Outlook

POP

From Concerned Residents Around Magee [redacted]
Date Wed 30/09/2026 09:59
To Local Development Plan <ldp@derrystrabane.com>

1 attachment (381 KB)
CRAM POP 300926.docx;

Good morning,
please see attached CRAM's response to the Preferred Option Paper.

Kind regards,

CRAM

4.3	Our Preferred option:
WHAT PERCENTAGE CAP? Option 1: 10% HMOs – (everywhere in the transition period to LPP and only outside of the HMO Management Areas thereafter) as is proposed in this PS-R: **PREFERRED OPTION**	**Option 1** -CRAM supports this option. However, as noted in 4.4, a 10% HMO cap should be a permanent limit.

- The 2017 Preferred Options Paper did not address HMO or propose a 30% HMO concentration threshold. Instead, the 30% figure emerged later during the Plan Strategy process, meaning residents were not afforded a meaningful opportunity at POP stage to comment upon or challenge a proposal that would allow up to one in every three properties within a street to become an HMO.

- 10% was the Council's original intended interim cap. The subsequent increase to 30% arose following representations from a limited number of consultees, including parties with a direct interest in HMO development. One consultee specifically warned that a lower cap would result in HMOs being dispersed into other residential areas. However, avoiding excessive concentrations and ensuring a more balanced distribution of HMOs is the very purpose of concentration control policies.

- DCSDC's consultation report does not show a large body of residents/stakeholders engaging with HOU 13. Residents in areas that would be particularly vulnerable to increasing numbers of HMO, were not informed by local representative's or MLA across the city and district, including those who were actively involved in the drafting of the LDP HMO policies.

- Council was subsequently persuaded to increase their intended HMO cap threefold by stakeholders with interests in increasing HMOs.

- Extensive research undertaken by the National HMO Lobby identifies 10% as the tipping point beyond which concentrations of HMOs can have significant

adverse impacts on settled residential communities. This threshold has been adopted or reflected in the policies of many local authorities across the UK and provides a robust evidence base for a 10% cap. https://www.hmolobby.org.uk/

- The justification for the 30% threshold relied heavily upon the EVB16b HMO study, which identified 485 HMOs across the Council area. However, more recent Department for Communities figures indicate that licensed HMOs increased from 188 in 2023/24 to 250 in 2025/26. Even allowing for a small number of unlicensed or newly approved HMOs, the current level of provision remains considerably below the figure relied upon in support of the 30% threshold. This calls into question both the accuracy of the original assumptions and the continued necessity of such a high cap when 10% would clearly allow HMO development in most areas. (https://www.derrystrabane.com/getmedia/d409ddaf-8d6c-4791-9bfd-3035363d961b/EVB-16b-HMO-Study.pdf)

- The assumptions regarding future HMO demand which underpin the case for higher concentration thresholds are questionable. As set out in Section 4.4, evidence relating to changes in international student numbers, the predominance of local students within Northern Ireland higher education, and the increasing provision of Purpose-Built Student Accommodation indicate that the need for a 30% concentration threshold has been overstated.

- The Council's own Sustainability Appraisal concludes that more restrictive HMO policies can improve resident wellbeing and community stability and that none of the options would give rise to significant adverse sustainability effects. Consequently, there is no compelling sustainability justification for retaining a 30% threshold where a 10% cap can achieve a better balance between meeting housing needs and protecting established communities.

- Imposing a city and district wide 30% interim cap, the same level of concentration proposed for HMOMA designation, risks allowing the very areas around Magee that are already vulnerable to HMO concentration to reach HMOMA-level densities before the boundaries of the HMOMA have even been determined. This leaves surrounding residential areas, which may ultimately fall outside the HMOMA, exposed to further significant HMO over development.

