

NORTH WEST GUIDELINE

Surrogacy

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3.	

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Conflict of Interest:

None declared	
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1 Summary / Introduction

A holistic approach is required when providing care for families involved in a surrogacy arrangement and staff should be aware of the legal aspects involved and how a Surrogate and Intended Parents may require support. This will enable maternity services to provide those families with a safe and high-quality experience of pregnancy, birth and postnatal journey that takes into account the wishes of the Surrogate and the Intended Parent/s (IPs) with good outcomes for the baby.

This guideline uses the term ‘*Surrogate*’ to describe the person carrying the pregnancy, and ‘*Intended Parent(s)*’ to describe those planning to parent the child. The terms ‘*woman*’ and ‘*mother*’ are used where these reflect the person’s self-identified gender or role, or where this is required for legal clarity. Each Surrogate and family will have individual preferences regarding how they are referred to; staff should sensitively establish these preferences on a personal level and use them consistently, while ensuring that terminology used in documentation complies with the law.

2 Purpose

The purpose of this guideline is:

- To ensure that professionals practice in accordance with the law in relation to surrogacy and are aware of their duty of care in relation to the Surrogate and the baby.
- To provide professionals with guidance in relation to providing care for the Surrogate, Intended Parent/s and the baby.
- To enable professionals to have a clear understanding of their duty of care and accountability.
- To support all staff when caring for Surrogates and IPs during the antenatal, intrapartum and postnatal period.

3 Scope

This guidance is intended for the maternity workforce supporting Surrogates and IP(s) through their pregnancy and early parenthood journey.

Including –

- All obstetric consultants, trainees, midwives, and clinical maternity support staff
- All obstetric anaesthetic staff and theatre teams
- All neonatal unit staff. shift coordinators and midwifery managers

4 Responsibilities

Healthcare providers should use this guideline as a framework for care but always use clinical judgement and individualise care based on discussions with the Surrogate and their family.

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5 Process/procedure/guidance etc. (main body)

6 Key terminology

6.1 Surrogacy

Surrogacy is the act of a woman carrying a pregnancy and giving birth for a family who are unable to conceive or maintain a pregnancy themselves.

The Surrogacy Arrangement Act 1985 defines a Surrogate 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 the parental rights being exercised (so far as is practicable) by another person or persons.”

Surrogacy in the UK is altruistic, meaning that organisations providing surrogacy services must be non-profit making.

6.2 Intended Parents (IPs)

IP(s) are individuals or couples who are considering surrogacy to become a parent. A broad range of people become parents through surrogacy, including couples (who could be in heterosexual or same-sex relationships, and who could be married, civil partners or unmarried) and single parents. In the majority of case, at least one of the IP(s) in a couple is a genetic parent of the baby born to them through surrogacy. To apply for a Parental Order (which is a court process for legal parenthood to be transferred from the Surrogate to the IP(s)) at least one IP must be genetically linked to the baby. However, there are other legal mechanisms that can confer legal parenthood to the IP(s) if there is not any biological connection, such as adoption. IP(s) should be referred to as the parents of the baby.

6.3 Surrogate

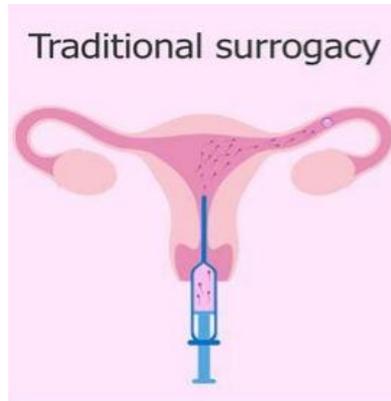
Surrogate is the preferred term for women who are willing to help IP(s) to create families by carrying children for them. A Surrogate may or may not have a genetic relationship to the baby that she carries. Surrogates should not be referred to as the mother or parent.

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6.4 Types of Surrogacies

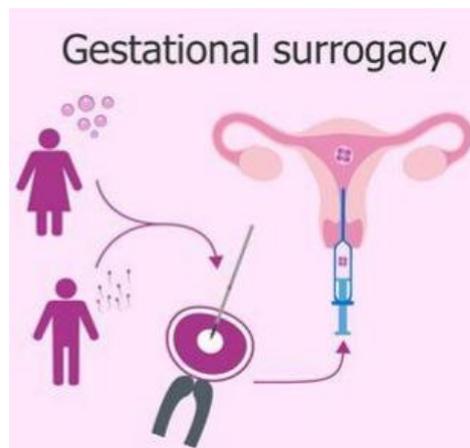
Traditional / Straight Surrogacy

Traditional surrogacy (also known as straight, genetic or full) is when the Surrogate provides her own egg, and an intended father provides the sperm. The egg is fertilised naturally or by artificial insemination at home or through artificial insemination with the help of a fertility clinic.



Gestational / Host Surrogacy

Gestational Surrogacy (also known as host or partial surrogacy) is when the Surrogate does not provide her own egg to achieve the pregnancy and has no genetic link with the baby. In such pregnancies, embryos are created in vitro and transferred into the uterus of the Surrogate using the gametes of at least one IP, plus the gametes of the other IP or a donor, if required.



7 Legal position of surrogacy

Surrogacy is an established and legal way of creating a family in the UK. Surrogacy agreements between a surrogate and IPs are not legally enforceable, and the surrogate is deemed legal parent of the baby at birth, and is recorded on the baby's birth certificate, along with her spouse or civil partner if she has one. In order to remedy this, the IP(s) can apply to the courts for a parental order after their baby is born to become the legal parents of the baby, and a new birth certificate is issued. There are several criteria that need to be met in order for the parental order to be granted, such as expenses, UK domicile, and genetic connection. There is no definition of expenses with elements of compensation routinely authorised by the courts

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The commercial arrangement of surrogacy, however, is illegal in the UK (in accordance with section 2 Surrogacy Arrangements Act 1985) and therefore it is an offence for an individual or agency to be paid to organise or facilitate surrogacy unless they are a non-profit organisation.

