SWANSEA LOCAL DEVELOPMENT PLAN

SWANSEA LDP EXAMINATION

STATEMENT OF UPLANDS COUNCILORS

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UPLANDS

POLICY H9

HOUSES IN MULTIPLE OCCUPATION

WEDNESDAY 13th JUNE 2018

1.0 Introduction

1.1 On 4th July 2017, Swansea Council's Planning Committee rejected a proposal for a Supplementary Planning Guidance. From the minutes of the meeting, it gave council planning officers the following instruction:

"***RESOLVED that the recommendations as outlined in the report be not approved and that further work be undertaken to revise the SPG and carry out further public consultation. It was resolved that the further work re-examines the threshold limits for HMO's in the County, including the impact of introducing a 15% threshold in the south of the Uplands ward and of introducing a policy to preclude 'sandwiching' of non-HMO properties between HMOs***."

1.2 The council recommissioned a planning consultancy called Lichfields who had written the original report to do further work on the issue.

1.3 On 27th February 2018, during the preparation of a revision to the SPG the Welsh Government Minister wrote to all councils instructing them to:

'***Put in place robust local evidenced based policies in their LDP against which planning applications for HMOs can be assessed', and that, 'LPAs must not delegate the criteria for decisions on planning applications to SPG***'

1.4 In light of evidence from officers of the Welsh Government [Examination Doc Ref HS13-0965_WG] stating:

"***Is the policy effective? No. LPAs are able to include policies to control the density and spread of HMOs when preparing LDPs, based on evidence. Such policies could involve a threshold approach in conjunction with being spatially defined on the Proposals Map (potentially on a ward basis) to consider how new proposals for HMO applications would, or would not, have an adverse effect on the existing character of an area and therefore whether further HMOs should be allowed. The policy should also be clear that it can be applied to both large (7+) and small (up to 6) resident HMOs. LPAs need to ensure that the LDP policy, amplified through SPG, provides an effective basis for determining planning applications for HMOs. The authority will need to ensure that the policy does what is intended, based on the evidence. To achieve this goal the policy should specify what level is considered a harmful concentration/intensification level and where spatially it would, or would not apply.***"

the following action point was issued to the council on 15th March 2018 at Hearing Session 13 of the LDP Examination.

Action point 13.7

Council to amend policy H 9:

"in light of the Minister's letter regarding Houses in Multiple Occupation, to provide an appropriate level of detail within the 2 Action Points HS13 policy, in

order that it is clear what will be considered 'harmful concentration/intensification', to include defining relevant HMO threshold limits to be fully justified by submitted evidence;

As a result of these events the council has therefore had change tack to include elements of the proposed SPG into policy H9 of the LDP.

1.5 The council's proposed wording for policy H9 is:

Proposals for the conversion of a dwelling or non-residential property to a House in Multiple Occupation (HMO) will only be permitted where,

i. **within the HMO Management Area, it would not lead to more than 25% of all residential properties within a 50m radius of the proposal being HMOs,**
ii. **outside of the HMO Management Area, it would not lead to more than 10% of all residential properties within a 50m radius of the proposal being HMOs,**
iii. **the development would not result in a Class C3 dwelling being 'sandwiched' between adjoining HMO properties**
iv. **the property is suited for use as a HMO, and will provide satisfactory private amenity space, dedicated areas for refuse storage and appropriate room sizes, and**
v. **there would be no unacceptable adverse impacts caused by noise nuisance and general disturbance**

HMO proposals within small streets that do not breach the 50m radius maximum threshold will not be supported if the proposal would create a disproportionate over concentration of HMOs within that street.

HMO proposals that would lead to a breach of the maximum thresholds will only be permitted where there are exceptional circumstances or overriding material considerations that demonstrably outweigh any concerns regarding harmful concentration or intensification.

2.0 Why we believe policy H9 is unsound and the precise wording which we are seeking:

2.1 Our precise wording for policy H9 is:

Proposals for the conversion of a dwelling or non-residential property to a House in Multiple Occupation (HMO) will only be permitted where,

i. **it would not lead to more than 10% of all residential properties within a 50m radius of the proposal being HMOs,**

ii. **the development would not result in a Class C3 dwelling being 'sandwiched' between adjoining HMO properties. Further to this, two or more HMOs should not be allowed adjacent to each other to prevent more localised clustering of such properties.**

iii. **the property is suited for use as a HMO, and will provide satisfactory private amenity space, dedicated areas for refuse storage and appropriate room sizes, and**

iv. **there would be no unacceptable adverse impacts caused by noise nuisance and general disturbance**

v. **the provision of adequate soundproofing measures can be demonstrated to combat the effects of noise nuisance to all sizes of HMO**

HMO proposals within small streets that do not breach the 50m radius maximum threshold will not be supported if the proposal would create a disproportionate over concentration of HMOs within that street.

HMO proposals that would lead to a breach of the maximum thresholds will only be permitted where there are exceptional circumstances or overriding material considerations that demonstrably outweigh any concerns regarding harmful concentration or intensification.

2.2 There are three modifications that we are therefore seeking to the council's proposed wording. The first modification is to a stance that we believe is fundamentally wrong. The second and third modifications are additions which we feel would clarify and strengthen the spirit and intention of policy H9.

1. To abandon the notion of an HMO Management zone and have a uniform 10% threshold across the city. This threshold is identified no fewer than eleven times in the council's statement as a 'tipping point' based on national research.
2. To include a 'non-clustering' policy to augment the welcome addition of a 'non-sandwiching' policy.
3. To include the provision of soundproofing measures to make the wording in the council's suggested point 'v', tangibly deliverable.

2.3 To suggest change we are aware that we need to do two things. We need to demonstrate why the policy will fail a soundness test and how our proposals would make the policy sound.

2.4 Therefore, Appendix 1 of this document will demonstrate why we believe the council's evidence does not reflect the outcome that they have produced for the policy H9. Appendix 1 will highlight how we feel that the council's statement:

1. Only superficially uses the available evidence to an extent that it is not robust enough to draw a conclusion from.
2. Does not contain clear rationale explaining how conclusions have been drawn.
3. Did not take up opportunities to improve the quality of relevant evidence despite giving assurances to do so.
4. Contains evidence that does not reconcile with their conclusion.
5. Contains evidence that is erroneous.

2.5 Appendix 2 of this document will outline our proposals and highlight the evidential basis by which we are supporting them, in line with the guidelines associated with Soundness Test 2 in the Local Development Plan Manual by:

1. Providing in depth local evidence to support and make our conclusions robust.
2. Explaining our rationale and methodology in evidential calculations.
3. Using a variety of checks to demonstrate the credibility of our evidence.

3.0 The soundness test which we believe the plan fails

3.1 We believe that the plan fails Soundness Test 2, set out in paragraph 2.72 of Planning Policy Wales.

The full set of questions associated with Soundness Test 2 is shown below in Figure 1

Test 2: Is the plan appropriate? (i.e. is the plan appropriate for the area in the light of the evidence?)

Questions

- Is it locally specific?
- Does it address the key issues?
- Is it supported by robust, proportionate and credible evidence?
- Can the rationale behind plan policies be demonstrated?
- Does it seek to meet assessed needs and contribute to the achievement of sustainable development?
- Are the vision and the strategy positive and sufficiently aspirational?
- Have the 'real' alternatives been properly considered?
- Is it logical, reasonable and balanced?
- Is it coherent and consistent?
- Is it clear and focused?

Figure 1: Local Development Plan Manual-Edition 2-August 2015

4.0 Why we believe that the plan fails Soundness Test 2:

4.1 A summary of examples is given below to show how we believe that council's plan fails the specific criteria in the soundness test. Appendix 1 provides the evidence to robustly demonstrate this.

Is it locally specific?
No. An example of this is that at no point in their evidence do the council calculate or even attempt to estimate the number of people living in HMOs. The council also do not investigate where the population densities are located, and what the trends of population movement are.

Does it support the key issues?
No. A key issue is that the city's universities are relocating to sites in the city which is actively moving the centre of gravity of their populations away from the proposed HMO management zone. The council are proposing a plan to incentivise the creation of HMOs in the proposed management zone by offering a higher limit in that zone. In doing so they are deterring the attempted recovery of a community. Families will not want to invest in a void property in an area that has the blight of a 25% label on it, when they have the option of investing in an area that enjoys 10% protection.

Is it supported by robust, proportionate and credible evidence.
No. The evidence is not robust and is superficial as it doesn't take advantage to utilise freely available data that the council hold in sufficient detail to form a conclusion. An example of this is its failure to use the data contained in HMO register to its full advantage.
The evidence is not proportionate, as by the council's own admission, it focuses on planning sustainability for HMOs. The council's evidence gives less weight to the needs of the residents in the city who have to deal with the effects of HMOs in their communities.
The evidence is not credible as it shows clear intent to use a different counting basis to calculate the percentage to the one that is being currently offered in HMO application reports at planning committees.

Can the rationale behind plan policies be demonstrated?
No. An example of this is the revision of the shape of the HMO management area and the perverse result that has been obtained by the absence of rationale. The original attempt at designing the HMO management area was also riddled with perverse results so no lessons have been learnt.

Does it seek to meet assessed needs and contribute to the achievement of sustainable development?
No. Despite requests and a promise to do so, the council has failed to investigate the fact that there are a growing number of unoccupied HMOs within the proposed management area. It is instead trying to pursue a plan which will encourage more empty houses in the proposed management area and discourage families from moving there against the principles of sustainable development.

Is it coherent and consistent?
No. A coherent argument has not been presented for the actual need for a bespoke HMO Management Area. In attempting this experiment to create a bespoke area, the council is merely advertising why other authorities are either steering clear, or moving away from this approach and substituting it for a lower threshold, city wide model.
The council's approach is therefore inconsistent with the evidence that they have produced to research the approach of other councils.
This evidence shows that other councils have disregarded the management area approach after their residents have told them that it has failed. It also shows a distinct trend of substantially lower thresholds either incorporating or moving firmly towards the respected national research of a 10% 'tipping point'.

5.0 How we feel that we can make the Plan sound:

5.1 Why we feel that our proposals for the Plan will pass soundness test 2 and make the Plan sound:

Is it locally specific?
Yes. We have researched and analysed a variety of sources of local data both in the proposed HMO management area and the wider city.

Does it address the key issues?
Yes. We have examined and analysed issues of capacity, trends and location of housing need to come to our conclusions.

Is it supported by robust, proportionate and credible evidence?
Yes. We have used a variety of checks to test that our evidence is robust.
Our evidence is proportionate as we have used council supplied evidence from their statement such as LSOA data to demonstrate our plan.
We believe that our evidence is credible as we have demonstrated the methodology of how we have created it.