4.4 **WHAT GEOGRAPHICAL AREA(S) SHOULD THE PERCENTAGE CAP(S) APPLY IN?**	Our Preferred Option
Option 2: as per the existing adopted LDP PS, to identify HMO Management Areas in the LPP (where 30% HMOs would be allowed). See broadly-similar policy in Belfast* **: PREFERRED OPTION (**HMO MAs are considered to be necessary Planning tool, to enable the Council to identify	**Option 1.** to not designate any HMO Management Areas at all (in the LPP where 30% would be allowed),

specific locations where a higher % HMOs are acceptable, in order to achieve adequate numbers of HMOs to meet these housing needs, as well as the regional policy to achieve increased density without town-cramming – in central/accessible locations.)	therefore the 10% HMOs cap to apply everywhere in the City & District **Streets that are already above 10% will be exempt from further HMO.*

- Following the LDP consultation, the Council proceeded on the basis that HMOMAs would be designated and that they would permit HMO concentrations of up to 30%. The 30% figure emerged from a consultation in which those with a direct interest in HMO provision were among the principal participants, while residents were not represented.

- The introduction of Preferred Option 1 now provides an opportunity to consider a genuinely alternative approach, informed by residents' input, which would protect residential communities across the City and District from high concentrations of HMOs, which we are told is the Council's desire and intention of the LDP HMO policies.

- A 30% HMO cap is among the highest concentration thresholds used in the UK.

- A 10% HMO cap will easily accommodate the increase in UU Magee students and provide HMO for other residents. 10% is widely recognised as the tipping point beyond which the percentage of HMO can cause demonstrable harm to local communities. See 3.21 of PFR

- A 10% city/town wide HMO cap has been adopted by many university towns across the UK.

- The Council's own Sustainability Appraisal concludes that more restrictive HMO options can improve resident wellbeing and community stability, while the assessment found that none of the options would result in significant adverse sustainability effects. In these circumstances, there is no compelling sustainability justification for permitting concentrations as high as 30% where a lower 10% threshold can deliver community benefits whilst avoiding excessive concentrations of HMOs.

- Derry City and Strabane District Council must acknowledge that designated Houses in Multiple Occupation Management Areas (HMOMAs) continue to accommodate long-term settled residents residing in single-dwelling properties. These established residents are entitled to the same degree of statutory consideration and protection of residential amenity as those residing in areas subject to the standard 10% threshold. Permitting an intensified 30% concentration ceiling (representing 1 in 3 properties) unfairly and disproportionately burdens specific streets compared to adjacent streets

capped at 10% (1 in 10). A 30% cap unacceptably compromises the demographic balance, infrastructural sustainability, and residential character of these areas, running directly counter to the public interest and the preservation of long-term family households.

- The High-density HMO demand was originally projected based on an increase in student numbers based on the perceived number of international students requiring accommodation. Following the changes to visas, there has been a 17% fall in international students at UU.

- However, figures released in September 2026 by the Department for the Economy stated across all Higher Education settings in NI during the 2024/25 academic year: 71% of students at NI HEIs are from NI. (https://www.economy-ni.gov.uk/news/enrolments-uk-higher-education-institutions-northern-ireland-analysis-202425-and-qualifications-gained-uk-higher-education-institutions-northern-ireland-analysis-202425)

- Home students disproportionately live with parents, commute from surrounding areas, or already reside in permanent local housing, meaning they do not require new private HMO properties. The 30% figure therefore is a significant overestimate of HMO need and a reliance on the HMO model has failed to promote any other housing solutions for university expansion.

- Multiple PBSA planning approvals, applications and developer expressions of interest mean that the remaining non-local student demand can be managed by other forms of accommodation and 10% HMO, rather than absorbing a disproportionate percentage of residential family housing.

- Option 1 removes the requirement of the much-delayed LPP issues relating to producing boundaries for HMOMA in residential areas and removes an unduly complicated process for planning officers.

- The planning system exists to protect the public interest and the residential amenities of local communities, not to absorb the infrastructural burdens of expanding institutions which have been discussed for decades.

- The failure of licensing and planning to operate consistently in planning decisions has resulted in ambiguity and lack of clarity around enforcement and thresholds. **DCSDC Licencing department must also acknowledge 10% as 'overconcentration', refusing new HMO licences for HMO above the cap. If planning and licencing operate at different percentages, it will undermine the intention of HMO planning policies**.

