

Surrogacy

Key Points

- Surrogacy is when a woman carries a child for someone who is unable to conceive or carry a child themselves. It is an established and legal way of creating a family.
- In the UK it is not a commercial industry but normally undertaken on an altruistic basis (expenses only). Surrogacy through commercial means is illegal in the UK. It is an offence for an individual or agency to act on a profit-making basis to organise or facilitate surrogacy for another person.
- The actions and attitudes of healthcare staff can have a significant impact on the experiences of surrogates and intended parents.
- Most surrogacy cases are straightforward, positive and rewarding experiences; disputes between parties are very rare (DHSC, 2021).
- Legal parenthood lies with the surrogate and her spouse (if she has one) until it is transferred to the intended parents through legal process. This currently can only be applied for from six weeks after the birth, although the law is due to change.
- Best practice is for a pre-conception agreement between the surrogate and intended parents which outlines their wishes (although this is not legally enforceable) and for complete transparency at the booking appointment.

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This Trust guideline should be used in conjunction with the Department of Health guidance on Having a Child through Surrogacy and the Trust's Mental Capacity Act Policy, which is available on the Trust intranet.

Purpose and Rationale

The purpose of this guideline is to assist staff providing maternity care who are involved with a surrogate pregnancy. In the event of a request for surrogacy all staff should be aware of the legal requirements of the surrogate parents and intended parents.

Principles

- To offer care in a non-judgmental and supportive manner.
- Maintain accurate and contemporaneous records of discussions and decisions reached.
- Confidentiality is vital, and disclosure should be made on a need-to-know basis.
- Any reference to the surrogacy arrangement in the medical notes should only be made after discussion with and permission from the surrogate mother.
- The needs of the surrogate mother should always be a priority and all (final) decisions rest with her.
- Information requested by the intended parents must be sanctioned by the surrogate mother and documented in her records.

Scope

This guideline is relevant to Obstetricians, Gynaecologists, Paediatricians and Midwives.

Key terminology

Intended parents (IP(s))

Individuals and couples who are considering surrogacy as a way to become a parent. Couples may be heterosexual or same-sex couples in a marriage, civil partnership or living together in an enduring relationship.

Surrogate

This is the preferred term for women who are willing to help IP(s) create families by carrying children for them. A surrogate may or may not have a genetic relationship to the child which she carries for a couple. Surrogates generally do not prefer to be referred to as the mother or parent of the baby.

Straight surrogacy

Straight (also known as genetic, full or traditional) surrogacy is when the surrogate provides her own eggs to achieve the pregnancy. One of the IP(s), or the IP in the case of an individual applicant, provides a sperm sample for conception through either self-insemination away from a licenced setting or artificial insemination with the help of a fertility clinic.

Host surrogacy

The surrogate doesn't provide her own egg to achieve the pregnancy. In such pregnancies, embryos are created in vitro and transferred into the uterus of the surrogate using the gametes of at least one IP, or the IP if an individual applicant, plus the gametes of the other IP or a donor, if required.

Legal framework

Whilst every effort should be made to adopt a holistic, family-centred approach which considers the wishes of both the surrogate and IP(s), the surrogate has the final authority regarding any decisions during the perinatal period (until parental responsibility is legally transferred).

The surrogate is the legal mother and therefore has parental responsibility (along with her spouse if married) of the surrogate child from birth until legal parenthood is transferred to IP(s) through a parental order made by a family court. If the surrogate is married or in a relationship, her partner will also assume legal parenthood status of the child from birth until the parental order is made. IP(s) can start the process to obtain a parental order from 6 weeks until 6 months after the birth if certain criteria have been met, including the child being in their care, having the consent of the surrogate and at least one IP or the IP, in the case of an individual applicant, being genetically related to the child. The parental order process is normally straightforward, and it is usual for a newborn to be cared for by the IP(s) from birth (with the surrogate's consent).

Role of surrogacy agreements

A surrogacy agreement is a document often drawn up by surrogates and IP(s) prior to conception, and sets out how the parties intend to:

- conceive and manage the pregnancy and birth
- care for the newborn post-partum

This should be uploaded onto the electronic records.

