Eastbourne Houses in Multiple Occupation (HMO) Study

Final Report

Eastbourne Borough Council

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Delivering a better world

Quality information

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Executive Summary

This research was commissioned by Eastbourne Borough Council (EBC) to understand the scale, role and impact of Houses in Multiple Occupation (HMOs) in the Borough. It may inform decisions about whether and what courses of action might be taken to mitigate the impacts identified.

This executive summary presents the conclusions of each section of the report, following its overall structure:

- **Section 1 – Introduction, Context and Literature Review** defines HMOs, reviews the available literature on their impacts, and considers EBC's existing policy context.
- **Section 2 – Eastbourne's HMO Stock** explores the current landscape in terms of the number and characteristics of HMO properties, their spatial distribution and trends over time.
- **Section 3 – Condition of HMOs** examines indicators of the physical condition of Eastbourne's HMOs and their surrounding environment, drawing primarily on evidence from a series of external inspections undertaken by AECOM.
- **Section 4 – Impacts** reviews evidence for the intangible impacts of HMOs on occupants, communities and the wider economy, drawing on a survey of local residents conducted by AECOM and other secondary data.
- **Section 5 – Market Dynamics** describes the role that HMOs play in the local housing market in terms of their occupant groups, affordability, size and tenure.
- **Section 6 – Options for Intervention** evaluates the evidence gathered in relation to the potential interventions open to EBC to control the quality and spread of HMOs.

A separate **Appendices** document presents a range of supporting data, tables and methodological information.

Section 1 – Introduction, Context and Literature Review

The common theme in all definitions of Houses in Multiple Occupation (HMOs) is the sharing of facilities by multiple unrelated individuals. However, there are different ways to identify HMOs and their sub-categories which have implications for the planning and licensing arrangements that can be used to set standards and control their spread.

The expansive statutory definition in the Housing Act 2004 provides three key sub-categories of HMO and determines which properties are subject to mandatory licensing. It distinguishes between licensable HMOs with more than 5 occupants, non-licensable HMOs with fewer than 5 residents, and Section 257 properties that take the form of blocks of self-contained flats.

The narrower planning system definition counts an HMO as any property occupied by 3 to 6 unrelated individuals sharing amenities. Such properties fall under their own use class (C4), distinct from that of standard residential dwellings (C3). Permitted development rights in England currently allow conversion from C3 to C4 without the need for planning permission, meaning that there are few controls on the supply of new HMOs through residential conversions. Larger HMOs (with more than 6 occupants) are classed as sui generis and conversions do require planning permission.

HMOs in all forms, and particularly in high concentrations, have a reputation for bringing detrimental impacts to residents, communities and housing markets – particularly in coastal towns like Eastbourne. The impacts most frequently cited in the literature and AECOM's review of precedents for intervention to manage HMOs (see Appendix 6.1) include tangible issues with upkeep, waste and parking, and intangible effects on anti-social behaviour and community cohesion.

As a consequence of these impacts, whether directly measured or perceived, HMOs are subject to various means of control by local planning authorities (beyond the default mandatory licensing of mid-sized properties required by law). The key potential courses of action include:

- Planning policy requirements for new or converted HMOs to provide additional amenities, demonstrate limited impact on existing amenities or avoid levels of geographical concentration.

- Article 4 Directions to remove permitted development rights from C3 to C4 conversions so that a larger number of potential HMOs are subject to planning policy requirements.

- Additional licensing for HMOs that are not already mandatorily licensed, coupled with prescribed standards needed to attain a licence. This can be expanded to selective licensing, which tends to cover the wider private rented sector.

- Landlord engagement and enforcement measures to incentivise high-quality management.

- Local authorities working with partners to use their own funds to purchase HMOs and convert them to affordable housing, including larger family sized homes for families in need or retention as bedsit accommodation.

- Linked to the above, intervention programmes which bring together different agencies to tackle impacts associated with HMOs, including the deprivation of some vulnerable HMO residents.

Eastbourne's existing Local Plan restricts HMO conversions in a defined tourist accommodation area, particularly from hospitality uses, but sets few broader requirements. The Local Plan is otherwise generally permissive of HMOs outside of this defined area, subject to amenity considerations. No relevant Article 4 Directions or additional licensing schemes are in force. Eastbourne therefore has an opportunity to intervene in ways that afford greater oversight over the conditions, number and concentration HMOs if desired. The remainder of this report seeks to understand the

evidence of the impacts HMOs may be having in Eastbourne and considers the options for action and their potential effectiveness.

Section 2 – Eastbourne's HMO Stock

There are serious limitations with any estimate of the total number of HMOs in Eastbourne, as in most Local Authority areas where licensing and planning controls have not been expanded (a step that tends to allow for more accurate monitoring). This section has reviewed the available data to draw some conclusions about the scale, distribution and trends in the various types of HMO in Eastbourne.

There are 318 licensed HMOs recorded on EBC's register. The register of licensed HMOs is a reasonably accurate snapshot of the number of HMOs with five or more unrelated occupants, although it is possible that the register undercounts properties granted a licence in the past year due to a reporting lag. It is also relevant to note that any HMOs illegally operating without a licence are not reflected in this figure.

The 2021 Census count of HMOs by local authority clearly undercounts properties for a variety of reasons and cannot be used to produce accurate totals. However, it does enable comparison between local authorities. Eastbourne has the 110th highest number of HMOs by this metric (of 318 local authorities), and the 86th highest percentage of all dwellings that are HMOs. This percentage – 0.6% – is nearly three times the median for English authorities of 0.2%. Eastbourne's number of licensed HMOs is the lowest of AECOM's review of precedents for intervention, although this sample by definition focuses on local authorities that have identified problems with the number or impacts of HMOs. It can be summarised that Eastbourne has a higher proportion of HMOs than most local authorities across the country, but lower totals than many of the authorities that have intervened in the market.

This study has reviewed broad trends over time in the number and characteristics of Eastbourne's licensed HMOs using a historic snapshot of the register and the age of current licences. However, regulatory changes in 2018 that expanded mandatory licensing to cover HMOs with fewer than three storeys has a large apparent impact on the change over time. Likewise, the requirement for licences to be renewed every five years makes it difficult to separate new licences from renewals.

Bearing these caveats in mind, the data suggests that the mean average number of new or renewed licences granted in the years 2016-2021 is 49. This includes only those properties with licences that remain active in 2022. There has been a decline in new licences issued in recent years, from a peak of 99 licences in 2018 to 42 in 2020 and 8 in 2021. However, this reflects a spike in 2018 driven by the regulatory change as well as a lag in reporting in the latest year. The overall total number of licences in 2022 (318) is significantly higher than the total in 2015 (188). However, this increase does not express only the creation or conversion of completely new HMO properties. Rather, the figures again reflect the additional properties required to have a licence by the regulatory change in 2018 and enforcement actions increasing the visibility of existing HMOs.

The key finding from a review of this temporal data is that the number of licensed HMOs in Eastbourne is broadly increasing over time. However, the actual rate of growth is likely to be significantly lower than the perception created by headline statistics, which conceal

a number of contextual factors leading to the greater visibility of HMOs which may have been operating for some time.

In terms of their characteristics, almost 60% of Eastbourne's licensed HMOs have five or six bedrooms, with the remaining 40% mostly split between properties with 7-19 bedrooms. Though data is not available for unlicensed properties, it is likely that most of the smaller HMOs (i.e. those below the size threshold for licensing) have between 3 and 4 bedrooms, and that the Section 257 properties have more than 10 bedrooms.

In terms of their spatial distribution, Eastbourne's licensed HMOs are heavily concentrated in the town centre. Nearly three-quarters of them are located in Devonshire Ward, 11% are in Meads Ward, 9% are in Upperton Ward, and no other ward is home to more than 4%. The proportion of the overall housing stock in each ward that are licensed HMOs remains small at 3% in Devonshire Ward, and around 0.5% in Meads and Upperton Wards.

The data on unlicensed HMOs is severely limited because they tend not to be centrally recorded for planning or licensing purposes. An indicative sample of smaller unlicensed HMOs (falling below the size threshold above which a licence is required) has been generated using a range of indicators detailed in Appendix 2.1. This process indicates that there are potentially many such properties across the town. Only a lower-bound sample of 72 properties that could be identified with a reasonable degree of confidence have been mapped. Their distribution is broadly similar to that of licensed HMOs. No information on their detailed characteristics (e.g. number of bedrooms) is available.

The methods available for identifying larger Section 257 and Schedule 14 properties are even more limited. No attempt to quantify these have been made, but an indicative sample of 10 probable Section 257 properties has been identifed through the local knowledge of EBC officers. This demonstrates the existance of such properties and, given the wide availability of former hotel and guesthouse accommodation in Eastbourne, suggests that many more are likely to be present in the town. They may exert similar impacts to other HMO categories, particularly with regard to their external condition and effects on the streetscape, but the degree of behavioural impacts is likely to vary depending on the physical and management arrangements in place.

Though the count of HMOs given in the 2021 Census is not sufficiently reliable for understanding overall numbers, it does enable a reasonable comparison of the rate of HMO provision across local authorities. Eastbourne has the 86th highest proportion of properties that are HMOs by this measure, of 318 authorities across the country. Its percentage of 0.6% is nearly three-times the national median of 0.2%.

