Southern Area Heart Failure Deep Dive: Data Summary

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EXECUTIVE SUMMARY

This report provides a detailed, evidence-based review of heart failure prevalence, trends and inequalities across the Southern Health and Social Care Trust (SHSCT) area from 2020/21 to 2024/25. It has been developed to support the Southern Area Integrated Partnership Board (SAIPB) in identifying and prioritising areas for early intervention and test site development.

Key findings include:

- Heart failure prevalence in the SHSCT has increased by 30.5% in the past five year, exceeding the Northern Ireland (NI) average increase of 20.2%.
- Armagh, Lagan River and Banbridge are the DEAs with the highest prevalence.
- Substantial variation across DEAs, with some areas experiencing rapid growth (Lagan River +46.7%).
- Some DEAs (Torrent and Cusher) show below-average prevalence but have experienced rapid growth, indicating possible emerging risk.
- Lagan River DEA despite its high heart failure burden, has the highest life expectancy in SHSCT. This may suggest better disease management or access to care.
- Newry DEA has the lowest life expectancy and faces compounded risks due to deprivation and multimorbidity.
- Hospital admission data shows that 87% of heart failure diagnoses are secondary, highlighting the complexity of patients.
- The 75-84 age group accounts for the majority of admissions, but a growing burden in the 50-64 age group is emerging as a key target for early diagnosis.
- Deprivation strongly correlates with premature mortality, hospital admissions and risk factor burden.

Suggestions:

- Prioritise early intervention in high prevalence and high deprivation areas (e.g. Newry, Lurgan or Portadown)
- Monitor areas with rapid growth or emerging inequality (e.g Torrent, Slieve Gullion).
- Leverage areas like Lagan River to identify protective factors supporting positive outcomes.

- Support test site selection with an equity led and data-drive explanation.

INTRODUCTION AND PURPOSE

The paper builds on the strategic direction set out by Professor Campbell in her recent presentation to the SAIPB. It is designed to inform decision-making by the SAIPB. It presents a detailed picture of heart failure prevalence and trends across DEAs and GP Federations, within sights into demographics, clinical and socioeconomic risk factors that influence burden and inequality.

The key aim is to:

- Present a granular analysis of heart failure prevalence and variation across the Southern area.
- Highlight socioeconomic and geographical inequalities using evidenced based data and projections.
- Highlighting potential test sites based on data.

This report integrates data population health, hospital admissions and prevalence registers to show the recent or emerging patterns.

The prevalence of heart failure in Northern Ireland is increasing with 23 082 people recorded on the Heart Failure 1 register in 2024/25 (11.18 per 1000 patients). The raw prevalence rate ranges from 9.5 per 1000 among practices in the Western LCG to 13.3 per 1000 in the Southern LCG (DOH 2025).

The Northern Ireland trend aligns with the broader UK prevalence where it is estimated 1 million people are currently living with heart failure. The are approximately 200 000 new diagnoses annually, with hospital diagnosis accounting for 80% (Bottle et al., 2018, BSH 2023)

LOCAL DATA INSIGHTS

Risk Factors and Disease Burden

Heart failure is a complex clinical illness that results from structural or functional cardiac disorders, It is influenced by a wide range of modifiable, non-modifiable and socioeconomic factors.

According to NICE (2018a) the most commonly identified risk factors for developing chronic heart failure are:

Modifiable Risks	Hypertension, coronary heart disease, diabetes, obesity, high cholesterol, smoking, alcohol consumption, physical inactivity, poor diet.
Medical/Clinical	Atrial fibrillation, chronic kidney disease, sleep apnoea, anaemia, thyroid dysfunction, valvular disease, cardiomyopathy.
Non- Modifiable	Age, family history, gender

Medication/Substances	NSAIDs, beta-blockers, air pollution, alcohol, cocaine.
Socioeconomic	Deprivation, poor access to healthcare, housing insecurity, health literacy (Kings Fund 2016, NICHS 2024)

These factors rarely act alone. Many individuals with heart failure have multimorbidity further complicating their management and prognosis (Groenewegen et al. 2020).

Analysis of raw disease prevalence data in the Southern area shows higher levels of:

- Hypertension (Armagh, Lagan River, Cusher and The Mournes DEAs).
- Diabetes Mellitus (Lagan River and Cusher)
- Coronary Heart Disease (Cusher and Armagh)

Multimorbidity significantly affects health outcomes, hospitalisation risk and treatment burden. The ESC (2021) reports over 70% of patients with heart disease have at least two other chronic conditions.