- It is a criminal offence to advertise that you are looking for a Surrogate or willing to act as a Surrogate.
- It is a criminal offence for third parties (that is, not the Surrogate or IP(s) to advertise that they facilitate surrogacy, although there are some exemptions for not-for-profit organisations.
- It is a criminal offence for third parties to negotiate the terms of a surrogacy agreement for any payment (for example a solicitor cannot represent IP(s) or Surrogates in agreeing the terms).
- Staff should be alert to any third parties (i.e. parties outside of the Surrogate and IP(s) who may be acting illegally on a profit-making basis. Should staff become suspicious that the parties are involved in a commercial arrangement, they must ensure that they contact the Named Midwife for Safeguarding for support and advice.

7.1 Surrogacy agreement

A surrogacy agreement is a document often drawn up by Surrogates and IP(s) (typically prior to conception). A comprehensive surrogacy agreement would cover all eventualities and decision-making events, for example thoughts around termination of a pregnancy and how this should be handled, where the birth should take place and other key decisions.

While surrogacy agreements are not legally enforceable and do not override other legal obligations, they can be used by staff to guide the provision of healthcare to the Surrogate, IP(s) and baby. A surrogacy agreement may also contain information on non-healthcare related matters and so staff should handle the document with extreme sensitivity and treat it as confidential patient information.

The guidance in this document assumes that a comprehensive surrogacy agreement has been prepared by the Surrogate and IP(s) and made available to healthcare professionals. If this is not the case then the parties should be encouraged by staff to prepare one and be advised that support is available, should they wish for it, from one of the UK surrogacy non-profit organisations.

Healthcare professionals have a duty of care, as when supporting any other pregnant woman, to the Surrogate and they should ensure that she has given her consent to any agreement regarding her care. Staff may wish to consider contacting the Specialist Safeguarding Midwife for further advice and guidance if they have any concerns.

During care provision, best practice should be observed with the Surrogate having an opportunity to be seen alone by a healthcare professional. This affords opportunity for routine and confidential discussion regarding social concerns (i.e., domestic abuse), physical or emotional well-being or any issues that may not otherwise be disclosed if accompanied.

7.2 Legal parenthood in surrogacy

The Surrogate is the legal mother of the Surrogate baby from birth until legal parenthood is transferred to IP(s) through a parental order made by a family court.

The Surrogate’s husband or wife if married, or civil partner if in a civil partnership, is the legal father/second parent of the baby. The Surrogate and her spouse/partner will be responsible for registering the baby’s birth, although the IP(s) can also attend. The Surrogate and her

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spouse/civil partner will be named on the baby’s initial birth certificate. The baby can still be given the IP(s) chosen names, including surname(s). It is not possible for an involved and consenting spouse to ‘opt out’ of being the second legal parent at birth. However, if the Surrogate is married but separated and it is possible to show that her spouse/partner did not consent to the surrogacy taking place, he/she will not be the legal parent. It is recommended that legal advice is sought prior to commencing treatment or any pregnancy plans as to the best way to evidence that lack of consent in the particular circumstances.

If the Surrogate is not married (either single or has partner to whom she is not married or in a civil partnership), then one of the IPs can be registered on the birth certificate as the father/second parent. This is normally the biological father, but if conception took place at a UK fertility clinic, the other IP could be nominated to be the second legal parent instead. The Surrogate’s unmarried partner, in this instance, is not seen as a legal parent to any baby born through surrogacy. A parental order would still be necessary to transfer the legal parenthood of the second IP and to extinguish the legal motherhood of the Surrogate. See Appendix 1 for further information relating to the Parental Order.

8 Safeguarding and Governance

All surrogacy births should be flagged for safeguarding oversight (not due to inherent risk, but due to legal complexity). This flag does not constitute a safeguarding referral. Families should be reassured that it is a standard step taken for all surrogacy cases to promote clear communication and ensure the wellbeing of everyone involved, explain the role of safeguarding here is not a social services referral. Any concerns about the welfare, safety, or consent of the Surrogate, baby, or Intended Parent(s) should be discussed sensitively and, if appropriate, escalated to the Named Midwife for Safeguarding in line with local procedures.

Disagreements over discharge or baby’s care must be paused and escalated to the on call Clinical team / SLT, bleep holder or on call matron in line with local escalation policy. The Trust safeguarding teams should also be informed. An urgent MDT meeting should be arranged if appropriate to drive resolution prior to discharge.

8.1 Documentation

The requirement for clear, concise and contemporaneous documentation that is reflective in both the Surrogate’s and baby digital records is paramount throughout the continuum. In addition to all birth / postnatal plans and all clinical care records please ensure presence of completed:

- Consent forms
- Discussions with IP(s)
- Wellbeing assessments.
- Safeguarding or referral actions

Prior to discharge ensure ease of access and clear handover to the community midwifery team and health visitors to ensure that they have access to the relevant documentation (with Surrogate’s consent).

9 Antenatal care

Antenatal care should be delivered in accordance with relevant clinical guidance, which is based on individual risk assessment. Surrogacy pregnancies, particularly those achieved through assisted reproductive technology (ART), may carry a slightly higher risk of obstetric

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complications such as increased risk of multiple pregnancy, VTE, pre-eclampsia, gestational hypertension, preterm birth, and abnormal placentation (placenta praevia or accreta) (Kallen et al 2010, Raperport et al 2022). These risks are related to factors such as donor gametes, multiple embryo transfer, and maternal age. Antenatal care should therefore include routine surveillance for these conditions, and ensure surrogates are aware of signs and symptoms. Care should be individualised according to the Surrogate’s medical and obstetric history and local guidance.

Requests set out in the surrogacy agreement or agreed between the Surrogate and the IP(s), within this should be accommodated, wherever possible.

Staff should be satisfied that the Surrogate consents to the sharing of information and/or attendance at appointments.

