

THE UK SKIN ASSESSMENT PATHWAY

From uncertainty to the right decision

Demand, capacity and the case for a better-connected route to clinical decisions in UK skin care

1 in 4

people in England and Wales see a GP about a skin condition each year¹

1.56m

new patients seen in adult dermatology in England, 2025–26¹⁸

423,217

people waiting for dermatology treatment in England, August 2026³

1,340

consultant dermatologists on the UK Specialist Register, 2024⁴

The central challenge is not simply a shortage of appointments. It is the difficulty of moving a high volume of varied skin presentations from uncertainty to the right clinical decision, using scarce specialist capacity only where it adds value.

EXECUTIVE SUMMARY

A pathway problem as well as a capacity problem

Skin disease is one of the largest and most varied areas of clinical demand in the UK. Around half the population experiences a skin condition in a typical year, and one in four people in England and Wales consults a GP about one.^{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.¹⁸ Those patients arrive at a specialty whose waiting list has more than doubled since 2020 and whose consultant workforce is already below the minimum its professional body has modelled.^{3,4,15}

This paper argues that adding appointments alone cannot close that gap. The pressure is created as much by how cases move through the pathway as by how many there are. Five findings run through the evidence:

- **Demand is broad and accelerating.** The category spans transient rashes, chronic inflammatory disease, benign lesions and potentially malignant change. Melanoma has reached a record level, and urgent referrals for suspected skin cancer in England rose by 57% between October 2021 and October 2025. Greater awareness brings more low-risk cases forward for reassurance.^{6,19}

- **The specialist workforce cannot absorb growth through appointments.** The 2024 British Association of Dermatologists (BAD) census found a material consultant shortfall, high vacancy levels, more part-time working and an ageing workforce. NHS and private provision draw heavily on the same clinicians. ^{4,5}
- **The pathway itself creates avoidable work.** Incomplete histories, inconsistent photography, uncertain thresholds and fragmented records lead to repeat consultations, returned referrals and duplicated specialist assessment. ^{1,2}
- **Remote, image-enabled pathways can improve flow, but results depend on design.** Published services show faster review and fewer face-to-face appointments for some groups of patients. National guidance also warns that poor images, weak integration or unfunded specialist review can move work rather than remove it. ^{1,7,8,11,12}
- **The opportunity is a managed clinical pathway, not a digital channel.** The unit of value is a safe, documented clinical decision and the correct onward route, not the number of images collected, cases opened or remote reviews completed.

THE QUESTION THIS PAPER ADDRESSES

How can primary and specialist care reach the right decision earlier, while protecting patient safety, clinical accountability and access for people who cannot use a digital route?

Scope. This paper examines medical dermatology rather than cosmetic skin care. It draws on national guidance, official waiting-list, outpatient and referral data, workforce research and published service evaluations, and does not assess or endorse any individual technology. Evidence is UK-wide, with England-specific operational statistics identified as such, and was reviewed to October 2026.

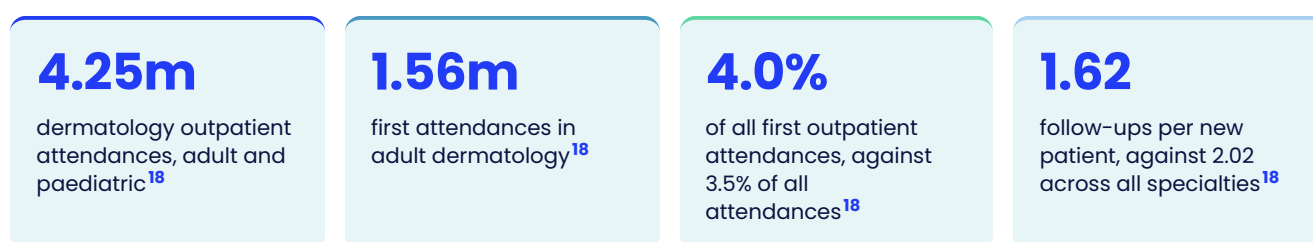
01 SCALE

A large category without a single market

The story starts with the size and shape of demand. Medical skin care is often described as one market, but patient need moves through several overlapping systems. Consumer skin care, GP-led treatment, specialist medical dermatology, skin-cancer diagnostics and procedural services each have different entry points, economics and clinical risks. Public, insured, self-pay and mixed NHS-private activity are measured in different ways, so a single revenue estimate would create false precision. What the layers share is a decision that has to be made at each one.