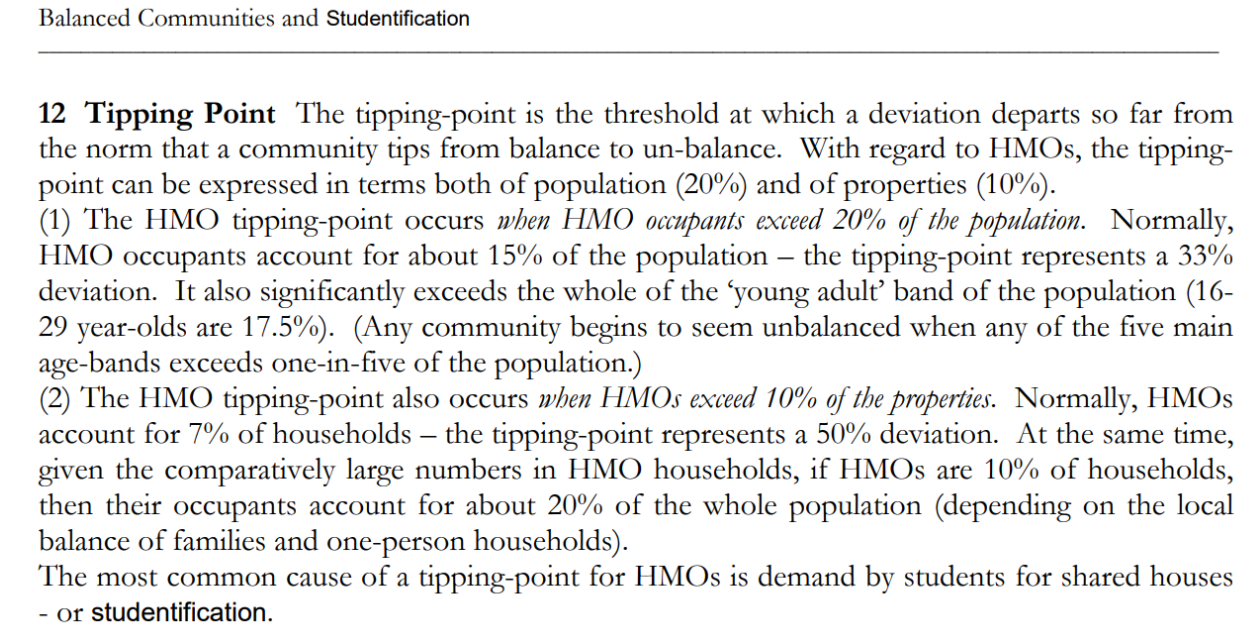
Can the rationale behind plan policies be demonstrated?
Yes. During our evidence and research, we provide summaries of key findings and how we have arrived at them.

Does it seek to meet assessed needs and contribute to the achievement of sustainable development?
Yes. We believe that by digging deep into the data and analysing it, we have formed a picture of assessed needs such as:

1. The rebuild of a recovering community.
2. The location and capacity of housing demands.
3. The need to spread the burden of future HMOs fairly, rather than concentrating the pain into a community that happens to lie in an ill-conceived, and badly manufactured management area.

We believe that we are contributing to the achievement of sustainable development by a Plan that is at least now pointing in the direction of the universally respected national research for sustainable communities, instead of encouraging the movement away from it.
We believe that our Plan is in line with Planning Policy Wales and the Future Generations Act in this regard.

Furthermore, the national research which the council repeatedly mention in their statement is from the National HMO Lobby and it displayed below in Figure 2 for absolute clarity. This research has been used and is universally respected by many other councils as a basis to define sustainable development credentials in their HMO policies. **Our council should take heed and act on it instead of just quoting it.**



Balanced Communities and **Studentification**

12 Tipping Point The tipping-point is the threshold at which a deviation departs so far from the norm that a community tips from balance to un-balance. With regard to HMOs, the tipping-point can be expressed in terms both of population (20%) and of properties (10%).
(1) The HMO tipping-point occurs *when HMO occupants exceed 20% of the population.* Normally, HMO occupants account for about 15% of the population – the tipping-point represents a 33% deviation. It also significantly exceeds the whole of the 'young adult' band of the population (16-29 year-olds are 17.5%). (Any community begins to seem unbalanced when any of the five main age-bands exceeds one-in-five of the population.)
(2) The HMO tipping-point also occurs *when HMOs exceed 10% of the properties.* Normally, HMOs account for 7% of households – the tipping-point represents a 50% deviation. At the same time, given the comparatively large numbers in HMO households, if HMOs are 10% of households, then their occupants account for about 20% of the whole population (depending on the local balance of families and one-person households).
The most common cause of a tipping-point for HMOs is demand by students for shared houses - or **studentification**.

Figure 2: Universally accepted definition of 'Tipping Point' (Source: National HMO Lobby 2008)

Are the vision and strategy positive and sufficiently aspirational?
Yes. We believe that the vision and strategy of taking steps to rebuild balanced and cohesive communities within the proposed HMO management area is positive and sufficiently aspirational. The opportunity to do so is presenting itself as there are void HMO properties appearing with increasing numbers in the proposed management area. We believe that our Plan should contains a supportive policy H9 to encourage this, and we wish that the council would be supportive of this view instead of resisting it.

Have the 'real' alternatives been properly considered?
Yes. We have looked at the council's statement in depth and thoroughly considered it in Appendix 1.

Is it coherent and consistent?
Yes. We have presented our evidence to back up our plan for H9 with full explanation in Appendix 2. We feel that our evidential conclusion of the policy wording is consistent with our research and findings.

Is it clear and focused?
Yes. Our message is clear on the 3 modifications that we would like to see made on the council's H9 policy. It is focused as our presented evidence in Appendix 2 leads to the same point as of our 3 modifications.

Appendix 1

Consideration of the council's statement

1.0 We agree with the council's conclusion for a threshold approach. We do not agree that there is a need for an HMO management zone and its associated 25% threshold.

1.1 Research from other authorities shows that an HMO management zone can either be bespoke or coincidental with ward boundaries. The council are attempting to design a bespoke HMO management area.

1.2 We believe that the council's evidence demonstrates sound reasons to avoid a bespoke management area and shows the perverse results when trying to design one.

1.3 We believe that the rationale behind the plan of having an HMO management area with associated threshold has not been supported by credible evidence and that the evidence relied on supports a different outcome.

1.4 Lichfield's have prepared two reports on the topic. Initially there was a report in July 2017 in preparation for the rejected SPG. In this report, they proposed the following bespoke HMO management area to house a 25% threshold (Figure 3).

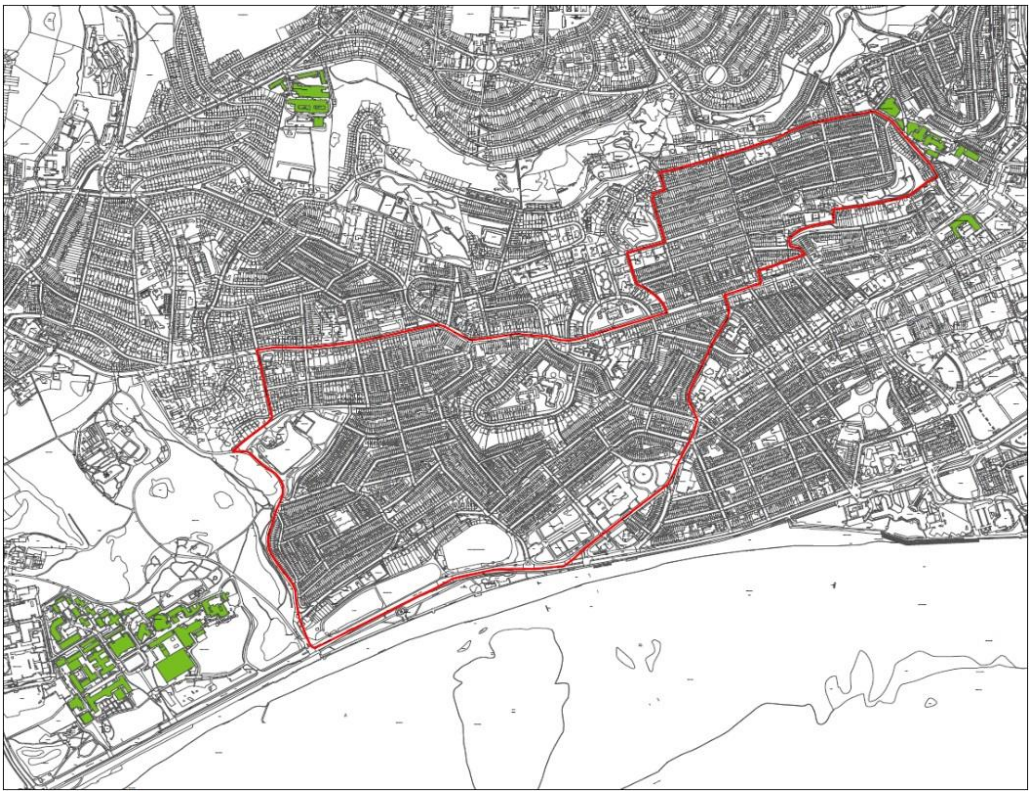


Figure 3: Original proposed bespoke HMO Management Area (Source: Lichfields Report July 2017)

1.5 In the April 2018 report, the HMO Management area had been expanded to include 4 extra streets. No rationale or explanation had been offered to justify this annexation which is shown below (Figure 4).

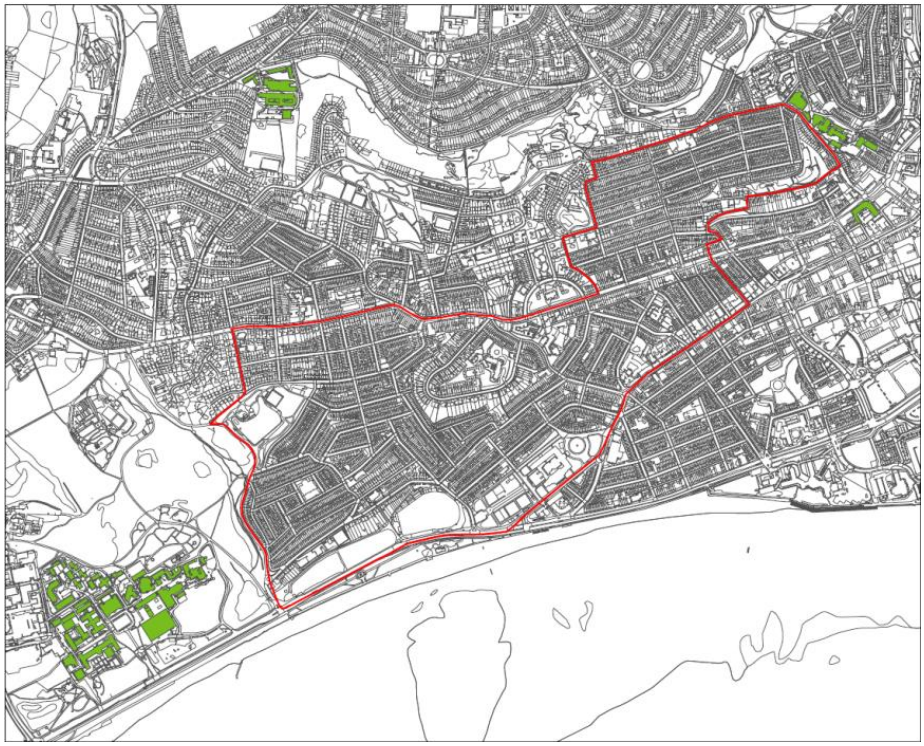


Figure 4: Revised proposed bespoke HMO Management Area (Source: Lichfields Report April 2018)

1.6 In their July 2017 report, Lichfields used data from the October 2016 HMO public register. In their April 2018 report, Lichfields used data from the November 2017 register.