Table 1: Raw Disease Prevalence Indicating Multimorbidity per DEA (2024/25)

Local Government District (within SHSCT)	District Electoral Area	Heart Failure 1 Raw Disease Prevalence per 1 000 Patients	Coronary Heart Disease Raw Disease Prevalence per 1 000 Patients	Diabetes Mellitus Raw Disease Prevalence per 1 000 Patients	Hypertension Raw Disease Prevalence per 1 000 Patients
Armagh, Banbridge and Craigavon	LURGAN	12.37	23.3	70.67	135.35
	PORTADOWN	12.51	34.18	68.06	135.99
	BANBRIDGE	15.51	36.67	70.6	141.39
	ARMAGH	15.79	**37.24**	69.53	**148.79**
	CRAIGAVON	10.31	30.73	68.61	122.34
	LAGAN RIVER	15.83	36.88	**71.36**	**154.24**
	CUSHER	11.41	**40.98**	**74.18**	**165.84**
Mid Ulster	TORRENT	9.24	35.74	62.32	129.89
	CLOGHER VALLEY	9.9	31.31	65.07	129.35
	DUNGANNON	11.69	33.6	59.34	130.06
Newry, Mourne and Down	NEWRY	14.87	34.53	64.73	138.1
	THE MOURNES	12.5	34.26	69.07	**152.07**
	SLIEVE GULLION	13.34	27.91	54.88	125.64
	CROTLIEVE	13.37	33.05	58.05	137.88
SHSCT		**13,32**	34.95	66.43	138.58
Northern Ireland		11.18	36.79	71.41	145.24

Deprivation is a key driver of inequality, across the SHSCT there is significant variation in deprivation and health outcomes. A number of DEAs have Super Output Areas that fall into the most deprived deciles regionally.

Armagh, Banbridge and Craigavon LDG	Newry, Mourne and Down LDG	Mid Ulster LDG
Woodville 1	Crossmaglen	Coalisland 2
Drumgask	Drumgullin 1	Ballygawley
Court 1	Creggan	Ballsaggart
Callen Bridge	Daisy Hill 2	
Church	Ballybot	
Annagh 2	Silver Bridge 1	

Drumgor 2 Drumnamoe 1 Corcrain 2 The Cut	Forkhill 2 Cathedral 2 Newtownhamilton	

(NIMDM17- with ns.pdf (nisra.gov.uk)

A number of these areas have a high prevalence of multimorbidity associated with heart failure as highlighted in Table 1.

From the NI Health Inequalities Report (2024) and the Health Inequalities Audit 2025-2030:

- Premature circulatory mortality (<75) is 46% higher in the most deprived areas.
- Emergency hospital admissions for heart failure are 30-50% higher in deprived areas.
- Individuals living in deprived communities are more likely to be diagnosed later, admitted in crisis and experience poorer outcomes (NICHS 2024, DHSC 2023.

Key Inequality Insights:

- Lagan River has the highest life expectancy in the SHSC despite having the highest heart failure prevalence and other chronic conditions (NISRA 2025). This may reflect earlier detection or better access to care.
- Newry DEA has the lowest life expectancy, aligning with higher deprivation and higher emergency admissions. Newry has a lower multimorbidity prevalence than Lagan River and other DEAs. Newry does have a higher alcohol related health inequalities which is a risk factor for heart failure.
- Deprived SOAs across Lurgan, Newry, Portadown and Slieve Gullion show higher circulatory mortality, emergency admissions and mental health prescribing (Health Inequalities Report 2024)