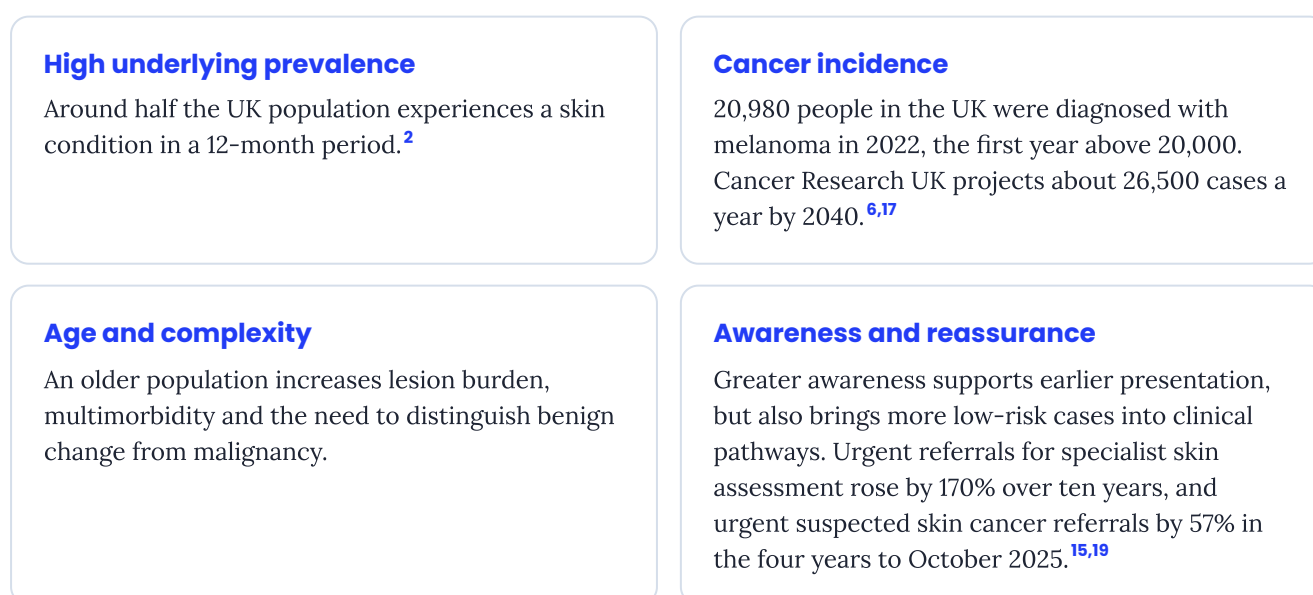
Category layer	Typical need	The decision to be made
Self-care and pharmacy	Minor, familiar or recurrent symptoms	Can the person manage safely without a clinician?
Primary and private general practice	First assessment, initial treatment and safety-netting	Can this be managed in primary care, or is specialist input needed?
Specialist advice and medical dermatology	Diagnostic uncertainty, treatment escalation and complex disease	Is advice sufficient, or is a specialist appointment required?
Cancer and procedural pathways	Suspicious lesions, biopsy, excision and treatment	How urgent is the case, and what is the correct definitive pathway? ¹³

