<table>
<tr><td>Title of Guideline (must include the word “Guideline” (not protocol, policy, procedure etc)</td><td>GUIDELINE FOR THE CARE OF WOMEN INVOLVED IN SURROGACY</td></tr>
<tr><td>Author: Contact Name and Job Title</td><td>Kursoom Khan Maternity Matron for QMC</td></tr>
<tr><td>Directorate & Speciality</td><td>Family Health/ Obstetrics</td></tr>
<tr><td>Date of submission</td><td>July 2016</td></tr>
<tr><td>Explicit definition of patient group to which it applies (e.g. inclusion and exclusion criteria, diagnosis)</td><td>Applies to all staff who work within maternity services</td></tr>
<tr><td>Version</td><td>1</td></tr>
<tr><td>If this version supersedes another clinical guideline please be explicit about which guideline it replaces including version number.</td><td></td></tr>
<tr><td>Statement of the evidence base of the guideline – has the guideline been peer reviewed by colleagues?

Evidence base: (1-6)
<table>
<tr><td>1</td><td>NICE Guidance, Royal College Guideline, SIGN (please state which source).</td></tr>
<tr><td>2a</td><td>meta analysis of randomised controlled trials</td></tr>
<tr><td>2b</td><td>at least one randomised controlled trial</td></tr>
<tr><td>3a</td><td>at least one well-designed controlled study without randomisation</td></tr>
<tr><td>3b</td><td>at least one other type of well-designed quasi-experimental study</td></tr>
<tr><td>4</td><td>well –designed non-experimental descriptive studies (ie comparative / correlation and case studies)</td></tr>
<tr><td>5</td><td>expert committee reports or opinions and / or clinical experiences of respected authorities</td></tr>
<tr><td>6</td><td>recommended best practise based on the clinical experience of the guideline developer</td></tr>
</table></td><td></td></tr>
<tr><td>Consultation Process</td><td>Senior midwives
Supervisor of Midwives
Consultant Obstetricians
Community Midwives
Maternity Guideline Development Group</td></tr>
<tr><td>Ratified by:

Date:</td><td>Maternity guideline group July2016</td></tr>
<tr><td>Target audience</td><td>Senior midwives
Consultant Obstetricians/Anaesthetists
Community Midwives</td></tr>
<tr><td>Review Date: (to be applied by the Integrated Governance Team)
A review date of 5 years will be applied by the Trust. Directorates can choose to apply a shorter review date, however this must be managed through Directorate Governance processes.</td><td></td></tr>
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Introduction

This guideline has been developed to provide the multi-agency team with clear guidance to enable appropriate care for surrogate women in pregnancy but to appreciate the position of the commissioning (intended) parents and include them in the care if appropriate.

Definitions

The surrogacy Arrangements Act 1985 chapter 45 page 1 defines a surrogate mother as:

A woman who carries a child in pursuance of an arrangement

a) Made before she is carrying the child and

b) Made with a view that any child carried in pursuance of it being handed over to, and parental rights being exercised (so far as practicable) by, another person or persons.

There are two types of surrogacy

1) Full Surrogacy - The surrogate mother provides the egg. The egg is then fertilised (either naturally or through artificial insemination) by either the intended father or a sperm donor.

2) Partial Surrogacy- The surrogate mother has no genetic link with the child but gestates embryos usually created from the eggs and sperm of the commissioning parents (or where applicable, donor eggs and/ or sperm).

Legal aspects of surrogacy

In the United Kingdom the birth mother is the legal mother irrespective of the conception method and genetic make-up of the baby.

Surrogacy is not prohibited by law. However, surrogacy through commercial arrangements is illegal (Section 2, 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 a surrogacy arrangements for another person.

Surrogate mothers can, however, receive reasonable expenses from the commissioning (intended) parents, such as maternity clothing, and travel expenses.

Surrogacy arrangements are not a legally binding contract and therefore either party is free to change their minds at any time.

What if the commissioning (intended) parents change their minds?

If the commissioning (intended) parents change their minds about taking the child, for example if their circumstances change, the surrogate mother will be legally responsible for the child.

In the event that the surrogate mother also refuses to take on the responsibility, social services should be contacted in the usual way.

What if the Surrogate Mother changes her mind?

