Surrogacy in maternity

University Hospitals of Leicester NHS Trust

Trust ref: C9/2022

Contents

1 Introduction and Who Guideline applies to

Surrogacy is when a pregnant woman or person carries a child for someone who is unable to conceive or carry a child for themself; some parents may require the assistance of a surrogate in order to create a family. It is very important to remember that these parents may have already been on a traumatic journey to become parents before resorting to surrogacy as a last resort, so sensitivity and non-judgemental practice is essential.
Currently there are no official statistics on the numbers of surrogacy arrangements in the UK but estimations taken from the number of parental orders granted suggests there were 390 in 2023 (RCM 2024)

The purpose of this guidance is to provide a clear framework within which Midwives, Obstetricians, Neonatologists and the wider professional team can best support surrogate women and people whilst appreciating the position of the commissioning (intended) parents.
This guidance applies to all health professionals irrespective of grade, level, location or staff group.

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

1.1 Related documents:

- **Mental Capacity Act UHL Policy.pdf B23/2007**
- **Consent to Examination or Treatment UHL Policy.pdf A16/2003**
- **Delegated Consent UHL Policy.pdf B10/2013**

1.2 Key Terminology:

Intended Parents (IPs):

These are couples (or an individual) 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. The IP may also be a single person of either sex providing they have a genetic link to the child.

Parental order:

A Parental Order is the way that legal parenthood is transferred from the Surrogate to the IP's. To apply for a parental order 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.

Surrogate:

This is the preferred term for a woman or person who is willing to help IP's to create families by carrying a child for them.

A Surrogate may or may not have a genetic link to the child that they carry.

Surrogates generally do not want to be called 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 parental rights being exercised (so far as is practicable) by another person or persons'.

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

The duty of care of the baby remains paramount even following transfer to the IP's.

2 Types of Surrogacy

Straight or Traditional surrogacy - This is where the surrogate uses their own egg, which is fertilised with the IPs/father's sperm: this may be done by self-insemination or in a fertility clinic.

Host, gestational or full surrogacy - The surrogate carries the intended parent's genetic child conceived through IVF.

2.1 Legal position of Surrogacy

Altruistic surrogacy is an established legal way of creating a family in the UK.

Surrogacy agreements are not legally enforceable and the IP's need to apply for a Parental Order once the baby is born in order to become the legal parents of the child.

The legal framework allows the surrogate to receive reasonable pregnancy related expenses from IP's. It is however illegal in the UK for surrogacy to be a profit making business. (Surrogacy Arrangement Act 1985)

2.2 Legal Parenthood in surrogacy

The surrogate is the legal mother of the child from birth until legal parenthood is transferred to IP's through a Parental Order made through the family court.

If the Surrogate is married or in a relationship, their partner will also assume legal parenthood status of the child from birth until the Parental Order is granted.

IP's can start the process to obtain a Parental Order from 6 weeks to 6 months following the birth if certain criteria are met, including the child being in their care, having the consent of the surrogate and at least one of the IP's being genetically linked to the child.

The parental order process is usually straight forward and it is usual for the baby to be cared for by the IP's from birth (with the surrogates consent).

If the conception in the surrogacy arrangement takes place in a licensed clinic and the appropriate 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 to the second IP.

2.3 Legal Aspects

In the UK the birth mother is the legal mother irrespective of the conception method and genetic makeup of the baby.

The surrogate's husband, if married, is considered the legal father and neither can surrender parental duties.

The courts have held that a surrogacy arrangement is not a legally binding contract and therefore an arrangement between the surrogate mother and the intended parents is not enforceable.
The Parental Orders (Human fertilisation and embryology) Regulations 1994 came into effect in November 1994 which bought into effect section 30 of the Human Fertilisation and Embryology Act 1990' also known as Parental Orders. This allows intended parents the opportunity to become the child's legal parents. Under English law, once the Parental Order is granted the intended parents will receive a new birth certificate stating they are the legal parents of the child.

A Parental Order is issued by the Family proceedings court in the applicants' home area and the following criteria should be met:

- They are over the age of 18 years
- The intended parents must reside in the UK
- At least one of the parents needs to be genetically linked to the child
- The application can be made after 6 weeks but before 6 months following the birth
- The surrogate parents must consent to the order
- No money must be paid in respect of the surrogacy, however reasonable expenses incurred as a result of the pregnancy can be claimed.
- The child must be resident with the intended parents

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 organisation to act on a profit making basis to organise or facilitate a surrogacy arrangement for another person.

Surrogate mothers can however receive reasonable expenses from the intended parents, such as maternity clothing, insemination and IVF costs and travel expenses for pregnancy associated appointments.

