the surrogate mother. The surrogate mother should be counselled about the risk of transmission to the child and recommended steps to minimise this as would be normal practice.
The Intended Parents do not have the authority to request or consent to antenatal screening tests. The staff must only perform tests which the surrogate mother consents to. Should an abnormality be identified during a screening test the staff must not share this information without the consent of the mother

Antenatal care .

The Trust's duty of care is with the Surrogate mother. All standard antenatal care should be offered to the Surrogate mother in the usual way. The Intended Parents can be involved in all aspects of the care that the Surrogate mother consents to, and the Trust should try and facilitate this where possible.
The Surrogate mother and Intended Parents should be offered contact with the Named Midwife for Safeguarding Children or a Midwifery Manager to discuss the plans for the care; especially the intrapartum and postnatal period. This will ensure that all parties are able to discuss and plan for this time and plans can be communicated to staff as appropriate, to ensure the Surrogate mother and Intended Parents are well supported.
Consent should be gained to complete and send a MASH referral for information sharing purposes, should their input be required in the future.

Pre-Birth Planning:

A pre-birth planning meeting should be held at approximately 24-26 weeks gestation and should include:

- The Surrogate.
- The surrogates partner (if relevant).
- The Intended Parents.
- All relevant professionals involved in the care.
- Named Midwife for Safeguarding Children or a Maternity Manager to be present if support is required by the Community Midwife completing the plan.

The aims of the meeting are:

- To devise a birth plan including management of labour, pain relief, immediate postnatal care of the mother and baby and infant feeding.
- To discuss the presence of one or both of the Intended Parents at delivery and in the immediate postnatal period.
- Amenity room for the Surrogate may be offered to provide privacy.
- An amenity room may be offered to the Intended Parents subject to availability.
- To discuss discharge from hospital, to include if Baby is on NICU, who will stay with Baby if Surrogate is fit for discharge?
- To support the surrogate mother and Intended Parents and help prevent potential conflicts regarding care.
- It is important to remember that final decisions and consent about events must be given by the surrogate mother.

Postnatal care:

Plans for the postnatal period should have been made in the antenatal period in agreement with the surrogate and the Intended Parents. This should reduce the risk of problems occurring.

Research suggests that surrogate mothers may have an increased risk of postnatal depression. It is recommended that the surrogate mother receives postnatal care for up to 28 days.

Post-natal care should be individualised and the community midwife should ensure that a detailed handover to the Health Visitor is given.

Birth registration:

As normal, must take place within 6 weeks. A child born to a surrogate mother must be registered as her child and if applicable, that of her partner or person treated as the father under legislation (LSCB).

Legal aspects following birth.

If the surrogate and her husband/civil partner are the legal parents of the child neither Intended Parent will be a legal parent, nor will they have parental responsibility. This means neither Intended Parent can consent to medical treatment for the baby.

If the surrogate is not married, nor in a civil partnership, one of the Intended Parents will be a legal parent when the child is born and will acquire parental responsibility when registered on the birth certificate. This can happen in different ways:

1) If the intended father is the biological father, he will be the legal father at common law when the child is born, if no one else is nominated. However, he will need to be registered on the birth certificate before he gains parental responsibility.

2) An intended father who is not the biological father will be the legal father when the child is born if all the following conditions apply:

a. Both the surrogate and the intended father have given written, signed consent;

b Neither consent has been withdrawn before insemination

c. The surrogate and intended father are not close relatives.

3) The intended female parent will be the other legal parent when the child is born if, at the time of insemination, all the following conditions apply:

a. Both the surrogate and the intended father have given written, signed consent;

b. Neither consent has been withdrawn before insemination

c. The surrogate and intended father are not close relatives.

In both point 2) and 3) above, the intended parent will only be granted parental responsibility once they are registered on the birth certificate.

This means that consent for any treatment, medication or screening of the baby, pre-registration, must be obtained from the surrogate mother.