IP(s) should receive sensitive and supportive care from staff where possible. If the hospital is talking about something that could have implications for the baby and its care and welfare, this should also be directed to the IP(s), with the Surrogate’s consent. IP(s) may wish to attend antenatal classes with the Surrogate or on their own. IP(s) should be given all the support that other new parent(s) receive in terms of advice for early care and bonding.

If a surrogacy agreement has not been prepared, staff should encourage the Surrogate and IP(s) to create one. Signpost to surrogacy support agencies, such as Brilliant Beginnings, My Surrogacy Journey or Surrogacy UK to assist with this process.

9.1 Duty of Care

It is important to recognise the Trust’s duty of care is to the Surrogate. All applicable antenatal care should be advised / recommend to the Surrogate in the usual way. The IP(s) can be involved in this process provided that the Surrogate consents to this. The trust should facilitate this so far as is practical. The Surrogate has the right to make all decisions relating to her antenatal care. It is important to remember that the baby is not recognised as a “person” until birth and therefore, the rights of the Surrogate should take precedence over the interests of the unborn baby. No one else can make decisions on her behalf.

9.2 Safeguarding

At the point of booking for maternity care, consider contacting the Trust safeguarding children team to discuss the surrogacy case and any potential issues. The safeguarding children’s team will be a source of support, information and guidance to staff during the process. If there are any safeguarding concerns about the health and welfare of the Surrogate and/or IP(s), or unborn baby, then the Children’s Safeguarding team should be notified as standard and a referral to the local pre-birth liaison team should be completed.

If there are any safeguarding concerns around the health and welfare of the surrogate and/or IP(s), or unborn baby, then the Trust Safeguarding team should be notified as standard and discussion undertaken regarding whether threshold for referral for support/assessment has been reached and at what level.

A member of the senior midwifery leadership team and Safeguarding Midwife should also have oversight of all surrogacy cases to ensure robust process are followed and staff have access to guidance and support with conversation etc.

9.3 Sharing Information

Staff should be satisfied that the Surrogate consents to the sharing of data/medical information and /or attendance at appointments. If the Surrogate has given consent, then it is important to make the IP(s) feel part of the process to achieve a safe, rewarding and positive experience

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for both parties. Staff should ensure a co-ordinated, flexible and consistent approach to care and conversations.

The Community Midwife should arrange to meet with the Surrogate and IP(s) if possible, to discuss the expectations from all involved. This should include the preferred terminology for both the Surrogate and the IP(s). Where possible the IP(s) should be offered the option to have contact from a Community Midwife and Health Visitor allocated to their GP surgery. The preparing for your baby discussion that covers important key information such as safe sleeping, home environment and equipment should also be completed at this time either with both parties together or separately. Ensure that all risks are considered such as alcohol consumption, smoking, previous social services involvement and contact information. Due to the additional information requiring discussion, an extended appointment time should be considered and support from a senior midwife if required.

Include the following information in the pregnancy records during the antenatal period (see Appendix 3, 4a, 6):

9.4 Ultrasound Scanning Appointments

With the consent of the Surrogate, IP(s) should be supported to attend ultrasound scan(s). Reasonable adjustment should be made where geographical distance prohibits them from attending, support should be given to facilitate virtual attendance.

9.5 Antenatal screening for infectious diseases

Fertilisation in Licensed Clinic

The Code of Practice guidance from the Human Fertilisation and Embryology Authority sets out the expectations for fertility clinic screening and outlines the requirements for testing for HIV and Hepatitis as well as other transmissible infections ([Code of Practice 9th edition – revised October 2023](#)). The Surrogate will be tested for these infections, as part of the patients' screening requirements.

Where treatment has been provided in a licensed fertility clinic, the gamete providers will also be tested for HIV, hepatitis and other transmittable infections. They will also be screened for blood karyotyping and cystic fibrosis, as well as other applicable genetic tests.

Sperm is required to be quarantined for six months. In November 2024, a new law came into force that allows those living with undetectable HIV to donate to known recipients. However, clinics must not carry out treatment involving known donation for individuals with undetectable HIV until their licence has been varied to include the updated Standard Licence Conditions (SLCs).

Self-insemination

With self-insemination, there is a risk of transmission of infection to the Surrogate and/or unborn baby. Therefore, the Surrogate (and her partner if she has one) should be advised of this risk and offered testing accordingly, prior to or after conception. The IP(s) should be included in this counselling and decision-making if the Surrogate has given her consent.

If the surrogacy is supported by one of the national non-profit surrogacy organisations and self-insemination is to be used, then parties are likely to have undertaken screening prior to joining. A risk could still exist at the point of conception; however, this guidance recommends that the Surrogate and intended father/sperm donor are tested again prior to self-insemination if this is the chosen method.

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Should the Surrogate be identified as having a transmittable infection, then the usual counselling should be given regarding the risks of vertical transmission of infection and any recommended steps at birth to minimise the risk. Staff are prohibited from sharing this information with the IP(s) or other third party without consent of the Surrogate. Where the Surrogate has given her consent, the IP(s) should be included in this counselling. Where one or both IPs is identified as having a transmittable infection, then they should be informed and advised to seek medical advice and treatment.

Sickle Cell and Thalassaemia Screening

Scenario	Screening Process
Surrogate's own eggs/intended father's sperm	Complete the Family Origin Questionnaire (FOQ) and offer screening as normal
Donor egg/intended father's sperm	<p>Screening is offered to the Surrogate for her own health.</p> <p>Complete the FOQ and send with the FBC sample, ticking the donor egg box. Refer to the Antenatal Screening team who will offer the intended father testing.</p> <p>If the couple have written documented proof of the donor egg's Sickle/Thalassaemia status this is beneficial</p>
Both the intended parent's egg and sperm	<p>Screening should be offered to the Surrogate for her own health.</p> <p>If IVF has been undertaken in the UK, those providing gametes will have already undergone screening. Offer the intended mother screening with a completed FOQ. Tick the appropriate box for donor sperm.</p>
Intended mother's egg and donor sperm	<p>Screening should be offered to the Surrogate for her own health.</p> <p>If IVF has been undertaken in the UK, those providing gametes will have already undergone screening. Offer the intended mother screening with a completed FOQ. Tick the appropriate box for donor sperm.</p>

9.6 Antenatal screening for fetal anomalies

All applicable and routine antenatal screening tests for fetal anomalies will be offered to the Surrogate in the usual way. Should any fetal anomaly be identified, staff should discuss this with the Surrogate and, where the Surrogate has given her consent, the IP(s), should be included in counselling, decision-making and information sharing.