A comprehensive surrogacy agreement would cover all eventualities and decision-making events.

Surrogacy agreements are not legally enforceable and do not override other laws and legal obligations.

They can be used by staff to guide the provision of healthcare to the surrogate.

Staff should handle the document with sensitivity and treat it as confidential patient information.

If a surrogacy agreement has not been prepared, the surrogate and IP(s) should be encouraged to prepare one and share with staff.

Where there is not a surrogacy agreement, the information in Appendix A and Appendix B must be documented.

The Surrogate must give consent to any agreement regarding her care.

Staff may wish to consider contacting the lead for maternity safeguarding for further advice and guidance if they have any concerns.

The surrogate must have opportunities to be seen alone by a healthcare professional. This affords opportunity for routine and confidential discussion regarding social concerns.

Confidentiality

It is common for the surrogate and the IP(s) to agree any information sharing by healthcare staff should include both parties. The approach they have agreed will normally be set out in their surrogacy agreement. However, since the surrogate has a right to confidentiality, great care should be taken to understand what information she has agreed may be shared with the IP(s). If the parties have not included this point in their surrogacy agreement, they should be encouraged to discuss it and to record it in their agreement.

Staff should make sure that any consent to share information is recorded, and they should take care to confirm any point where confidentiality may be an issue.

Disputes

Healthcare professionals should attempt to work with the surrogate and the IP(s) at all times. However, in the event of an unresolvable dispute, the surrogate's wishes must be respected as priority, regardless of what is set out in any surrogacy agreement or consents that may previously have been provided.

If the surrogate changes her mind and wishes to keep the newborn herself or no longer wishes to transfer the newborn to the IP(s), staff must respect this and should ensure accurate notes of the circumstances are kept. If the IP(s) want to challenge this situation, then it will be a matter for the family courts to decide.

If the IP(s) change their minds and no longer want to keep the baby, then parental responsibility remains with the surrogate as the legal parent of the newborn (and her spouse if she has one). In the event the surrogate is not prepared to take responsibility for the newborn, then social services should be contacted in the usual way.

If staff have any concerns about the welfare of the newborn, they should follow standard procedures for making a risk assessment, involving other appropriate agencies and invoking child protection procedures (if applicable).

Staff may wish to consider contacting the lead for Maternity safeguarding for further advice and guidance if a dispute continues or a concern arises.

Maternity Care

Antenatal care

Antenatal care should be delivered in accordance with relevant clinical guidance which is based on individual risk assessment, in the usual way. Requests set out in the surrogacy agreement or agreed between the surrogate and the IP(s) should be considered and accommodated, wherever possible, including who will be present during consultations.

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

Antenatal screening for infectious diseases

With self-insemination, there is a risk of transmission of infection to the surrogate and/or unborn baby. It is therefore important the surrogate (and her partner if she has one) is advised of this risk and offered testing accordingly.

Antenatal screening for foetal abnormality

All applicable and routine antenatal screening tests for abnormalities will be offered to the surrogate in the usual way. Should any abnormalities 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.

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.

Involving the surrogate and intended parents

Healthcare professionals should:

- give clear medical information to the surrogate (who is experiencing the physical loss), and seek her consent to sharing information with the IP(s) and anyone else supporting her (with the expectation the surrogate will typically want the IP(s) parents to be fully involved in any decisions)
- ensure the IP(s) are given clear information and are involved in decision-making about the baby, assuming the surrogate gives consent
- understand and acknowledge that the IP(s) are the parents of the newborn
- bear in mind the IP(s) may have also experienced previous losses in their journey to surrogacy
- acknowledge the grief being felt by the surrogate and IP(s) may be slightly different - for instance, a surrogate may be feeling a sense of loss and guilt for her IP(s), while the parents may feel grief for themselves and for their surrogate

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

Birth planning (Refer to Consultant Midwife for support)

A surrogacy birth plan is normally prepared by the surrogate and IP(s), often as part of the surrogacy agreement. This sets out the many issues commonly found in birth plans, such as:

- preferred method of birth
- who will be present at the birth
- who will attend theatre if the need arises
- who will hold the baby after birth
- infant feeding choice
- who will make decisions about the newborn's welfare
- discussion about postnatal stay on the ward
- discussion about discharge of surrogate and baby (with written consent from the surrogate, it is acceptable for the baby to be discharged earlier than the surrogate with the IP(s) (see Appendix C)
- documented planned discharge addresses for all parties
- discussion about parental consent for routine screening (NIPE, hearing, NBBST, vaccinations if required)

Every effort should be made to accommodate all reasonable requests.