Finally, EBC data on planning applications for residential to 'sui generis' conversion (the only form of HMO conversion currently requiring planning permission) suggests that an average of 13 such HMOs have recieved permission in each of the last ten years. Though the data appears to show a significant uptick in the most recent four years, EBC officers note that this is likely to be a function of enforcement action requiring HMO licence holders without appropriate planning permission to apply retrospectively. As such, some of this growth again reflects the increased visbility of existing properties. Nevertheless, the new permissions among this small sub-set of HMOs indicates that their numbers may be rising overall, and the EBC Development Management team have

also observed a growing trend of conversions from small terraced dwellings and tourist guest houses to HMOs.

Section 3 – Condition of HMOs

Fieldwork conducted by AECOM in Spring 2023 to assess the external condition of a representative sample of Eastbourne HMOs produced the following key findings. The sample was limited in size and represents a single snapshot in time, so the results may not be representative of all HMOs or of the condition of the HMOs assessed over the log-term. Indeed, anecdotal evidence from EBC officers suggest that problems are more widespread than indicated by this element of the research.

- **Condition & Management:** the most common issues related to the condition of property roofs, external walls and boundary walls/fencing. More properties within the HMO sample were rated as showing deterioration and requiring repair in these areas than being in good condition. Although such issues are widespread, the specific problems identified are relatively minor. They include missing roof tiles, spalling (weathering) and hairline cracks. On the more serious topic of structural damage, less than a third of properties required light repair and none required more serious attention. Perhaps surprisingly, and which possibly indicative of attentive management, the sample received positive ratings for issues related to bins in or clearly associated with a given property boundary, post/mail facilities and garden maintenance.

- **Safety & Security:** the majority of HMOs inspected received a positive rating across all of the categories considered. The concerns raised were concentrated in the topic of safety issues, with 10 properties identified as requiring attention – mostly related to loose wires and exposed gas mains. There were very few security issues highlighted; the two that were identified related to broken or open entryways that are considered significant impacts on occupant safety.

- **Surrounding Environment:** this category sought to assess the knock-on impacts of HMOs on their immediate surroundings, although most of the evidence gathered would be circumstantial (i.e. it is not clear that the HMOs directly cause issues of local character such as vandalism). The majority of HMOs received positive ratings on the various sub-topics. Only waste issues presented more than five non-positive ratings. These cases involved a lack of bins or of waste resembling fly tipping in the back garden.

To summarise the inspections findings, it is observed that Eastbourne's HMOs are for the most part free of issues relating to their security and environment. The inspection for the condition of HMOs did reveal wider concerns related to the state of roofs, external walls, and boundary walls in over half of the properties surveyed. However, these concerns were noted to need repair, rather than replacement. This might imply similar issues of condition internally (as AECOM's inspections were external only) but this cannot be confirmed in this study.

Issues of higher concern were identified in the inspection for only a small number of properties. The specific issues were broken entryways, significant waste in the garden, and matters requiring structural repair.

Overall, the story of the inspections data is one of a small number of problem properties rather than of widespread issues; although Eastbourne's HMO stock could generally benefit from some form of maintenance to improve the condition of the properties. It can also be concluded that most of the more significant physical and visible issues are of greater concern to HMO occupants than to the wider streetscape and community. The potential impacts affecting the latter may be more a function of the activities of occupants than of the physical presence of HMO buildings and their condition. This will be tested in Section 4.

EPC data suggests that HMOs are generally less efficient than the non-HMO housing stock, but this is predominantly because fewer HMOs excel in their energy performance than other homes in the mainstream stock. HMOs are no more likely to have an extremely poor energy rating than the wider stock. This relationship holds true when comparing specific categories such as window and lighting quality and efficiency.

Section 4 – Impacts

Intangible Impacts

A survey of Eastbourne residents was carried out in Spring 2023 to capture the intangible impacts of HMOs on occupants, their neighbours and the wider community. 426 interviews were conducted, split across a core sample of residents in areas of high HMO concentration and a control sample of residents in areas of low concentration (but that were otherwise similar on key metrics). Some datapoints have a sufficiently robust sample to isolate the responses of those actually living in HMOs, although those conclusions should be treated with more caution. The key findings of the survey are as follows:

- Generally, survey respondents are satisfied with their neighbourhoods. Across all samples the most common satisfaction score out of 10 was 9 and the mean average ranged from 7.5 (among occupants of HMOs) to 8 (among the control sample with few HMOs in the area). However, a modest proportion of respondents gave low scores: at least 13% gave 3 or below across all samples. 44% of HMO residents gave scores below 7 compared with 36% for the control group. The median satisfaction rate was 8 for the core sample, 8 for HMO occupants, and 9 for the control sample.

- Residents of areas with high concentrations of HMOs are less likely to feel very safe in the daytime than in control areas, but no more likely to feel unsafe. However, the feeling of safety is lower at night across all groups. This is particularly true among HMO occupants – only 35% of whom feel safe or very safe at night, compared to 49% in the core sample and 54% in the control sample.

- The biggest differences between the core and control samples were found in relation to antisocial behaviour. 54% of respondents in the core sample reported that drunk or disorderly behaviour was a problem in the neighbourhood, compared with only 27% in the control area. The respective figures for issues with drugs were 47% and

27%, and this issue featured strongly in respondents' additional comments. For groups loitering on the streets they were 40% and 24%. However, issues with troublesome neighbours were of concern to few respondents in either sample.

- There was reported to be only a slightly stronger general sense of community and sense of mutual helpfulness in the control than the core areas. However, a greater distinction was found when respondents were asked whether they would expect a lost item to be returned: only 39% of core sample residents expected a returned item, compared to 50% in the control group.

- Perhaps surprisingly, given that parking was by far the most common issue raised during the part of the survey inviting further specific comments (a number of those qualitative responses linked parking to HMOs), there was little statistically significant difference in the proportion of people viewing parking as a problem between the core and control areas. That said, a majority of respondents in both samples saw this as an issue.

- Similarly, littering and cleanliness are widespread issues but do not vary significantly between areas with more or fewer HMOs. Issues with vandalism and graffiti are less widespread and again not a greater concern where there are higher concentrations of HMOs.

- 8% of respondents who opted to provide additional comments at the end of the survey raised HMOs explicitly (almost all in the core sample area). These comments mentioned the fast growth in the number of HMOs, overcrowding and parking issues, and linked HMOs to broader social issues including drugs and alcohol.

In summary, the survey found a slight negative correlation between the concentration of HMOs and residents' satisfaction with their neighbourhood as well as the general sense of community. Some of the most common reasons for dissatisfaction, such as parking, appear to be widespread but not worse in areas with many HMOs. The strongest contrasts between the core and control sample were found in relation to the behaviour of people in the neighbourhood, particularly around alcohol, drugs, loitering groups, and safety at night. This correlation does not necessarily imply causation, but the perception among those who opted to provide further comment is that HMOs are linked to various social issues. It is also interesting to note that residents of HMOs themselves often provided the most negative responses, suggesting that the impacts of their living conditions are felt most strongly by occupants themselves.

Index of Multiple Deprivation (IMD) data shows that most of Eastbourne's HMOs are located in the Borough's more deprived areas overall. Rather than HMOs causing deprivation or vice versa (although occupants do tend to have lower incomes), there may be a third factor that drives both deprivation and the presence of HMOs, such as the lower attractiveness of an area for residential use or the higher rates of crime common in town centres. Indeed, in a pattern familiar across the country, the correlation is equally strong for the indicators of crime and the quality of the living environment.

The Hotel Market

The hotel market in Eastbourne is relevant to this study because tourist accommodation can be relatively easily converted into HMOs because most of the space is already in

the form of self-contained bedrooms. There is little data about the actual number of hotels that have been converted to HMOs, although it is clear from AECOM's inspections that a number of the properties visited (particularly potential Section 257 properties) are former hotels. This trend is established in Eastbourne to the extent that the Local Plan explicitly protects hotels from conversion to HMOs within a defined tourist accommodation area (TAA). Yet this remains a risk for the wider town.

Conversations with local stakeholders emphasise the growing incentive to convert hotels and guesthouses to HMOs during the current volatile market, as well as the implications on the tourist and wider economy if too much hotel accommodation is lost. In addition, local businesses have reported that the social impacts associated with HMOs (such as those reviewed above) have a deterrent effect on hotel guests that can lead to low occupancy and further potential HMO conversions.

The Eastbourne Tourist Accommodation Retention SPD notes that HMOs are a '…significant threat to the attractiveness of the seafront. The presence of HMOs in the prime tourist areas does not portray a positive image of the destination, and could adversely impact the visitor experience'. For these reasons, Eastbourne has a designated TAA along the seafront, which protects this area from the perceived negative impacts of HMOs by limiting their existence. HMOs and hotels occupy broadly the same region of the town centre near to the coastline but, due to the TAA, rarely exactly the same roads.

Although the increase in HMO numbers and gradual loss of hotels are both clearly established in the data, a causal connection is difficult to establish given the impact on hotel revenues of the COVID-19 pandemic, energy costs and wider cost-of-living pressures. The hotel market has broadly recovered to pre-pandemic occupancy rates but at the cost of a modest decline in operational properties – particularly since 2019. A small number of properties no longer functioning normally as tourist accommodation now house asylum seekers in the form of hostels, which may have similar implications for the wider community as HMOs housing vulnerable people. This particular trend may also increase demand for HMO accommodation from such groups in the near term due recent enforcement notices affirming that hotels used for this reason fall into a different planning use class, combined with a national regulatory change exempting HMOs from licensing requirements for a temporary period if used to house refugees and asylum seekers (intended to reduce reliance on hotels).