1.7 To seek the rationale for increasing the size of the HMO management zone we compared the number of HMOs in the annexe between the two dates. The results in the table below show that there was no significant change in number between the two dates to provide rationale as to why this annexation had happened.

Date of Lichfields Report	Annexed Streets	
	Licensed HMOs	% of total stock
Oct 16	55	3.4
Nov 17	56	3.4

Figure 5: Table showing number of Licensed HMOs in the annexed area (Source: Swansea Council HMO Public Register of HMO Properties)

1.8 The Castle 6 LSOA (Figure 6 below) provided the answer. Initially, Lichfields had terminated the HMO management zone at the dotted ward boundary running along Phillips Parade and Duke Street. The annex involved expanding the management zone to incorporate the southern portion of the Castle 6 LSOA below Walter Road (the northern portion of the LSOA was in the initial management zone). There is no rationale in the council statement to either explain or justify this manoeuvre.

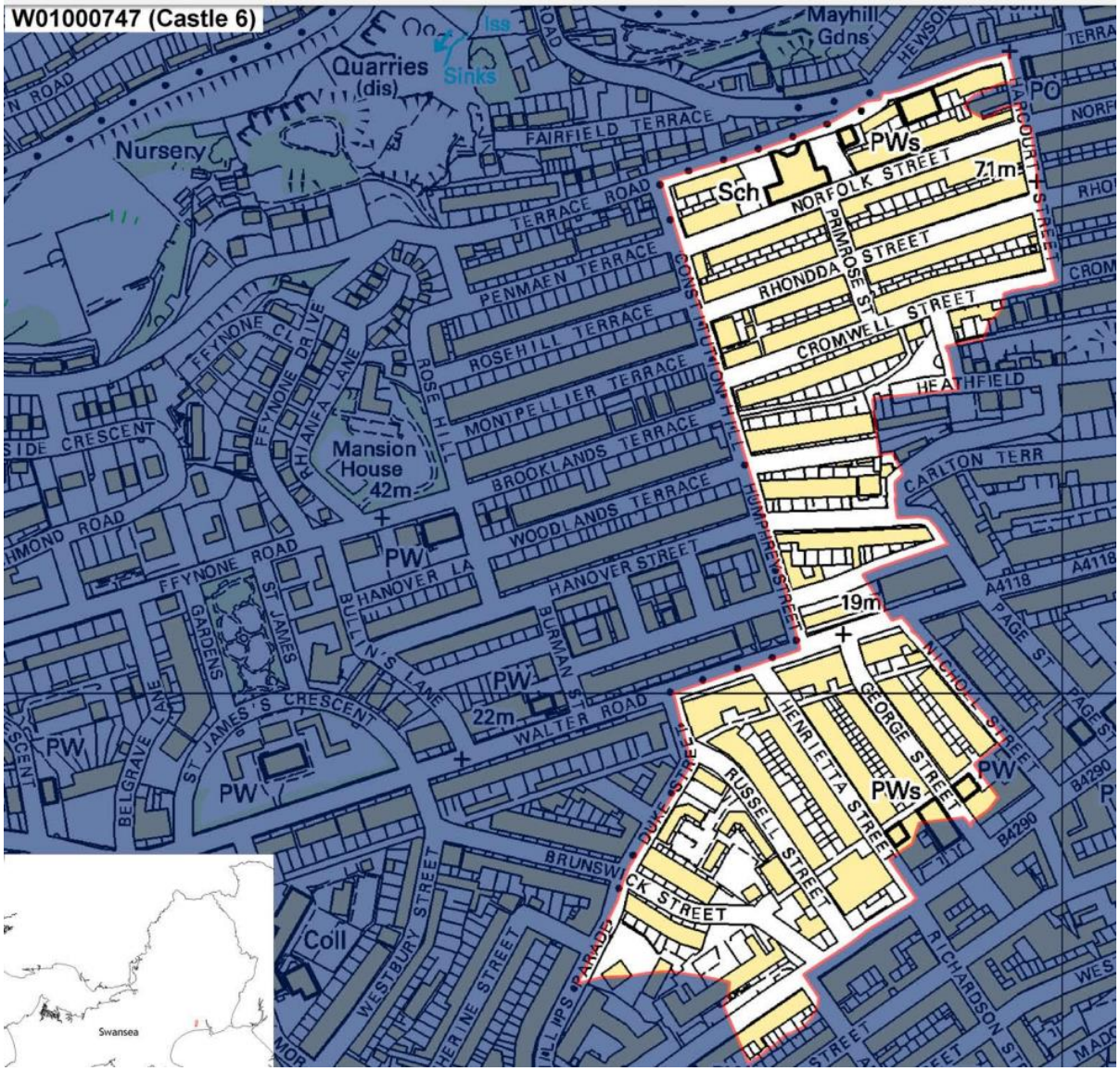


Figure 6: Detailed map of the Castle 6 Lower Super Output Area (Source: gov.wales)

1.9 This annexation has created the following perverse result:

Nicholl Street has now been split between the two zones. On the 25% side there are 16 houses, 1 of which is an HMO giving a percentage of 6.2%. On the 10% side there are 15 houses, 5 of which are HMOs giving a percentage of 33.3%.

Page Street which is the first street in the 10% zone has 31 houses, 12 of which are licensed HMOs giving a percentage of 38.7%.

1.10 This annexation alone has produced a perverse result where the percentage of HMOs outside the proposed management area is above three times its 10% threshold, whereas the percentage of HMOs inside the management zone is about a quarter of its 25% threshold.

1.11 This is one of many anomalies that have been created due to a lack of rationale in the creation, design and modification of the HMO management zone. This also highlights the haphazard nature and associated pitfalls of attempting to create a bespoke zone itself.

1.12 The extent of the evidence presented by the council from local data to make the case for a 25% bespoke zone can be categorised below:

1. The type of occupancy within individual HMOs
2. The total number of licensed HMOs using the council's public register.
3. The percentage of HMOs in LSOAs.
4. The perceived future demand of HMOs.
5. The location of the future demand for HMOs.
6. The counting method when assessing an application.

We will now demonstrate how we think that this evidence in each category fails to meet Soundness Test 2:

1. The type of occupancy within individual HMOs

1.13 This public register is useful as it technically includes every HMO in the proposed management area. This is due to Uplands and Castle wards enjoying additional licensing.

1.14 The council have only used numbers and locations of HMOs in their evidence. This is the superficial extent to which they have utilised this useful database taken from Appendix 2 of their statement.

> **Number and Distribution of HMOs**
>
> 4.2 As of September 2017 there were 1,666 licensed HMOs in Swansea. Based on Council Tax data, approximately 65% of these properties are exempt from Council Tax because they are fully occupied by students. According to research undertaken by the Welsh Government in April 2015[5], Swansea has the second highest number of licensed HMOs in Wales after Cardiff.
>
> 4.3 The vast majority (98%) of existing licensed HMOs are located in either Uplands Ward (67%) or Castle Ward (31%). The proliferation of HMOs in these two Wards has contributed to them being defined as an 'Additional Licensing' area where all HMOs require licensing. There are therefore comprehensive up to date records regarding the number and location of HMOs within these Wards.

Figure 7: Superficial extent of the use of data from HMO public register (Source: Statement of Swansea Council)

1.15 In para 4.2 of Figure 7, the council state that approximately 65% of properties are exempt from council tax because they are fully occupied by students.

1.16 This implies that there are 1083 (65%) HMOs are fully student occupied and that 583 (35%) are not.

1.17 The council do not refer to the fact that student and non-student HMOs behave in entirely different ways such as:

1. A non-student HMO is populated for twelve months of the year and doesn't contribute to annual cycle of a massive peak and trough effect that the population of mass student occupied HMOs have in an area.
2. The student occupiers of an HMO are on the main only likely to spend one or two academic years in the HMO before either moving to another HMO or elsewhere.
3. The student household is more likely to move on as a unit, albeit in different directions, as they are group that have a common interest which is studying for a degree at university.
4. The student house would have pre-planned to occupy their HMO as a friendship unit when viewing it in the previous academic year. A non-student occupied HMO is more likely to behave in a different manner with occupants moving in and out one by one, at different times of the calendar year, as they have totally independent lives of one another.

1.18 For the council to make a robust analysis of the local evidence, they need identify and display where the 65% and 35% are. This would allow identifications of any concentrations of the two different types.

1.19 As it stands, we would estimate that at least 90% of HMOs in the Uplands ward are student occupied due to many pieces of local based evidence such as:

1. The annual cycle of letting boards.
2. The comparative availability of parking in term and holiday time.
3. The large volumes of refuse on the streets when the whole HMO is vacated at the end of the academic year.

1.20 The council imply that 583 HMOs are not fully student occupied but are not offering any rationale as to what their occupation status is. This could be:

1. Empty.
2. Partially student occupied.
3. Wholly occupied by non-students either with some, none, or all on welfare benefits.
4. Or any combination of 2 and 3.

1.21 The council have shown no evidence of analysis in this regard. Analysis does matter as it can influence where the demand for HMOs are based on who is occupying them and where in the city different types of occupancy are trending.

1.22 We believe that the council and universities could be a little more proactive and share information on the 583 HMOs in question to ascertain type of occupancy as a starting point.

1.23 In the various sections of Lichfields' Evidence base review (4.0) of the council statement they are placing emphasis that Welfare reforms will be a driver in future HMO need. They have not done any analysis on how many existing bedspaces are being provided by those on welfare benefits or where they are either.

1.24 **We believe that the councils statement, does not provide enough locally based evidence to draw a conclusion on occupancy type. Furthermore, we feel that they have not used enough of their available evidence and partnerships when they have had the clear opportunity to do so.**

2. **The total number of licensed HMOs using the council's public register.**

1.25 Point 4.2 in Figure 7, states that there were 1,666 Licensed HMOs in Swansea. This information was taken from the HMO public register. Along with their location, the bare extent to which the council have used the document to provide local evidence.

1.26 The HMO public register includes data on the maximum number of occupiers or bedspaces that each HMO can accommodate. The register tells us that capacities of individual HMOs vary between 3 and 58 people. At no point anywhere in the council's statement is any reference made to capacity data whatsoever.