3 GENERAL GUIDANCE

3.1 Mental capacity –

It is essential that the surrogate has mental capacity to consent to surrogacy and make decisions about their care and the child's after birth. Should there be any concerns regarding mental capacity then an assessment of capacity should be undertaken as per Trust policy. In the event that the surrogate lacks capacity to provide consent or make decisions then treatment should be given in the best interests of the surrogate. As part of this process the Adult Safeguarding team should be involved in the assessment.

The Surrogacy Agreement should be clear as to whether the surrogate agrees to the IP's being the sole decision maker for the care of the child from birth. In rare cases, healthcare staff may have concerns regarding the mental capacity of the IP's. In this situation further advice will need to be taken by the multidisciplinary team and a mental capacity assessment may be required. The child should remain in the care of the surrogate until the assessments and plans involving social care are complete.

Healthcare professionals have a legal duty to provide care to the surrogate mother and the baby once born. The wishes of the surrogate are paramount and the IP's will only become involved with direct consent from the surrogate, or until such time as the IP's seek a Parental Order or adopt.

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

Documentation regarding the surrogacy should be in the notes and the surrogacy plan should be uploaded onto E3, paper copy in the notes and a copy sent to the surrogate mother and intended parents. The matrons should also receive a copy of the plan.

Safeguarding: Surrogacy is not a safeguarding issue. However, if additional concerns are identified regarding either the surrogate or the IP's a safeguarding referral should be made as per policy raising those concerns.

3.2 CONSIDERATIONS FOR BIRTH PLANNING:

Planning of care is vital to ensure that the surrogate and the baby receive safe care. If the surrogate consents then the plan should be made with the Intended Parents present (see appendix 1)

Arrangements should be made for the community midwife to meet both the surrogate and the Intended Parents to discuss the agreement and produce a plan.

It is important to manage the care/plan within the legal framework, whilst considering the wishes of the surrogate mother and the intended parents.

However the surrogate mothers wishes take precedence over those of the Intended Parents.

In most surrogacy cases the IP's and surrogate have a close relationship and have often discussed what they wish together. It is our role within maternity to ensure that their preferences can be facilitated and are within the legal framework. Where wishes cannot be supported, early planning allows time for compromises and a robust fully informed plan to be made prior to the birth.

3.3 SURROGACY BIRTH PLAN

(see appendix one)

Family Demographics (Surrogate and Intended Parents)

Antenatal Plan

Things to consider

What does surrogate want to be called? Mother- yes /no

Surrogate mothers history: e.g. previous births/ children, high risk/low risk pregnancy

Intended Parents history if appropriate: e.g. any previous baby's (only document if appropriate/ relevant, e.g. Still birth that may indicate elevated anxieties in the IP's regarding the birth)

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Type of surrogacy: e.g. Host surrogacy /Straight surrogacy

Confirm that IP's understand that full parental responsibility remains with surrogate until a parental order or adoption.

Plan for full parental order/ adoption

Document the discussion regarding parental consent:
The surrogate has to give consent but can write to say they give permission to IP's being involved in discussions around consent process for care and can sign for necessary care to be given to baby (see appendix 2).

Although consent rests with the surrogate mother, the IP's must be treated as the parents of the baby *at all times*. They must be facilitated to attend all appointments and ultrasound scans where requested by the surrogate.

Does the surrogate consent to ultrasound scans? (IP's to be supported to attend where surrogate consents)

Does the surrogate consent to pregnancy and newborn screening programmes?

The Birth

Things to consider

Place of birth

The Birth partners (where the surrogate wishes both IPs and an additional person to support them to be present at the birth, this should be supported. Early discussions with the ward managers and matrons are important to ensure the surrogate is cared for in the most appropriate location).

The baby at birth: who is baby passed to? Skin to skin - with whom? Cutting the cord by whom?

Does the surrogate want to hold the baby at birth? Or is baby going straight to IP?

Plan for third stage of labour

In the event of surrogate requiring a caesarean section who is going to be the birth partner? Only one person will be able to accompany the surrogate in theatre.

In the event of an emergency caesarean section under GA anaesthetic they are aware that no birth partner will be able to go to theatre. Baby will be brought out of theatre to the intended parents if surrogate consents.

Postnatal Plan

Vitamin K: discussion and informed consent?

The IP's should be made aware that baby labels will have surrogates details on whilst in hospital, but would they like a set of labels with their names on?

Feeding Plans:
Type of feeding
Is the surrogate going to express EBM for IP to give to baby?

The surrogate may not want to be involved with the baby post-birth and may request to be moved to a different part of the ward to that of the baby. This should be facilitated and the IP's supported to remain on the ward with the baby (early discussions with the ward managers and matrons are important to ensure the surrogate/baby are cared for in the most appropriate location).

If Baby were to need to attend the neonatal unit (NNU) for care who would like to attend NNU to provide care for the baby: IP's or IP's and surrogate?

