

The UK skin pathway is now under critical pressure

A summary of our white paper on demand, capacity and the route to clinical decisions in UK skin care

The medical skin pathway has reached a point where increasing appointment capacity alone will not resolve the pressure. Newly published data show demand is accelerating while specialist supply remains structurally constrained.^{3,6,11} This makes now a critical time to redesign how skin presentations are assessed, prioritised and routed, so that patients reach the right clinical decision sooner and scarce specialist expertise is focused where it adds most value.

Skin disease is one of the largest and most varied areas of clinical demand in the UK. One in four people in England and Wales sees a GP about a skin condition each year.^{1,2} Most are managed in primary care, yet hospitals in England still recorded 4.25 million dermatology outpatient attendances in 2025–26, including 1.56 million new patients in adult dermatology alone.¹⁰ The challenge is not simply a shortage of appointments. It is moving a high volume of varied presentations from uncertainty to the right clinical decision, using scarce specialist time only where it adds value.

1.56m

new adult dermatology patients, England, 2025–26¹⁰

+57%

rise in urgent suspected skin cancer referrals in four years¹¹

+170%

rise in urgent referrals for skin assessment in ten years⁴

423,217

people waiting for dermatology treatment, England, Aug 2026³

69%

seen within 18 weeks, against a 92% standard³

6%

of urgent skin cancer referrals confirmed as cancer⁴

1 Demand is rising faster than specialist capacity

Melanoma has reached a record level, and urgent suspected skin cancer referrals in England rose by 57% in four years, from 44,149 a month in October 2021 to 69,452 in October 2025. They are on course to pass 800,000 in 2025–26, up from 715,803 in 2023–24.^{6,11} By January 2025 the dermatology waiting list stood 118% above its July 2020 level.⁴ The workforce cannot absorb that growth: the UK has 1,340 consultant dermatologists, BAD modelling puts the England shortfall at 89.5 whole-time-equivalent consultants, and around 27 a year are expected to retire.⁵ NHS and private care draw on the same people: of 720 NHS consultants surveyed, 323 also work privately.⁵

2 The pathway itself creates avoidable work

Each hand-off adds waiting and rework. Patients describe the same problem more than once, images are retaken, referrals are returned for missing information, and consultant time is spent reconstructing cases. The cost is felt most on the urgent pathway: urgent suspected skin cancer referrals are now equivalent to around half of all new adult dermatology patients, yet only 6% lead to a cancer diagnosis. At around 800,000 referrals a year, roughly 750,000 people go through the urgent pathway without one.^{4,7,10,11}

3 The output that matters is a decision, not an appointment

Most skin presentations need a safe decision about the right route, not an appointment. A structured history and clinically usable images make that decision possible early: a Royal Cornwall tele-triage pathway managed 49.8% of patients without a face-to-face assessment, with consultant review taking about 3 minutes instead of 20.⁸ Information quality is a capacity intervention.

4 New models must not simply move the bottleneck

A remote front door only helps if it removes work rather than relocating it. If photos have to be retaken, specialists are asked to review cases with no time or funding set aside, or patients come back because their next step is unclear, the appointments saved simply reappear as work elsewhere. New models should therefore be judged across the whole episode: on safety, time to the right decision, total activity, patient experience and equity.⁹



Behind every urgent cancer referral is a person facing weeks of anxiety waiting for a consultation or a diagnosis.

Dr Tamara Griffiths, President, British Association of Dermatologists, July 2025⁴

What this means for private GPs and dermatologists

Four pressure points, their effect on the pathway, and where improvement lies

01

Specialist capacity is finite and shared

Effect

Routine and lower-risk cases compete with complex and urgent patients for the same consultant time.



Improvement

Focus specialist input on cases where it changes the decision, with advice and triage treated as planned, paid clinical work.

02

Information is inconsistent at referral

Effect

Histories are repeated, images retaken and referrals returned, creating delay and avoidable work.



Improvement

Capture a structured history and clinically usable images once, then reuse them throughout the pathway.

03

An appointment is often the default

Effect

Patients wait for consultations when an earlier clinical decision might safely direct them elsewhere.



Improvement

Introduce an earlier risk-based decision point, with clear routes into primary care, specialist advice, face-to-face review or urgent assessment.

04

Responsibility becomes fragmented

Effect

Patients experience unclear next steps, repeated contact and gaps in follow-up or safety-netting.



Improvement

Define clinical ownership, inclusion criteria, response times, escalation rules and outcome tracking before introducing a new pathway.

CLINICIAN OPINION

“Better information, earlier, is how we protect specialist time”

Every week in clinic I meet patients who have waited, often anxiously, for an answer that a well-documented history and a good-quality image could have reached far sooner. The figures in this bulletin reflect what dermatologists see: only around one in seventeen urgent skin cancer referrals turns out to be cancer, while the patients who genuinely need us compete for the same scarce appointments.

The answer is not simply more appointments, because there are not enough of us to provide them. It is better information, earlier, and a clear route to the right clinician. When a GP and a dermatologist share a structured case with clinically usable images, decisions are faster and safer, referrals improve, and consultant time is kept for complex and higher-risk patients. That matters in private practice and in the NHS alike, and it is a change we can make now.

Dr Natasha Kapur · Consultant Dermatologist; previously Clinical Lead at The Whittington Hospital and Joint Teaching Lead in Dermatology at UCL Medical School; Member of the RADAR Skin Health Advisory Board

Read the evidence and see how your practice compares

This bulletin summarises a longer body of work. Go deeper into the analysis, see the approach tested in everyday general practice, and benchmark your own skin pathway.

FULL WHITE PAPER

The UK skin assessment pathway

[\[white paper link\] →](#)

The full analysis of demand, capacity and the route to clinical decisions in UK skin care, with 20 referenced sources.

CASE STUDY

8 in 10 skin cases resolved without an appointment

[\[case study link\] →](#)

Results from an 8-week tele-dermatology pilot in a UK GP practice: how structured remote triage frees clinical time and gets patients answers faster.

UK SKIN PATHWAY BENCHMARK

Take the 2-minute questionnaire

[Click here →](#)

Tell us how your practice manages skin cases, and we will send you the findings report showing how your approach compares with other UK practices.

Get in touch or request a demo

See how RADAR Skin Health could work in your practice or clinic. We will walk you through the patient journey, the clinician review and how outcomes reach your records, and answer your questions on governance and integration.

[Name]

[Job title]

[email address]

[phone number]

[website]

Sources: 1. [GIRFT, Dermatology national specialty report, 2021](#). 2. [NHS England, Referral optimisation for people with skin conditions, 2022](#). 3. [NHS Wait Helper, dermatology waiting times, England, August 2026](#). 4. [British Association of Dermatologists, AI roadmap press release, 2 July 2025](#). 5. [BAD Workforce Census Report 2023–24](#) and [Workforce Strategy, 2024](#). 6. [Cancer Research UK, 22 May 2026](#). 7. [UK Parliament, written questions 113907–8, March 2026](#). 8. [Royal Cornwall Hospitals NHS Trust, February 2025](#). 9. [GIRFT, 2021](#). 10. [NHS England, Hospital Outpatient Activity 2025–26, September 2026](#). 11. [West Midlands Cancer Alliance, Skin cancer best practice implementation handbook, April 2026](#); 2025–26 figure estimated. Full references are given in The UK skin assessment pathway.