1.27 **We regard this as a major omission and consider it both incredible and impossible for a council to construct a housing policy without paying regard to the number of people living in the houses.**

3. **The percentage of HMOs in LSOAs**

1.28 Around 90% of the proposed HMO management area is made up from 6 entire Lower Super Output Areas (LSOAs). Small fringes of other LSOAs make up the remainder.

1.29 In their July 2017 report, Lichfields' have quoted from council supplied data of licensed HMOs as a percentage of residential stock by LSOA (using 4th October 2016 figures). (Figure 8)

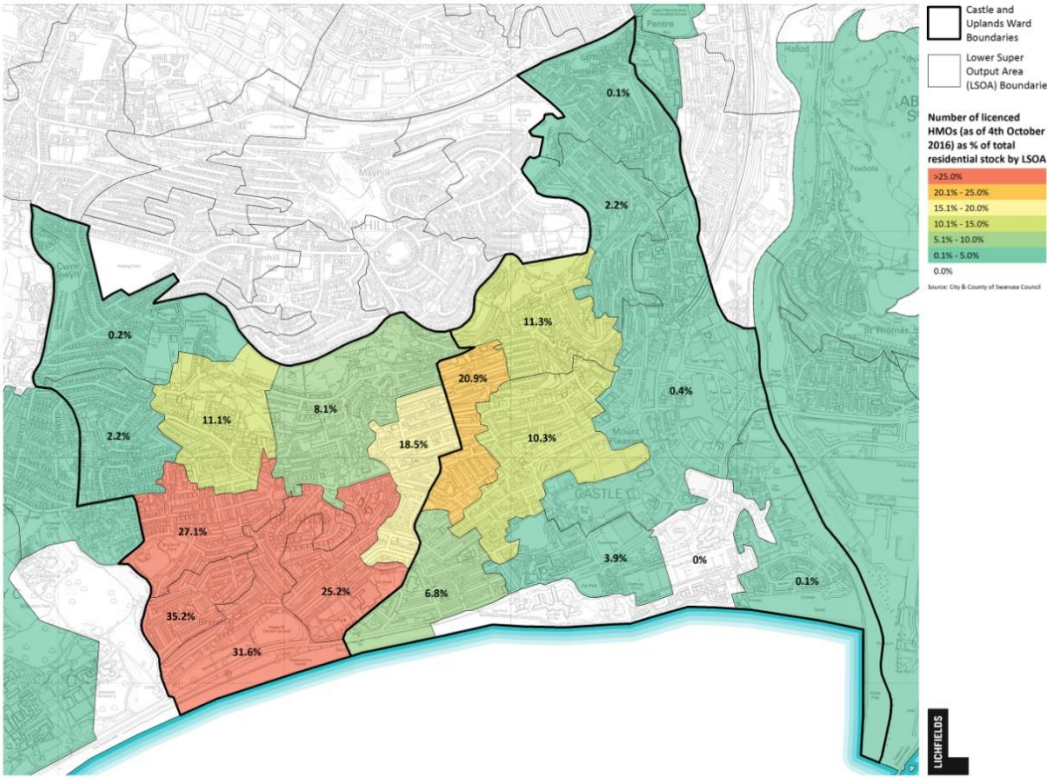


Figure 8: Map showing number of licenced HMOs (as of 4th October 2016) as % of total residential stock by LSOA (Source: Lichfields report July 2017 with data provided by City & County of Swansea Council)

1.30 In their April 2018 report, Lichfields have quoted from council supplied data of licensed HMOs as a percentage of residential stock by LSOA (using 21st September 2017 figures). (Figure 9)

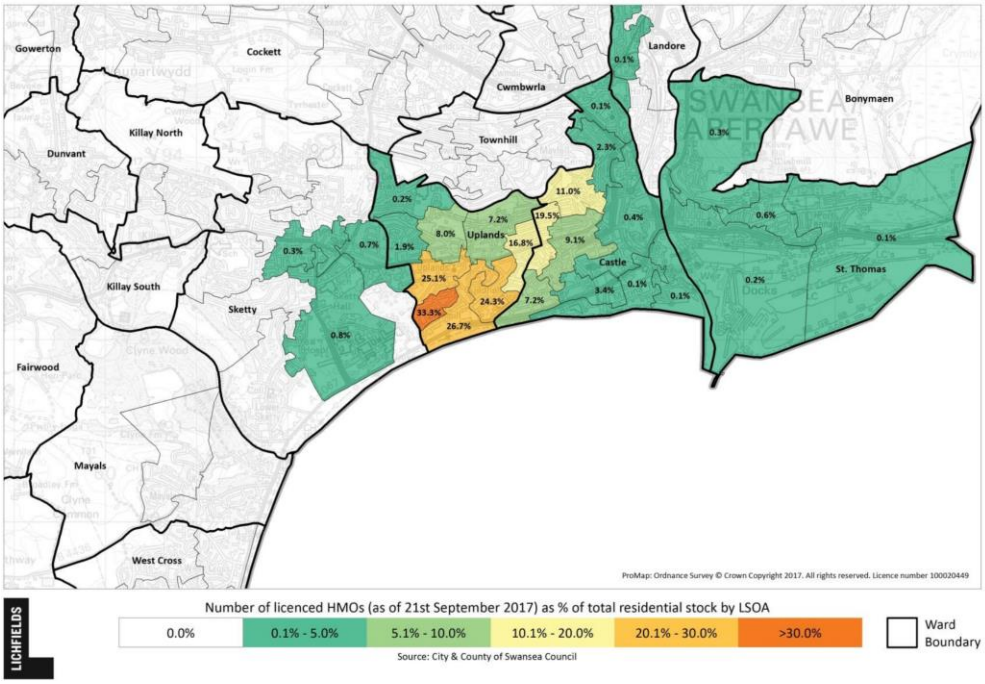


Figure 9: Map showing number of licenced HMOs (as of 21st September 2017) as % of total residential stock by LSOA (Source: Lichfields report April 2018 with data provided by City & County of Swansea Council)

1.31 **Comparing Lichfields' two reports, they have used council data in both cases to demonstrate that the percentage of HMOs in all 6 LSOAs is actually in remission.**

1.32 A table demonstrating the evidence provided by the council showing that HMO demand is falling within the HMO management area is shown below in Figure 10.

LSOA	% of HMOs in LSOA (Council Figures)		Change
	Oct 16	Sep 17	
Castle 6	20.9	19.5	**-1.4%**
Uplands 4	18.5	16.8	**-1.7%**
Uplands 6	31.6	26.7	**-4.9%**
Uplands 7	27.1	25.1	**-2.0%**
Uplands 8	25.2	24.3	**-0.9%**
Uplands 9	35.2	33.3	**-1.9%**

Figure 10: Table showing fall in the number of licenced HMOs (between 4th October 2016 and 21st September 2017) as % of total residential stock by LSOA (Source: Data provided by City & County of Swansea Council)

1.33 **They are however recommending a policy to grow HMOs in these areas which is contrary to their own evidence that demand in the area is falling.**

1.34 Furthermore, the council's justification of a 25% limit is concerning. According to their data in Figure 10, three of the six LOSAs (Castle 6, Uplands 4 and Uplands 8) have percentages **under** their proposed 25% threshold.

The council in Figure 11 claim that there will be '***small pockets'*** where '***opportunities [for growth] are likely to be limited***'.

5.19 This option would contain any further concentration or intensification of HMOs within the defined HMO Management Area wards of Uplands and Castle to a limit of 25%. This would restrict growth of HMOs within the areas where there is existing high concentration of HMOs, such as Brynmill. There may be small pockets within these areas where further HMOs will not breach the threshold when applying the radius approach, although these opportunities are likely to be limited. Further concentration or intensification of HMOs in all other areas would be limited to 10%. Whilst allowing higher levels of HMOs, this would be focussed on a suitably targeted area where levels of HMO concentration are already high meaning that opportunities for new HMOs will be more limited than if it applied to the whole Licencing Area.

Figure 11: Justification of recommended threshold level (Source: Statement of Swansea Council May 2018)

1.35 We would argue that this statement may apply to the Uplands 9 LSOA. It would however, provide significant opportunity for growth in the Uplands 6 and Uplands 7 LSOAs. This is as the figures are an average, meaning that there will be areas significantly below 25% to counterbalance the hotspots. The three LSOAs below the 25% threshold would automatically allow for growth up to the threshold.

1.36 **We therefore say that the council's conclusion in recommending 25% threshold levels in Figure 10 is not reflecting their own evidence, which we have tabulated in Figure 9**

4. The perceived future demand of HMOs

1.37 The extent that the council statement attempts to evidence demand is superficial. In Appendix 2 of their statement, they produce a weak and uncertain conclusion.

> ### Conclusion
>
> 4.16 Whilst it is difficult to identify an exact level of future HMO demand, indicators suggest that it will increase and that provision of new HMOs will play a role in meeting:
>
> 1. the needs of the City's important growing Higher Education establishments;
> 2. those who require the more flexible form of tenure provided by the private rented sector;
> 3. those unable to access home ownership and requiring smaller shared accommodation in the interim; and
> 4. the demands created by welfare reforms.

Figure 12: Extent of council's conclusion regarding future HMO demand (Source: Statement of Swansea Council May 2018)

1.38 Although data is provided on student numbers and housing needs in paragraphs 4.45 to 4.60, it is focussing on the context of PBSAs. It does not show in any depth where HMO demand would be. There is also no analysis of existing HMO capacity and the gap required to fulfil demand. Its conclusion however does state that there is anecdotal evidence that HMO growth is likely to be outside the proposed HMO management area.

> 4.66 The highest levels of demand for student occupied HMOs is likely to remain within the Uplands and Castle Wards, however, there is already anecdotal evidence of an increase in HMOs (that do not require a licence under Mandatory Licensing) in St Thomas Ward due to the proximity of Swansea University's Bay Campus and the increased presence of UoWTSD at SA1.

Figure 13: Extent of council's analysis regarding future HMO demand (Source: Statement of Swansea Council May 2018)

1.39 A good example of what we believe would be a robust analysis of the HMO demand is shown below from an ARUP report commissioned by Bath and North East Somerset Council.

Table 3 – Estimated Demand for HMOs in Bath to 2020/21[12]

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Projected student housing need	16,654	17,673	18,749	19,197	20,073	20,691
Projected bedspaces in PBSA	7,095	7,457	7,818	8,180	8,541	8,903
Student HMO bedspace requirement	9,559	10,216	10,931	11,017	11,532	11,788
Student HMO requirement	2,390	2,554	2,733	2,754	2,883	2,947

For 2015/16 the modelled need is 16,654 bedspaces and available purpose built beds is 7,095. This leaves an overall residual demand for 9,559 bedspaces which equates to approximately 2,390 HMOS. The Council's housing department data shows there are in the region of 2,395 HMOs across the district, suggesting that in the last year, demand was met. However, the growth projected for the next five years shows an increased demand that will exceed existing supply of HMOs. In the absence of any new PBSA developments, if the university growth aspirations set out were to be realised, there would be a need for a further 2,229 HMO bedspaces in a further 557 HMOs to 2020/21.