CoStar data suggests that declining revenues in economy and midscale hotels makes them more vulnerable for conversion to HMOs or asylum seeker accommodation, but this may in fact be a greater risk for Eastbourne's many guesthouses and B&Bs, which may change use more gradually and are harder to identify.

Section 5 – Market Dynamics

This section describes how HMOs currently function in Eastbourne and reflects on the trajectory of supply and demand going forward.

HMOs play a valuable and distinctive role in the Eastbourne housing market (and the wider multi-authority housing market area) by providing the smallest and lowest cost accommodation available. This attracts various occupant groups, from students and

professional house sharers to low-income workers, single people relying on housing benefits and individuals placed in emergency temporary accommodation. However, when HMOs are created through the conversion of Eastbourne's relatively scarce and much-needed family housing, these market segments are served (and sometimes not optimally served) at the expense of other groups.

Demand for HMO accommodation in Eastbourne also depends on market conditions and trends that could interact in unpredictable ways in future years. These include:

- Demand trends in the wider private rented sector (PRS), including the availability and costs of self-contained accommodation.
- The future delivery and availability of affordable rented housing.
- Changing employment and immigration levels affected by the cost-of-living crisis, wider economic trends (notably interest rates) and evolving Government policy (such as the Renters (Reform) Bill).
- The expected decline in student numbers associated with the closure of the University of Brighton campus.
- Homelessness prevention initiatives in Eastbourne and neighbouring authorities.
- The recovery of tourism following the Covid-19 pandemic, impacting hospitality employment as well as the viability of guesthouses that could be converted to HMOs.

Size

HMOs are usually large houses but tend to function in the same way as the smallest dwellings in the market by catering for single people and small households. Whether this is a beneficial and efficient use of such properties depends on the availability and need for homes at both ends of the size spectrum.

Eastbourne is notable for its high overall proportion of 1-2 bedroom and flatted dwellings compared to the County and national averages. This feature of the housing stock has been exaggerated by recent development (81% of new homes built in the last decade have 1-2 bedrooms) and is likely to persist due to the limited availability of land. This imbalanced housing mix is not inherently problematic: the Eastbourne Core Strategy broadly supports residential densification in appropriate locations, and the Local Housing Needs Assessment (LHNA) emphasises that the Borough operates within a wider housing market area where a wider range of options, including large family homes, exists.

Yet the LHNA also finds that demand pressure in Eastbourne is highest for mid-sized and larger family housing, and that the future need for the smallest dwellings is limited. The availability of residential land in the Borough is a clear practical limitation to building larger homes in future. In this context, halting the conversion of existing houses to HMOs (which simultaneously add to the 1 bedroom equivalent stock and deplete the 3+ bedroom stock) would help to mitigate Eastbourne's worsening dwelling size imbalance. Because the conversion of residential homes to HMOs currently does not require planning permission, it is difficult to establish the precise rate at which this is taking place and therefore the scale of the impact exerted by HMOs.

The dominance of small dwelling units is particularly apparent in the town centre wards, where population densities are rising and 25-33% of homes have 1 bedroom. That these are also the wards with the highest HMO concentrations suggests that a proportion of the few 4+ bedroom properties in those areas are in practice functioning as even more small units. (Note that many of the town centre HMOs, especially in Devonshire, are converted from hotels and guesthouses rather than residential homes.) Although diversity in the housing stock does not need to be achieved at the scale of wards, and it is natural for a town centre to have dense housing and a high transient population, there may be benefits to improving housing choice, promoting balanced communities and avoiding HMO concentrations in the town centre specifically.

Household composition

The Census considers an HMO to be occupied by a single 'other' household (i.e. neither of the two main alternatives of single individuals and family groups). As of 2021, 1,061 or 2.3% of all Eastbourne households both fall into this category and rent from a private landlord. Although these households do not necessarily occupy HMOs, the three wards that exceed the Borough average on this metric are those with the highest HMO concentrations: Devonshire (5.6%), Meads (3.0%) and Upperton (2.6%). The number of such households across Eastbourne overall rose by 91% between 2001 and 2011 but fell back by 24% between 2011 and 2021. The recent decline is explained in part by the timing of the Census during the Covid-19 pandemic, particularly its impact on students – the number of whom followed a similar trajectory.

The type of households that HMOs tend to accommodate can be broken down into several broad market segments, each with their own indicators of future demand, described below.

The overall direction of travel suggested by this high-level analysis is toward increasing demand for HMO accommodation, driven primarily by economic factors, limitations in the supply of affordable housing and policy changes around homeless people and asylum seekers. This is counterbalanced to some extent by an expected drop in demand from students. It should be noted that this combination of trends will have a significant impact on the mix of people occupying HMOs in addition to overall levels of demand: generally speaking, students are likely to be replaced by vulnerable people and key workers on low incomes. This is likely to have a knock-on impact on the kinds of effects the concentration of HMOs in Eastbourne exerts on the wider community.

- **Students**, cohabiting for social or financial reasons. Future demand from this household type is expected to strongly reduce following the imminent closure of the University of Brighton Eastbourne campus, potentially equating to vacancies in 20% of Eastbourne's HMOs.
- **Young professionals**, cohabiting for social or financial reasons. Demand for this household type is expected to remain robust in the near-term due to low unemployment, high inflation (living costs) and high housing costs.
- **Low-income workers**, sharing for financial reasons and access to employment. As with young professionals, low-income demand for HMOs from low-income workers is likely to remain high, driven by cost-of-living concerns coupled with robust employment in high-demand sectors such as care.

- **Benefit-funded individuals**, limited in their housing choices by Local Housing Allowance rates (which limit certain groups to shared accommodation only). HMO occupation by benefit-funded households is likely to remain common and possibly to increase given the persistent backlog on the affordable housing waiting list and the projected newly arising need over the Local Plan period, alongside wider cost-of-living pressures.
- **Those experiencing relationship breakdown**, requiring transitional and low-cost accommodation when they cease to cohabit with partners or families. This segment may grow in response to broader economic challenges and trends in family structures.
- **Vulnerable people**, placed in HMOs by local authorities and other organisations as a temporary measure. The number of such placements has stabilised at a modest proportion of the HMO stock following a temporary spike during the Covid-19 pandemic. It is expected to remain at current levels or to rise slightly due to the present economic climate and as refugees from Ukraine begin to require follow-on accommodation from host families.
- **Refugees and asylum seekers**, currently predominantly housed by host families or in hotels and hostels. This is likely to be a key near-term driver of demand for HMO accommodation due to temporary national regulatory changes that incentivise HMO and other landlords to house asylum seekers through the relaxation of licensing requirements.

Tenure

HMO accommodation is by definition part of the PRS, tending to offer lower rental costs as well as shorter minimum tenancies than self-contained rented accommodation. The PRS has expanded significantly in Eastbourne in recent years, nearly doubling from 16% to 27% of the housing market overall between the 2001 and 2021 Censuses. Rising rates of renting are driven by demand linked to affordability as well as supply from an expanding buy-to-let sector and HMO conversions. The highest rates of renting are found in the town centre wards where HMOs are most common: Devonshire (47% private renting), Meads and Upperton (both 37%). As noted above, however, HMOs represent a relatively small proportion of the PRS.

The Census classifies all HMO occupants as private renters, many of whom cover their rent payments through housing benefits or Universal Credit. 44% of Eastbourne households receiving some form of housing benefit (and over 50% in the town centre wards) live in the PRS rather than affordable or social rented housing. In addition, a majority of all benefit-funded households in the Borough (and up to 83% in Meads ward) are only eligible for a 1 bedroom property. As part of the PRS, HMOs therefore provide the additional function of accommodating single-person households who cannot afford to rent on the market without support, or who are on the waiting list for affordable rented housing. The Eastbourne waiting list stood at 1,118 households in 2021, of which 471 applicants are eligible for a 1 bedroom property. This suggests a large volume of households on the waiting list are using HMO accommodation in lieu of being allocated affordable rented housing.

The provision of additional affordable rented housing, which offers the occupant a lower-cost and more secure form of tenancy, could therefore theoretically reduce the demand

for HMOs. However, the opportunities for new supply in Eastbourne are limited. The LHNA estimates the need for an additional 169 social/affordable rented units per year to meet the existing backlog and meet newly arising needs. In this context, HMO accommodation usefully, if imperfectly, addresses some of Eastbourne's unmet need for 1 bedroom affordable rented housing.

Affordability

Rooms in HMOs generally offer the lowest-cost non-subsidised housing option in the market. ONS statistics suggest that Eastbourne's median monthly room rate of £500 is 31% cheaper than the median 1 bedroom rent (£725). Monthly prices for a room in a HMO tend to range from £400 to £600. A closer analysis of current rental listings reveals two fairly distinct segments of the HMO market: purpose-designed, refurbished and usually smaller HMOs, sometimes marketed as co-housing for professionals; and more traditional shared housing, often with a larger number of rooms in the property and sometimes in poorer in condition.

Although HMOs are cheaper than other options, the current median room rent in Eastbourne is higher than that of East Sussex, the South East and England, and has risen by a third in the last four years – a fact corroborated by local agents. This is a significantly higher rate of increase than was experienced for the PRS in Eastbourne overall in the same period, and reflects the ability of local market demand to absorb the increasing stock of HMOs in recent years. Eastbourne's affordability context is similarly challenging across other tenures, as established in the LHNA, with 53% price growth in lower quartile market housing to purchase in the decade to 2021.

For the current median priced HMO room in Eastbourne, an occupant will need an annual income of around £20,000 to afford the annual rent of £6,000. A minimum income of £16,000 is needed to afford a room at the lower end of the market, and an income above £24,000 would provide access to higher-value options. The range of incomes required overlaps with affordable rented housing at the low end and self-contained rental accommodation at the high end.

