NHS
Northamptonshire
Clinical Commissioning Group

PA47 Commissioning Policy for Surrogacy

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Version control

NAME	CHANGES	DATE
Dr Azhar Ali Planned Care Clinical Lead Nene CCG Dr Joanne Watt Clinical Lead Corby CCG	Review existing policy, no changes	May 2015 Version 1.1
Tony Ferrari	Review upon transition to a single CCG	April 2020 Version 1.0

1. Definitions

Surrogacy is the practice whereby one woman (the surrogate mother) caries a child for another person (the commissioning couple) as a result of an agreement prior to conception that the child should be handed over to the commissioning couple after birth).

Traditional (straight) surrogacy refers to situations where the surrogate uses her own egg fertilised with the intended father's sperm. This is usually done by artificial insemination.

Gestational (Host IVF) surrogacy refers to situations where the surrogate carries the intended parent's genetic child conceived through IVF.

An individual funding request (IFR) is a request received from a provider or a patient with explicit support from a clinician which seeks funding for a single identified patient for a specific treatment.

Exceptional clinical circumstances refers to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition at the same stage of progression as the patient.

2. The policy

2.1 This policy applies to any patient for whom NHS Northamptonshire CCG (the CCG) is the Responsible Commissioner.

2.2 The CCG will not provide routine funding for the medical treatment required to give effect to a surrogacy arrangement because (a) this treatment is not considered by the CCG to be a priority for NHS investment, (b) the CCG is unlikely to be in a position to be able to reach an assessment as to whether the parties have concluded a lawful surrogacy arrangement, and (c) the CCG is concerned that the funding of such treatment raises substantial risks that NHS bodies and doctors providing care connected to surrogacy arrangements would be exposed to unknown medico-legal risks. IVF treatment will not be provided as part of surrogacy arrangements.

2.3 Please refer to the local Assisted Conception Policy for funding arrangements regarding egg storage for a woman who will become infertile as a result of medical treatment.

2.4 For privately arranged surrogacy the NHS will continue to provide normal maternity care to the surrogate mother.

2.5 The CCG is prepared to consider providing funding for individual patients who are able to demonstrate exceptional clinical circumstances. The CCG does not consider retrospective funding requests

3. Key principles supporting this policy

3.1 The CCG will not engage in commissioning with unacceptably high legal risks.

Documents which have informed this policy

The National Health Service Act 2006, The National Health Service (Wales) Act 2006 and The National Health Service (Consequential Provisions) Act 2006, Department of Health - Publications

NHS Confederation Priority Setting Series, 2008,
http://www.nhsconfed.org/publications/prioritysetting/Pages/Prioritysetting.aspx

The Human Fertilisation and Embryology Authority, Surrogacy
http://www.hfea.gov.uk/60.html

Appendix 1 – Background Information

The Legal Position

Surrogacy is legal in the UK but the Surrogacy Arrangements Act 1985 makes commercial surrogacy illegal.

The mother

The legal parentage remains with the mother carrying the child – regardless of whether the child is genetically related or not. If the host mother, therefore, wishes to keep the child she has been carrying, it is her right to do so.

The father

If the surrogate is married, in virtually all cases the sperm donor rules have the effect of making the surrogate husband the legal father with full parental responsibility. The surrogate's husband's name is therefore recorded on the birth certificate as the father, regardless of the fact he has no biological connection with the children and regardless of whether or not he attends the birth registration. Further steps have to be taken for genetic father to gain parental rights. In the past the commissioning couple had to apply for formal adoption but this process has been simplified providing certain conditions are met.

If the surrogate is not married (or her husband genuinely does not consent – signing a letter to say he does not consent is not enough) then the situation is slightly different. The intended father is, provided that he is the biological father, then the legal father at birth and his name can be recorded on the birth certificate, though only if he attends the birth registration in person together with the surrogate.

It is significant for the intended father to be named on the birth certificate in these circumstances, as this gives him 'parental responsibility' ('all the rights and duties of a parent') as well as legal parenthood. If, rarely, for any reason he cannot be named on the

birth certificate, he can acquire parental responsibility afterwards either by signing an agreement with the surrogate mother or by applying to court for a parental order.