Heart Failure Prevalence, Admissions and Demographic Trends

Table 2: Heart Failure Data by DEAs 2020/21 to 2024/25

Local Government District (within SHSCT)	District Electoral Area	Number of Patients on Register 2020/21	Raw Disease Prevalence per 1 000 Patients 2020/21	Number of Patients on Register 2021/22	Raw Disease Prevalence per 1 000 Patients 2021/22	Number of Patients on Register 2022/23	Raw Disease Prevalence per 1 000 Patients 2022/23	Number of Patients on Register 2023/24	Raw Disease Prevalence per 1 000 Patients 2023/24	Number of Patients on Register 2024/25	Raw Disease Prevalence per 1 000 Patients 2024/25
Armagh, Banbridge and Craigavon	LURGAN	379	8.27	393	8.53	483	10.39	507	10.79	587	12.37
	PORTADOWN	424	9.03	486	10.24	508	10.57	552	11.36	616	12.51
	BANBRIDGE	598	11.87	623	12.24	638	12.41	686	13.26	809	15.51
	ARMAGH	532	12.07	568	12.88	616	13.89	687	15.33	714	15.79
	CRAIGAVON	80	8.51	79	8.22	87	8.92	91	9.21	104	10.31
	LAGAN RIVER	136	10.79	152	11.84	172	13.32	182	14.01	203	15.83
	CUSHER	147	9.38	150	9.53	141	8.92	158	9.92	183	11.41
Mid Ulster	TORRENT	117	6.88	116	6.79	126	7.34	144	8.3	161	9.24
	CLOGHER VALLEY	103	7.42	105	7.46	105	7.43	118	8.27	142	9.9
	DUNGANNON	426	9.26	442	9.55	468	10.02	529	11.13	562	11.69
Newry, Mourne and Down	NEWRY	675	12.87	695	13.2	701	13.26	763	14.38	792	14.87
	THE MOURNES	398	11.86	395	11.67	391	11.44	399	11.62	432	12.5
	SLIEVE GULLION	225	8.9	249	9.78	305	11.92	327	12.72	345	13.34
	CROTLIEVE	173	11.06	180	11.37	205	12.87	212	13.23	214	13.37
SHSCT		4 346	10.21	4 574	10.67	4 907	11.35	5 331	12.22	5 860	13.32
Northern Ireland		19 323	9.63	19 719	9.77	20 231	9.95	21 701	10.58	23 082	11.18

(Source: DISPREVDEA - Raw disease prevalence [Accessed 29.07.2025]

Table 2, details the year-on-year changes, over a five-year period for the number of patients on the Heart Failure register on the 31st March year and the raw disease prevalence per 1 000 patients. Between 2020/21 and 2024/25, the prevalence of heart failure has increased significantly for the SHSCT and across Northern Ireland.

SHSCT vs Northern Ireland Trends

Table 3: Heart Failure Prevalence per 1 000 patients for SHSCT and NI

Area	2020/21	2024/25	Increase	% Growth
SHSCT	10.21	13.32	+3.11	+30.5%
NI	9.30	11.18	+1.88	+20.2%

Calculation of Percentage Growth:

- *SHSCT*
  (13.32-10.21= 3.11 3.11÷10.21 x 100= 30.5%)
- *Northern Ireland*
  (11.18- 9.30= 1.88 1.88÷9.30 x 100= 20.2%)

Heart failure is becoming more common in both the SHSCT and regionally, however the increase in the SHSCT has been sharper. The SHSCT not only has a higher starting prevalence in 2020/21, but the growth rate has been greater over the five-year period.

Since 2022/23, the **SHSCT** has had the **highest prevalence** across the five HSC Trusts. This may reflect:

- An aging population.
- Higher incidents of associated long-term conditions.
- More consistent identification and recording of heart failure within primary and secondary care.
- Higher level of demand on acute and community services that will require targeted planning.

Table 5: Heart Failure Prevalence per HSC Trust (2020/21-2024/25)

Trust	2020/21	2021/22	2022/23	2023/24	2024/25
BHSCT	9.43	9.25	9.25	9.92	10.33
NHSCT	9.43	9.57	9.52	10.05	10.35
SEHSCT	**10.60**	**10.77**	10.92	11.52	12.35
SHSCT	10.21	10.67	**11.35**	**12.22**	**13.32**
WHSCT	8.50	8.57	8.71	9.16	09.94
NI	*9.63*	*9.77*	*9.95*	*10.58*	*11.18*

Table 5 represents the DEA-level prevalence per 1 000 patients for 2020/21 and 2024/25, along with the calculated growth over the 5-year period. Figures have been sorted to identify the areas with both highest and lowest prevalence, and growth.