HMOs in Eastbourne primarily serve households with incomes of between £17,500 and £22,000 per year, which is around 4,480 households or 9% of the total. In theory, households with lower incomes will need affordable rented housing and those with higher incomes can afford self-contained rented accommodation. However, in practice the potential market is much larger, including anyone with an income below £22,000 but unable or waiting to access affordable rented housing, and some people/households with incomes above that level who nevertheless seek out HMOs by choice for financial, social or other reasons. The potential market for HMOs is approximately 10,540 households or 22% of the total. This represents all households with incomes below £22,000 minus the number of households living in affordable rented housing. It therefore is an upper bound estimate that includes larger households for whom single rooms are not appropriate and older households with low incomes but who own their homes and have more limited outgoings. It is important to remember that income alone does not determine the scale of need for HMOs.

There is a particularly large degree of overlap between those eligible for affordable rented housing and those using housing benefits to live in the PRS. Housing benefits and Universal Credit cover around £325 per month for households eligible for a room in

a shared house, leaving a minimum £75 per month shortfall (on the cheapest available rooms) to be topped up through income or other benefits arrangements. This finding corroborates the DWP statistic that local housing allowance (LHA) rates do not cover the rent of 56% of those on Universal Credit in Eastbourne. For unemployed households, even those receiving the maximum LHA allowance, HMO accommodation may still present significant affordability challenges, resulting in limited funds for other essentials such as food and transport costs.

Finally, it is worth noting from property market listings that there appears to be fairly high turnover of existing HMOs listed for re-sale as well as a modest pipeline of potential future HMOs advertised as such. Offers are in place for the vast majority of current listings, indicating robust appetite from potential purchasers, based on the potentially attractive gross rate of return of more than 8.5% of the purchase price.

Market dynamics – key points

- Rooms in Eastbourne HMOs cost between £400 and £600 per month, which is significantly cheaper than self-contained alternatives, but higher than the regional and national average. Between 10% and 25% of Eastbourne households potentially benefit from the availability of relatively more affordable HMO accommodation. This includes single people aged under 35, for whom housing benefits extend only to shared housing.
- The median room rent has risen by a third in the past four years, making this option slightly less affordable over time because demand has remained higher than supply. This reflects the market's ability to absorb additional HMO conversions – a point echoed by local agents.
- By offering a flexible and low-cost option in the private rented sector (PRS), HMOs accommodate a range of self-funding household types, but are also able to serve unmet demand for affordable rented housing and those requiring temporary accommodation placements.
- Students potentially occupy 80-220 HMOs in Eastbourne (with the remainder living in student halls, family homes and self-contained rental accommodation). The imminent closure of the University of Brighton Eastbourne campus could reduce this figure by 80, or 20% of the total.
- Demand from low income working people is likely to remain robust due to low unemployment, high inflation and the health of key market segments such as care workers.
- In the context of limited affordable rented accommodation and rising numbers of benefit recipients, demand from single people reliant on benefits is expected to remain stable or gradually increase. However, it is noteworthy that the maximum housing benefit level that can be claimed for a room in a shared house in Eastbourne is substantially below actual rental costs. Households reliant on benefits therefore need to find additional funds to cover their rent.
- Temporary accommodation placements into HMOs are rarer than widely perceived – the perception may be due to the visibility of associated impacts. This demand stream has stabilised following the pandemic at the equivalent of around 18-25 HMOs (though their occupants may be spread across more properties, mixing with

other occupant groups in practice). However, it may rise again due to nationwide drivers of housing vulnerability and local homelessness prevention initiatives.

- HMOs effectively add to the 1 bedroom equivalent stock that is already plentiful in Eastbourne and, if converted from other residential uses, do so at the expense of the Borough's more limited larger family housing. It is not possible to gauge the extent of this trend because conversions take place without planning permission under permitted development rights.
- The town centre wards of Devonshire, Meads and Upperton, where HMOs are concentrated, exhibit many of the dwelling stock and demographic characteristics associated with this type of housing in heightened ways. These include Eastbourne's bias toward smaller homes, increasing rates of private renting and high levels of benefit recipients in the mainstream housing market.
- There appears to be relatively high turnover in the ownership of HMOs and a modest pipeline of planned conversions, with robust appetite from purchasers attracted by high investment yields.

Section 6 – Options for Intervention

Clear and recent precedents exist for a range of interventions to mitigate the spread and impacts of HMOs. Combinations of planning policy requirements, Article 4 Directions and additional licensing regimes are common responses to similar issues and objectives to those present in Eastbourne. Key ingredients that could be impactful have been identified, including concentration thresholds, space standards and additional measures beyond planning and licensing.

The supporting evidence cited by other local authorities varies in scope and content, and does not suggest a particular minimum standard of evidence needs to be met (with the exception of Selective Licensing that applies to all private rented sector properties). It is considered that the evidence gathered in this report provides sufficient justification for intervention in a form to be determined by EBC, subject to the resources the Council has available, any consultation requirements and further strategic considerations.

When each of the key potential impacts of HMOs are tested against the evidence present in Eastbourne, it is apparent that a small number of issues are directly caused by current concentrations of HMOs and are capable of being addressed through interventions to manage them and/or limit their number or concentration.

The primary arguments for intervention are to stem the loss of family housing and hotel accommodation in certain locations (though planning controls) and to reduce the impact on occupants and communities from behavioural issues (through licensing and enforcement). Furthermore, there are numerous additional impacts that are exacerbated (rather than generated) by HMOs, exerted indirectly or in combination, or are harder to conclusively evidence. These add up to a clear, cumulative picture of the issues associated with HMOs that could warrant intervention.

There is, however, also clear evidence of the valuable role that HMOs provide in the housing market by providing low-cost accommodation that people on lower incomes, key workers, and vulnerable groups rely on. Though alternative forms of housing could

also meet their needs, in Eastbourne's present context there could be significant adverse consequences from overly restricting the current provision or future supply of HMOs. Interventions that mitigate impacts and improve standards for residents rather than aiming primarily to control HMO numbers may be more prudent.

The justification for intervention in Eastbourne appears to meet the standard of relevant precedents, so the decision whether to implement additional policy provisions, an Article 4 Direction and/or additional licensing is a matter for the Council to weigh in the context of their resourcing and other implications, with consideration to the value provided by HMOs.

In addition, a range of supplementary or alternative actions are proposed as ways to target specific issues that are not exclusive to HMOs, although the appropriate combination of actions again depends on their trade-offs and EBC's wider objectives. Producing and implementing strategies that address the reasons people rely on HMO accommodation in the first place, such as the delivery of affordable rented housing and support for vulnerable people, could bring benefits that apply beyond the mitigation of the specific impacts considered in this research.

Data limitations and monitoring opportunities

It should be noted that there are serious limitations with counting HMOs in Eastbourne's current landscape, and with the types of subjective primary research that form the core of parts of this analysis. The table in this section summarises some of the key limitations identified in the course of this research and identifies potential opportunities for further data gathering and/or closer monitoring going forward. These include making the most of the greater oversight brought by additional licensing if this option is pursued, potential ways to keep track of HMO numbers over time, and additional sources that could expand upon this study's findings in relation to the impacts of HMOs on local people and occupants themselves.

1. Introduction, Context & Literature Review

1.1 Introduction

1.1.1 This report was commissioned by Eastbourne Borough Council (EBC) to understand the scale, role and impact of Houses in Multiple Occupation (HMOs) in the Borough. Its purpose is to inform decisions about whether and what courses of action might be taken to mitigate the impacts identified.

1.1.2 This section:

- Defines what is meant by HMOs
- Reviews the available literature on HMOs and their impacts, and
- Considers EBC's existing policies in relation to HMOs

1.1.3 The rest of this report is structured as follows:

1.1.4 **Section 2 – Eastbourne's HMO Stock** explores the current landscape in terms of the number and characteristics of HMO properties, their spatial distribution and trends over time.

1.1.5 **Section 3 – Condition of HMOs** examines indicators of the physical condition of Eastbourne's HMOs and their surrounding environment, drawing primarily on evidence from a series of external inspections undertaken by AECOM.

1.1.6 **Section 4 – Impacts** reviews evidence for the intangible impacts of HMOs on occupants, communities and the wider economy, drawing on a survey of local residents conducted by AECOM and other secondary data.

1.1.7 **Section 5 – Market Dynamics** describes the role that HMOs play in the local housing market in terms of their occupant groups, affordability, size and tenure.

1.1.8 **Section 6 – Options for Intervention** evaluates the evidence gathered in relation to the potential interventions open to EBC to control the quality and spread of HMOs.

1.1.9 A separate **Appendices** document presents a range of supporting data, tables and methodological information.

1.2 Defining HMOs

1.2.1 Houses in Multiple Occupation (HMOs) are properties occupied by multiple unrelated individuals who share living space or amenities.

1.2.2 Exactly how many individuals, which amenities and what other characteristics constitute an HMO differs depending on the definition used. There is significant

overlap but also slight variance between the statutory definition and that used in the planning system. The former determines which properties are subject to mandatory licensing and the latter determines what use class buildings fall under.

1.2.3 Because more expansive licensing and greater scrutiny of applications to change use class are the key potential ways of managing the proliferation of HMOs, it is worth considering these definitions in depth.