If possible does IP intend to stay on ward and provide care for baby? (This should be supported - early discussions with the ward managers and matrons are important to ensure the surrogate/baby is cared for in the most appropriate location). It may be possible for the IPs to stay in a side room if available; otherwise a bed in a bay will be allocated. If there are two IPs, the visiting arrangements for the second IP will be the same visiting hours and arrangements as for the rest of the ward.

Confirm arrangements for the newborn infant physical examination (NIPE) and hearing test and required consent.

The surrogate can write a letter for consent for baby to have any treatment whilst in the care of IPs. This includes the Newborn Blood Spot screening, phototherapy and any other treatment that may be required (Appendix 2).

Discharge

There is no reason why the 'handover' of the baby to the IP's should take place outside the hospital premises and the hospital should not suggest this. However usual practice is for surrogate and IP to leave hospital together with baby.

If the surrogate is 'fit for discharge' and the baby needs to remain in hospital, the IPs can remain in hospital with the baby with the surrogates consent.
In the unlikely event that the baby is in the NNU and is discharged home, confirm who is taking baby home? The IPs can take the baby home with the surrogates consent.

The surrogate will require a set of discharge papers and have care from their community midwife.

IP's will require a set of discharge papers for the community midwives providing care for the baby at home.

Ensure a fully comprehensive plan of care is written to ensure that the whole team within maternity are aware of the plan and that it meets the needs of the surrogate, the intended parents and fits within the legal framework. This in turn will facilitate a positive patient experience supporting the surrogacy birth experience for all concerned. (Appendix 1)

What to do with the plan once written

- Once completed a copy of the surrogacy birth plan should be sent to both the surrogate and intended parents for comment and agreement.
- The surrogacy plan once completed and agreed with the surrogate and intended parents should be sent to one of the maternity matrons for review and comment.
- Further planning meetings may be required if plans / issues raised need to be discussed further.
- On completion of the plan a copy should be uploaded onto E3.
- A paper copy to be put in the surrogates notes.
- A copy to be sent to the surrogate and intended parents.
- A copy sent to the matrons for dissemination to labour ward coordinators, named consultant and community managers.
- A copy sent to the NNU matron.
- Copy to be sent to GP of the surrogate
- Copy to be sent the GP of the intended parent
- A copy to be sent to the health visitor.

4 Education and Training

None

5 Monitoring Compliance

None

6 Supporting References

Surrogacy Arrangements Act 1985, Legislation.gov.uk https://www.legislation.gov.uk/ukpga/1985/49

The Surrogacy Pathway, Department of Health and Social care https://www.gov.uk/government/publications/having-a-child-through-surrogacy/the-surrogacy-pathway-surrogacy-and-the-legal-process-for-intended-parents-and-surrogates-in-england-and-wales

Surrogacy UK, Care in Surrogacy, Department of Health and Social Care, 2018

https://www.gov.uk/government/publications/having-a-child-through-surrogacy/care-in-surrogacy-guidance-for-the-care-of-surrogates-and-intended-parents-in-surrogate-births-in-england-and-wales

The Childrens act 1989

https://www.legislation.gov.uk/ukpga/1989/41/contents

Mental Capacity Act UHL Policy B23/2007

Consent to Examination or Treatment UHL Policy A16/2002

Delegated Consent UHL Policy B10/2013

7 Key Words

Surrogacy, Intended Parents, legal

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Contact and review details	
Guideline Lead (Name and Title) L Cunningham	**Executive Lead**
Details of Changes made during review: **Added estimated numbers of surrogacy arrangements to intro**	

Appendix 1: Example Surrogacy Plan

: - to be written in conjunction with Surrogate, IP's and consideration of preferences / legal considerations within this Guideline.

Family Demographics

Date:

Attendees at meeting:-

Surrogate (Birth Mother)

Name:-

Address:-

Telephone number:-

GP name:-

GP address:-

GP telephone Number:-

Community Midwife:-

Practice Health Visitor:-

Intended Parents:

Intended Parents:-

Name:-

Name:-

Address:-

Telephone Number:-

GP details intended parents:

Name:
Address:

Telephone number:

Community Midwife:

Practice Health visitor:

Background information

EDD:

Information giving / consent

Antenatal care plan
Complete as required

Birth plan

Arrangements for birth including location, birth partners and birth preferences

Postnatal care

Staying in hospital

Following birth

Neonatal care if required

Discharge

Circulation list

- Surrogate and intended parents.
- Midwifery Matrons for dissemination to labour ward coordinators, named consultant and community managers.
- NNU matron.
- Copy to be sent to GP of the Surrogate
- Copy to be sent the GP of the intended parents
- A copy to be sent to the health visitor.

Appendix 2: Decision making arrangement form

Form for documenting the arrangement that birth mother has requested for intended parents 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)

I give consent for baby to have the following treatments/screening if required

Address:

Contact number:

Signed:……

Witnessed by……..

Date……..