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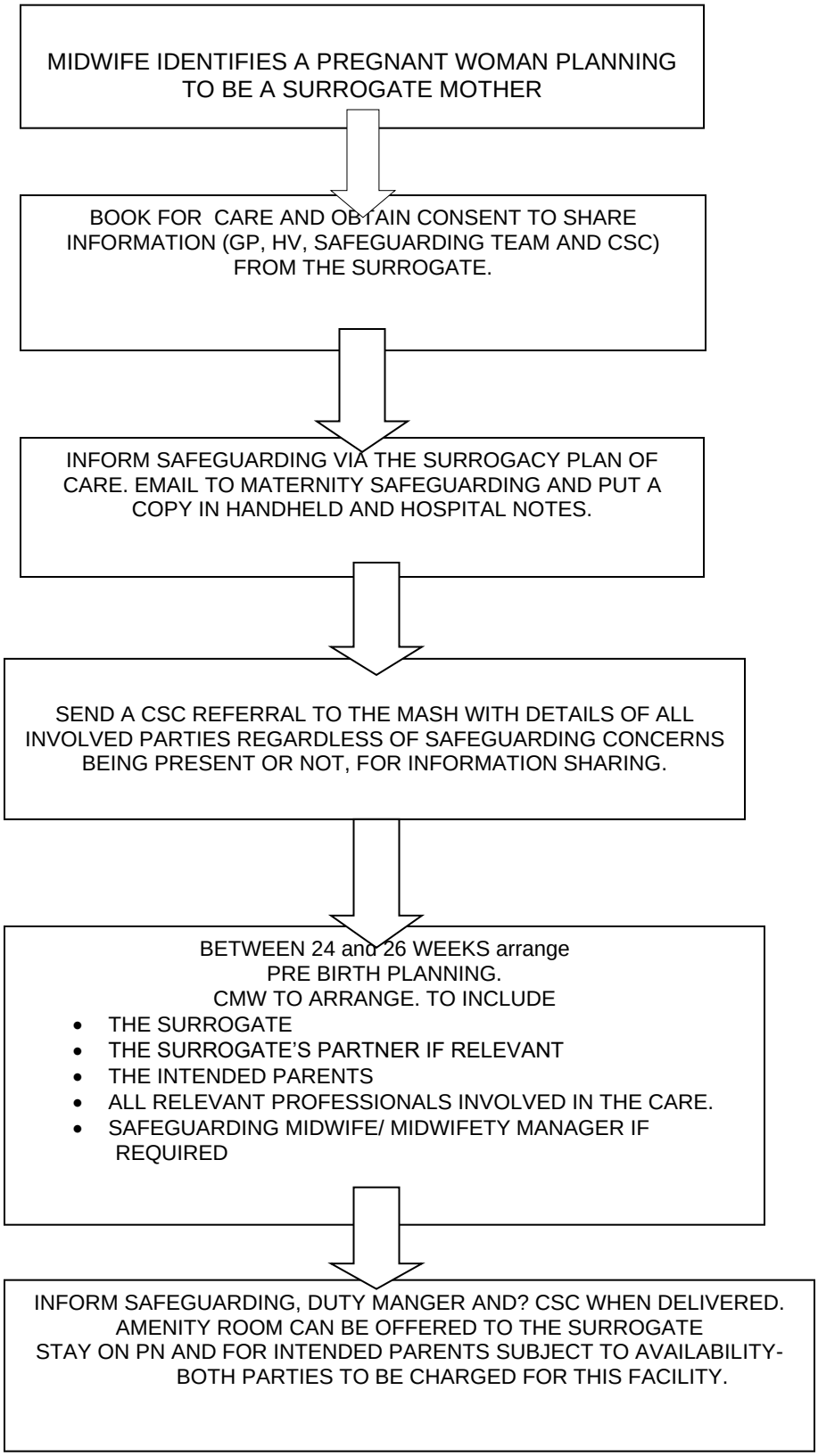
The baby cannot be removed from hospital by the Intended Parents without consent of the surrogate mother.

If the surrogate mother requires admission to hospital following the birth but the baby is able to leave, the surrogate mother may wish to delegate responsibility for the care of the baby to the intended parents.

The baby is required to be registered by 6 weeks after birth.