The B&NES report provides tentative predictions for university population growth to 2028/29. This states that a continuation of a 3% growth rate at the University of Bath would result in 24,069 students, of which 18,725 would need housing. This would represent an additional 3,712 bedspaces and 928 HMOs required between 2020/21 and 2028/29. If combined with an estimated projection of 1-2% growth in Bath Spa University in the same period, the bedspace need increases by another 500-1000 and the resulting HMO requirement increases by 130-260.

Figure 14: Example of a robust analysis regarding future HMO demand (Source: B&NES HMO SPD Review & Options Analysis by ARUP. Issue 4. 19 April 2017.)

1.40 The analysis from Bath shows how many HMOs are perceived to be required by doing a proper supply and demand which has is focus on HMO bedspaces.

1.41 **Such a robust evidential analysis and rationale is lacking for the creation of the H9 policy in Swansea.**

5. The location of the future demand for HMOs.

1.42 We accept that there is likely to be a need for more HMOs across the city but feel that the evidence lacks a robust analysis of what the trends of growth are in different parts of the city. Without this robust analysis it is difficult to define a management area let alone a threshold that should be applied within it.

1.43 After the rejection of the SPG by the planning committee in July 2017, the council embarked on a second report. During its preparation, they were asked by the

both local councillors and the community to examine the fact that there were HMOs in the management zone which were not being let due to lack of demand.

1.44 In the workshop of 25th October 2017 with councillors and residents which is mentioned in their *Appendix 2: Engagement with Stakeholders* (Paragraph 1.10m) of the Lichfields report, the council's statement acknowledges that a resident has researched the following data from various local estate agents.

> m Considered that there was no demand for more HMOs and information provided by a local estate agent showed that there were 150 empty HMOs.

Figure 15: Acknowledgement of evidence provided by a local resident about unmet demand for HMOs in the proposed management zone at the start of the 2017-18 academic year (Source: Statement of Swansea Council May 2018)

1.45 At the meeting the resident said that the data was collected the day before and pointed out that these the agents had been specifically asked whether these vacant HMOs referred specifically to the current academic year, which had just begun. It was also confirmed that the empty HMOs being referred to were in the HMO management area.

1.46 Prior to this, representations on this topic were made to the planning department by a local councillor as shown below.

From: May, Peter (Councillor)
Sent: Friday, September 15, 2017 11:33:37 AM
To: [redacted]
Cc: [redacted]
Subject: Fw: HMO St Albans Street

Dear Gentlemen

I writing to ask you for an update on progress with the revised SPG.
Also something that has sprung to light in recent days is the annual advertising by landlords who fail to fill their HMOs. These properties often lie empty for the year if they are not let now and are easily found due to large adverts in the windows themselves.
When designing a planning policy of this type, what evidence is supplied for the actual housing need that HMOs produce. In simple terms, why does the policy encourage more of them when existing stock is not being filled. There are normally over 50 void HMOs in Brynmill year in year out. Is this taken into account? Could this aspect be considered please in the redraft?

Peter

Figure 16: Email to planning department officers in Swansea Council questioning analysis of HMO need (Source: Councillor Peter May)

1.47 Attached to the email was the following picture (Figure 17) which clearly demonstrates an example of 2 adjacent HMOs in St Albans Road totally 13 bedrooms which had not been let. The date that the picture was taken was 15th September 2017 at a time when students were in the process of or had already moved into their new homes for the academic year. The HMO is in the Uplands 9 LSOA which was recorded to have a percentage HMO stock of 33.3% in that very month.

Figure 17: Picture demonstrating an example of unlet HMO bedspaces at the start of the 2017-18 academic year within the Uplands 9 LSOA of the proposed HMO management zone (Source: Councillor Peter May)

1.48 A prompt response (Figure 18) to the query was given from the planning department acceding to the request shown in the highlighted text.

From: [redacted]
Sent: 18 September 2017 07:48:25
To: May, Peter (Councillor); Mann, Irene (Councillor)
Cc: [redacted]
Subject: FW: HMO St Albans Street

Dear Councillors

Further to the queries raised by Councillor May in the email below I can confirm the following:

- Following the resolution of the Planning Committee in July this year to not approve the previously produced version of HMO planning guidance, the Planning Authority has re-commissioned consultants Litchfields to work in partnership with the Council to produce a revised document. As mentioned previously, the production of a revised document will necessitate a new period of engagement and public consultation
- The new commission is programmed to deliver key milestones according to the following timetable:

Workstage	Dates
Evidence base review, Impact Analysis and Strategy Formation	Sept-Nov
Engagement with stakeholders – includes Members, landlords, Universities	Oct-Nov

Presentation to Members to seek agreement to publically consult on revised SPG document	Nov/Dec
6 Week Public Consultation	Jan-Feb 2018
Review consultation responses, prepare consultation report and revised SPG. Report back to members to seek adoption of SPG	March-April 2018

- The evidence base review highlighted above includes an analysis of demand/need for HMOs.
- The re-commission will include site visits to streets within the additional licence area during term time – this will provide some indication of the level of HMO properties that are advertising rooms to let in window displays. This evidence will be supplemented by information obtained through the upcoming program of engagement with landlords and agents regarding the extent of unoccupied properties to let

I hope the above is useful and answers your queries. Please be assured that Councillors will be contacted further in due course during the engagement process to develop the revised planning guidance.

Figure 18: Email from planning department officers in Swansea Council analysis of empty HMOs (Source: Councillor Peter May)

1.49 **Throughout the council's statement, we cannot find any evidence that an independent analysis involving site visits to streets has been carried out. We regard this an omission, a broken promise, and a failure to use available local evidence in constructing the policy.**

6. The counting method when assessing an application.

1.50 The council are proposing to use a method when assessing future calculations which we believe artificially lowers the percentage of HMOs. We believe that there proposed method engineers an increase to the denominator of the calculation that represent the total number of houses in an area.

1.51 If we were to ask a resident what the HMO concentration of Bryn Road is, the answer you would get would probably be in excess of 60%. This is what the real feel of the street is. The actual percentage for Bryn Road under the counting method proposed is only 34%.

1.52 This proposed practice is best explained by considering their intentions in Figure 19 below.

Application of the Threshold

5.22 In considering whether a proposal breaches the defined threshold level the following approach is recommended;

5.23 The LPA will assess the concentration of HMO properties within a 50 metre radius of the HMO planning application proposal. The radius will be measured from the centre-point of the proposed property's street frontage.

5.24 All residential properties falling within planning use class C3 will be included as part of the count. For the avoidance of doubt this includes social housing.

5.25 Flats will be counted as individual properties where these have a front entrance onto the same street as the proposed HMO property.

Figure 19: Proposal of how the council will calculate the percentage when a planning application is submitted. (Source: Swansea Council Statement)

1.53 The worrying paragraph in Figure 19 is 5.25. Counting a house split into flats as multiple properties will artificially lower the percentage. This in turn will allow more HMOs into the street.

1.54 The disturbing aspect is that the council is not using this method now to inform its planning committee of the percentage of HMOs in a street. Figure 20 demonstrates how information was presented to them in a recent HMO application in St Helen's Avenue.

Planning Committee – 6th March 2018

Item 8 (Cont'd) **Application Number:** 2018/0161/FUL

St Helens Avenue contains 214 residential properties, 88 of which are registered as HMO's alongside two shops and a business use. The corner of St Helen's Road contains an empty Church building which was most recently used as a restaurant and a bar to the other side. Brynymor Road, which backs onto the application site, contains a number of commercial properties. It is noted that No.198, which is on a corner plot, is not a registered HMO property and No.200 is registered. The conversion of the existing dwelling would result in the concentration of HMOs increasing from 41.12% to 41.58%. Taking into account the volume of commercial properties in the local area and the existing high numbers of HMOs in neighbouring streets it is not considered that the proposed conversion would result in an unacceptable harmful concentration relative to the existing circumstances.

Figure 20: Report to Planning Committee using a different method of calculation as proposed in their statement (Source: Swansea Council)

1.55 Under the proposed counting method for the plan the number of properties would rise from 214 to 250. 214 is the number of **houses** in the street, 250 is the number of **households** is subdivision of houses into flats was used as a basis. This household data has been obtained from the Electoral Services department of the council where every **household** has a unique numeric ID.

1.56 This would mean that the concentration of HMOs would be increasing from 35.2% to 35.6% which is lower than the figures in the report.

1.57 The conclusion of this finding is that the method used by the council now shows higher percentages giving the impression that a 25% threshold would be justified. If

threshold is granted in the Plan, the council will then propose a different counting method which lowers the percentage thus allowing the addition of more HMOs the current method of counting would allow.

1.58 In essence the ‘new’ 25% would have the real feel of a much higher percentage, such as 40%, dependant on how many flats were in the vicinity.

1.59 **We feel that this approach to justifying a threshold in not credible and is potentially misleading.**

Appendix 2

Our supporting evidence

2.1 In the Welsh Government letter to councils dated 27th February 2018, the minister emphasises the need for council to: "***Put in place local evidenced based policies in their LDP against which planning applications for HMOs can be assessed***".

2.2 The first stage of our evidential analysis included referencing the HMO Public register at 5 separate dates from the around the point when the C4 Use Class Order came into being (25th February 2016).

2.3 The rows highlighted in red indicate the registers at the time of Lichfields' first and second reports. The results are shown in Figure 21 below.

Date of HMO register	Total		Proposed HMO Management Area including Annexed streets		Annexed Streets	
	Licensed HMOs	Number of bedspaces	Licensed HMOs	Number of bedspaces	Licensed HMOs	Number of bedspaces
Jan 16	1608	8842	1212	6676	60	296
Oct 16	**1615**	**8919**	**1218**	**6721**	**55**	**264**
Jan 17	1662	9227	1238	6853	57	274
Sep 17	**1666**	**9223**	**1259**	**7015**	**56**	**280**
May 18	1674	9222	1246	6901	61	299

Figure 21: Table showing licensed HMOs and respective bedspaces (Source: HMO public registers from Swansea Council)

2.4 Our findings from this table were:

1. The number of Licensed HMOs and Licensed bedspaces across the city was growing between January 2016 and January 2017, but in the period up to May 2018 growth had slowed.
2. The number of Licenced HMOs and Licensed bedspaces in the HMO Management Area showed growth up to September 2017 but had shown a recent fall.
3. The data for the annexed streets showed little or no change in either bedspace or number of HMOs in this area. This confirmed the lack of rationale or evidence shown by the council in suddenly including them into the HMO Management zone.