Activity in numbers: dermatology in England, 2025–26



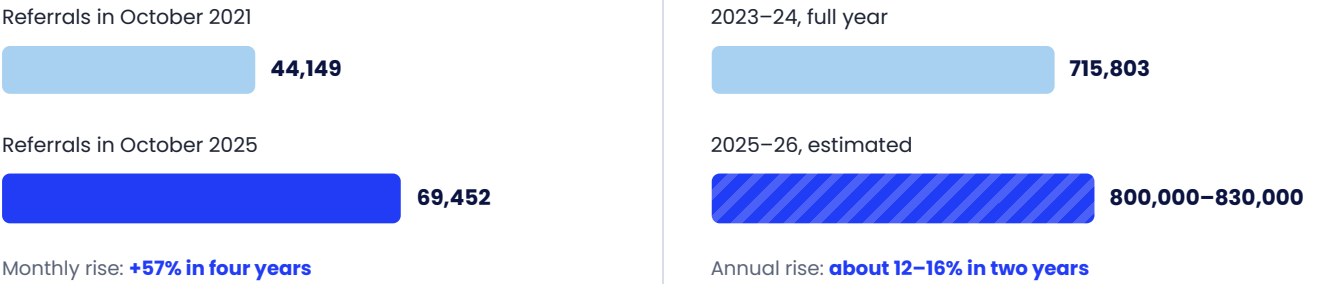
Dermatology is a front-door specialty. It accounts for a larger share of new outpatient patients than of total hospital activity, and sees fewer follow-ups per new patient than the average, so its pressure arrives largely as new demand rather than as a long tail of review. Primary care is under similar strain: 387.8 million appointments were recorded in GP practice systems in England in the 12 months to August 2026, 4.6% more than in the previous 12 months. Those data do not record why people attend, so they describe the setting skin demand lands in rather than its size.²⁰

Five forces are expanding assessment demand



Access expectations are the fifth force. Patients increasingly expect rapid, convenient answers and visibility of the next step, whether their care is NHS, insured or self-pay. For most of them, the answer they need is reassurance, and they need it quickly.

Urgent suspected skin cancer referrals, England



Source: West Midlands Cancer Alliance, Skin cancer best practice implementation handbook, April 2026.¹⁹ The 2025–26 total is an estimate based on monthly referral levels to October 2025 and should be replaced by the published annual figure when available.

“ It probably won't be cancer, but if it is, getting it diagnosed and treated early can make all the difference. ”

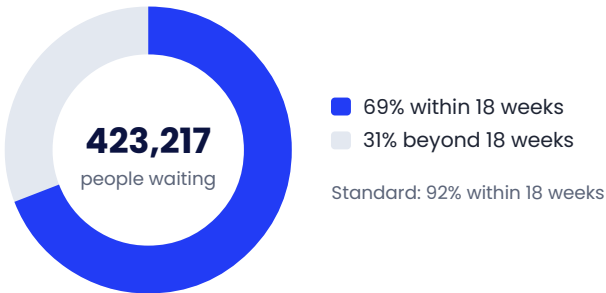
Michelle Mitchell, Chief Executive, Cancer Research UK, May 2026¹⁷

02 CAPACITY

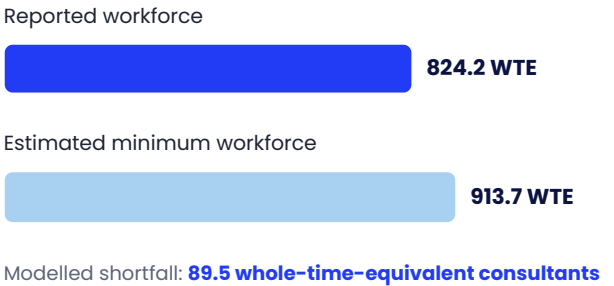
The constraint is structural

That rising demand meets a specialty with little room to expand. At the end of August 2026, 423,217 people were waiting for dermatology treatment in England, 5.9% of the entire NHS waiting list of 7,189,213. Only 69.0% had waited less than 18 weeks. That is up from 64.2% a year earlier, but still far short of the 92% constitutional standard, which the Government has committed to restoring by March 2029.^{3,16} Some 5,256 people, roughly 1 in 83, had been waiting for more than a year. Because reporting coverage has changed over time, the percentages are a more reliable guide to the trend than the headcount.³ In January 2025 the BAD reported that dermatology waiting lists stood 118% above their July 2020 level.¹⁵

England dermatology waiting list, August 2026



Consultant dermatologists, England 2023



Sources: NHS Wait Helper, dermatology waiting times, August 2026;³ BAD Workforce Census 2023–24.⁴ The minimum workforce is the BAD model, not a government target.