FLOW CHART:


MIDWIFE IDENTIFIES A PREGNANT WOMAN PLANNING TO BE A SURROGATE MOTHER
BOOK FOR CARE AND OBTAIN CONSENT TO SHARE INFORMATION (GP, HV, SAFEGUARDING TEAM AND CSC) FROM THE SURROGATE.
INFORM SAFEGUARDING VIA THE SURROGACY PLAN OF CARE. EMAIL TO MATERNITY SAFEGUARDING AND PUT A COPY IN HANDHELD AND HOSPITAL NOTES.
SEND A CSC REFERRAL TO THE MASH WITH DETAILS OF ALL INVOLVED PARTIES REGARDLESS OF SAFEGUARDING CONCERNS BEING PRESENT OR NOT, FOR INFORMATION SHARING.
BETWEEN 24 and 26 WEEKS arrange
PRE BIRTH PLANNING.
CMW TO ARRANGE. TO INCLUDE
• THE SURROGATE
• THE SURROGATE'S PARTNER IF RELEVANT
• THE INTENDED PARENTS
• ALL RELEVANT PROFESSIONALS INVOLVED IN THE CARE.
• SAFEGUARDING MIDWIFE/ MIDWIFETY MANAGER IF REQUIRED
INFORM SAFEGUARDING, DUTY MANGER AND? CSC WHEN DELIVERED.
AMENITY ROOM CAN BE OFFERED TO THE SURROGATE
STAY ON PN AND FOR INTENDED PARENTS SUBJECT TO AVAILABILITY-
BOTH PARTIES TO BE CHARGED FOR THIS FACILITY.

3. Evidence Base

Summary of evidence, review and recommendations

Ber R, (2000) Ethical issues in gestational surrogacy Theory of Medical Bioethics :21 153-69
British Medical Association (1996) Changing conceptions of motherhood: The practice of surrogacy in Britain. BMA: London.
COTS (1997) Childlessness overcome through surrogacy. Comprehensive Guide to Surrogacy. COTS: London.
Golombok s, Murray c, Jadva v, MacCallum F, Lycett E. (2004) Families created through surrogacy arrangements: parent – child relationships in the first year of life. Developmental Psychology; 40: 400-11
Human Fertilisation and Embryology Act (HFEA) 1090 Parental Orders (Human Fertilisation and Embryology Regulations) 1994: Powers and Duties of Local Authorities, Health Authorities and Guardians ad Litem available at:
www.dh.gov.org/enPublicationsandstatistics/Lettersandcirculars
Her Majesty's Stationary Office. Human Fertilisation and Embryology Act 1990.(1990) London: HMSO www.opsi.gov.uk/acts/acts1990
Jadva V, Murray c, Lycett E, MacCallum F, Golombok S. (2003) Surrogacy: the experiences of surrogate mothers. Human Reproduction 18 2196-204 doi: 10.1093/humrep/deg397
Mason, J.K. and Laurie, G.T. (2006) Mason & McCall Smith's law and medical ethics seventh edition, Oxford University Press.
LSCB Somerset Local Safeguarding Children Board Multi-Agency Guidance RE Surrogate Pregnancy Surrogacy Protocol
Schenker JG, Eisenberg VH. (1996) Surrogate pregnancies: Ethical, social and legal aspects. Prenatal and Neonatal Medicine 1 (1): 29-37
The Royal College of Midwives (1997) Position paper No 18 Surrogacy: Defining Motherhood. RCM London.

4. Audit

.4.0 Audit indicators.

Surrogacy is relatively rare in this trust so the expectation would be that any surrogacy case will be reviewed to audit that the guideline has been followed.

SURROGACY DOCUMENTATION AND PLAN OF CARE.

Tobe completed and put min handheld notes, hospital notes and emailed to Maternity Safeguarding.

	SURROGATE MOTHER	SUROGATE MOTHER'S PARTNER	INTENDED PARENT	INTENDED PARENT
NAME				
DOB				
ADDRESS				
CONTACT TEL NUMBER				
GP AND SURGERY				

HEALTH VISITOR				

GENETIC MOTHER'S MEDICAL HISTORY:
GENETIC FATHER'S MEDICAL HISTORY:
FERTILITY CLINIC DETAILS IF INVOLVED:
TYPE OF SURROGACY: **TRADITIONAL (Egg of surrogate and sperm of the Intended father)** **OR** **GESTATIONAL (IVF using embryo created by the commissioning couple. Surrogate is not genetically related)**
ANY SAFEGUARDING CONCERNS:
LEGAL RESPONSIBILITY FOR THE CHILD

CSC REFERRAL MADE AND	**ASSESSMENT OF NEEDS FORM**	**GP AWARE?**	**HV AWARE?**	**NAMED MIDWIFE FOR SAFEGUARDING**

SENT TO MASH?	COMPLETED AND SENT TO SAFEGUARDING			AWARE?