Statutory definition

1.2.4 The Housing Act 2004 sets out the current statutory definition of HMOs, which adds specificity to the description given in the Housing Act 1985 and expanded in 1989.[1] Section 254 of the Housing Act 2004 uses several tests to determine if a building is a HMO, including:

a) The standard test;

b) The self-contained flat test;

c) The converted building test;

d) Whether there is an HMO declaration in force (Section 255); and

e) Whether the property is a converted block of flats (Section 257).

1.2.5 The “standard test” defines a HMO as:

a) Consisting of 1 or more units of living accommodation not consisting of a self-contained flat[2] or flats;

b) Occupied by persons who do not form a single household;[3]

c) Occupied by those persons as their only or main residence;

d) The persons’ occupation of the living accommodation constitutes the only use of that accommodation;

e) Rents are payable or other consideration is to be provided in respect of at least one of those persons’ occupation of the living accommodation; and

[1] National HMO Network

[2] A self-contained flat is defined as a separate set of premises which forms part of a building, either the whole or material part of which lies above or below some other part of the building, and in which all 3 basic amenities are available for the exclusive use of its occupants.

[3] Persons are to be regarded as not forming a single household unless they are all members of the same family (with persons a member of the same family if they are married (or live together as if married), one person is a relative (parent/grandparent/child/grandchild/brother/sister/uncle/aunt/nephew/niece/cousin) of the other, or one of them is a relative of one person in the couple).

f) Two or more of the households who occupy the living accommodation share one or more basic amenities[4] or the living accommodation is lacking in one or more basic amenities.

1.2.6 The "self-contained flat test" captures HMOs that meet criteria b) to f) listed above, but that do consist of self-contained flats. The "converted building test" includes buildings where living accommodation has been created since the time it was initially constructed.

1.2.7 A key type of HMO, particularly relevant in Eastbourne, is that formed from the conversion of a block of flats, outlined in Section 257 of the Housing Act 2004. In order to be considered a HMO these self-contained flats must meet 2 criteria:

a) Building work undertaken in connection with the conversion did not comply with the appropriate building standards[5] and still does not comply; and

b) Less than two thirds of the self-contained flats are owner occupied.[6]

1.2.8 These Section 257 HMOs are not subject to mandatory licensing but are subject to management regulations, and individual flats within them can also be considered HMOs.

1.2.9 A further category of large HMOs exempt from mandatory licensing is those controlled or managed by a local housing authority or registered provider of social housing. The exemption of such properties is provided for in Schedule 14 of the Housing Act.

1.2.10 In England and Wales mandatory licensing applies to large HMOs, defined as those rented to 5 or more people who form more than 1 household, with at least 1 tenant paying rent, and some or all tenants sharing toilet, bathroom, or kitchen facilities[7]. This reflects changes in the Licensing of Houses in Multiple Occupation (Prescribed Description) Order 2018, which extended the scope of the relevant provisions of the Housing Act to properties under three storeys high (which were previously excluded).

1.2.11 Licensing is carried out by the local authority, which can also introduce additional licensing arrangements for smaller properties, Section 257 HMOs, and other subsets of the private rented sector (PRS).

1.2.12 The statutory definition therefore makes a distinction, important to this study, between licensed (or licensable) HMOs with 5 or more occupants, unlicensed HMOs with fewer than 5 occupants, Section 257 properties (which function as blocks of flats), and other large HMOs exempt from mandatory licensing under Schedule 14.

[4] Defined as a toilet, personal washing facilities, or cooking facilities.

[5] The "appropriate building standards" in the case of a converted block of flats means on which building work was completed before 1st June 1992 or which is dealt with by Regulation 20 of the Building Regulations 1991. In the case of any other converted block of flats, the requirements imposed at the time in relation to it by regulations under Section1 of the Building Act 1984.

[6] A flat is considered "owner-occupied" in these circumstances if it is occupied by a person who has a lease of the flat which has been granted for a term of more than 21 years, by a person who has the freehold estate in the converted block of flats, or by a member of the household of these people.

[7] Available at: https://www.gov.uk/house-in-multiple-occupation-licence

Planning system definition

1.2.13 The planning system determines the use class of a building at the time that planning permission is granted for its construction or conversion from another use. Standard residential dwellings fall under use class C3, while HMOs fall under their own use class (C4), defined as "small, shared houses occupied by between 3 and 6 unrelated individuals, as their only or main residence, who share basic amenities such as a kitchen or bathroom".[8] HMOs containing more than 6 unrelated individuals are excluded from classification and are considered "sui generis" in planning terms.

1.2.14 This distinction is important because the conversion of properties from use class C3 to C4 (mainstream residential to small HMO) falls under Class L of the Town and Country Planning (General Permitted Development) Order 2015. This means that the conversion of mainstream residential dwellings to small HMOs does not normally require planning permission. This effectively removes the power of the local planning authority to refuse permission or place conditions on such conversions. The conversion of C3 dwellings to sui generis uses does not fall under permitted development and would require planning permission.

1.2.15 The Census defines an HMO in a very similar way to the planning system definition, as "a dwelling where unrelated tenants rent their home from a private landlord", at least three unrelated individuals live there, and toilet, bathroom or kitchen facilities are shared. The Census definition places no limit on the number of unrelated individuals that can share an HMO.

1.2.16 In summary, the common theme in all definitions of HMOs is the sharing of facilities by multiple unrelated individuals. However, there are different ways to identify HMOs and their sub-categories which have implications for the planning and licensing arrangements that can be used to set standards and control their spread.

1.3 Impacts of HMOs

1.3.1 HMOs, particularly where they exist in high concentrations, are widely perceived to have detrimental effects on their occupants and neighbouring residents as well as on the broader community, housing market and economy.[9] This is reflected in the extensive efforts made by local authorities to control and restrict the proliferation of HMOs.

1.3.2 It is helpful to make a distinction between two broad categories of impacts that HMOs might exert:

- Tangible impacts that change the physical environment and can be visibly measured. Examples include poor property condition, waste issues and the loss of alternative forms of accommodation.

[8] Planning Portal Use Classes (updated 01/09/2020)

[9] Brookfield, K. (2022). Planned Out: The Discriminatory Effects of Planning's Regulation on Small Houses in Multiple Occupation in England. *Planning Theory & Practice.* 23:2. Pp.194-211.

- Intangible impacts that affect the experience of people and are therefore more subjective. Examples include community cohesion, anti-social behaviour.

1.3.3 The table below lists a number of potential tangible and intangible impacts drawn from relevant literature and initial research in Eastbourne. Though these are primarily negative potential impacts, it is worth noting that many of them also have the potential to be positive, such as the renovation of derelict or badly kept properties through HMO conversion. Much also depends on the quality of management of the property and the circumstances of occupants.

1.3.4 For example, there are significant differences in the potential impacts of HMOs occupied by students, professional sharers and those housing vulnerable people in need of urgent accommodation – including those referred from homelessness, probation, or addiction services.[10] The former tend to have a greater sense of community and belonging within the property itself but may aggravate neighbours resistant to living in a "student area" or needing to compete for scarce parking with additional professionals. More vulnerable occupants tend to be at greater risk of social isolation and, while they have less impact on aspects like parking, can experience problems that can affect the wider community if they are not well supported.

1.3.5 It is also worth noting that HMOs are known to create particular challenges in coastal towns, linked in part to their seasonality of employment.[11] This economic context tends to increase reliance on HMOs and create transient populations with weaker roots in the community. A greater proportion of seaside HMOs have also been classified as non-decent to live in compared to England as a whole.[12] In addition, the decline of domestic tourism has led to a particular type of HMO in coastal areas, created through the conversion of former hotel and guesthouse accommodation.[13] Due to their size, some of these will be classed as Section 257 properties, as defined above, which are not licensed and tend to face heightened management challenges. The potential knock-on impacts on the wider tourism economy are discussed in Section 4 of this study.

1.3.6 The key potential impacts for which the evidence in Eastbourne can be assessed are listed below.

[10] Barratt C and Green G. (2017). Making a Housing in Multiple Occupation a Home: Using Visual Ethnography to Explore Issues of Identity and Well-Being in the Experience of Creating a Home Amongst HMO Tenants. *Sociological Research Online.* 22:1.

[11] Ward K. (2015). Geographies of exclusion: Seaside towns and Houses in Multiple Occupancy. *Journal of Rural Studies.* 37. Pp. 96-107.

[12] Ward K. (2015). Geographies of exclusion: Seaside towns and Houses in Multiple Occupancy. *Journal of Rural Studies.* 37. Pp. 96-107; House of Lords Select Committee on Regenerating Seaside Towns and Communities – 'The Future of Seaside Towns' – 2017-2019.

[13] Green G, Barratt C, and Wiltshire M. (2016). Control and care: landlords and the governance of vulnerable tenants in houses in multiple occupation. *Housing Studies.* 31:3. Pp.269-286.

Table 1-1: Potential Impacts of HMOs in Concentration

Tangible	Intangible
• Internal condition of property • External condition (e.g. public-facing areas, gardens, fences, walls) • Condition of streetscape / appearance of neighbourhood (e.g. litter, cumulative effect of badly kept properties) • Additional stress on infrastructure (e.g. waste, parking, traffic) • Loss of alternative forms of accommodation (e.g. family housing) • Provision of low-cost housing • Increased population density	• Concentration of vulnerable groups and potential for social exclusion • Anti-social behaviour of occupants (e.g. noise, crime) • Population churn / transience • Sense of community cohesion (e.g. loss of familiar settled families, lower community engagement among HMO occupants) • Increased pressure on local services (e.g. NHS, social care) • Knock-on impacts on economy (e.g. tourism)

1.4 Existing HMO licensing, standards and planning policy in Eastbourne

1.4.1 The suite of measures currently employed by Eastbourne Borough Council (EBC) to manage the characteristics, impacts and spread of HMOs is fairly limited. It consists of the application of national mandatory licensing requirements, a set of Prescribed Standards for licensed properties, and a number of Local Plan policies that indirectly touch on HMOs in the broader context of land uses.