Should an anomaly be identified in the unborn baby, staff should not share this information with the IP(s) or other third party without the consent of the Surrogate. The surrogate should be supported to share the information with the IP(s), this may include arranging an appointment for the IP(s) to discuss directly with staff.

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9.7 Termination of pregnancy

Where a termination of pregnancy is being considered and the relevant legal conditions are met, the Surrogate makes any final decision about a termination. If the Surrogate discloses that she is considering termination, then she should be referred to a counsellor and the relevant healthcare professionals in accordance with the gestation period of the pregnancy. The IP(s) should be included in this counselling, information sharing and decision making if the Surrogate has given her consent.

The IP(s) have no right to prevent a termination taking place and they cannot be informed about a termination unless the Surrogate has given her consent for this information to be shared.

Baby loss before the 24th week of pregnancy

Pregnancy loss before 24 weeks can be a result of complications including:

- miscarriage
- ectopic or molar pregnancy
- deciding to terminate a wanted pregnancy for medical reasons

All baby loss, at any gestation, can be traumatic and it is important bereaved parents are supported.

In surrogacy cases involving baby loss, both the IP(s) and Surrogate should be routinely offered emotional support following a loss. Consideration should be given to the varying individual needs of those involved.

If a loss is identified during a scan or medical appointment, the IP(s) may be present and able to receive information directly from healthcare professionals. If a loss occurs outside a medical setting, the Surrogate will usually inform the IP(s) in line with their agreement. Support should be provided to the Surrogate during this process, and medical professionals should share information directly with the IP(s) where possible, rather than relying on the Surrogate to do so.

Although the Surrogate is the legal birth parent, the IP(s) should be included in communication and decision-making with the Surrogate's consent. Decisions such as termination or induction may affect everyone involved. These scenarios are often considered in advance within surrogacy agreements. Healthcare professionals should ensure inclusive, sensitive decision-making that recognises all parties as a team.

9.8 Involving the Surrogate and Intended Parent(s)

Healthcare professionals should:

- provide clear medical information to the Surrogate and seek consent to share it with the IP(s) and others supporting her
- ensure the IP(s) receive clear information and are involved in decision-making, with the Surrogate's consent
- recognise the IP(s) as the baby's parents
- be aware the IP(s) may have experienced previous losses
- acknowledge that grief may differ between the Surrogate and IP(s)

IP(s) should be supported to create memories and physical keepsakes where possible. It may be possible for pictures of the baby to be taken. If so, everyone should be involved and should have their own opportunity for photographs (together and/or separately) if they wish.

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Some teams may ask for a post-mortem, or for funeral arrangements to be made. At these times, inviting the Surrogate and IP(s) to take time to discuss and agree a plan that is comfortable for all concerned will help to avoid issues of exclusion for anyone.

The [Women’s Health Strategy for England](#) (2022) introduced voluntary pregnancy loss certificates for losses before 24 weeks in England, allowing parents to formally recognise their loss.

9.9 Birth Planning

The birth plan is a vital part of pregnancy care and provides an opportunity for Surrogate and IP(s) to jointly express their preferences for labour, birth, and early postnatal care. While not legally binding, birth plans help guide healthcare professionals in delivering safe, respectful, and personalised care.

A surrogacy birth plan should reflect key decisions agreed in the surrogacy arrangement.

A birth planning check list can be located in Appendix 4b: Surrogacy Birth Planning.

The Surrogate’s wishes take precedence in all matters relating to her care, body, and including decisions made during labour and birth. However, collaborative planning ensures clarity and shared understanding between the Surrogate, IP(s), and maternity team. It should be acknowledged that the Surrogate may change her mind about some aspects of the plan, such as whom she wants to be present at birth, and this must be respected.

If no birth plan has been completed by 34 weeks gestation and the Surrogate agrees, staff should facilitate a planning meeting involving the Surrogate, IP(s), and a named Community Midwife. This meeting supports communication and coordination between the family and multidisciplinary team. Use of standardised templates (e.g. from Surrogacy UK, or Brilliant Beginnings) is encouraged to ensure all relevant points are captured.

9.10 Documentation and Information Sharing

Once agreed, the birth plan must be uploaded to the Trusts digital Maternity record or case notes and flagged for visibility. And share with Neonatal Team
With consent, the plan should also be shared with the senior leadership and the multi disciplinary team in birth suite, triage, inpatient areas and neonates to ensure continuity.

10 Intrapartum Care

This section of the guideline provides maternity staff with a clear framework for managing the intrapartum care of women acting as Surrogates, with particular focus on legal responsibilities, informed consent, birth preferences, and multidisciplinary coordination. It applies to all staff involved in the care of Surrogate women during labour and birth in hospital and community birth settings.

All care must follow the principles outlined in national (NICE 2023, updated 2025) and local intrapartum clinical guidelines to ensure safe, evidence-based practice.

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10.1 Support During Birth

The Surrogate may choose her birth partner(s). This may include:

- One or both IP(s)
- A family member/partner or friend.

The number of people planned to be present should be documented in the personalised birth plan.

If birth is taking place in theatre, it is best practice to ensure the Surrogate has her choice of birth partner present and with the Surrogate's consent, the IP(s) have the opportunity to be present. Reasonable adjustments should be made to accommodate this. There may be some instances where this is not possible or appropriate. In that case, it is best practice to have discussions about this prior to labour on set to prevent clinical delay and increased anxiety in labour/during a clinical emergency.