If the intended father is able to acquire parental responsibility, then he can in turn give parental responsibility to the intended mother (on the slightly strange premise that she, as his spouse, is the child's legal step-parent). The surrogate and both intended parents simply need to sign a parental responsibility agreement after the birth is registered to do this.)

An intended mother who has parental responsibility in these circumstances has legal authority to act as a parent (so she can make decisions and sign forms etc), but she does not become the legal mother. This has various implications e.g. the child has no automatic right of inheritance from her.

Her rights are also held in addition to those of the surrogate mother, who remains the legal mother with all the rights and responsibilities this entails.

Parental orders

A parental order is the means by which both intended parents acquire full legal parenthood, and extinguish all the rights and responsibilities of the surrogate and her husband. After a parental order is granted, the intended parents are issued with a new birth certificate recording their details as the legal parents.

Though in certain situations intended parents can acquire parental responsibility without getting a parental order, it is still important to apply for a parental order as this is the only way of:

1. giving the intended mother full parenthood status (rather than just step parent parental responsibility), and

2. extinguishing the rights and responsibilities of the surrogate.

In cases involving married surrogates, the intended parents will usually have no recognition as legal parents until a parental order is granted. In situations where this causes problems (e.g. over giving consent to immunisations), it is possible to apply to the court for an interim order (a residence order) giving the intended parents parental responsibility.

Before embarking on a surrogacy arrangement it is therefore very important to ensure that you will qualify for a parental order and that you understand how the rules work. If you are in any doubt whatsoever about your eligibility, you should seek specialist legal advice. There are alternative ways of securing parenthood after surrogacy using adoption law if a parental order is not available, but the rules are complex and you risk committing a criminal offence if things are not organised properly at the outset.

The conditions for getting a parental order are:

1. The application must be made within six months of the birth (the court has no discretion to extend this time limit).

2. Both intended parents must be over 18.

3. The intended parents must be married to each other at the time of the application (civil partnership does not currently qualify, though the Human Fertilisation and Embryology Bill 2008 currently going through Parliament will change this, allowing applications from unmarried and same sex couples as well as married couples).

4. At least one intended parent must be domiciled in a part of the UK (please note that domicile is not to do with where you are living, but your origins – if you or your parents have foreign roots, you should seek legal advice on your status).

5. At least one of the intended parents is the child's biological parent (the court may request a DNA test to prove this).

6. The child is living with the intended parents at the time of the application.

7. The surrogate has not been paid anything apart from 'reasonable expenses' (this is often a difficult question and great care is needed. The court does have the ability to authorise additional payments, but this power has only once been exercised).

8. The surrogate fully and freely consents (and her consent can only validly be given after 6 weeks).

9. The surrogate's husband (if she has one) fully and freely consents.

The Department of Health's position

The Department of Health does not have an official position on surrogacy.

The Government undertook a review of surrogacy in 1997. The resultant report recommended:

1. Payments to surrogate mothers should only cover genuine expenses associated with the pregnancy.

2. Agencies involved in surrogacy should be registered with the relevant UK Health Department and operate in accordance with the code of practice which should be drawn up by the Department of Health.

3. The Surrogacy Arrangements Act 1985 and section 30 of the HF&E Act 1990 should be repealed and replaced by a new surrogacy act.

None of these recommendations have as yet been implemented.

The Human Fertilisation and Embryology Authority

The Human Fertilisation and Embryology Authority have agreed to its use.

The medical profession's position

The BMA has endorsed its use as an acceptable treatment but only as an option of last resort. Guidelines for clinical practice have been issued by the BMA's Ethics Committee.

Some key issues for third party funding surrogacy

- What are the medical – legal implications for a third party funder?

- What are the risks to the third party funder if the position if the host mother changes her mind and wishes to have an abortion?

- What are the risks to the third funder if the genetic parents change their mind or both parents reject the child?

- What are the risks to the third party funder is the surrogate mother becomes disabled or dies as a result of the pregnancy particular in relation to any existing children of the surrogate mother?

- What are the long term effects on the existing children of the surrogate mother?

- What are the long term effects on the surrogate mother?

- In considering equity - can the NHS justify funding IVF treatment for a woman not in clinical need of IVF?