1.4.2 EBC requires HMOs to be licensed in line with national policy, with landlords needing to apply for a licence if the HMO has 5 or more tenants (regardless of the number of storeys), with some sharing of facilities. A licence is valid for 5 years and requires certain conditions to be met (e.g. electrical and gas safety certificates). The Council's website also notes that licensing applies to host families with four or more students living in a property for 90 or more days in any year.

1.4.3 Licensed HMOs in the Borough must comply with EBC's prescribed Standards for Houses in Multiple Occupation. These standards determine the maximum number of individuals allowed to occupy different sizes of HMO and set out a range of additional requirements, such as provisions around anti-social behaviour and nuisance to neighbours. Applicable to all HMOs subject to licensing are requirements relating to heating, gas safety, electrical safety, fire safety, and the disposal of rubbish. Further to this, there are detailed requirements for shared houses and non-self-contained units including:

- Washing facility requirements, including the number required for different number of occupants;

- Kitchen requirements in relation to sufficient equipment (e.g. sinks with draining boards, sockets, worktop space, adequate supply of hot and cold water, etc.) for different numbers of occupants;
- Room sizes for shared spaces (where applicable); and
- Room sizes for bedrooms.

1.4.4 The current approach to enforcement is to work with landlords to ensure compliance, while striking a balance between the necessary standards and the needs of tenants. For example, where properties are considered safe but do not meet an element of the Prescribed Standards, the Council would request that the appropriate changes be made rather than cause the tenant to have to find alternative accommodation.

1.4.5 It should be noted that in March 2023 the government temporarily relaxed licensing and other requirements for properties let to asylum seekers as part of an effort to house more of them in private rented accommodation rather than hotels. This means that HMOs may be exempted from licensing for a two-year period from the first date of letting to asylum seekers. A number of hotels are known to house asylum seekers so this change is likely to impact the HMO market in terms of demand, but will also reduce EBC's oversight over the number and condition of HMOs used for that purpose, as well as income from licensing fees that may be needed for enforcement and other potential measures to mitigate HMO impacts more widely.

1.4.6 A limited measure of control over the proliferation of HMOs is asserted through planning policy, against which applications for new building and conversions (not subject to permitted development rights) are tested. Policies outlined in the following documents are relevant to HMO management arrangements and strategies for the wider market in which this form of land use sits in Eastbourne:

- Eastbourne Core Strategy Local Plan, adopted February 2013;[14]
- Eastbourne Borough Plan, adopted 2003 (saved policies);[15] and
- Eastbourne Town Centre Local Plan, adopted November 2013.[16]

1.4.7 Full details of relevant policies are supplied in Appendix 1.1. Here, it is worth summarising the key points that have a direct or indirect bearing on HMOs:

- New housing is to be provided, including through change of use, as a mix of dwelling types and sizes to suit the needs of different groups.
- Options for the emerging Local Plan include three housing density scenarios that seek to balance the efficient use of land and the homogeneity of housing supply.
- New residential development in the town centre should protect residential amenity by minimising noise disturbance and other potential conflicts between uses.

[14] Available at: https://www.lewes-eastbourne.gov.uk/_resources/assets/inline/full/0/257948.pdf

[15] List of saved policies available at: https://www.lewes-eastbourne.gov.uk/_resources/assets/inline/full/0/259050.pdf

[16] Available at: https://www.lewes-eastbourne.gov.uk/_resources/assets/inline/full/0/259253.pdf

- Planning permission will be granted for HMOs subject to residential, visual, and environmental considerations.
- Houses with 3 or fewer bedrooms should be retained as single private dwellings.
- Existing tourist accommodation is generally to be protected from conversion. Within the tourist accommodation area, planning permission will be refused for proposals incompatible with tourist accommodation uses unless those uses can be demonstrated as no longer viable. HMOs will specifically not be permitted in this area.
- Planning permission will not be granted for the change of use of dedicated student accommodation unless there is no longer a proven need within the Borough. Additional purpose-built student accommodation may be encouraged.

1.5 Mitigation and management options

1.5.1 The primary and default method of managing HMOs is through mandatory licensing, as discussed above. This primarily provides oversight of the living conditions of the property, rather than whether or not it can be used as a HMO in the first instance (although in more extreme cases the refusal to grant a licence could theoretically have this effect). Indeed, mandatory licensing represents a minimum standard for properties to meet and licences can be difficult to revoke if issues emerge down the line. In addition, many HMOs fall outside of the occupancy thresholds that require licensing – notably those with fewer than 5 occupants. Poor conditions in such properties are therefore not proactively monitored, but are dealt with when complaints arise through the wider powers that apply to all housing rather than HMOs specifically, namely the health and safety provisions of the Housing Act 2004 and statutory nuisance provisions of the Environmental Protection Act 1990.[17]

1.5.2 Additional courses of action can be taken to manage existing HMOs more intensively, better scrutinise potential new conversions, and bring a larger number of properties within the purview of the planning system, licensing and management.

1.5.3 In July 2022 a 'Review of Planning Policy and Licensing for Houses in Multiple Occupation' was submitted to Cabinet at EBC. This highlights the perception that there are adverse impacts associated with HMOs in the Borough, particularly where they exist in high concentrations. It proceeds to outline two overarching options for mitigating those impacts, while emphasising that any decision on future actions would need to be informed by robust evidence. These two main approaches are summarised as follows:

a) Planning policy

– Currently a change of use from Class C3 (dwelling house) to Class C4 (HMO) falls under Permitted Development Rights and therefore does not

[17] Rugg J, and Rhodes D. (2018). The Evolving Private Rented Sector: Its Contribution and Potential. *University of York, Centre for Housing Policy.*

require planning permission. For large HMOs (containing more than 6 unrelated individuals) that fall within 'sui generis', planning permission is required.

- Eastbourne Borough Plan (2003) Policy HO14 restricts the granting of planning permission for HMOs within the Tourist Accommodation Area (seafront from the Grand Hotel to Treasure Island). This policy position can only be changed through the adoption of a new Local Plan supported by evidence to justify why it is an issue to be addressed. A new Local Plan policy that restricts the granting of permission for new HMOs within a specified area could be considered by the Council if it is demonstrated that the concentration of HMOs is creating a significant impact on the amenity of the area.
- In order for a new Local Plan policy to apply to HMOs of all sizes it would be necessary for an Article 4 Direction to be implemented to remove existing permitted development rights that currently allow the change of use from Class C3 to Class C4 for HMOs occupied by between 3 and 6 unrelated individuals without planning permission. Article 4 Directions are designed only to be used by local authorities in exceptional circumstances and should apply to the smallest area possible. The report notes that introducing an Article 4 Direction to require changes of use from Class C3 residential to Class C4 HMO is unlikely to be an effective way of controlling the number of HMOs within an area without a new Local Plan. This is because any application submitted would currently be assessed against the policy in the current Local Plan, which is generally permissive of HMOs.

b) Licensing

- Smaller HMOs are not subject to mandatory licensing. Local authorities have the discretion to introduce additional licensing requirements if they believe that a significant proportion of HMOs are poorly managed or giving rise to impacts on residents or the wider community. Introducing additional licensing would involve a 10-week consultation period and a draft proposal identifying what would be designated and the consequences.
- The General Approval given to all local housing authorities to make such a designation does not apply if the selective licensing designation would apply to more than 20% of the geographical area of the borough or if it would affect more than 20% of private rented homes in the area.

1.5.4 Building on the above and AECOM's literature review, the broad actions that might be taken to mitigate the impacts of HMOs in Eastbourne can be summarised as follows:

Planning approaches, affecting the supply of new HMOs

- Reinforced policy in the emerging Local Plan or, if not feasible, an Interim Policy Statement or Supplementary Planning Document, setting out principles for determining planning applications for HMO conversions. These might include:
    - Concentration thresholds for HMOs in a given area.

- The protection of local amenities, such as car parking.
- The requirement of additional amenities, such as waste storage.

- An Article 4 Direction to require planning permission for smaller HMO conversions (C3 to C4) in a defined area, which would be subject to the reinforced policy provisions proposed in the bullet above.

Licensing approaches, affecting the ongoing management of HMOs

- Ongoing additions and changes to Prescribed Standards, where appropriate, to address new evidence of problems.
- Additional licensing for categories of HMOs not currently subject to mandatory licensing (notably smaller HMOs but also potentially Section 257 properties), which would be subject to the Prescribed Standards and ongoing monitoring.
- Selective licensing schemes to address specific problems in particular areas, which would cover all private rented properties rather than HMOs alone.

Other measures

- Incentives and proactive working with landlords and referring agencies to encourage high-quality management (contingent on Council resources). Incentives could be financial, such as exemptions from rate increases for those with a satisfactory track record, or process-based, such as arrangements for direct payment of housing benefits.
- Enhanced enforcement resourcing or processes to manage poor management. It is relevant to note that revoking licences completely can be expensive and detrimental to occupants without appropriate alternative arrangements
- Harmonised data collection on the number of HMOs across planning, licensing and other functions.
- Funding arrangements for the above measures to reduce resource strain on the Council, e.g. funding enforcement through additional licence fees.