The surrogate's dignity should be respected at all times and personalised care principles applied throughout.

10.2 Pain Relief and Labour Management

The Surrogate has full autonomy over pain relief options and may choose from all standard forms available in the local maternity unit. Pain management should be discussed antenatally and reviewed again on admission in labour. Maternity staff must ensure the Surrogate's comfort and emotional needs are prioritised throughout.

10.3 Documentation and Escalation

All decisions regarding birth, support presence, and neonatal care must be clearly documented in both the Surrogate's and baby's records. Any disagreements between the Surrogate and IP(s), or concerns regarding safety or consent, must be escalated immediately to:

- Senior Midwife or Labour Ward Coordinator
- Consultant Obstetrician
- Safeguarding Lead
- Trust Legal Team (if indicated).

11 Postnatal Care

This section of the guideline outlines the care and legal responsibilities of inpatient and community midwifery staff in the immediate and ongoing postnatal period for Surrogates and babies born through surrogacy. It applies to midwives, maternity support workers, neonatal staff, obstetricians, neonatologists, paediatricians and community practitioners.

11.1 Consent and Responsibility for Neonatal Care.

The Surrogate must provide formal consent for all standard neonatal procedures including but not limited to:

- Vitamin K administration.
- Feeding
- Newborn infant physical examination (NIPE).
- NICU admission and all investigations/interventions.
- Blood tests/antibiotics/clinical interventions and treatments.
- Screening tests.

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All written and / or verbal consent should be clearly recorded in both the maternal and neonatal digital records. With the Surrogate’s consent IP(s) may carry out day-to-day cares including nappy changing, feeding and skin to skin contact. This section lists some of the things whereby consent will need to be obtained from the surrogate; refer to appendix 5 for examples of signed consent.

11.2 Infant Feeding.

The parents of a baby born through surrogacy have a number of choices when considering how they would like to feed their baby:

- **Inducing lactation** - This involves the intended mother(s) taking medications and supplements to simulate pregnancy and encourage breastmilk production. Exclusive breastfeeding through induced lactation may not always be possible due to the lower volumes of breastmilk produced. Also, colostrum is not produced during induced lactation. Therefore, IP(s) and Surrogates may wish to discuss this antenatally to decide whether the Surrogate will provide colostrum or expressed milk in the immediate postnatal period. The use of an at-breast supplementer, also known as a supplemental nursing system, can be helpful to ensure the baby receives adequate nutrition whilst supporting the intended mother’s wishes to breastfeed. Alternatively, a combination of breastfeeding and formula feeding may be used.
- **Surrogate breastmilk** - Some Surrogates are willing to breastfeed for a short duration and/or express breastmilk to provide to the baby, or they may choose to donate their breastmilk to a milk bank. If this is the case, the Surrogate should be supported in her wishes and provided with practical and emotional support throughout the perinatal period.
- **Donated breastmilk:** Milk banks will occasionally provide donated breastmilk for a baby born through surrogacy, and IPs can approach their GP to discuss a potential referral to a milk bank. Some IPs may consider obtaining donated breastmilk from other sources, including directly from individuals. This should be strongly discouraged due to the risk of transmission of infectious diseases and/or other harmful substances through breastmilk of non-screened individuals.
- **Formula milk:** Some IPs will choose to use formula milk to feed their baby. Maternity staff should support IPs in their decision and ensure they are aware of how to safely prepare and give formula milk to their baby.

If a Surrogate chooses to suppress lactation, a discussion should be held prior to discharge from hospital regarding the best way to achieve this. It is common for Surrogates to experience an emotional reaction following the birth of the baby. Consideration should therefore be given to the use of medication to suppress the Surrogate’s milk supply, if she so wishes.

11.3 Postnatal Inpatient care.

Surrogates should be offered full postnatal care, equivalent to any birth mother, including:

- Physical recovery monitoring in line with national (NICE 2021, NICE 2023) and local care guidelines.
- Mental health and emotional wellbeing checks
- Pain relief, contraception advice, safeguarding screening

Surrogates may have a range of emotional responses to birth. Validate all emotions and offer referral to perinatal mental health or specialist counselling where appropriate. Document any discussion or request regarding future contact with the baby or IP(s)IP(s).

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11.4 Postnatal Ward Practical Arrangements

The Surrogate should be offered a private room wherever possible, especially if she does not wish to be near mothers with babies. If the Surrogate consents, the baby may remain with the IP(s) on the ward in a separate room or bed space.

In such cases:

- The baby’s identification bands must reflect the legal mother (Surrogate); additional temporary bands for IP(s) may be used where Trust policy allows.
- The Surrogate must sign a written consent for the IP(s) to care for the baby - written consent provides evidence that the Surrogate has authorised the Intended Parent(s) to provide day-to-day care for the baby while in hospital. It does not transfer legal parenthood or parental responsibility, which remains with the Surrogate until a parental order is granted.

IP(s) should not be admitted as a patient of the Trust. If the Surrogate requests that the IP(s) are permitted to stay this should be accommodated but clear documentation of both the request and any permitted cares. The IP(s) must be advised that they do not have legal decision-making authority without the Surrogate’s documented agreement, this discussion should be clearly documented in both the Surrogate’s and baby’s records.

11.5 Discharge Planning for the Baby and Surrogate

Prior to discharge from the inpatient environment the following should be completed -

- The Surrogate and baby must have separate discharge summaries
- The Surrogate must sign the discharge consent form for the baby.

The discharge record for the baby must reflect:

- Legal mother's name (the Surrogate)
- IP(s) names (if Surrogate agrees)
- Consent statement from Surrogate authorising discharge with IP(s).

The baby cannot be removed from the hospital by the IP(s) without the consent of the Surrogate. Maternity staff must ensure that they have consent from the Surrogate before handing over the baby and that this is done, wherever achievable in the presence of both the Surrogate and the IP(s).