With the agreement of the surrogate, a copy of the completed birth plan should be uploaded onto the hospital records and brought to the attention of the Head of Midwifery via email.

Whether a vaginal birth or a caesarean section birth is planned, the surrogate and the IP(s) should be supported by healthcare staff to outline, in the surrogacy birth plan, if the surrogate wishes for the IP(s) to be in attendance. Early planning by healthcare staff should enable such preferences to be discussed and accommodated, with acceptance it is equally important for the surrogate to be supported by her chosen birth partner, as it is for the IP(s) to be present during

the birth of their baby. Where possible, such requests should be accommodated to promote immediate bonding between the IP(s) and the baby, with skin-to-skin contact also being supported.

The birth plan should also outline the wishes of the surrogate and the IP(s) should transfer to the operating theatre be necessary (that is, if an instrumental delivery or an emergency caesarean section is required). Ultimately, under these circumstances, it should be accepted the health professionals will make the decision with regards to who can be in attendance in accordance with clinical care needs being prioritised. This will be considered on a case-by-case basis.

Post-birth

Postnatal care

The baby's name band must contain the information relating to the surrogate whilst in the care of the hospital. IP(s) can request name bands with the IP(s) details on as a keepsake, but these should not be applied to the baby whilst in hospital as the baby will exist under the surrogate details whilst under the care of the hospital.

Since the surrogate remains the legal mother at birth, staff should ensure they are satisfied that she consents to the provisions within the surrogacy agreement and that the postnatal arrangements, including any delegations she has made to the IP(s), are written clearly in the medical notes. While it is often the case for a surrogate newborn to be transferred to the IP(s) at birth, the written consent of the surrogate should be provided if the newborn is to be discharged with the IP(s) and independently of her (see Appendix C).

Usually, the newborn will be fully cared for by the IP(s) from birth and so parenting support, advice and decision making should be directed to them until they are discharged with the newborn. While this is what often happens, it is not universal and it is very important to ensure that the parties agree (this is likely to have been agreed in advance and set out in the surrogacy agreement if there is one).

Every effort should be made to fulfil all reasonable requests regarding post-natal care, which may include a desire for the surrogate and IP(s) (with newborn) to be accommodated separately, but with access to each other after the birth. Wherever possible, it may be advantageous for surrogates and IP(s) to be accommodated away from the other mothers on the postnatal ward to maintain privacy at a sensitive time.

If there are 2 IP's caring for the newborn, this should not be limited by normal visiting hours or restrictions on overnight stays.

Often the surrogate will consider her role to be finished after the birth and may wish to be discharged independently of the newborn.

If the newborn and surrogate are discharged at different times and the newborn is not already being cared for by the IP(s), transfer of the newborn to the IP(s) should happen in an appropriate place on the hospital premises.

Under no circumstances should the newborn be discharged with the IP(s) without the surrogate's consent.

There is no need to inform a social worker or lead for safeguarding unless staff determine that either party may be experiencing difficulty, or there is some other safeguarding reason staff consider a social worker should be contacted.

Treatment of sick newborns

Where the surrogate has given her consent for IP(s) to care for the newborn and this has been included in the surrogacy arrangement, it is usual practice for the IP(s)' wishes to be considered by staff regarding the treatment of a sick newborn and for them to be included in any important decisions regarding the health of that newborn while recognising that the surrogate has the overall responsibility until a parental order has been issued (BMA 2008).

The written consent of the surrogate should be provided which delegates treatment-related decision-making to the IP(s) and this should be clearly recorded in the medical notes again taking into consideration the legal framework for who can legally make those decisions.