Table 6: DEA Heart Failure Prevalence Percentage Growth

DEA	2020/21	2024/25	Change	% Growth
Lagan River!	10.79	**15.83**	+5.04	**+46.7%**
Dungannon!	8.35	11.69	+3.34	**+40.0%**
Portadown!	9.08	12.51	+3.34	**+37.8%**
Slieve Gullion!	9.78	**13.34**	+3.56	+36.4%
Torrent*	6.88	9.24	+2.36	**+34.3%**
Clogher Valley	7.42	9.90	+2.48	+33.4%
Armagh!	12.07	**15.79**	+3.72	+30.8%
Lurgan	9.87	12.37	+2.50	+25.3%
Craigavon	8.25	10.31	+2.06	+25.0%
Banbridge!	12.41	**15.51**	+3.10	+25.0%
Crotlieve	11.06	**13.37**	+2.31	+20.0%
Newry	12.87	**14.87**	+2.0	+15.5%
The Mournes	11.86	**13.50**	+1.64	+13.8%
Cusher	10.25	11.41	+1.16	**+11.3%**

Symbol Key:

!: Concerning Trend, very high growth or high burden.

*: Noteworthy Trend, emerging risk or moderate concern.

Bold: Highlights specific DEAs included in the interpretation.

Green: Prevalence below SHSCT & NI average.

DEA data in green highlights areas with prevalence rates which are lower than the SHSCT and NI average. This may indicate positive outliers, good practice or a younger population with lower disease risk. These areas include Craigavon, Cusher and Clogher Valley, these areas may merit further exploration for learning.

No DEA has plateaued or decreased, instead there is a system wide upward trend similar to the rest of the region and nationally. In 2020/21, most DEAs prevalence ranged from 9.88 -12.87 per 1000 patients. By 2024/25, the range has widened from 9.24 to 15.83. This may reflect an increasing inequality in the burden of disease and detection across areas.

Newry and The Mournes show a more modest increase in prevalence, which may warrant further observation to determine whether their growth rates are stabilising.

Areas such as Torrent, Clogher Valley, Craigavon and Cusher could be considered as transition zones because although the prevalence is below SHSCT and NI average now, it is increasing. This may be an early indicator of future need.

Lagan River has experienced the highest prevalence growth at +46.7% over the past five-year, followed by Dungannon, Portadown and Slieve Gullion. These areas are experiencing a more rapid rise in heart failure that may warrant prioritised early intervention.

Armagh (15.79), Lagan River (15.83) and Banbridge (15.51) have the highest current prevalence rates. Their combination of high burden and significant growth provides rational for these areas to be prioritised for intervention strategies.

Cusher (11.41) had the lowest growth rate at 11.3% and remains close to the NI average and consistently below the Trust average over the past five-years.

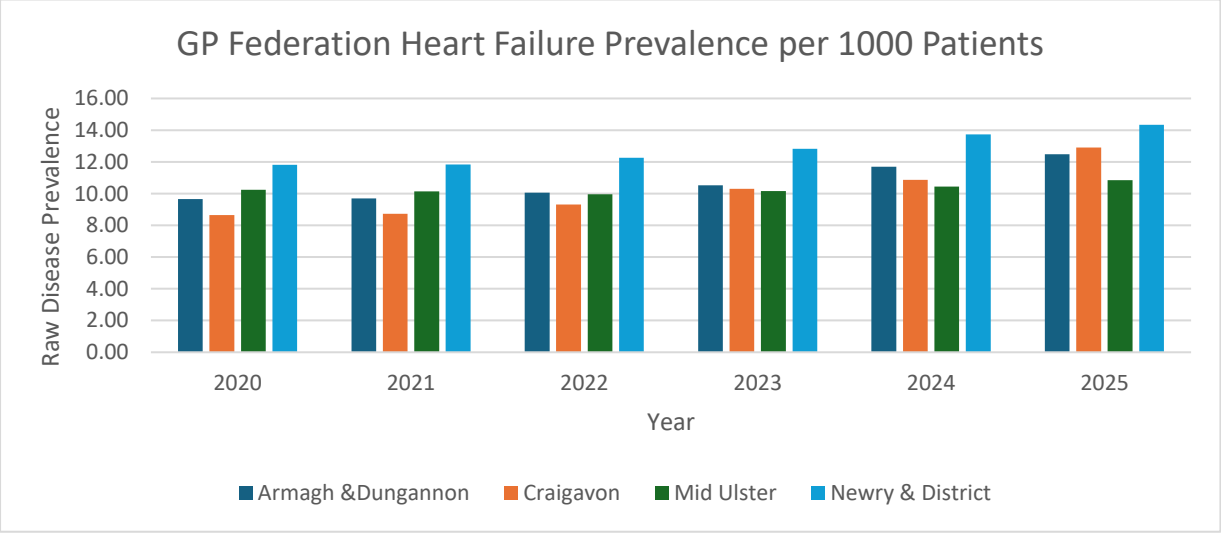
Torrent (9.24) continues to have the lowest overall prevalence in the Southern area, despite a 34.3% growth.