If the Surrogate chooses to accompany the IP(s) or say goodbye, this should be sensitively facilitated. If she prefers not to be involved, staff must ensure her wishes are respected.

11.6 Community Midwifery Follow-Up

The community team must be fully briefed before discharge, including:

- Legal status of the Surrogate and the baby.
- Any consent arrangements in place.
- Contact preferences for follow up visits for both the Surrogate and the IP(s).

11.7 Postnatal Community Care for the Surrogate

The Surrogate remains the patient and must be offered routine postnatal care at home, in line with local Trust guidelines. The Surrogate’s postnatal visits should be separate and confidential.

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11.8 Postnatal Community Care for the IP(s) and the Newborn.

The IP(s) should be allocated community visits in line with national and Trust guidance and the baby's discharge should be communicated to the IP(s) intended GP and Health Visitor in line with routine guidance. NB – This might be out of area.

Clear documentation is required for any neonatal concerns raised during community visits; legal responsibility remains with the Surrogate until the Parental Order is granted.

At the point of discharge from community midwifery services there must be robust transfer arrangements, documentation and follow-up in place between the midwifery and health visiting team in the area of residence.

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12 APPENDIX

12.1 Appendix 1: Parental order

IP(s) can start the process to obtain a parental order once they receive the birth certificate, and the application should be made before six months after the birth. In order for a parental order to be granted, certain criteria need to be met:

- The baby must have been conceived through the transfer of an embryo or artificial insemination
- At least one of the applicants must be the baby’s biological parent
- If the IP(s) are applying as a couple they must be married, civil partners or living as partners in an enduring family relationship (single applicants may also apply and there are then no relationship status criteria)
- One or both of the IPs must be domiciled in the United Kingdom
- The baby must have their home with the IP(s)
- The IP(s) must be over 18 years of age
- The Surrogate and her spouse/civil partner must consent to the making of the order (the Surrogate’s consent being invalid if given earlier than 6 weeks following the birth)
- The court must be satisfied that no more than expenses reasonably incurred have been paid, or alternatively must retrospectively authorise any payments
- The granting of the parental order must be appropriate to safeguard the baby’s lifelong welfare

The parental order process is normally straightforward, and it is usual for the baby to be cared for by the IP(s) from birth (with the Surrogate’s consent). As is clear from the criteria, the law expects the baby to be handed over to the IP(s) from birth and to have his or her home with the IP(s) before the court application is made. To enable this, the law explicitly exempts IP(s) in a surrogacy arrangement from the private fostering regulations (which would otherwise require the handover of a baby to someone else to involve social services) provided that they intend to apply for a parental order. Therefore, there is no legal difficulty associated with a baby being handed over to IP(s) at birth following a surrogacy arrangement in the UK even if they are not at that stage the legal parents, and there is no need to notify or involve social services unless there are separate safeguarding concerns.

Under English law, once the parental order is granted the IP(s) will receive a new birth certificate stating they are the legal parents of the baby.

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12.2 Appendix 2: Surrogacy Pregnancy Flowchart

Surrogacy Pregnancy Flowchart

The flowchart has been devised to act as an overview of the care that should be provided to the Surrogate and IP(s) throughout the journey of pregnancy, birth and the postnatal period.



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12.3 Appendix 3: Checklist for Surrogacy documentation

Checklist for Surrogacy documentation

The following checklist should be adhered to for all Surrogate births. A thorough risk assessment should be carried out, and any reasons or potential problems that may deviate from the usual surrogacy pathway should be documented clearly.

Antenatal period

Please ensure that the following information is collected and documented in the pregnancy records during the antenatal period:

- Ensure that a birth plan is completed with the Surrogate's (and IP(s)' if appropriate) wishes for the birth/postnatal period, which should include the Surrogate's wishes for the IP(s) (for example, whether to be present at the birth/during postnatal inpatient stay).
- Ensure that the preferred terminology is agreed with both the Surrogate and IP(s) and clearly documented in the maternity notes.
- Ensure that all parties are aware of how medical consent and informed consent works.
- Clearly document all aspects of surrogacy including what the Surrogate and IP(s) have agreed in terms of participation and decision-making.
- Clearly document any consents that the Surrogate has given, for example consent to share information with the IP(s) and parenthood consents.
- Ensure that full contact details for the IP(s) are recorded: - names, contact numbers, home address - Address / email / telephone numbers for the following: Local maternity hospital, community midwives, health visitors, local GP surgery.

Intrapartum

- Ensure that the birth plan is discussed with the midwife caring for the Surrogate and that all team members have had the opportunity to read the notes and are aware of the situation.
- Ensure that the Surrogate's wishes for the IP(s) are clear (for example, whether to be present at the birth / during postnatal inpatient stay).

Post-natal period

- Ensure that the postnatal ward staff are clear of the Surrogate's wishes relating to the IP(s) and a realistic expectation regarding plans for accommodating the Surrogate's wishes, and those of the IP(s) is achieved.
- Ensure that the agreement between the Surrogate and IP(s) regarding the care of the baby is clearly documented in the maternity notes and the baby notes and clearly record any necessary consent by the Surrogate for the IP(s) to make decisions about the baby (note that the existence of a surrogacy agreement does not override any subsequent decision by the Surrogate who remains the baby's legal mother until parenthood is transferred).
- Check discharge details for the IP(s); names, contact numbers, home address
- Provide Address / email / telephone numbers for the following: local maternity hospital, community midwives, health visitors, local GP surgery
- To ensure that both the Surrogate and baby receive follow-up care in the community, please:
 - send the Surrogate's details to her community midwife and GP
 - send the baby's discharge details to the community midwife and GP of the IP(s)

Staff should ensure that correct protocols are followed as explained in the guidance if any concerns arise with regards to the Surrogate, IP(s) or baby.