The workforce cannot be treated as two separate pools

The BAD identified 1,340 consultant dermatologists on the UK Specialist Register in 2024. Its census found 75 members working only in private practice, and among 720 NHS consultant respondents, 323 also undertook private work: 99 of the full-time consultants and 224 of the part-time consultants. These are survey results rather than a complete census, but they show substantial overlap between NHS and private capacity.⁴

The gap is set to widen. BAD modelling estimated an England shortfall of 89.5 whole-time-equivalent (WTE) consultants in 2023. Hospitals responding to its survey reported 96.8 WTE vacancies across the UK, and its membership analysis projected about 27.2 WTE retirements a year over the following five years, before accounting for consultants already working beyond 65.^{4,5} Official data on the shortfall is limited: asked about it in Parliament in March 2026, the Government replied:



The Department does not hold data on the current shortfall, or vacancies...

Karin Smyth MP, Minister of State for Health, answering a written parliamentary question on consultant dermatologists, March 2026¹⁶

IMPLICATION

Private provision can improve access for individual patients, but it does not create a separate supply of consultant expertise. Better use of clinical time matters in both sectors.

03 PATHWAY FRICTION

Where the pathway becomes blocked

If capacity cannot grow quickly, the next question is how it is being used. Volume explains only part of the pressure. Each hand-off can add waiting, uncertainty and rework: the same patient may describe the problem more than once, have images taken more than once, and wait for more than one clinician to decide what should happen next.



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 2025¹⁵

Stage	Typical friction	System consequence	The better-pathway question
Patient entry	Uncertainty about whether a change needs clinical assessment	Anxiety, delayed presentation or an avoidable consultation	Can the patient reach a safe first decision quickly?

Stage	Typical friction	System consequence	The better-pathway question
Initial assessment	Short appointments, variable experience and inconsistent images	Repeat consultations or precautionary referral	Is there enough information to make or support a decision?
Referral	Incomplete history, variable thresholds and unclear service criteria	Returned referrals, duplicated work or inaccurate priority	Can the receiving clinician act without reconstructing the case?
Specialist review	Scarce clinical time used on incomplete or low-risk cases	Slower review of complex and higher-risk patients	Is specialist expertise being used where it changes the outcome?
Follow-up	Fragmented records, unclear ownership and weak safety-netting	Missed follow-up, repeated contact and unresolved anxiety	Is the outcome recorded, communicated and tracked?

The cost of that friction is felt most sharply on the urgent pathway. Skin cancer referrals make up about half of all dermatology referrals: the 715,803 urgent suspected skin cancer referrals made in 2023–24 compare with 1.56 million new adult dermatology patients seen in 2025–26. Yet NHS England data cited by the BAD show that only 6% of urgent referrals for suspected skin cancer led to a confirmed diagnosis.^{15,16,18,19} For the other 94%, the outcome is reassurance, often reached only after weeks of waiting. At an estimated 800,000 urgent referrals a year, that is roughly 750,000 people.

Of every 100 urgent referrals for suspected skin cancer



Source: NHS England data, cited by the British Association of Dermatologists, July 2025. Annual figures are illustrative, applying the 6% rate to an estimated 800,000 urgent referrals in 2025–26.¹⁹

The output that matters is a decision, not an appointment

A skin presentation does not automatically need a face-to-face GP or dermatologist appointment. It needs a safe determination among a limited number of routes: self-care or advice, primary-care treatment, specialist advice, routine specialist review, urgent cancer assessment or a procedural pathway.^{2,13} An appointment is one way of reaching that decision, not the unit of value in itself. Four questions sit at the heart of every case:

1
Does this need clinical review?

2
Can primary care manage it safely?

3
Would specialist advice change the plan?

4
Does it require urgent review or a procedure?

Better information is the pathway infrastructure

Answering those four questions well depends on what the decision-maker can see. Remote review succeeds or fails on the quality of the case presented. National guidance consistently emphasises structured clinical information, usable images, clear responsibility and communication of the outcome. The 2024 BAD standards specify core history and image requirements, including location, close-up and profile images where appropriate, and state that dermoscopy is essential for virtual diagnosis in urgent suspected skin-cancer pathways.^{7,8} Six components make up a decision-ready case:

Structured history

Symptoms, duration, change, treatment, relevant history and risk factors are captured once, in a consistent form.

Clinically usable images

Images show location and detail, meet an agreed standard and can be viewed securely by the decision-maker.

Named clinical responsibility

The patient and referrer know who is responsible for the decision, communication and onward action.

A defined outcome set

Advice, treatment, monitoring, referral, urgency and safety-netting are recorded in standard terms.

Record integration

The original information, images, decision and next step remain visible in the patient record.

Closed-loop follow-up

Patients receive the outcome, understand what to do next and can re-enter the pathway if the condition changes.

Image quality is not a technical detail

Good images can reduce unnecessary double handling, but poor images can turn a remote interaction into an extra step before a face-to-face appointment. NHS England therefore recommends that high-quality images, including dermoscopic images of lesions where appropriate, accompany specialist advice requests. Patient-supplied images may be useful, but they are not always sufficient for specialist review.^{2,7}

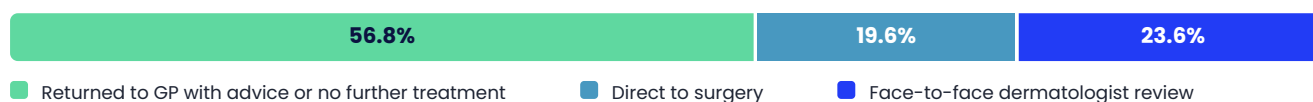
Quality also has an equity dimension. Digital access, language, disability, confidence with technology, lesion location and the representation of different skin tones can all affect whether a remote route works. Pathway redesign must keep practical alternatives in place and monitor who is excluded, delayed or returned to face-to-face care.⁹

Remote pathways can release capacity, but the model matters

Where those foundations are in place, the evidence is encouraging. Outcomes still vary with patient selection, image capture, specialist integration and the measure used, so case studies should not be read as universal conversion rates.

Evidence	Finding	What it suggests	Important qualification
National pathway guidance	NHS England advocates pre-referral specialist advice followed by triage as the main route into specialist dermatology, except for urgent suspected skin cancer. ^{2,8}	Supports redesign around earlier decisions and closer generalist–specialist working.	Requires agreed response times, interoperability and clear communication.
Royal Cornwall community imaging	Among 438 patients, 49.8% avoided a face-to-face assessment. Clinician review averaged about 3 minutes, against 20 for a traditional appointment. ¹¹	Standardised imaging and consultant tele-triage can change how patients are routed.	A single service; results depend on pathway design and case mix.
Large urban store-and-forward service	Across 8,352 patients, 56.8% were returned to their GP, 19.6% went directly to surgery and 23.6% had face-to-face specialist review. ¹²	Remote review creates several onward routes, not simply discharge or appointment.	Medical photographers produced unusually high image quality; not directly transferable to patient-captured models.
GIRFT national review	Wide variation in integration, and conflicting evidence on outcomes, cost and referral reduction. ¹	A necessary counterweight to promotional case studies.	Long-term safety, referral-rate and health-economic evaluation is needed.

Onward routes from one mature UK store-and-forward pathway (8,352 patients)



Source: Lowe et al., Clinical and Experimental Dermatology, 2022.¹² Observational service data, not a controlled comparison.