4.5 SHOULD THE PS-R INCLUDE POLICY RESTRICTIONS ON CONCENTRATIONS / SANDWICHING?	Our Preferred option
Option 3: Apply a compromise policy, restricting sandwiching / two-adjoining but not extending to a radius: PREFERRED OPTION. (This will be more manageable, to implement by Planning officers and to be understood by all stakeholders, to achieve the policy objectives without being unduly complicated.)	**Option 2:** Apply a Bristol-type policy re sandwiching / two-adjoining and radius restrictions *Applying a 10% cap everywhere See also 4.7

- Sandwiching restrictions are needed to ensure that no single dwelling is trapped between two properties operating as transient residences. Sandwiching can disproportionately impact that specific occupant's "residential amenity" (due to issues like increased noise). Sandwiching will protect dwellings at a property-level impact that an area/street percentage cannot capture.

- At a PAC hearing for 11 Aberfoyle Terrace, the applicant's representative, a corporate town planner involved in promoting a 30% cap at the LDP consultation, highlighted the fact that both properties on either side of number 11 were both HMO. He stated, '*who wants to live between two HMO'*.

- Clustering restrictions are needed so 'blocks' are not created with parts of residential streets entirely transformed into an institutional student or transient zone fundamentally changing the residential character of the street/area. A 10% HMO allowance distributed evenly across an entire street is fundamentally different from a localized, 100% uninterrupted concentration of 10 properties in a single row.

- Terms such as 'nearby' and 'adjacent' are meaningless and need a clear means to calculate HMO pressure. 'Nearby' and 'adjacent' are not quantifiable and have been repeatedly questioned at PAC hearings by commissioners who rely heavily on precise definitions. If left to professional judgement, officers will come up against the professional judgement of applicant representatives and PAC commissioners, all of whom may take an entirely different view.

- HOU 13 should introduce a clear localized saturation cap with a 50m radius boundary for all HMO applications located within 50 metres of a junction, street ends, and ambiguous boundaries, or any application where there is ambiguity about HMO percentages. For example, at the PAC hearing from 11 Aberfoyle Terrace, the applicant argued that his property was in fact, part of 'Strand Road' and that properties on the other side of Strand Road should also be counted to determine the HMO percentage allowance. A 50m radius stress test must be introduced to remove the potential loopholes available when only the ambiguous 'professional judgement' is relied on.

- Evaluating an application solely on the street it is addressed to ignores severe cross-boundary impacts particularly in densely packed narrow streets typical in areas around Magee. The real-world impact on residential amenity caused by HMO clusters within a tight 50m radius must not be overlooked by rigid street-name calculations. The impact on residential amenity of HMO within a 50m radius must not be overlooked. For example, Grafton St has an HMO concentration of under 10% 'lawful' HMO (with an additional 3 unlawful HMO). On paper it appears that there is room for further development of HMO. However, Grafton Terrace, at the end of Grafton St has a 75% HMO concentration with each accommodating 5 residents equating to 20 occupants. Due to the high number of these residents owning cars, and the serious lack of available parking spaces on Grafton Terrace/Park Avenue, residents park their cars on Grafton St, which is already dealing with the cumulative impact of the approved and unlawful HMO. There is constant coming and going of Grafton Tc cars. There is frequent and sometimes unsettling excessive noise coming from Grafton Terrace. Grafton Tc bins are left at the bottom of Grafton St sometimes for days, and the pavement outside of the HMO are frequently littered with cigarette butts. Policy HOU13 should therefore recognise that HMO impacts can cross administrative and planning boundaries.

4.6 SHOULD THE PS-R AMEND/CLARIFY THE DEFINITIONS OF 'DWELLING UNITS' / 'HOUSES' (from the denominator part of the % calculation)?	Our Preferred option
Option 2: exclude flats/apartments/blocks of flats and short-term lets: PREFERRED OPTION (This is a manageable and logical option, to achieve a sensible balance of HMOs to conventional houses.)	**Option 3:** exclude flats/apartments ≤100m^2, short-term lets, NIHE/HA dwellings, etc. 1. Exclude NIHE/HA properties used as emergency/ temporary accommodation. 2. Exclude NIHE/HA properties not suitable for HMO conversion such as elderly /vulnerable accommodation. 3. Exclude ALL flats/apartments (including NIHE/HA) that are less than150m^2 4. Include all other NIHE/HA single dwelling properties

- If the core purpose of the Local Development Plan (LDP) HMO policies is to protect the established character of residential areas and prevent a disproportionate number of single-family dwellings from being converted into HMOs, then the mathematical denominator must strictly reflect conventional, settled housing.