Mid Ulster (Torrent, Clogher Valley, Dungannon) DEAs remain below the SHSCT and NI averages. While growth is accelerating, the historically low prevalence may reflect a younger population, under diagnosis or access variations. Further engagement with local primary and community care may help clarify whether the data represents lower population need, variation in clinical practice regarding identification and management or better primary prevention in place

GP Federation Level Data

Table 7: Heart Failure Prevalence by Southern Area Federation

Federation	Heart Failure Prevalence per 1000 Patients (using full lists)					
	2020	2021	2022	2023	2024	2025
Armagh & Dungannon	9.67	9.70	10.06	10.54	11.70	12.49
Craigavon	8.66	8.73	9.32	10.31	10.87	12.90
Mid Ulster	10.24	10.13	9.97	10.17	10.44	10.84
Newry & District	11.81	11.84	12.26	12.83	13.74	14.34
NI	9.68	9.63	9.77	9.95	10.58	11.18
SHSCT	10.16	10.21	10.76	11.35	12.33	13.32



All four Southern Federations show rising trends. Craigavon has increased by 49% and Armagh & Dungannon by 29% over the five-year period.

Overview of SHSCT Hospital Admission Trends (2020/21- 2024/25)

Between 2020/21 and 2024/25, there was a total of **15 270 heart failure inpatient admissions** (primary or secondary diagnosis) recorded across Craigavon Area and Daisy Hill Hospitals. Reflecting an 42.5 % increase in admissions for heart failure over the five- year period. 12.7% of heart failure related admissions had a primary diagnosis of heart failure. The vast majority had a secondary diagnosis (87.3%) which would be consistent with co-morbidity patterns.

***Secondary diagnosis of heart failure data included as it may have influenced treatment, care, length of stay and required active management during admission.

Table 8: Heart Failure Related Hospital Admissions 2021/22-2024/25.

Year	CAH Admissions	DHH Admissions	Total Admissions
2020/21	1749	595	2 344
2021/22	1866	1113	2 979
2022/23	2037	1133	3 170
2023/24	2240	1196	3 436
2024/25	2113	1228	3 341
TOTAL	**10 005**	**5 265**	**15270**

CAH admissions increase by 20.8% over the five-year period, DHH admissions increased by 106.4%.

CAH continues to manage the majority of the admissions (63%), however DHH's admissions have more than doubled. This increase may reflect:

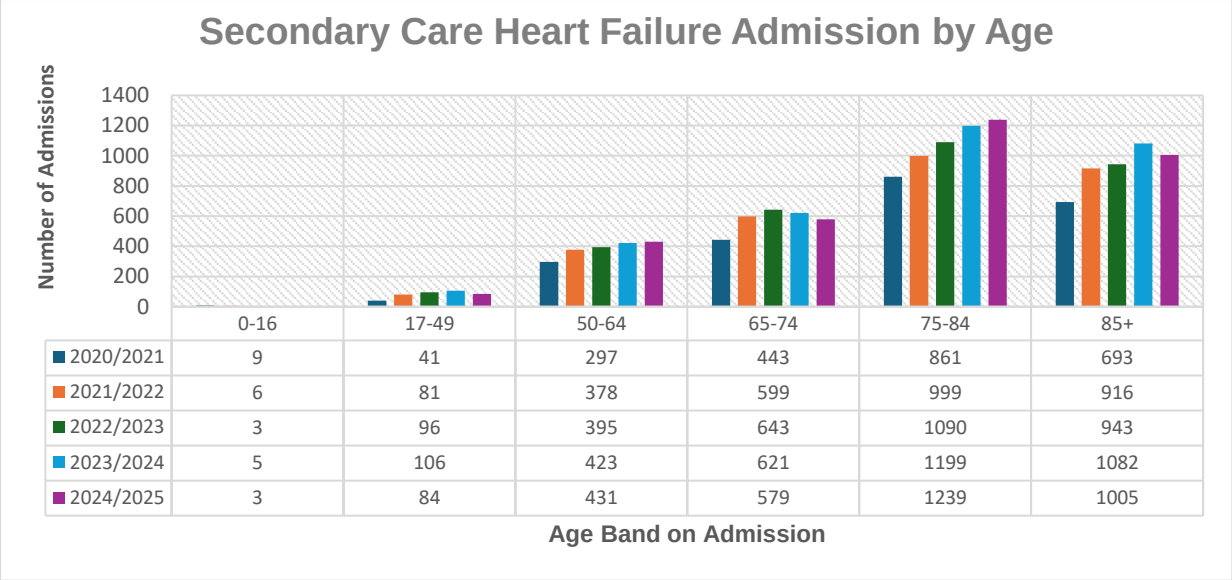
- Increasing demand from the Newry and South Armagh areas, possibly driven by an aging population or higher co-morbidity rates.
- Improved identification or referral pathways.
- A shift in hospital usage patterns fur to service reconfiguration.