Technology can also move the bottleneck

A remote front door may reduce booked appointments yet increase total contacts, create image-taking work, add specialist review outside job plans, or generate demand from patients who would otherwise have self-cared. GIRFT therefore recommends measuring referral rates, safety, time to correct diagnosis, treatment effectiveness, patient experience, equity and the overall health-economic effect.¹ The same caution applies to artificial intelligence: NICE's 2025 assessment of AI technologies for triaging lesions on the urgent suspected skin-cancer pathway underlines how much depends on evidence and implementation.¹⁰



Diagnostic AI in dermatology is already here, and soon its usage will be widespread ... [but] it is not inevitable that diagnostic AI in dermatology will improve current services.

Dr Rubeta Matin, Chair, British Association of Dermatologists' AI Working Party Group, July 2025¹⁵

Eight principles for a better skin assessment pathway

The evidence points to a consistent set of design choices. Together they shift the focus from the channel to the decision.

1 Start with the clinical decision

Choose the care channel after assessing what information and expertise the case requires.

2 Capture once and reuse

A structured history and image set should support advice, referral, triage and follow-up without re-keying.

3 Apply explicit inclusion criteria

Define which conditions, body sites, patient groups and urgency levels are suitable for remote review.

4 Protect specialist capacity

Allocate funded, job-planned review time and route cases to the lowest appropriate level of expertise.¹⁴

5 Keep clinicians accountable

Decision support may organise information, but clinical responsibility and escalation rules must remain clear.

6 Integrate the outcome

The decision, reasoning, images and next step should form part of the longitudinal patient record.

7 Design for equity and choice

Provide supported image capture and non-digital alternatives, and test performance across skin tones and patient groups.⁹

8 Measure net pathway impact

Judge the model on resolved episodes, safety, total activity, patient experience and cost across the pathway.¹

The minimum operating model

Capture

history and images

Assess

completeness and risk

Decide

clinical outcome

Route

right service and urgency

Track

communication and safety-net

Learn

audit and improve

THE TEST OF COMPLETION

A remote service is not complete when the clinician sends an answer. It is complete when the decision is understood, recorded, acted on and safely followed through.

What this means for private GPs and dermatologists

Private care has greater freedom to redesign access and service models, but it works within the same clinical constraints and, as Section 2 showed, largely the same consultant workforce. The opportunity is not simply to offer a remote consultation. It is to build a more reliable interface between patients, generalists and specialists.

Issue	For private GPs	For dermatologists
Access	Offer a rapid route for skin concerns without automatically consuming a standard appointment.	Extend specialist input beyond booked clinics where governance, time and payment are explicit.
Decision quality	Use structured information to manage appropriate cases and refer with greater precision.	Receive cases with usable history and images, reducing reconstruction and rework.
Patient proposition	Provide faster certainty, continuity and a visible next step.	Prioritise complex, procedural and higher-risk patients while supporting lower-risk cases remotely.
Economics	Measure cost and revenue per resolved episode, including staff time and onward activity.	Value advice and triage as clinical work, not as an unpaid prelude to an appointment.
Governance	Define responsibility, escalation, consent, records and safety-netting before launch.	Set inclusion criteria, image standards, turnaround times and links to local urgent pathways. ^{7,13}
Relationship	Build an ongoing GP–specialist interface rather than a one-way referral transaction.	Use advice as a route to education and better future referrals, without de-skilling primary care.

Avoiding a false win

A practice may appear to improve access while transferring work elsewhere. Digital intake can reduce reception calls but increase clinician review; remote review can reduce booked appointments but increase imaging activity; specialist advice can avoid a referral but create unfunded consultant work. A credible model counts the whole episode, including patient effort, administrative work, repeat contact and downstream care.