- Including properties that either generate the exact same transient impacts as HMOs (such as short-term holiday lets) or properties that are physically and legally incapable of HMO conversion (such as restricted social housing) artificially inflates the dwelling denominator. This mathematical distortion falsely reduces the visible HMO percentage on paper, leaving the remaining stock of genuine family single dwellings highly vulnerable to further HMO conversions.

- Flats conversions and apartment blocks must be completely excluded from the denominator. Counting multiple flats within a single building footprint multiplies the dwelling count numbers artificially. This masks the true, physical concentration of shared or temporary housing on a street level.

- For example, if a single Victorian terrace house is converted into four self-contained flats, counting it as four distinct units in the denominator instantly dilutes the local HMO percentage. This creates an artificial mathematical allowance for further HMO approvals on that row, despite the physical footprint and infrastructure of the street remaining entirely unchanged.

- When calculating HMO concentrations, the suitable dwellings denominator should include ordinary Northern Ireland Housing Executive (NIHE) and Housing Association social housing, as these properties provide long-term, settled residential accommodation. However, the denominator must strictly exclude any properties actively functioning as emergency or temporary accommodation.

- NIHE's Northern Ireland Housing Market Review 2024/25 confirms that its temporary accommodation supply includes a broad range of accommodation, including dispersed NIHE and Housing Association stock, **HMOs and short-term hotel and B&B accommodation.** Temporary accommodation therefore represents a distinct, short-term and transitional housing function, rather than an additional unit of conventional settled housing. Discounting such properties could easily result in 10% HMO + many NIHE HMO/Emergency Accommodation/Temporary accommodations. The cumulative impact on residential amenity would be overwhelming, completely undermining the core objective of the LDP.

- Determining the exact function of NIHE or Housing Association properties will not impose a complex or time-consuming investigative burden on the local authority. The specific operational use of every property is already clearly recorded by the NIHE and relevant Housing Associations. This data is readily accessible and can be quickly verified by Council Planning Officers when performing standard HMO percentage calculations.

- Furthermore, flats suitable for HMO conversions must realistically be greater than 150m^2. Including smaller flats in the formula artificially inflates the dwelling denominator calculation with units that cannot even legally or physically be converted. This mathematical inflation directly results in a disproportionate number of larger, conventional family dwellings becoming vulnerable to HMO conversion.

4.7 SHOULD THE PS-R AMEND/CLARIFY THE DEFINITIONS OF 'STREET / AREA' (from the % HMOs calculation)?	Our Preferred Option
Option 2: include consideration of immediately adjacent or 'nearby' streets: PREFERRED OPTION (This is a manageable option that allows reasonable professional judgement to be applied by the Council, to achieve the policy objectives but to exclude anomaly situations.)	**Option 3**: consider a wider definition e.g. 100m, 200m or 300m radius, etc. For a long road / street, over 600m. Apply a 10% HMO cap across the whole city and district. Apply a 50 M radius test at end of streets/ junctions/ roads within which the HMO percentage must not exceed 10%. See also 4.5

- Apply a 10% HMO Cap across the whole city and district. This removes the need for officers to work with conflicting percentages (30% and 10%) when an HMO application is in close proximity to boundaries.

- The PS-R must address the boundary flaws in HOU13 now. This amendment window provides the opportunity to replace subjective interpretation with a clear, mathematically defined spatial limit that provides transparency and reduces the scope for disputes over boundaries.

- The PAC commissioners repeatedly questioned the ambiguity surrounding terms such as **‘nearby’** and the definition of **‘streets’ and ‘roads’**. Where the application of these terms depends upon professional judgement, the resulting calculation can itself become open to challenge, particularly where different parties may reasonably argue for different boundaries.

- A clearly defined 50m radius spatial test would apply an absolute mathematical boundary providing greater certainty for everyone. It provides transparency for the public, developers and community groups to be able to calculate the relevant HMO concentration in advance using standard mapping tools, rather than having to rely on an interpretation of where a street or road begins and ends, or what constitutes a ‘nearby’ area.

- A 50m radius can be completely automated using the council’s existing Geographic Information System, removing the requirement for case officers to conduct extensive, time-consuming site visits and manual map reviews for every single application to define what is 'nearby'.