Outlook

Preferred Options Paper & Associated Assessments for LDP 2032 Plan Strategy Revision (PS-R) - Policy HOU 13: HMO Management Areas

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Date Mon 21/09/2026 11:15
To Local Development Plan <ldp@derrystrabane.com>

Hi please find my submission to the Preferred options paper below

4.3 Percentage Cap

I support Option 1, a 10% cap during the transition period and a 10% cap outside any future HMO Management Areas.

The proposed 10% threshold represents a more balanced approach than the existing 30% limit and provides a clearer safeguard against excessive concentrations of HMOs whilst still allowing appropriate accommodation to come forward.

4.4 HMO Management Areas

My preferred option is Option 1, with no HMO Management Areas.

I believe the 10% threshold should apply consistently across the Council area. Existing concentrations should not automatically justify future concentrations and there should be no presumption that areas currently experiencing high levels of HMO development should accommodate even higher concentrations in the future.

If the Council decides to retain HMO Management Areas, they should be evidence-based, narrowly defined, subject to meaningful public consultation and reviewed periodically.

4.5 Concentration and Sandwiching

My preferred option is Option 2, the Bristol-style approach.

The proposed anti-sandwiching and adjoining-HMO controls are welcome; however, a street-based approach may fail to identify harmful concentrations occurring around junctions, across adjoining streets, between short terraces or where road names change despite properties being only metres apart.

For that reason I believe a radius-based cumulative impact assessment would provide greater protection and more accurately reflect the concentration experienced by residents.

4.6 Definition of Dwelling Units / Houses

I fully support Option 2.

Excluding flats, apartments, blocks of flats and short-term lets prevents concentration figures from being artificially diluted and allows a more realistic assessment of the proportion of traditional housing stock that has become HMO accommodation.

4.7 Definition of Street / Area

My preferred option is Option 3.

The proposed consideration of nearby streets is a positive step, but it remains unclear how that judgement will be applied in practice. A defined assessment area would provide greater certainty, consistency and transparency than reliance on professional judgement alone.

Whilst I generally support a number of the proposed revisions within the Preferred Options Paper, I believe some areas could be strengthened before the final policy is prepared.

In particular, I believe the final policy should focus not only on overall HMO numbers, but on the actual concentration experienced by residents and the long-term sustainability of established residential communities.

The Council's preferred approach already acknowledges that a 10% threshold is appropriate during the transition period. In my view, that same principle should continue into the long term. Any proposal to permit concentrations above 10% should require clear and robust evidence demonstrating why a higher concentration is necessary and why alternative accommodation solutions cannot meet demand.

If HMO Management Areas are retained, the Council should publish the evidence supporting each proposed area, clearly define boundaries, consult residents before designation and review each area periodically to ensure the justification remains valid.

The proposed anti-sandwiching controls are welcome but may not fully address cumulative impacts. A property may avoid being technically sandwiched whilst still experiencing multiple HMOs around corners, across adjoining streets or within a very short walking distance. This illustrates why concentration should be assessed across a wider area rather than solely by reference to individual streets.

Important terms should be defined within the policy itself rather than being left solely to supplementary guidance or interpretation. These should include:

- street;
- nearby street;
- dwelling;
- existing HMO;
- concentration;
- adjoining;
- sandwiching; and
- cumulative impact.

Clear definitions would improve transparency and consistency in decision-making.

The final policy should also clarify how concentrations will be calculated and ensure that all relevant HMOs are included. At a minimum, calculations should include:

- licensed HMOs;
- established HMOs;
- CLEUD-certified HMOs;
- approved HMOs;
- permissions granted but not yet implemented; and
- other lawful HMO uses recognised by Council records.

The Council should also clarify how multiple pending applications will be assessed where several HMO proposals are submitted within the same locality over a short period. Failure to account for approved but unimplemented HMOs, or multiple concurrent applications, could

result in concentrations increasing beyond intended limits before the true scale becomes apparent.

The purpose of the policy is to manage concentration rather than simply record overall numbers. Monitoring should therefore include:

- concentration by street;
- clustering patterns;
- sandwiching occurrences;
- concentrations around corners and junctions;
- approved but unimplemented permissions;
- loss of conventional family housing;
- parking impacts;
- waste-management impacts; and
- cumulative impacts over time.

Without this information, significant local concentrations could emerge whilst overall district-wide HMO figures continue to appear acceptable. Monitoring outcomes should be published regularly so that residents, applicants and decision-makers can understand how the policy is performing and whether further intervention is required.

The final policy should also contain a clear cumulative impact test allowing applications to be refused where there is evidence that an additional HMO would contribute to unacceptable harm. Potential impacts should include:

- residential character;
- community balance;
- local housing mix;
- residential amenity;
- parking capacity;
- waste management; and
- the sustainability of long-term residential communities.

A proposal may technically comply with a percentage limit whilst still creating an excessive concentration of HMOs in practice. Decisions should therefore consider cumulative impact rather than numerical compliance alone.

Overall, I support a number of the proposed revisions to Policy HOU 13 and believe they represent a significant improvement on the current position. However, I believe the final policy would be stronger if 10% became the long-term standard, if any future HMO Management Areas were subject to robust evidential requirements, if cumulative impacts were assessed on a radius basis, and if monitoring arrangements focused on actual concentrations rather than overall HMO totals alone.

Regards Emmet