2.5 The next stage of the analysis was to investigate the total population make up contained in within the LSOAs identified by Lichfields. (Figure 10 from Appendix 1 is reproduced below for ease of reference)

LSOA	% of HMOs in LSOA (Council Figures)		Change
	Oct 16	Sep 17	
Castle 6	20.9	19.5	**-1.4%**
Uplands 4	18.5	16.8	**-1.7%**
Uplands 6	31.6	26.7	**-4.9%**
Uplands 7	27.1	25.1	**-2.0%**
Uplands 8	25.2	24.3	**-0.9%**
Uplands 9	35.2	33.3	**-1.9%**

Figure 10: Table showing fall in the number of licenced HMOs (between 4th October 2016 and 21st September 2017) as % of total residential stock by LSOA (Source: Data provided by City & County of Swansea Council)

2.6 The do this the following methodology was followed:

1. The HMO Public Register dated 29th May 2018 was broken up into the LSOAs to make an analysis of bedspaces in each LSOA.
2. Non-HMO data was collected by using the monthly updated electoral roll dated 1st May 2018. This was done by removing the Licensed HMO dwelling electors so that the non-HMO electors remained. Again, this was broken down into LSOA to give a direct comparison.
3. No data was available for Castle 6 as access is only granted to Uplands data.

LSOA	Bedspace capacity	Non-HMO Electors	Total Population	HMO capacity as a percentage of total population
Castle 6	952			
Uplands 4	787	813	1600	49.2%
Uplands 6	1245	496	1718	72.5%
Uplands 7	1088	755	1843	59.0%
Uplands 8	1230	749	1979	62.2%
Uplands 9	1169	572	1741	67.1%

Figure 22: Table showing total Licensed HMO bedspace capacity as a percentage of the total population on the electoral roll. (Source: Uplands Ward Electoral Roll 1st May 2018, Swansea Council HMO Public Register 29th May 2018)

2.7 Our findings from this data set were that:

1. If every bedspace was filled in the existing HMO stock, residents of HMO would make up between 49.2 and 72.5 percent of the population.
2. Even if an allowance is made for non-HMO dwellers who are not on the electoral roll, the percentage would still be far greater 20%. The full definition of the nationally researched 'tipping point' (Figure 2) recognises that this is also achieved the number of HMO occupants exceeds 20% of the population.

3. Lichfields quote that an LSOA is typically a unit of 650 households and 1500 residents. Every LSOA has a population exceeding 1500, yet a policy is being recommended for HMO growth in the management zone increasing the population even further.

2.8 To provide a real-life example of what such a high percentage of transient population does to our community, we talked to local schools.

2.9 Brynmill Primary School is an English medium primary school located in LSOA Uplands 9. They have provided us with data, to demonstrate the regular cycle of pupils on the roll, quarterly over the last four years. This is shown in figure 20 below.

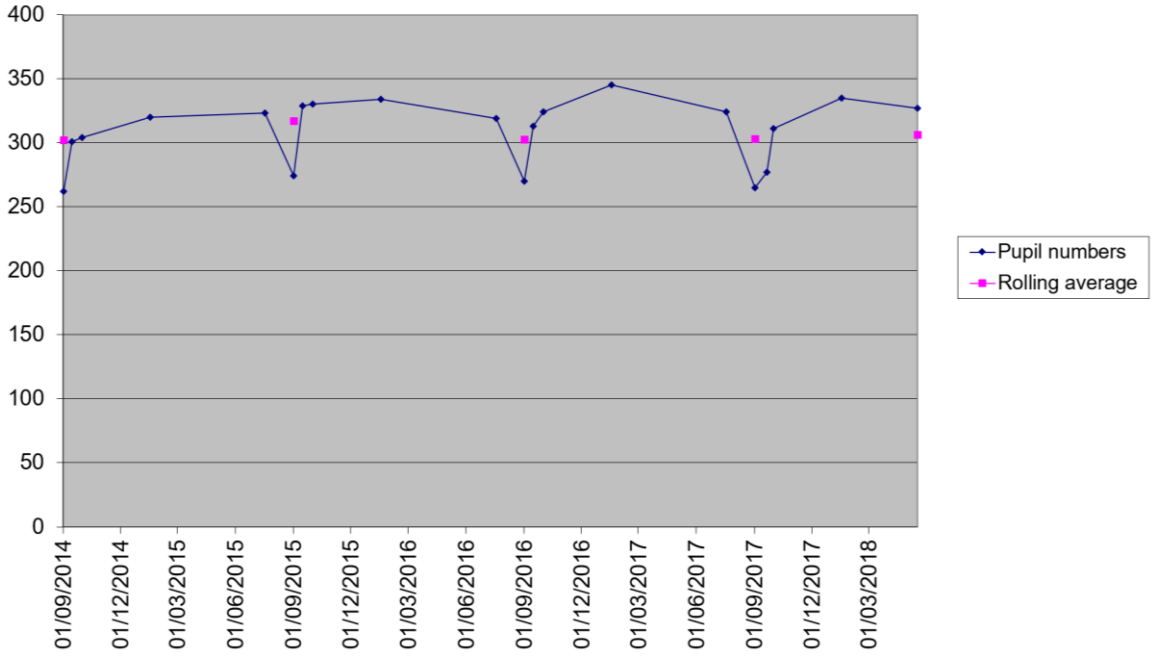


Figure 23: The annual cycle of school admission data at Brynmill Primary School (Source: Brynmill Primary School)

2.10 Every September the roll starts at its lowest point. Between October and December numbers rise due to the arrival of the children of postgraduate and international students.

The result of this annual cycle yields the following issues for the school.

1. Their budget is determined by the number of pupils on roll in September.
2. The arrivals have a drain on school resources in terms of time, finance and staffing capacity.
3. The size of transient roll is unpredictable meaning very organised planning is required for surprises, with stretched resources to do cater for them.

2.11 The school also provided a breakdown of pupil movements for the last academic year to give an accurate analysis of what was happening on the ground in Figure 24 below.

Summary for last academic year

Leavers and arrivals Summary for 16/17

323 pupils on roll on 20 – 7 - 17

Including Nursery and Reception No of joiners: 74
Excluding Nursery and Reception September Starters: **51** Pupils **arrived** in 16/17.
Number of **leavers**: **50**
32 pupils Left and joined in the same academic year

Mobility = 31.2 % (50 + 51 /323 x 100)
Breakdown of duration on roll of 16/17 leavers:

-
Out of the 50 **pupils who** left the school in 2016/17
10 were on roll for under 6 months
24 were on roll between 6 months and 1 year
9 were on roll for between 1 year + and 2 years
5 were on roll for between 2 years+ and 3 years
1 was on roll for between 3 years + and 5 years
1 was on roll for 5 years +

Figure 24: Breakdown of pupil movements for Brynmill Primary School 2016/17 (Source: Brynmill Primary School)

2.12 **We believe that this is one demonstrable consequence of having a high percentage transient population as demonstrated from the data in Figure 22. As council data shows that the HMO concentration is now in remission, the council are going against sustainable development and cohesive community principles by trying to raise it again.**

2.13 We then analysed the different rates of HMO growth in the city and where this growth was happening.

2.14 To do this the following methodology was used.

1. Data was used from the HMO public registers dated January 2016 and 29th May 2018.
2. The HMO stock was split into those inside and outside the proposed management zone.
3. This accounted for all HMOs in Uplands and Castle Ward. It also accounted for larger HMOs outside the two wards which were subject to mandatory licensing. This is because they had 5 or more rooms or, 3 or more storeys.
4. To get data on the remaining HMOs, a search was done on planning applications since 25th February 2016. This was the date the Use Classes Order required all HMOs to have planning permission. HMOs inside the Additional Licensing area were not considered having already been counted.

5. The HMOs found in planning applications were then split into those that fell in the SA1 8… postal code area and those that didn't. SA1 8… is St Thomas postal code where there is current growth.
6. Percentage growth in the different areas was calculated over the 28 month period. I was also converted to an annual compound rate.
7. An estimate for the total bedspace was also obtained to show the existing supply of HMO capacity across the city. This was done on the assumption that every HMO was fully tenanted.

Date	Proposed HMO Management Zone		Licensed HMOs outside proposed HMO Management Zone		Smaller HMOs outside additional licencing area (SA1 8 Postcode)		Other smaller HMOs outside additional licensing area		Totals	
	HMOs	Beds	HMOs	Beds	HMOs	Beds	HMOs	Beds	HMOs	Beds
Jan 16	1212	6676	396	2166	0	0	0	0	1608	8842
May18	1246	6901	428	2321	27	94	9	31	1710	9347
Growth in 28 month period	2.8%	3.4%	8.9%	7.2%					6.3%	5.7%
Annual compound growth	1.2%	1.4%.	3.7%	3.0%					2.7%	2.5%

Figure 25: Table showing percentage growth of all types of HMO in different areas of the city (Source: Swansea Council HMO Public registers, Planning application data obtained from Swansea Council's public website since 25th February 2016)

2.15 Our key findings from this area were:

1. Outside the Castle and Uplands Wards (Areas of Additional Licensing) and the SA1 8 postcode area, there is a nugatory share of non-licensable HMOs and bedspaces. **It is clear that the rest of the city is not sharing the burden.**
2. Growth in the proposed HMO management zone since January 2016 has been small compared to that of the rest of the area of additional licensing and the SA1 8 postcodes.

2.16 On 1st November 2017, research results comparing the January 2017 and September 2017 HMO public registers were communicated to the council's planning and HMO Licensing Departments.

2.17 The purpose of the research was to gather two aspects of local evidence relating to HMO stock:

1. To further examine the extent of void properties.
2. To examine net movement of numbers of HMOs in the Uplands ward.

2.18 The full results were sent to the council in a spreadsheet which was coded and referred in detail to individual properties.

2.19 The summary results of the research are contained in Figure 26 below which was the email communicated to the departments.

From: May, Peter (Councillor)
Sent: 01 November 2017 10:47
To: [redacted]
Cc: [redacted] ncillor);
[redacted]
Subject: Accuracy of the HMO register

Dear [redacted]

Last week at the stakeholder meeting to discuss the Supplementary Planning Guidance for HMOs Uplands Councillors and residents presented evidence to Litchfields (the consultants). It was agreed that we would provide a written submission with all our substantiated evidence. We intend to do this by Monday to feed in to the proposed draft document.
Part of the work that we have been undertaking is to ascertain whether there is in fact a demand for fresh HMOs in Uplands. On the ground, there are observed cases of void HMOs. In an attempt to substantiate this, I have carried out an analysis of Uplands licenced properties by comparing the public HMO register for two different dates (13th Jan and 21st Sept) which are 8 months apart.

The initial finding was that there were 1129 licensed HMOs in January. September's figure either indicates a net increase of 4 or a net fall of 7 depending on the explanation of the UX code (below). This gives an indication of the demand or lack of it for future HMOs in Uplands.

If you examine the data further however, you can get the story behind it.
To do this, I have used the following codes.
L-Licensed on the 13th January and on that register. (1121 properties)
LX- Licensed on the 13th January but not on that register. (8 properties)
U-License expired, not renewed and not appearing on September register. (53 properties)
UX- Not appearing on the September register despite the licence still having time to run. (11 properties)
N- A property that has a new licence on which appears on the September register but does not appear on the January register. (57 properties)

Figure 26: Email showing summary results of HMO movements in Uplands ward between January 2017 and September 2017 (Source: Swansea Council HMO Public registers, Councillor Peter May)

2.20 The response from the council (28th Nov) relevant to this evidence was that **8 of the 11 HMOs with tagged with the UX code had been sold.** Other responses related to specific properties.