1.5.5 The limited research about HMO interventions provides context about the implementation of these approaches elsewhere and what additional measures may be required to address unintended consequences.

1.5.6 Research by Brookfield in 2022 found that of the 43 local planning authorities included in the study, 72% had an Article 4 Direction in place to suspend permitted development rights for change of use from Class C3 to Class C4, with 52% of these covering the entire local authority area.[18] Covering an entire local authority area requires strong justification, as Directions are intended to cover the smallest appropriate geographical area, but it appears that the evidence has been sufficiently robust to justify this in many cases (see case studies in Appendix 6.1).

[18] Brookfield, K. (2022). Planned Out: The Discriminatory Effects of Planning's Regulation on Small Houses in Multiple Occupation in England. *Planning Theory & Practice.* 23:2. Pp.194-211.

1.5.7 Research also suggests that increasing planning controls in areas with a high number of HMOs could further constrain housing availability for people with already limited options in the housing market.[19] This, it is suggested, may serve simply to displace the most vulnerable people to other areas where they are able to find low-cost shared housing, in turn further increasing social exclusion. The research recommends that interventions around HMOs should take into consideration the local authority's overall strategies for tackling homelessness and supporting residents with potential multiple complex needs.

1.5.8 A Centre for London 2023 report on selective licensing for the private rented sector[20] found that it is common across England for licensing fees to be calculated to fund expansions in staffing necessary to fill the scheme's objectives rather than to generate a budget surplus. Those objectives tended to include poor standards for occupants, high levels of deprivation and crime, and antisocial behaviour reports. The positive effects identified include significantly improved standards, more attentive landlords, increased information collection, and improved joint working between local authorities and other public services. A key challenge identified is the need for a clear strategy for identifying unlicensed properties along with maintaining inspection rates.

1.5.9 Although not a policy approach to managing HMOs, research also suggests that some of the challenges landlords of HMOs face with tenant management could be more appropriately addressed through a 'caring lens'.[21] Local authorities could provide support or signposting for landlords to relevant services and organisations for both landlords and tenants, potentially reducing some of the issues arising from vulnerable tenants.

1.5.10 To fully understand the range of approaches that can be taken to manage HMO numbers and impacts, it is helpful to review the examples undertaken by other local authorities. Section 6 summarises the interventions undertaken by a number of other authorities and the evidence they drew upon. The particularly relevant example of neighbouring Hastings is summarised below.

Example – Hastings Borough Council

1.5.11 Hastings Borough Council under Section 56 of the Housing Act 2004 exercised powers to designate additional licensing of HMOs in the wards of Braybrooke, Gensing, Castle, and Central St Leonards. This came into force on 4th May 2018 and ceased to have effect on 3rd May 2023.[22] This effectively required every HMO (with some exceptions[23]) to be licensed in these areas, capturing smaller HMOs that are not normally required to be licensed.

[19] Iafrati S. (2021). Supporting Tenants with Multiple and Complex Needs in Houses in Multiple Occupation: The Need to Balance Planning Restrictions and Housing Enforcement with Support. *Social Policy & Society.* 20:1. Pp. 62-73.

[20] Centre for London (2023) *Licence to Let: How property licensing could better protect private renters.*

[21] Green G, Barratt C, and Wiltshire M. (2016). Control and care: landlords and the governance of vulnerable tenants in houses in multiple occupation. *Housing Studies.* 31:3. Pp.269-286.

[22] The Hastings Borough Council Designation of an Area for Additional Licensing of Houses in Multiple Occupation 2017

[23] Exceptions include:

- Section 257 HMOs consisting solely of 2 flats where neither of the flats is situated above or below commercial premises.
- Section 257 HMOs which share no internal or external common parts.
- Smaller Section 254 HMOs (shared facilities) with less than 5 occupiers where the building containing the HMO does not extend over 2 storeys.

1.5.12 Hastings Borough Council previously had a licensing scheme which operated from 19th September 2011 to 18th September 2016. Due to the success of this the local authority opted to implement the new scheme to continue to tackle poor standards in HMOs. A 'Report on New Additional Licensing Scheme' to Cabinet in October 2017 outlined that on completion of the initial licensing scheme, 911 HMOs were licensed in the wards of Braybrooke, Castle, Central St Leonards, and Gensing, with (unspecified) improvements to 465 properties noted. Consultation[24] that followed found that 70% of tenants supported further additional licensing, with 73% of landlords opposed. Alongside the issue of condition, the Report to Cabinet noted the concentration and proliferation of HMOs to be a key part of the rationale for the steps taken.

1.6 Summary

1.6.1 The common theme in all definitions of Houses in Multiple Occupation (HMOs) is the sharing of facilities by multiple unrelated individuals. However, there are different ways to identify HMOs and their sub-categories which have implications for the planning and licensing arrangements that can be used to set standards and control their spread.

1.6.2 The expansive statutory definition in the Housing Act 2004 provides three key sub-categories of HMO and determines which properties are subject to mandatory licensing. It distinguishes between licensable HMOs with more than 5 occupants, non-licensable HMOs with fewer than 5 residents, and Section 257 properties that take the form of blocks of self-contained flats.

1.6.3 The narrower planning system definition counts a HMO as any property occupied by 3 to 6 unrelated individuals sharing amenities. Such properties fall under their own use class (C4), distinct from that of standard residential dwellings (C3). Permitted development rights in England currently allow conversion from C3 to C4 without the need for planning permission, meaning that there are few controls on the supply of new HMOs through residential conversions. Larger HMOs (with more than 6 occupants) are classed as sui generis and conversions do require planning permission.

1.6.4 HMOs in all forms, and particularly in high concentrations, have a reputation for bringing detrimental impacts to residents, communities and housing markets – particularly in coastal towns like Eastbourne. The impacts most frequently raised in the literature and AECOM's review of precedents for intervention to manage HMOs (see Appendix 6.1) include tangible issues with upkeep, waste and parking, and intangible effects on anti-social behaviour and community cohesion.

1.6.5 As a consequence of these impacts, whether directly measured or perceived, HMOs are subject to various means of control by local planning authorities (beyond the default mandatory licensing of mid-sized properties required by law). The key potential courses of action include:

[24] There was limited response, with 45 landlords/letting agents, 10 tenants, and 17 other interested parties responding to an online questionnaire.

- Planning policy requirements for new or converted HMOs to provide additional amenities, demonstrate limited impact on existing amenities or avoid levels of geographical concentration.

- Article 4 Directions to remove permitted development rights from C3 to C4 conversions so that a larger number of potential HMOs are subject to planning policy requirements.

- Additional licensing for HMOs that are not already mandatorily licensed, coupled with prescribed standards needed to attain a licence. This can be expanded to selective licensing, which tends to cover the wider private rented sector.

- Landlord engagement and enforcement measures to incentivise high-quality management.

- Local authorities working with partners to use their own funds to purchase HMOs and convert them to affordable housing, including larger family sized homes for families in need or retention as bedsit accommodation.

- Linked to the above, intervention programmes which bring together different agencies to tackle impacts associated with HMOs, including the deprivation of some vulnerable HMO residents.

1.6.6 Eastbourne's existing Local Plan restricts HMO conversions in a defined tourist accommodation area, particularly from hospitality uses, but sets few broader requirements. The Local Plan is otherwise generally permissive of HMOs outside of this defined area, subject to amenity considerations. No relevant Article 4 Directions or additional licensing schemes are in force. Eastbourne therefore has an opportunity to intervene in ways that afford greater oversight over the conditions, number and concentration HMOs if desired. The remainder of this report seeks to understand the evidence of the impacts HMOs may be having in Eastbourne and considers the options for action and their potential effectiveness.

2. Eastbourne's HMO Stock

2.1 Introduction

2.1.1 This section explores the current HMO landscape in Eastbourne. It seeks to establish:

- The number and characteristics of HMOs overall, and of different sub-categories (i.e. unlicensed smaller HMOs and Section 257 properties).
- Trends over time in HMO numbers.
- The spatial distribution of HMOs across the Borough.

2.1.2 There is no centralised source of data for all types of HMOs. EBC keeps a register of properties holding a HMO licence, which forms the backbone of this analysis. However, data is less readily available for unlicensed smaller HMOs, Section 257 properties and other large HMOs that are exempt from mandatory licensing under Schedule 14 of the Housing Act 2004. This means that assumptions need to be made when identifying such properties, and their detailed characteristics and changes over time cannot be accurately reported. The analysis to follow therefore begins with the licensed HMO register before additional datasets are incorporated and evaluated.

2.2 Licensed HMOs: Characteristics and Distribution

2.2.1 Eastbourne adheres to the mandatory licensing regime set out in the Housing Act 2004 and currently has no supplementary licensing arrangements. The HMOs holding a licence in Eastbourne therefore exhibit the characteristics set out in the statutory definition presented in Section 1 and have 5 or more occupants. HMOs with fewer occupants or that otherwise do not conform to the mandatory licensing definition (e.g. Section 257 properties) are not included in this dataset and are explored later in this section.

2.2.2 Eastbourne's current register of licensed HMOs counts 318 unique properties. The register is dated August 2022 but the most recent licence granted is from 2021. Their characteristics and distribution are discussed below.

Size and Household Composition

2.2.3 Figure 2-1 and Figure 2-2 present the number of bedrooms and the maximum number of people permitted to occupy each of Eastbourne's licensed HMOs.

