Policy No: 47 - Surrogacy Policy

VERSION	2
DATE OF ISSUE:	March 2023
REVIEW INTERVAL:	3 yearly
NAME AND DESIGNATION OF GUIDELINE AUTHOR(S):	Linda Bryceland (DoN&MW)

All policies and guidelines will be circulated to appropriate staff for a two week consultation prior to being finalised. The date of issue reflects the date finalised after this consultation has taken place.

MONITORING COMPLIANCE WITH THE POLICY	
Process for monitoring	Audit of Guideline
Frequency of monitoring	3 yearly
Responsible individual development of action plan	Head of Midwifery

NATIONAL GUIDANCE RELATING TO THIS POLICY (E.G. NIHCE, NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE)
• Individual cases will be reviewed on a case by case basis against the principles in this policy

DOCUMENT REVIEW HISTORY			
Version	**Review Date**	**Reviewed by**	**Updates**
2	March 2023	Linda Bryceland	Minor changes to gramma and format

AUDITABLE STANDARDS	
1.	All birth options, choices and consent of the surrogate should be documented in the Case Notes
2.	Surrogacy Care Plan completed in Case Notes
3.	Head Office notified of Surrogate Mothers details to be added to Confidential Register

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INTRODUCTION

Surrogacy is when a woman carries a child for someone who is unable to, or chooses not to conceive or carry a child themselves. The professional guidance and Laws around surrogacy are complex and vary between countries. This guidance only applies to England and Wales.

Definitions

Intended Parents (IPs)

Couples who are considering surrogacy as a way to make a family and become parents. To become the legal parents of the child, they will need to apply for a PARENTAL ORDER. IPs normally prefer to be referred to as the parents of the child.

Surrogate

This is the preferred term for women who are prepared to help IPs by carrying a child for them. Generally they prefer not to be referred to as the mother of the child.

Straight surrogacy

Straight, genetic, traditional or full surrogacy is when the surrogate provides her own egg to achieve the pregnancy. One of the IPs provides the sperm.

Host surrogacy

Host, gestational or partial surrogacy involves IVF with the fertilised ovum transferred to the uterus. One (or both) of the IPs provides either an egg or sperm.

Commercial surrogacy

Whereby an individual or agency makes a profit to organise or facilitate surrogacy for another person.

Surrogacy arrangement

An agreement drawn up between the surrogate and the IP before conception which outlines the process, decision making, care of the child etc. It is not legally binding.

Parental Order

The surrogate is the legal mother of the child from birth until the Parental Order (PO) is granted to the IPs by the family court. IPs can start this process from 6 weeks to 6 months after birth if they have care of the child, the surrogate consents and at least one of the IPs is genetically related to the child. The application must be made by a couple.[a]

COUNSELLING

In all cases, counselling is recommended for all parties. If the surrogacy arrangement is taking place outside of a fertility clinic, the parties involved should be advised to access

[a] The requirement for gametes to be from one of the IP and for the PO application to be made by a couple have both been successfully challenged in UK law as they are deemed discriminatory.

and appropriately trained counsellor. Further information is available from the British Infertility Counselling Association.

Additional information and support is produced to guide IPs and surrogates through the process and they should be encouraged to access this.[1]

KEY PRINCIPLES RELATING TO SURROGACY IN ENGLAND AND WALES

- The health and safety of the surrogate and child are paramount.
- Heath care professionals are pivotal in ensuring that all parties have a positive and safe experience. In all cases, all parties should be treated with dignity, sensitivity and respect.
- A coordinated but flexible approach is required so that all physical and emotional care can be planned in a safe and positive way.
- Health care staff have a duty to ensure that the surrogate has consented to the process and confidential discussions to explore social, emotional and physical aspects should always be facilitated.
- The gametes of at least one IP must be used

LEGAL CONTEXT

Surrogacy agreements are not legally enforceable, and the IPs need to apply for a parental order after the child is born in order to become the legal parents.[2]
Commercial surrogacy is illegal and the midwife has a professional duty to report this to local safeguarding teams.

CONFIDENTIALITY

It is common that the surrogacy agreement involves information sharing between all parties and joint decision making. However the surrogate has a right to confidentiality and the health professional should always check consent before information is shared.

SAFEGUARDING

Commercial surrogacy is illegal in the UK[3] and if suspected, staff have a duty to report this under Child Protection Legislation. The surrogate can only receive “reasonable expenses”.

It is important that the surrogate has the mental capacity to make informed decisions about her care and the surrogacy arrangements. In the presence of doubt a full capacity assessment should be undertaken.

Most assisted conception clinics are governed by the Human Fertilisation and Embryology Act (1990) which includes a code of practice detailing how all those who wish to enter into a surrogacy arrangement should be assessed for suitability. This is controversial as infertile couples are arguably being discriminated against.

Many NHS policies include an automatic referral to safeguarding in the case of surrogacy. This is not in line with best practice and national guidance which recommends individual

assessment and clinical judgement. However, trying to avoid such a referral could be seen as evasive and, in most cases, all parties should be encouraged to be open and engage with social care from the start.