2.21 Key findings

1. Even though the numbers of licenced HMOs in the Uplands ward was relatively stable in the 8 month period, there was now evidence that this was due to churn rather than a stable market.
2. Landlords were now selling HMOs whilst new landlords were embarking on converting new houses. This meant that family homes were being unnecessarily converted to HMOs, whilst existing HMOs were lying empty and being sold on.
3. HMOs were not necessarily being sold to other developers. There is at this stage anecdotal evidence of some families buying them.

2.22 This trend has continued. Below is a photograph of the latest HMO for sale (June 2018) within the proposed HMO management zone. This HMO has been empty and on the market for this academic year.

Figure 27: HMO sold after being on market for around 6 months in the proposed HMO management zone. Photograph taken 6th June 2018 (Source:Councillor Peter May)

2.23 As part of our evidence gathering we too have researched the approach of other cities. Glasgow council has operated a diametrically opposite view to Swansea council's approach to areas of high concentrations. Rather than create a management zone to invite growth in the area, they stop further applications. Figure 28 below explains their rationale for this approach.

Key Criteria – Locational

1.10 A high concentration of flats in multiple occupancy within a particular neighbourhood has the potential to change the dynamics of a community and undermine its stability. High turnover of residents and under-occupied buildings during university/college holidays, along with the potential for lack of routine maintenance of properties in these areas, can discourage owner- occupation and detract from residential amenity.

1.11 Historically, multiple occupancy has been concentrated within parts of the West End, close to Glasgow University and with easy access to the other universities and colleges in the City. The density of flats with an HMO Licence in Hillhead and Woodlands, in the heart of Ward 11, has now reached such a level that further development would undermine residential amenity within these areas.

1.12 The following locational criteria will be applied to all multiple occupancy development proposals:

a) In Hillhead and Woodlands, no further planning applications for multiple occupancies will be supported (see Figure 1).

Figure 28: Rationale explaining Glasgow's decision to stop supporting planning applications altogether for HMOs in high density areas. (Source: Glasgow City Council, SG10 meeting housing needs)

Figure 1 – Hillhead and Woodlands areas of Ward 11 where no further planning applications for multiple occupancies will be supported

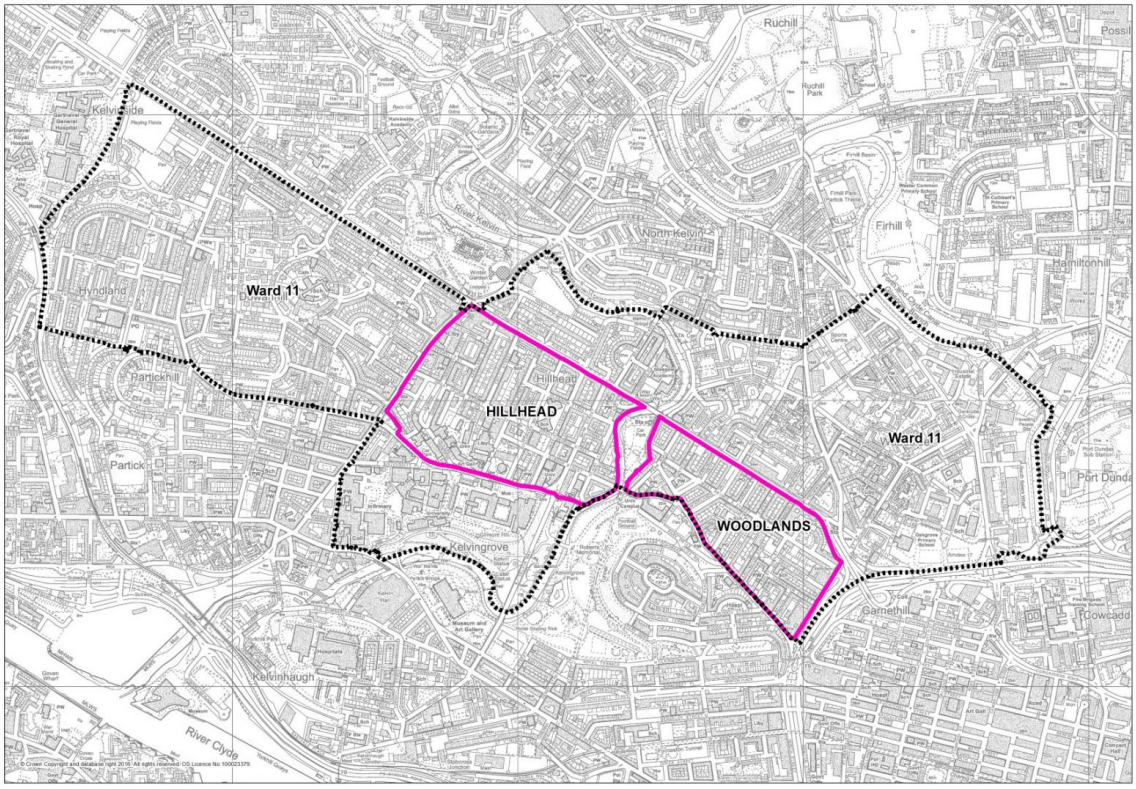


Figure 29: Map showing Glasgow's area of HMO housing restraint. (Source: Glasgow City Council, SG10 meeting housing needs)

2.24 We also note from the council statement that authorities have reduced their thresholds as shown in figure 27 below:

> Southampton and Bath and North East Somerset (BaNES) Councils have recently adopted a 10% city-wide threshold due to concerns raised by the local community on previous thresholds being too high (20% and 10% in Southampton and 25% in Bath and North East Somerset);

Figure 30: Thresholds in the cities of Bath and Southampton (Source: Swansea Council Statement)

2.25 The common reason that unites Bath and Southampton's decision to reduce their thresholds down to the 10% level, which is widely recognised as the tipping point, is because **these councils are making policy based on the concerns of their residents**. Figures 31 and 32 illustrate this point perfectly.

1.37 However, since the adoption of the 2012 SPD, the council experienced consistent reporting of concerns from local residents about the negative impacts of introducing a new HMO in their neighbourhood. In light of the concerns, in May 2016, the Council adopted a revised SPD on HMO in order to address issues with the previous approach. The revised SPD introduced a consistent 10% threshold throughout the city, a 'non-sandwich policy', and also provides further clarity on exceptional circumstances.

Figure 31: Southampton council producing policy to act on concerns of residents (Source: Swansea Council Statement)

1.45 Liaison with the Planning Policy Team highlighted:

1 Threshold lowered from 25% to 10% due to concerns amongst the local communities on the level of HMOs that were being allowed within areas that already had high concentration of HMOs.

Figure 32: Bath and North East Somerset council producing policy to act on concerns of residents (Source: Swansea Council Statement)

2.26 Key Findings

1. Southampton and Bath have given significant weight to the experiences and views of residents when reducing their thresholds to the nationally researched 'tipping point' of 10% from higher thresholds.
2. Glasgow has given significant weight to the impact that HMOs have on residential amenity when deciding to stop approving applications altogether in parts of the city.
3. We believe that Swansea Council however, are giving significant weight to the factors of HMO demand, identified in figure 12, such as the "important growing Higher Educational establishments" and unresearched projections about the impact of welfare reforms. **The residents' views appear to be subordinate to this.**

2.27 On the 18th May 2018 the following question was emailed by Uplands Councillor Peter May to the Welsh Government Planning Policy Branch:

"***Our council is suggesting that 25% threshold is the lowest possible defensible figure to provide a robust policy and has suggesting creating an management area for this threshold to apply whilst the rest of the city has a 10% threshold.***
Some English towns such as Bath do not have a management area.

Do the Welsh Government Planners have a view that policies have to contain a management area with a higher threshold or can a policy have a city-wide threshold? Or does a local planning authority have discretion to interpret the evidence and decide on an approach accordingly?
Again referring to Bath. This city had a an SPD dated 2013 in which a city wide threshold of 25% was adopted, using a radius approach to determine applications. In 2017, they lowered the city wide threshold to 10% based on evidence from the National HMO lobby which defines 10% as a tipping point for communities.
On comparing the demographics Swansea and Bath appear not to be dissimilar as far as HMO numbers and distributions go. The fundamental difference is that Swansea appears to be favouring building a robust case for 25% and Bath robust case for reducing their 25% threshold to 10% based on both national and local indicators. In short the approaches are diametrically opposite which concerns us.
Do the Welsh Government Planners have a checklist of evidence for Local Authorities to consider when presenting their views and if so what is it? Or again is this stance and evidence presentation on threshold entirely at the discretion of the local authority? If there is a disagreement can their evidence be legally challenged?"

2.28 This was the response of Welsh Government Planning Policy branch:

From: [redacted]
Sent: 25 May 2018 09:23
To: May, Peter (Councillor)
Subject: RE: Planning policy for Houses in Multiple Occupation

Dear Cllr May,

Thank you for your e-mail below regarding planning policy for Houses in Multiple Occupation (HMOs).

The changes to the Town and Country Planning (Use Classes) Order 1987 made by the Welsh Government in February 2016 were to enable Local Authorities to have the ability to manage future growth of HMO concentrations. It is for individual Authorities to consider the balance of costs and benefits in their particular area in deciding whether or not to have specific local policies in their LDP to control the number of HMOs. Typically, such policies involve a threshold approach to determine whether an area has reached a point at which further HMOs would have a harmful effect; however this, and the appropriate threshold (or thresholds), is a matter for each Authority to consider based on local evidence. As with all LDP policies, any policy on HMOs should be supported by robust evidence which will be tested through the LDP Examination. Once a policy is included in an adopted LDP, relevant planning applications would be assessed against these local policies. The decision-maker, whether this is the Local Planning Authority or a Planning Inspector, will need to assess the proposal against these local policies, including assessing the relevant local evidence.

Figure 33: Response from Welsh Government Planning Policy Branch clarifying that policies are locally driven (Source: Councillor Peter May)

2.29 Key findings

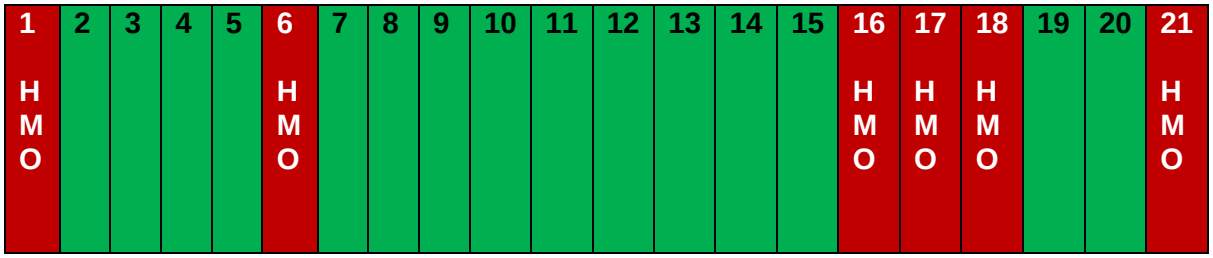
1. There is no Welsh Government preference to insist on multiple thresholds or a management zone. It is entirely down to Swansea Council if they wish to head down this avenue.
2. Swansea Council "consider the balance of costs and benefits" of the policy.