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12.4 Appendix 4a: Initial Surrogacy Assessment

Initial Surrogacy Assessment

Names and contact details	Comments
Surrogate name DOB Contact details	
Intended Parents Name Date(s) of birth Contact details	
Intended Parents Name Date(s) of birth Contact details	
Spouse of Surrogate name DOB Contact details	
Community MW name	
Surrogate pregnancy details	
Surrogacy organisation (if any)	
Form of surrogacy-gestational or traditional	
Expected due date	
Summary of fertility treatment (if available)	
Antenatal Care	
Alert / Banner added to EPR record to ensure staff are aware of Surrogate pregnancy (<i>to ensure appropriate names used when addressing Surrogate and IP(s)</i>)	
Confirm all routine care has/will be received	
Who will attend scans and appointments	
Birth Planning meeting	
Date of birth planning meeting	
Who attended the meeting	

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12.5 Appendix 4b: Surrogacy Birth Plan

Surrogacy Birth Plan

The Birth	Comments
The Surrogate's intended place of birth	
Who will be the birth partner / s	
Who will attend the birth if: Vaginal	
Planned caesarean birth	
Unplanned caesarean birth	
Pain relief options discussed	
Who will make decisions for Surrogate if she can't speak during birth	
Handling baby at birth	
Who will cut the cord	
Skin to skin	
Holding the baby after birth	
Feeding	
Surrogate expressed breast milk	
IP breast feeding – inducing lactation	
Donated breast milk	
Formula	
Name bands	
Aware Surrogates name will appear on the bands due to security	
Would the IP/s like name bands with their names on	
Post-partum care	
Who will care for the baby following birth and when and where will transfer of care take place	
Who will make medical decisions about care/treatment for the baby	

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Does the surrogate give consent for Vitamin K	
Does the surrogate give consent for newborn NHSP and NIPE screening	
Visiting	
Family members who will be visiting	
The plan for IP/s to stay on the ward after birth	
Discharge of Surrogate, IP/s and baby, including early discharge of the Surrogate if birth uncomplicated and information for IP/s	
Who will the baby be discharged with	
ANTENATALLY - Confirm following professionals have been informed of pregnancy & impending arrival of baby	
Intended parents GP GP contact details	
Date notified	
Intended parents' health visitor Health visitor contact details	
Date notified	
Confirm birth plan has been communicated with/made available to following people & provide their names and contact details	
Head / Director of Midwifery at Surrogate's trust – for appropriate dissemination	
Share postnatal care plan with Community MW of IP's	
POSTNATALLY - Confirm appropriate professionals informed of discharge of Surrogate & baby - relevant documentation sent to ensure appropriate & seamless handover of care	
Intended parents' local trust Name Date	
Intended parents' Midwife Name Date	
Intended Parents' Health Visitor Name Date	
Intended Parents' GP	

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Name	
Date	
'Child Health' information to include intended parents and their health care professionals as above. Inform surrogates local child health of transfer out to IP's locality	
Appropriate written consent signed (appendix 5) for transfer of care and neonatal screening tests and treatment decision. Date uploaded to maternity electronic patient record	

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12.6 Appendix 5: Surrogate Consent

Surrogate Consent for Neonatal Discharge

Consent to be signed by the Surrogate for baby being discharged with the IP(s), independently from the Surrogate

I understand that (Baby).....can be discharged independently of me

I confirm my explicit consent for (Baby).....D.O.B.....
to be discharged to the care of IP/IP's

Name/s.....

In accordance with the terms of the surrogacy agreement (Date).....

Signature of

Surrogate.....Date.....

Surrogate Consent for Vitamin K

Consent to be signed by the Surrogate for the baby to have Vitamin K (if in care of IP(s))

I (the Surrogate)..... give explicit consent for the Baby
.....DOB..... to receive Vitamin K (Oral/ IM) by a Midwife whilst in
the care of the IP(s)

Signature of Surrogate.....Date.....

Surrogate Consent for Newborn Screening

Consent to be signed by the Surrogate for baby to undergo Newborn screening

I (the Surrogate) give explicit consent for the Baby
.....DOB..... to undergo the neonatal screening, by way of a blood spot
test and hearing screen performed by a Healthcare professional whilst resident with the IP(s)

Signature of Surrogate..... Date.....

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Surrogate Consent for Treatment for Baby

Consent to be signed by the Surrogate for baby to undergo Treatment

I (the Surrogate) give explicit consent for the Baby
DOB..... to undergo any necessary treatment recommended by a
 Healthcare professional whilst resident with the IP(s) (name of IP(S))
prior to a Parental Order being granted

Signature of Surrogate..... Date.....

Surrogate consent should be discussed antenatally and confirmed through completion of forms following birth. Once completed upload into scanned documents within the maternity EPR, alongside a paper copy to the IP(s). It must be completed prior to the discharge of the Surrogate and baby from hospital. Community Team to access via the Maternity electronic patient record or IP(s) paper copy.

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12.7 Appendix 6: Risk Assessment for Intended Parents

Your Details: Intended Parent 1
 Name:
 DOB:
 Address:

 GP:

Your Details: Intended Parent 2
 Name:
 DOB:
 Address:

 GP:

Social Assessment

Difficulty in understanding English	Y	N
Difficulty in reading/writing	Y	N

Social Assessment

Difficulty in understanding English	Y	N
Difficulty in reading/writing	Y	N

Tobacco Use

Are you a smoker?	Y	N
Have you ever smoked tobacco?	Y	N
Was this in the last 12 months?	Y	N
When did you stop?		
Anyone else in the house smoke?	Y	N

Tobacco Use

Are you a smoker?	Y	N
Have you ever smoked tobacco?	Y	N
Was this in the last 12 months?	Y	N
When did you stop?		
Anyone else in the house smoke?	Y	N

Drug use

Have you ever used street drugs, cannabis or psychoactive substances	Y	N
Have you ever injected drugs?	Y	N
Have you ever shared drug paraphernalia	Y	N
Are you receiving cessation support?	Y	N
Any drug/alcohol concerns at home?	Y	N

Drug use

Have you ever used street drugs, cannabis or psychoactive substances	Y	N
Have you ever injected drugs?	Y	N
Have you ever shared drug paraphernalia	Y	N
Are you receiving cessation support?	Y	N
Any drug/alcohol concerns at home?	Y	N

Alcohol use

Do you drink Alcohol?	Y	N
How many units per week		

Alcohol use

Do you drink Alcohol?	Y	N
How many units per week		

Children's social care

Have you ever had a social worker?	Y	N
Social Worker's name:		
Referral required?	Y	N
Referral shared with safeguarding and CMW	Y	N

Children's social care

Have you ever had a social worker?	Y	N
Social Worker's name:		
Referral required?	Y	N
Referral shared with safeguarding and CMW	Y	N

13 Monitoring / Audit

The guideline has been peer reviewed by the Regional Guidelines Group.