This makes Daisy Hill catchment areas relevant for early intervention test site selection.

Age and Gender Profile of Admissions to Secondary Care in the SHSCT

Table 9: Admission for Heart Failure by Age.

Age on Admission Band	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	Grand Total
0-16	9	6	3	5	3	26
17-49	41	81	96	106	84	408
50-64	297	378	395	423	431	1924
65-74	443	599	643	621	579	2885
75-84	861	999	1090	1199	1239	**5388**
85+	693	916	943	1082	1005	4639
Grand Total	**2344**	**2979**	**3170**	**3436**	**3341**	**15 270**

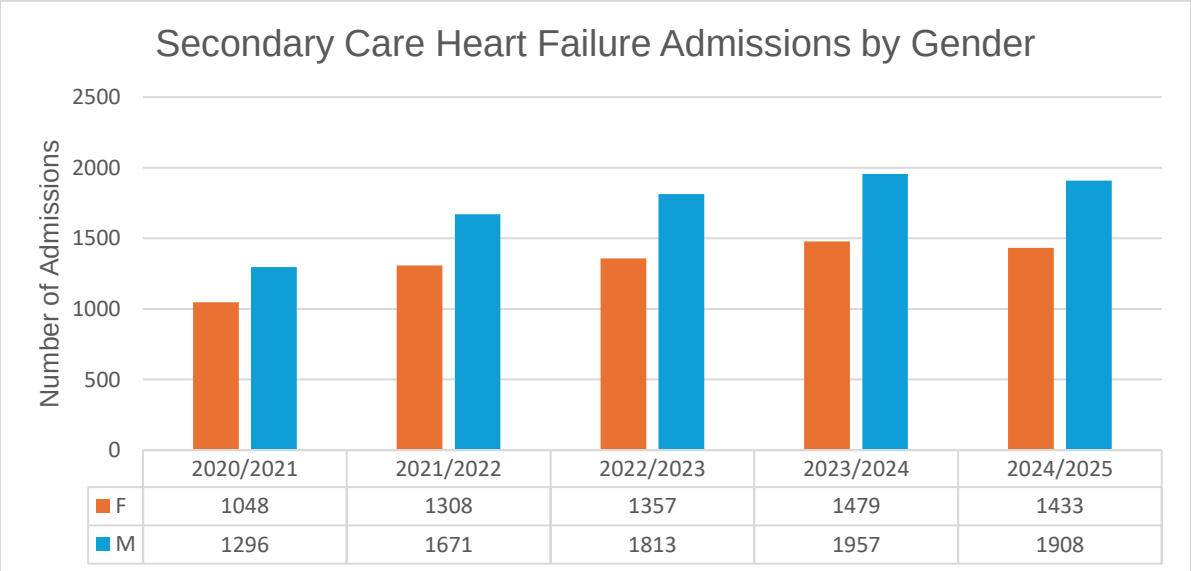


The average age of admission is 76.9 years (Median age 79 years). The most common age group for admissions is 75-84 years. Oldest admission age was 105 years, youngest age was infant under 1 year.