If the surrogate mother changes her mind and wants to keep the baby, this must be respect. In this situation, the Courts will usually allow her to keep the baby. If there is a disagreement between the surrogate mother and the commissioning (intended) parents the Lead for Safeguarding Children should be contacted.

Parental Orders

This allows commissioning (intended) parents the opportunity to become the child's legal parents. They need to meet the criteria below in order to apply for a Parental Order issued by the Family Proceedings Court in the applicant's home area.

- Over 18
- Commissioning parent must be resident in UK
- At least one of the applicants must be genetically related to the child
- Apply after 6 weeks of birth and before 6 months

- The surrogate parents must consent to the making of the order
- No money other than expenses must have been paid in respect of the surrogacy arrangement
- The child must reside with the commissioning parent
- Under English law once the Parental Order is granted the commissioning (intended) parents will receive a new birth certificate stating that they are the legal parents of the child

General guidance

Health care professionals have a legal duty of care to the surrogate mother and the baby once born. The wishes of the surrogate are paramount and the commissioning (intended) parents will only become involved with direct consent from her.

Antenatal care

Planning of care during pregnancy is vital so that the midwife ensures that the surrogate receives the care she requests and requires which may include involvement of the commissioning (intended) parents. The community midwife should make contact with the commissioning (intended) parents so she can make an assessment of the commissioning (intended) parents and the home the baby will be going to.

The community midwife should ensure that she contacts the maternity matron for the area the surrogate mother intends to give birth so that a meeting can be arranged which will include the attendance of:

- Community midwife
- Maternity matron
- Surrogate mother
- Commissioning (intended) parents
- Supervisor of Midwives
- Labour suite Sister
- Ward Sister

If necessary the following should also be invited:

- Safeguarding midwife
- Consultant obstetrician

During the meeting the following should be discussed and agreed:

- Place of birth.
- If the surrogate agrees it may be appropriate for the commissioning (intended) parents to be present.
- What happens in the event of BBA.
- Management of labour and birth including pain relief.
- Birth support.
- Do they want to be told the sex of the baby/ cut the cord?
- Skin to skin.
- Method of feeding and immediate care of the baby.
- Labelling the baby- as normal with surrogate mothers details, these could have commissioning (intended) parents details on too
- Vitamin K and route of administration
- Two sets of part 2 notes one for the baby and one for the surrogate mother
- One red book
- Visiting the ward
- Commissioning (intended) parent staying in the hospital
- Admission to the Neonatal unit
- Consent for treatment for baby
- NIPE examination
- Hearing screening
- NBBS where/ when this will be completed, does the Surrogate Mother need to provide written consent
- Details of the community midwife, health visitors, General Practitioner for when the baby is discharged
- Exchange of the baby must not occur on Trust premises
- Parental Order
- Registering the birth- Parental responsibility is joint if not married

Intrapartum care

If the surrogate mother agrees the commissioning (intended) parents may be present at birth, but the wishes of the surrogate mother remain paramount.

Postnatal care

- Routine postnatal care should be provided to the surrogate mother and baby
- The baby and surrogate mother should not be routinely separated as the surrogate mother has parental responsibility
- Particular care should be paid to her psychological state and additional support offered. Additional postnatal visits may be beneficial and should be decided on an individual basis.
- The commissioning (intended) parents may require additional support relating to baby care and feeding.

Checklist for Surrogacy Documentation

Antenatal Period

- Birth plan completed with surrogate mother and Commissioning (intended) Parents
- Full details for the commissioning (intended) parents
    - Names
    - Telephone Numbers
    - Home Address
- Plan emailed to all relevant staff
- Plan uploaded to Medway and Systmone

Intrapartum Period

- Midwife caring for the surrogate mother is aware of the plan

Postnatal Period

- Postnatal ward staff are aware of the plan
- Check the commissioning (intended) parents discharge details

- Address/fax/telephone numbers for the following
    - Community midwives
    - General Practitioners Surgery
    - Health visitors
- On discharge ensure both surrogate mother and baby details are sent to the relevant community midwife
- Inform both the surrogate mother and the commissioning (intended) parents General Practitioner and health visitor

References

1) 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/enPublications andstatistics/Lettersandcirculars
2) Mason, J. K. and Laurie, G. T. (2006) Mason & McCall Smith's law and medical ethics
seventh edition, Oxford University Press.