Private Midwives will be alert to the signs of safeguarding issues and ask appropriate questions in the same was as they would do for any couple having a baby.

As part of the process for applying for a PO the child's welfare is assessed by the courts, with the best interests of the child the primary consideration.[4]

BOOKING CONTRACT(S)

Care for the surrogate

The booking contract will be in the name of the surrogate and must be signed by her. She is the client. All care relating to her will be covered within this contract. If the IPs fail to pay the care fees, the surrogate will be responsible for the money owed. Within the contract the surrogate will be asked if she is happy for information to be shared with the IPs.

Care for the IPs

A second booking contract may be required for the IPs. For example they may require parent education or postnatal care. It may also be possible to induce lactation in some cases. This contract will be in their name, signed by them and they are responsible for fees.

Consideration will be given all factors (location, care required etc). It may be that different midwives are allocated to the surrogate and to the IPs. This would avoid any conflict of interest.

ANTENATAL CARE

When the surrogacy arrangement has been undertaken via a licenced fertility clinic, appropriate infectious disease screening will take place at the clinic. With self-insemination there is a risk of infection to the surrogate and unborn child. The surrogate may be offered infection screening before or after conception. The routine booking bloods includes all of the tests usually screened for (HIV, hepatitis, syphilis).
All other routine antenatal care should be offered to the surrogate with the involvement of the IPs if she consents.

The midwives need to ensure that whether screening is performed by Private Midwives or through the NHS, that the parties understand that openness regarding biological facts is necessary for appropriate screening. This includes:

a. Sickle cell and thalassaemia -if host surrogacy the biological mother should be screened for and it is not necessary to screen the surrogate.
b. If partner testing is required it is vital to ensure that it is the biological father.

c. Discussion should be initiated between the parties *in advance* of any screening about what actions may be appropriate in the case of a "screen positive" result.
d. If the combined test is being done, a host surrogate must ensure that the biological mother's ethnicity and age at egg collection are provided to the screener in order for appropriate calculation to be made.
e. Specialist advice regarding screening choices may be required.

If a client booked with Private Midwives informs you that they are part of a surrogacy arrangement, then you should notify the Head of Midwifery so that they can be added to a confidential register held at Head Office. This register will include the details of the IPs and the surrogate so that any enquiry to us from NHS safeguarding teams can be dealt with efficiently. This will enable us to give assurance to the safeguarding leads that care is being provided and so could avoid any undue delays, concerns or escalation. The midwife(s) providing care will also be offered support and guidance if needed.

Consideration should be given to the options relating to colostrum harvesting and induced lactation. A lactation consultant may be advised to support with this.

Any midwife who has a conscientious objection to involvement in care for surrogates or IPs should make this known in advance.

BIRTH PLANNING

A birth plan is typically a joint agreement between the IPs and the surrogate. The midwife should make every effort to accommodate all reasonable requests. In the UK, surrogacy organisations (Surrogacy UK, COTS, Brilliant Beginnings) offer advice and support for all parties to consider when deciding on a birth plan.

The birth planning agreement should also include discussions and agreements relating to expressed colostrum, breast feeding and lactation induction/suppression.

INTRAPARTUM CARE

Surrogates will often consider a home birth with a known midwife so that a relationship can be built, care plans respected and a positive experience with dignity and respect is more likely. Knowing who is caring for them and that they are aware of their situation can reduce a lot of anxiety that IPs may experience. The midwife should do all she can to explore all eventualities and a detailed plan of care should be stored within the notes.

In ideal circumstances, it could be that the midwife caring for the surrogate and the midwife caring for the IPs are the two midwives who are present for the home birth.

If intrapartum transfer is required it is normally the midwife who is providing care to the surrogate who would accompany the woman as she is the lead for that client.

If transfer is required in the immediate post-birth period (for example, PPH) then the baby should accompany the surrogate until a full assessment can take place and the situation is stable.

POSTNATAL CARE

Usually (but not always), the baby will be cared for by the IPs from immediately after birth. The IPs may need help and support with parenting skills, feeding and care for the baby. The midwife providing care to the IPs and baby should ensure before baby is born, that all arrangements are in place for screening (NIPE, NBBS etc). For the NIPE to be completed, access to the birth notes is required.

The surrogate also needs postnatal care and arrangements should be made for both parties to receive midwifery support. The midwife responsible for the intrapartum care is responsible for birth notification.

REFERENCES

[1] The surrogacy pathway: Surrogacy and the legal process for intended parents and surrogates in England and Wales. (2019) *Department of Health and Social Care*

[2] Care in Surrogacy: Guidance for the care of surrogates and intended parents in surrogate births in England and Wales. (2019) *Department of Health and Social Care*

[3] Surrogacy Arrangements Act 1985

[4] Wade, K. (2017) The regulation of surrogacy: A children's rights perspective. *Child and family law 29(2).*