Heat Failure Admissions by Gender

Table 10: Heart Failure Admission by Gender

Gender	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	Grand Total
F	1048	1308	1357	1479	1433	6625
M	1296	1671	1813	1957	1908	8645
Grand Total	**2344**	**2979**	**3170**	**3436**	**3341**	**15 270**



The gender distribution is 56.6% male (8 645), 43.4% female (6 625).

This mirrors national heart failure trends which has been attributed to men being at higher risk of developing heart failure with reduced ejection fraction, thus tending to present earlier, while women present later due to preserved ejection fraction (ESC 2021., British Heart Foundation 2025).

According to the British Heart Foundation's *Heart and Circulatory Disease Statistics* 2025, NI male admissions for heat failure is 56% and females 44%. The mean age is 77 years. The SHSCT profile closely aligns with regional patterns.

Northern Ireland: *Mean age 77 years, male 56%, female 44%.*

UK: *Mean age 78 years, male 52%, female 48%*

Admissions increase after the age of 50, rising more sharply from 65 years, then peaking for the 75-84 age group. The 50-64 age group represents a key opportunity for early detection, risk factor modification and proactive interventions.

Evidence suggests that early identification and proactive intervention in at-risk individuals as key to preventing or delay progression and improving outcomes and quality of life (NICE 2023., British Society for Heart Failure 2024., BHF 2025).

Table11: Admissions by Age Band and Local Government District (2020/21-2024/25)

LDG	0-16	17-49	50-64	65-74	75-84	85+	Grand Total
ABC	4	205	977	1 397	2 786	2 439	7 808
Mid Ulster	0	35	304	377	712	647	2 075
NMD	0	137	544	1 014	1 744	1 383	4 822
Grand Total	4	377	1 825	2 788	5 242	4 469	14 705

NB: The admissions presented above include only patients whose registered addresses fall within the three SHSCT LGDs. The additional 565 admissions recorded reside in LGDs outside of the Southern area and been excluded from the locality base analysis.

Age and gender are the most significant non- modifiable risk factors (NICE 2018a). The Southern area confirms this, with hospital admissions increasing sharply after 65 years. The 75-84 age group accounts for the highest proportion of admissions at both hospital sites between 2020/21 and 2024/25.

Length of Hospital Stay

Table12: Length of Patient Stay

Length of Stay	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025	Grand Total
0-6 Days	1259	1651	1671	1895	1867	8343
7-13 Days	615	733	825	807	781	3761
14-20 Days	259	289	314	337	324	1523
21-27 Days	101	137	168	169	145	720
28-34 Days	39	68	77	95	88	367
35-41 Days	28	37	41	48	46	200
42-50 Days	20	29	33	35	31	148
50+ Days	23	35	41	50	59	208
Grand Total	**2344**	**2979**	**3170**	**3436**	**3341**	**15 270**