Amendment 2 Anti-clustering policy

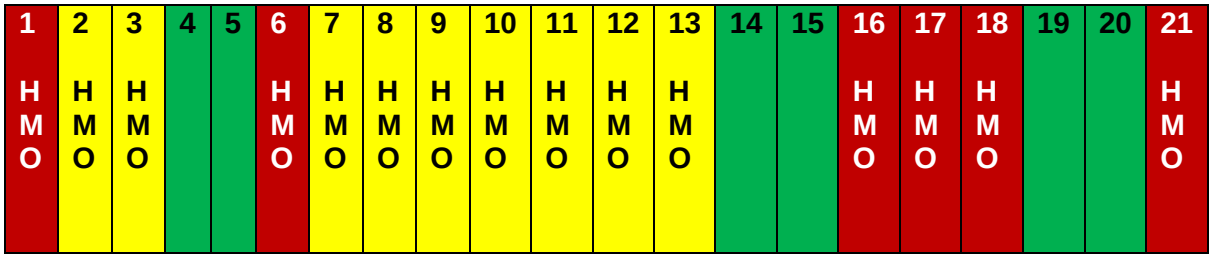
2.30 Local Authorities are starting to add this policy into their plans. The council's statement acknowledged that Worcester have a non-clustering policy to supplement their non-sandwiching policy. In May 2018, Rhondda Cynon Taff became the first Welsh Council to do the same. There therefore seems to be a growing trend and it would be a shame for Swansea Council to miss the opportunity to afford this extra protection for its residents.

2.31 Consider the example of Chesshyre Street in the Uplands Ward but applying the non-clustering and non-sandwiching measures in complete isolation to percentage thresholds and the small streets protection.

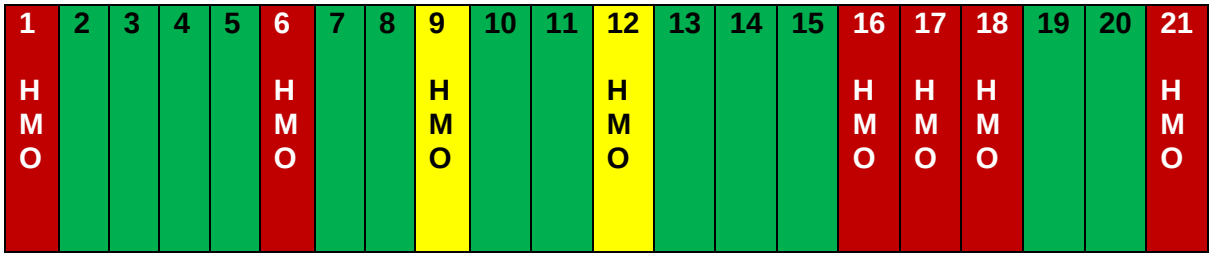
2.32 This is what Chesshyre Street looks like now.



2.33 If the council were to rely on the sandwich policy alone, the worst-case scenario for the street would be this.



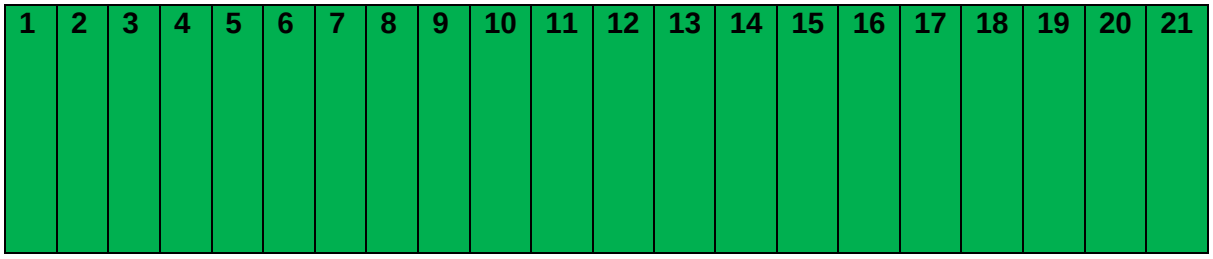
2.34 If the council were to combine the non-sandwich policy with the non-clustering policy, the worst-case scenario for the street would be this.



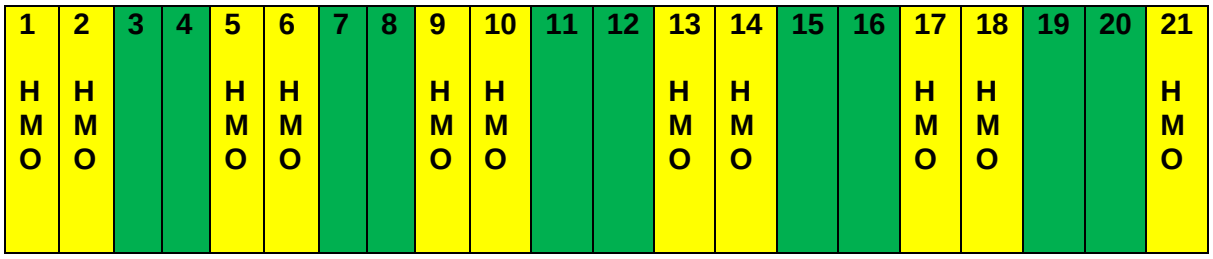
2.35 We are simply asking the council to use the opportunity to add non-clustering into policy H9 as we believe that it will provide further protection to the resident.

2.36 It will also provide an extra tool inhibit the localised concentration of HMOs developing in new areas of HMO growth such as the community of St Thomas.

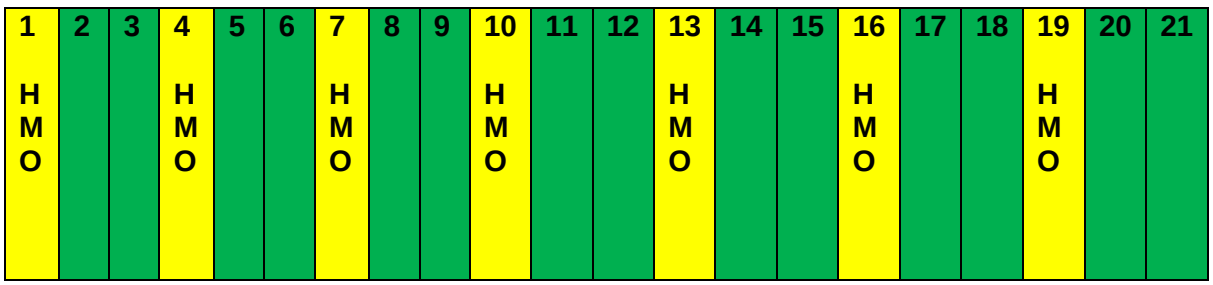
2.37 To do this consider a street with no HMOs in it.



2.38 Non-sandwiching alone could provide this level of protection. (Assuming that the HMOs were not converted sequentially from 1-21. In this extreme and likely case non-sandwiching alone would offer no protection at all.)



2.39 A non-clustering policy in conjunction with a non-sandwiching policy alone would provide an extra safeguard against this happening giving a worst-case scenario of this.



Amendment 3 Soundproofing

2.40 Noise Insulation: We believe that should include both sui generis and smaller HMOs. There should be no distinction between them with regard to this matter. The Council Statement appears to make a distinction in only advocating it for large HMOs. The statement gives no reason for this and offers no evidence supporting this distinction.

2.41 Without specific reasoning and/or evidence , it seems unreasonable and ridiculous to make such a distinction. It may be that their thinking is along the lines of larger HMOs having more “movements” and therefore more likelihood for noise nuisance.

2.42 If this is the case, it may well be that there will be a greater number of “movements” in and out of a house with more occupants, but movements in and out are neither the sole nor necessarily the greatest source of noise nuisances.

Reasons for not making a distinction

2.43 Many of the sources of noise nuisance actually come from the inherent nature of the buildings which are converted into HMOs (be they large or small), and of course, the neighbouring houses. In Swansea, these buildings are usually located in rows of terraced houses built between the late 1800s and about 1915. The walls between the houses are single brick thickness. Often the houses are only one room wide. They may have inherent back extensions with an alleyway separating the back end of the houses but these “alleys” are very narrow. The effect of this is that all sounds can be heard from one house to another. This includes any form of loud speech (not necessarily shouting) and even coughing or sneezing. In the past this was mitigated by a separation between quieter sleeping areas upstairs and more noisy areas downstairs, carpeting on floors and stairs, heavy material curtains and the tendency for neighbouring households to follow similar routines with regard to time of sleep and work.

2.44 With conversion to HMOs all rooms are used for all purposes so there is no quieter “upstairs” for sleeping. Although it may be intended that there is a community room downstairs for shared socialising, in practice, individuals will often invite their friends into their own rooms for socialising, listening to music, playing computer games and watching films etc. This is the case whether the HMO is large or smaller. The effect, may actually, be worse in a smaller than larger HMO because in a small HMO which is only 1 room wide and with only 2 floors the sounds transmitted along and through the shared wall with next door are actually audible in every room. There is no where to go to get away from it.

2.45 Similarly, in both large and smaller HMOs there is a tendency to avoid carpeting on stairs and floors and replace old floors with laminate, and use thin blinds rather than heavy material curtains, this reduces any natural sound insulation.

2.46 Additionally it is a requirement both in large and smaller HMOs, to fit fire-doors. These are rated with regard to fire resistance but have no rating with regard to noise. They are meant to close softly, but the test for this, by law, must be done with all windows shut.

2.47 Unfortunately, actual usage is frequently with windows open for prolonged periods, this causes fire doors to slam (information obtained by residents speaking to member of Council Env/ HMO team).

2.48 Again, this is the case regardless of whether an HMO is large or smaller. The effect of this may, actually, be greater in a small HMO, as one fire door slamming is often heard throughout the house next door. Often it is possible to follow the slamming of all the doors sequentially from the house next door, along with the running along the landing, down the stairs, into someone else's room etc.

2.49 Also the frequent young age demographic of occupants of many HMOs, the marked differences in times of daily routine to that of a family household, the unrelatedness, transiency and lack of a "head/heads " of household inevitably cause noise nuisance – not necessarily because of antisocial behaviour but because of the interaction with the nature of the buildings and the closeness of living. This is not less because a property is a smaller HMO.

2.50 In conclusion, there does not seem to be a justification for dealing with large and smaller HMOs differently within the Council evidence, with regard to noise insulation, and the actual local situation would seem to provide reasoning that there should be no such distinction.