Care after a miscarriage or stillbirth

Baby loss before the 24th week of pregnancy

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 and individual needs of those involved. If the surrogate is required to inform the IP(s), efforts should be made to ensure the surrogate is supported in doing this and the medical care team is available to discuss any specific details, rather than relying on the surrogate to relay that information.

Despite the surrogate's legal status as the person carrying the baby, it is important to include the IP(s) in all communication and decision-making, provided the surrogate agrees. Decisions may need to be made around termination or inducing labour which will affect all involved in different ways. The surrogate and the IP(s) will typically have considered these scenarios before proceeding with their surrogacy arrangement and recorded their wishes in writing, to ensure they have considered how to deal with things if difficult decisions need to be made.

Healthcare professionals should try to ensure everyone involved is included sensitively in decision-making on the basis they are a team.

A pregnancy loss after 24 weeks is a stillbirth. Specific physical and emotional care should be available to both the surrogate and the IP(s).

Under current UK law, a stillbirth certificate needs to record the baby's legal parents, which will be the surrogate and either her spouse if she is married, or one of the IP(s) if she is not married. However, the baby can be registered with the IP(s) surname, if everyone agrees. It is important for any documentation to be completed sensitively and for everyone's wishes to be followed where possible.

Community support

The surrogate should be provided with all discharge information relating to her aftercare. When discharged from hospital, this should be communicated to the community midwife, GP and health visitor in the normal way.

The IP(s) and newborn will require a community midwife to visit them and the newborn's discharge should be communicated to the community midwife, health visitor and GP in the normal way. If this is an out-of-area discharge then the IP(s)' address and telephone number along with names and contact details of their local hospital, community midwives, health visitors and GP details should be recorded in the antenatal records.

Follow-on care

It would be for the GP to consider monitoring the surrogate with regards to post-natal depression and offer support and advice if required.

Both the surrogate and IP(s) may also receive ongoing support and advice from the national altruistic surrogacy organisations if they are members and choose to do so.

Hospital staff should ensure the timely transfer of information about the newborn to the community healthcare team where the IP(s) live so that care and support can be picked up locally in a seamless manner.

Safeguarding

Surrogacy in itself is not a safeguarding concern and does not require an automatic safeguarding referral. However, referral to safeguarding is required if there are concerns regarding:

- A surrogacy arrangement which appears unplanned and only comes to the attention of the maternity services late in pregnancy, in labour or the postnatal period
- The ability of the IP(s) to care for the baby
- Conflict between the adults in the surrogacy agreement e.g. the Surrogate appears under pressure to relinquish the baby against her will.
- the amount of expenses being paid or the degree of voluntarism involved an unborn/newborn baby

Staff should be alert to any third parties (i.e. parties outside of the Surrogate Mother 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 should contact the Named Midwife for Safeguarding for further advice and guidance.

In the event of the Surrogate leaving the baby in hospital without informing staff of her intention, this may be considered as abandonment and a referral to children's social care made if there is no one else with parental responsibility. The IP(s) can make an application for a parental order without the agreement of the Surrogate if she cannot be found, or is incapable of giving agreement.

Reference

Surrogacy: legal rights of parents and surrogates (Gov.UK) <https://www.gov.uk/legal-rights-when-using-surrogates-and-donors> (Accessed March 2025)

Appendix A: Checklist of information to be included in surrogacy birth plan

Aim: to ensure that maternity care is appropriate for both the surrogate, as the woman receiving care, and IP(s) and to ensure that communication between them and the multi-professional maternity team is facilitated.

Where the surrogate and IP(s) are supported by a national altruistic surrogacy organisation, their documentation for birth planning can be used.

The Surrogacy birth plan should be uploaded onto the electronic record.

Names and contact details

Surrogate name, date of birth and contact details.

IP(s)' name(s), date(s) of birth and contact details.

Where the surrogate has a spouse/partner, name and contact details.

Details of community midwife/midwives supporting surrogate and IP(s).

Birth-planning meeting

Date of surrogacy birth-planning meeting.

Who attended birth-planning meeting.

Which healthcare professional(s) the plan was created and agreed with.

Surrogate pregnancy details

Surrogacy organisation used (if any).

Form of surrogacy – straight or host.

Expected delivery date for baby.