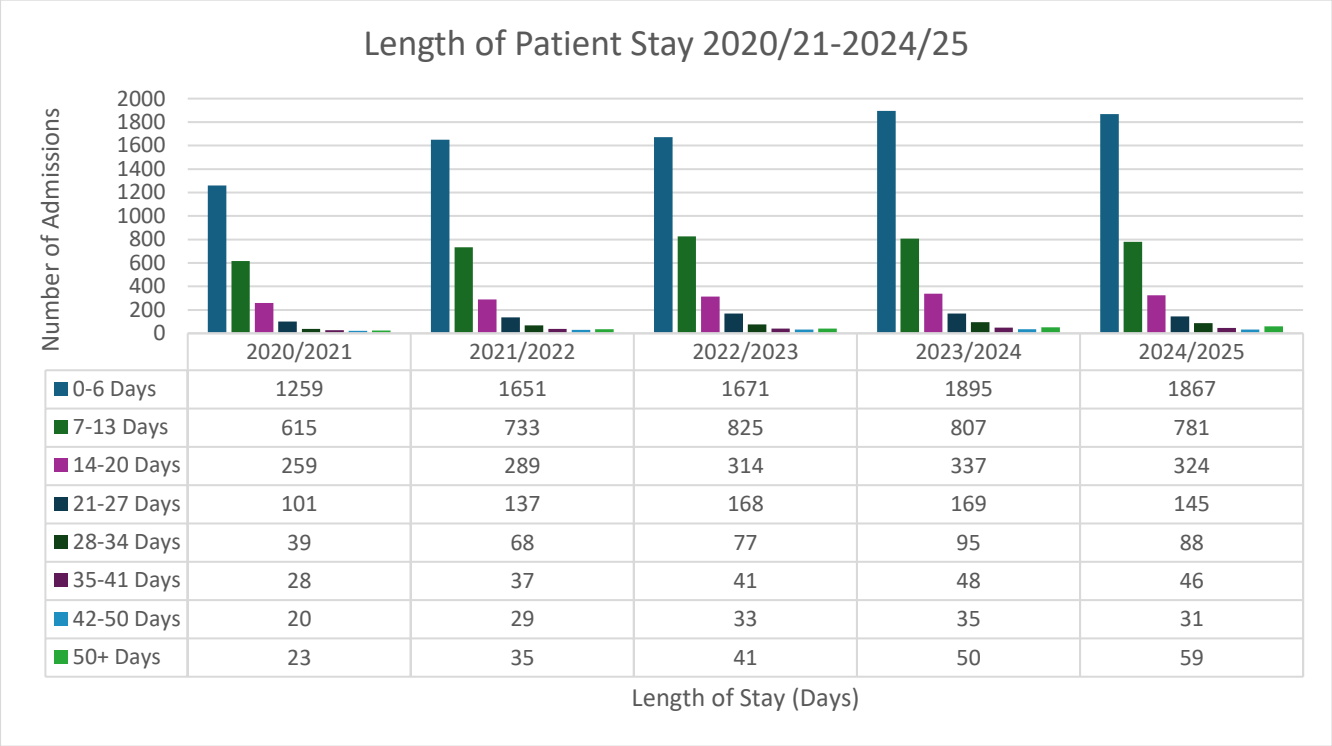


Table13: Length of Stay Summary by Age Band (2020/21- 2024/25)

Age Band	Admissions with a recorded Length of Stay	Mean Days	Median	Min. Days	Max. Days	Q1 25th percentile	Q3 75th percentile	IQR
0-16	6	1.2	0.5	0	4	0	1.8	1.8
17-49	408	8.4	4	0	860	2	8	6
50-64	1924	7.7	5	0	148	2	9	7
65-74	2885	8.4	5	0	113	2	11	9
75-84	5388	10	6	0	369	3	12	9
85+	4639	10.1	7	0	222	3	13	10

NB: The Interquartile Range (IQR) represents the middle 50% of hospital stays, it shows the spread between shorter and longer admissions. It helps highlight the typical stay durations as it is less affected by outliers compared to the mean.

Length of hospital stay increases with age, peaking with the 75-84 age group who have a mean hospital stay of 10 days and a stay range of between 3-12 days.

Patients under 50 years have shorter stays, with a medium of 4 days, however this figure may have been affected by outlier data (hospital stay of 860 days).

The length of stay IQR widens from 65+, this suggests rising complexity and possible delayed discharges.

Patients 65+ account for over 75% of admissions and occupy the longest hospital days. This suggests the need for more discharge support, community care and frailty pathways.

SUMMARY AND NEXT STEPS

This data confirms that heart failure is increasing in both burden and inequality across the Southern area. The findings support the SAIPB decision to prioritise heart failure and enable targeted local planning.

Based on the integrated data analysis, observed trends several areas have emerged as potential test sites. The DEAs outlined below may offer suitable conditions to pilot early identification and preventative models, with rational grounded in high disease burden and health inequality. Selection should be shaped by both data and local professional insight.

DEA	Heart Failure Prevalence (2024/25)	Deprivation Profile	Additional Rational
Lurgan	12.37 per 1000	High	Elevated heart failure burden and socioeconomic barriers- opportunity for upstream interventions.

			Rural-urban mix.
Newry	14.87 per 1000	High	Lowest life expectancy in the SHSCT. Significant increase in hospital admissions (DHH). Mix of rurality, deprivation and access issues. Opportunity for risk-reduction interventions.
Portadown	12.51 per 1000	High	Rapid heart failure growth and multimorbidity. Highest aging Population.
Torrent	9.24 per 1000		Low overall prevalence but steep growth. Mix of rural access and pockets of deprivation. Younger population, opportunity for prevention and early identification.
Craigavon	10.31 per 1000	High	High hospital activity in CAH. Areas of deprivation and moderate disease burden. High interface potential between primary, secondary and community care

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