A scorecard for new service models

Avoiding a false win requires measuring the right things. Providers should evaluate a pathway before evaluating its technology. These measures distinguish genuine service improvement from channel substitution.^{1,7}

Evaluation domain	Questions and measures
Clinical safety	Diagnostic concordance where measurable; urgent escalation; adverse incidents; missed or delayed malignancy; quality of safety-netting.
Decision quality	Proportion of cases with a documented outcome; appropriateness of onward route; returned or rejected referrals; repeat assessment.
Pathway time	Submission to clinical decision; decision to treatment; time to communicate the outcome; urgent-pathway compliance. ¹³
Capacity effect	Face-to-face appointments avoided; specialist and GP review time; image-capture work; net change in total contacts.
Integration	Proportion of cases recorded without re-keying; access to original images and history; completion of onward action.
Patient experience	Understanding of the outcome; reassurance; convenience; choice; ease of re-access; travel and time saved.
Equity	Access and outcomes by age, ethnicity, skin tone, disability, language, deprivation and digital confidence. ⁹
Economics	Cost per resolved episode; revenue and margin by pathway; avoided duplication; effect on higher-value clinical capacity.
Workforce sustainability	Review work included in job plans; training and supervision; effect on primary-care confidence and specialist workload. ^{5,14}
Evidence maturity	Sample size; comparator; case mix; follow-up period; independent evaluation; transparent limitations.

09 CONCLUSIONS

Skin care needs a better front end

The UK skin pathway carries a large and growing volume of clinically diverse demand into a constrained workforce. The result is not simply a long specialist waiting list. It is repeated assessment, variable information, uncertain routing and too much scarce clinical time spent reconstructing or reprioritising cases. The way forward follows from the evidence:

- **The problem begins before referral.** Patients and GPs need faster access to a reliable first decision, not just faster access to the same appointment pathway.
- **Information quality is a capacity intervention.** A structured history and clinically usable images can reduce rework and allow earlier, more confident routing.
- **Specialist advice must be designed as a service.** It needs explicit capacity, response times, governance, integration and payment, rather than relying on discretionary clinician effort.^{8,14}
- **Remote care is valuable when it shortens the whole pathway.** Avoiding one appointment is not success if the patient needs repeated contact or the work simply moves to another clinician.

- **Evidence should follow the episode.** The strongest evaluation links early decisions to subsequent referrals, treatment, safety, patient experience and total cost.

Questions the sector still needs to answer

- What proportion of skin presentations can be safely resolved without a conventional appointment, by condition and risk group?
- Which information and image standards most improve decision quality without creating excessive work for patients or practices?
- How should clinical responsibility and payment be allocated when care crosses patient, GP and dermatologist interfaces?
- Do remote pathways reduce total activity and time to treatment, or merely redistribute contacts?
- How do outcomes vary across skin tones, age groups, lesion locations, digital ability and socioeconomic groups?
- What is the cost per safely resolved episode, compared with existing private and NHS pathways?

Contribute to the UK Skin Pathway Benchmark

We are inviting private GPs and dermatologists to share how skin presentations are currently assessed, managed and referred. It takes two minutes. Contributors will receive the aggregated findings and can compare their pathway with the wider market.

[Click here →](#)

METHOD AND SOURCES

Scope and limitations

This white paper was prepared and published by RADAR Skin Health in Q4 2026. It is a secondary-research discussion paper. It combines UK and England-specific evidence published by NHS England, the Department of Health and Social Care, the British Association of Dermatologists, Getting It Right First Time, NICE, Cancer Research UK and peer-reviewed or provider-reported service evaluations. It does not estimate a single commercial market value, because comparable public and private activity and revenue data are not available across the full pathway. Figures refer to different periods, populations and definitions: waiting-list statistics count pathways rather than unique patients and may exclude non-reporting providers, and workforce figures combine register data, published whole-time-equivalent statistics and survey results. Outpatient figures are from Hospital Episode Statistics for 2025–26; they count attended appointments rather than unique patients, include NHS-commissioned activity in the independent sector, and record first attendances, which are not the same as referrals. Urgent referral and outpatient figures are for England only, and the 2025–26 urgent referral total is an estimate. GP appointment data do not record the reason for an appointment, so they describe overall primary-care activity rather than skin-specific demand. Service evaluations illustrate achievable pathway effects; they do not predict outcomes for another service. Quotations are reproduced from the published sources listed. This paper does not provide clinical advice and does not evaluate a named product. Any pathway change requires local clinical governance, information-governance review, an equality impact assessment and appropriate evaluation.

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