Summary of fertility treatment from clinic (if available).

Antenatal care

Confirm that all routine antenatal care has been/will be received.

Who will attend scans and appointments with the surrogate.

The birth

Where the surrogate would like to give birth.

The surrogate's birth partner.

Who will attend the birth, if:

- vaginal
- planned caesarean section
- emergency caesarean section, epidural
- emergency caesarean section, general anaesthetic

Pain-relief options.

Who will advocate for surrogate if she can't speak during birth.

Handling of newborn at birth:

- cord cutting including intentions for delayed cord clamping
- skin-to-skin
- holding the baby thereafter

Post-partum care

Who will care for the newborn following birth, and when and where will transfer of care take place.

Who will make medical decisions about care/treatment for newborn.

Feeding method:

- surrogate breast milk through expressed feeds
- intended parent breast milk
- donated breast milk
- formula

Name bands:

- what name appears on newborn's name band (The name band must contain the information relating to the surrogate whilst in the care of the hospital. IP(s) can request name bands with the IP(s) details on as a keepsake.)

Guest/family visiting rights.

Discharge of surrogate, IP(s) and newborn, including surrogate's wishes regarding early discharge if delivery uncomplicated.

Who the newborn will be discharged with.

Surrogate postnatal healthcare needs (assessment and care should include physical, emotional and mental health).

IP(s)' and baby's postnatal healthcare needs (for example, midwifery support with care of baby; assessment of, and support for, IP(s)' emotional well-being and mental health).

Where surrogate, IP(s) and newborn will stay after birth, both in the immediate post-partum period and if longer stay is required (including possibility of side rooms for IP(s) and newborn following birth).

Communication and consents

Confirm that the following professionals have been informed of the pregnancy and impending arrival of the newborn.

Provide names and contact details of:

- surrogate's GP and community midwives
- IP(s)' GP, community midwives and health visitors

Confirm birth plan has been communicated with / made available to the following people, and provide their names and contact details to:

- Head of Midwifery at surrogate's local hospital
- Consultant midwife at surrogate's local hospital
- Maternity unit at surrogate's local hospital

Confirm that the appropriate professionals will be informed of the discharge of the surrogate and newborn following birth and relevant documentation sent to ensure appropriate and seamless care is provided to all:

- surrogate's community midwives, health visitors and GP

- IP(s)' local maternity hospital, community midwives, health visitors and local GP surgery

'Child health' information to include IP(s)' and their local GP's address and contact details to ensure information, for example vaccination appointments and so forth is addressed appropriately.

Appropriate written consents from the surrogate for transfer of care for the newborn to the IP(s), for neonatal screening tests and for decision making for treatment.

Appendix B: 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 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/ 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 newborn is clearly documented in the maternity notes and the new-born 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 newborn's legal mother until parenthood is transferred).

Check discharge details for the IP(s):

- names, contact numbers, home address

Address / telephone numbers for the following:

- local maternity hospital
- community midwives
- health visitors
- local GP surgery

To ensure that both the surrogate and newborn receive follow-up care in the community, please:

- Send the surrogate's details to her community midwife and GP
- Send the newborns' discharge details to the community midwife and GP of the IP(s)

Appendix C: Baby discharge consent form

This document can be used if no written consent has been already provided in the antenatal period. It is NOT necessary for this document to be completed if alternative written consent has already been provided.

THIS DOCUMENT IS NOT LEGALLY BINDING.

I,(full name) use this support document to
provide the hospital with my written consent for Baby (DOB.....) to be
discharged separately to myself, with the Intended Parent(s) (detail their names):

Baby discharge address:

I also give written consent for ongoing care decisions about Baby to be made by IP(s) (*delete if consent is not being provided for this*)

Signed:

Name:

Date:

(Please scan and upload to electronic patient record. Original signed copy to be given to surrogate and further copy to be provided to IPs)

Full version control record

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This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

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1.0	April 2025	Nicola Rose Stone, Rebecca Edwards	Final	First cross site version

Related Documents

Document Type	Document Name
Policy	Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy – available on the trust intranet https://ourplace.xfph-tr.nhs.uk/our-trust/trust-policies//