Compliance should be monitored through routine feedback from all surrogates and intended parents accessing care. Where this is not collected and reviewed in real time, the Trust should include an annual audit within its audit programme.

14 Details of attachments (e.g. list of appendices)

Appendix 1: Parental Order

Appendix 2: Surrogacy Pregnancy Flowchart

Appendix 3: Checklist for Surrogacy documentation

Appendix 4: Appendix 4a: Initial Surrogacy Assessment

Appendix 4: Appendix 4b: Surrogacy Birth Plan

Appendix 5: Surrogate Consent Forms

Appendix 6: Risk Assessment for Intend Parents

15 Details of other relevant or associated documents (including links)

[Understanding and dealing with issues relating to parental responsibility - GOV.UK](#)

[The surrogacy pathway: surrogacy and the legal process for intended parents and surrogates in England and Wales - GOV.UK](#)

[Surrogacy](#)

16 Supporting references & national guidance

Källén B, Finnström O, Nygren KG, Olausson PO (2010) *In vitro fertilisation (IVF) in Sweden: risk for placenta praevia, placental abruption and other placenta disorders. Human Reproduction*, 25(5): 1182–1188.

Raperport, C., Chronopoulou, E., McLaughlin, A., Cox, S., Srivastava, G., Shah, A. and Homburg, R. (2022), 'It takes a village' – fertility treatment using donor gametes, embryos and/or surrogacy. *Obstet Gynecol*, 24: 251-259. <https://doi.org/10.1111/tog.12830>

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17 Definitions / glossary

See section 6 of the guideline

18 Consultation with Stakeholders

Fiona McCarron	Consultant Midwife, Mid Cheshire
Joanne Dent	Service User - Surrogate
Angela Sproston	Service User – Intended Parent
Joke Lambers	Midwife and Service User - Surrogate
Nicky Reid	Brilliant Beginnings
Claire Darling	Associate Director of Midwifery, NCA
Tildy Ashcroft	Specialist Midwife for Antenatal and Newborn Services, Warrington and Halton Service User – Surrogate
Gavin Shields	Service User, Intended Parent
Helen Prosser	CEO, Brilliant Beginnings
Charlotte McVittie	Midwife, Service User, Surrogate
Angela Kerrigan	Consultant Midwife

Acknowledgements:

Thanks to all maternity units that shared their current Surrogacy Guideline to support the creation of the guideline.

East Lancashire Hospitals NHS Trust
 Tameside and Glossop Integrated Care NHS Foundation Trust
 Milton Keynes University Hospital NHS Foundation Trust
 North West Anglia NHS Foundation Trust
 Shrewsbury and Telford Hospital NHS Trust
 Warrington and Halton Teaching Hospital NHS Foundation Trust
 Wirral University Teaching Hospital NHS Foundation Trust
 University Hospitals of Morecombe Bay

19 Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the group to identify where a policy or service may have a negative impact on an individual or particular group of people.

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	North West Guideline - Surrogacy
Directorate and service area:	Maternity

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Information Category	Detailed Information
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Michelle Waterfall, Deputy Regional Chief Midwife
Contact details:	Michelle.waterfall2@nhs.net

Information Category	Detailed Information											
1. Policy Aim - Who is the Policy aimed at?	Clinical Guideline											
2. Policy Objectives	Improve experiences for individuals involved in surrogacy											
3. Policy Intended Outcomes	Positive service user experience Increase knowledge and support for clinicians											
4. How will you measure each outcome?	Service User feedback											
5. Who is intended to benefit from the policy?	Clinicians supporting Surrogates and Intended Parents Surrogates and Intended Parents											
6a. Who did you consult with? (Please select Yes or No for each category)	<ul style="list-style-type: none"> • Workforce: Yes • Patients/ visitors: Yes • Local groups/ system partners: No • External organisations: Yes • Other: No 											
6b. Please list the individuals/groups who have been consulted about this policy.	<p>Please record specific names of individuals/ groups:</p> <table border="1"> <tbody> <tr><td>Fiona McCarron</td></tr> <tr><td>Joanne Dent</td></tr> <tr><td>Angela Sproston</td></tr> <tr><td>Joke Lambers</td></tr> <tr><td>Nicky Reid</td></tr> <tr><td>Claire Darling</td></tr> <tr><td>Tildy Ashcroft</td></tr> <tr><td>Gavin Shields</td></tr> <tr><td>Helen Prosser</td></tr> <tr><td>Charlotte McVittie</td></tr> <tr><td>Angela Kerrigan</td></tr> </tbody> </table>	Fiona McCarron	Joanne Dent	Angela Sproston	Joke Lambers	Nicky Reid	Claire Darling	Tildy Ashcroft	Gavin Shields	Helen Prosser	Charlotte McVittie	Angela Kerrigan
Fiona McCarron												
Joanne Dent												
Angela Sproston												
Joke Lambers												
Nicky Reid												
Claire Darling												
Tildy Ashcroft												
Gavin Shields												
Helen Prosser												
Charlotte McVittie												
Angela Kerrigan												
6c. What was the outcome of the consultation?	Create of the clinical guidance											

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

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Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: [Michelle Waterfall](#)

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