2.2.4 Figure 2-1 shows that almost 60% of licensed HMOs have five or six bedrooms, with almost 200 HMOs falling within these two size categories (use class C4 in planning terms). The remaining, larger, HMOs (sui generis in planning terms) are found in much smaller quantities. The median number of bedrooms per HMO is six and the mean average is seven.

2.2.5 It is likely that the 'smaller' licensed HMO properties (those on the left-hand side of Figure 2-1) have been converted from residential properties. The 'larger' HMO properties (those on the right-hand side of Figure 2-1) are more likely to be non-residential conversions such as hotels or purpose-built accommodation such as student flats. Given the size distribution shown in Figure 2-1, it is likely that most of Eastbourne's licensed HMOs are converted residential properties.

Figure 2-1: Number of Bedrooms in Eastbourne's Licensed HMOs

Number of Bedrooms	Frequency
5 Bedrooms	98
6 Bedrooms	89
7 Bedrooms	35
8 Bedrooms	31
9 Bedrooms	16
10-19 Bedrooms	29
20-49 Bedrooms	2
50+ Bedrooms	1
No Data	17

Source: EBC HMO Register

2.2.6 The pattern of maximum occupancy shown in Figure 2-2 (generally) matches that of the available bedrooms in Figure 2-1. Although this similarity is unsurprising, it helpfully confirms that the rooms in licensed HMOs are generally only suitable for single-occupancy rather than couples or families. If that was not the case, one would expect higher frequencies recorded on the right-hand side of the Figure 2-2. The median maximum number of people permitted per HMO is again six, and the mean average of eight is slightly higher than the mean number of bedrooms.

Figure 2-2: Maximum Number of People Permitted in Eastbourne's Licensed HMOs

Maximum Number of People Permitted	Frequency
5 People	72
6 People	91
7 People	33
8 People	28
9 People	21
10-19 People	46
20-29 People	3
30-39 People	4
40+ People	1
No Data	19

Source: EBC HMO Register

Spatial Distribution

2.2.7 Figure 2-3 presents the geographical location of Eastbourne's licensed HMOs, grouped by postcode.

2.2.8 Whilst HMOs can be found in limited numbers across the town, Figure 2-3 demonstrates that there are significant levels of clustering: the majority of Eastbourne's HMOs are located in the eastern half of the town, with the highest concentrations found to the north and east of the Beacon Shopping Centre.

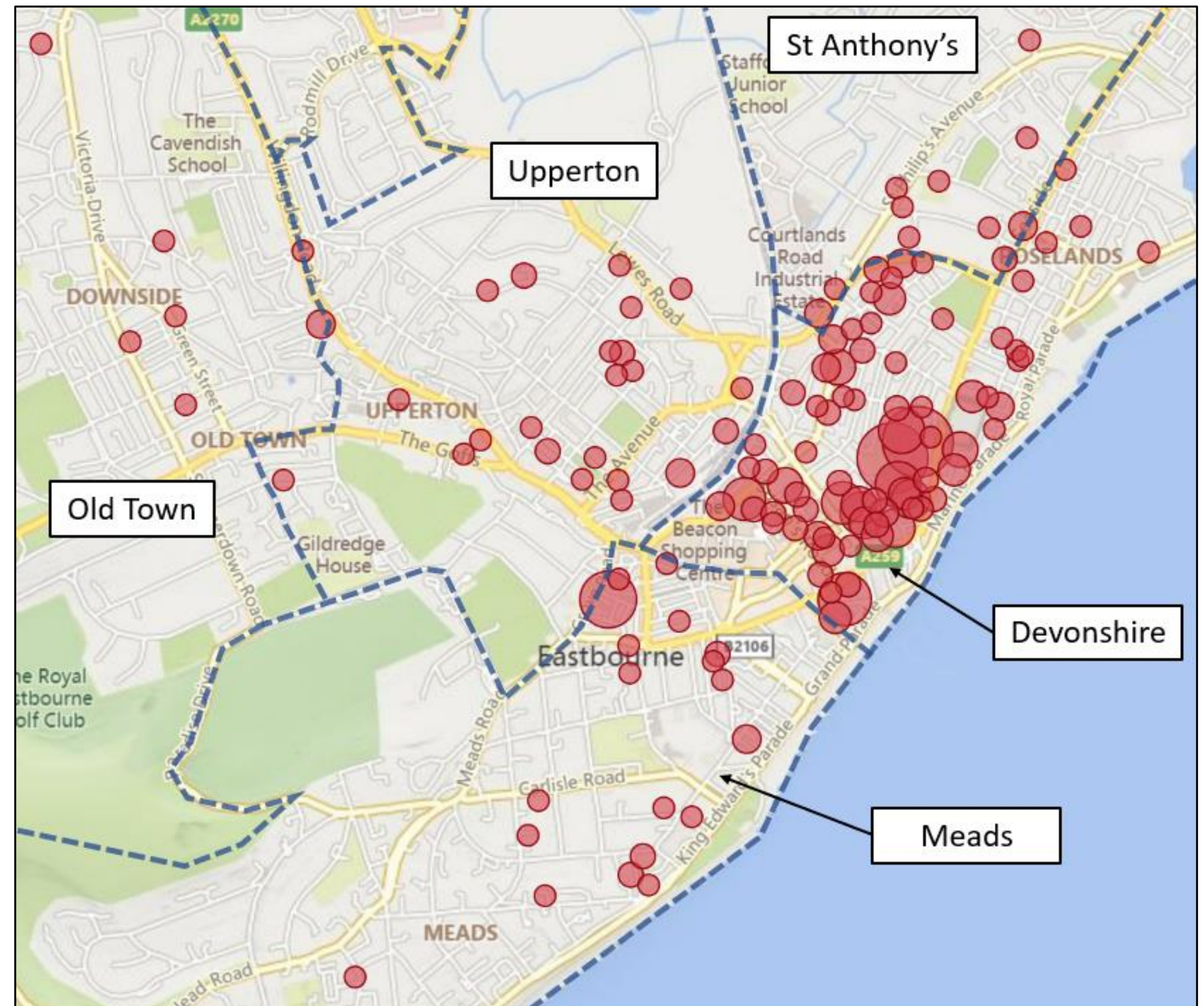
Figure 2-3: Location of Eastbourne's Licensed HMOs

Source: EBC HMO Register

(Red bubbles represent Licensed HMOs within a postcode; the larger the size of the bubble, the more HMOs within that postcode)

2.2.9 The map in Figure 2-4 below magnifies central Eastbourne, where the vast majority of licensed HMOs are located, and adds ward boundaries. This clearly shows the significant concentration of properties in Devonshire Ward and, to a lesser extent, Meads and Upperton.

Figure 2-4: Central Eastbourne's Licensed HMOs by Ward



Source: EBC HMO Register

(Red bubbles represent Licensed HMOs within a postcode; the larger the size of the bubble, the more HMOs within that postcode. Blue dashed lines represent electoral ward boundaries)

2.2.10 Table 2-1 then presents this data in the form of a table. It reveals that almost three quarters of HMOs are located in Devonshire Ward (73%). The remaining HMOs are mostly found in Meads Ward and Upperton Ward (each containing around 10% of Eastbourne's HMOs), with a few also located in St Anthony's Ward and Old Town Ward (each containing under 5% of Eastbourne's HMOs). The remaining wards in Eastbourne have just 1 or no recorded HMOs within their boundary. The proportion of all properties in each ward that are licensed HMOs (using 2021 Census data) is very modest, although Devonshire's Ward's share of 3.1% far exceeds any other.

2.2.11 When the same analysis is repeated for the number of HMO rooms, as opposed to properties, a similar picture emerges. However, one key difference stands out: while Meads Ward only has 11% of all HMO properties it has 18% of HMO rooms, suggesting that HMOs located there tend to be larger, meaning that their potential impacts may be greater than a simple count of properties would suggest.

Table 2-1: Eastbourne's Licensed HMOs by Ward

Ward	HMO Count	% of Stock	% of all HMOs	Number of Bedrooms	% of All Licensed HMO Bedrooms
Devonshire	233	3.1%	73%	1,458 (excluding 13 properties with no data)	68%
Hampden Park	0	0.0%	0%	n/a	0%
Langney	1	0.0%	0%	6	<1%
Meads	34	0.5%	11%	384	18%
Old Town	7	0.2%	2%	43	2%
Ratton	1	0.0%	<1%	5	<1%
Sovereign	0	0.0%	0%	n/a	0%
St. Anthony's	13	0.3%	4%	67 (excluding 1 property with no data)	3%
Upperton	29	0.5%	9%	183 (excluding 3 properties with no data)	9%
Totals	**318**		**-**	**2,146 (excluding 17 properties with no data)**	**-**

Source: EBC HMO Register

2.3 Licensed HMOs: Trends Over Time

2.3.1 This sub-section explores how the number and characteristics of licensed HMOs have changed over time in Eastbourne. This can be done in two main ways: by looking at the dates that new licences were granted in the current register, and by comparing the current register (August 2022, data to 2021) with a historic version of the same dataset provided by EBC (for October 2015). Note that the historic dataset predates the regulatory changes introduced in 2018 which extended licensing requirements to HMOs with fewer than three storeys, meaning that the overall growth in HMOs between 2015 and 2022 reflects a more expansive definition in addition to any actual growth. It is also worth keeping in mind that some of the figures in this analysis for 2019 and subsequent years may be affected by the Covid-19 pandemic.

Age of HMO Licence

2.3.2 The current register of licensed HMOs includes the year that each active HMO licence was granted. This data is visualised in Figure 2-5. It should be noted that this does not represent the absolute number of licences granted in that year; it shows the

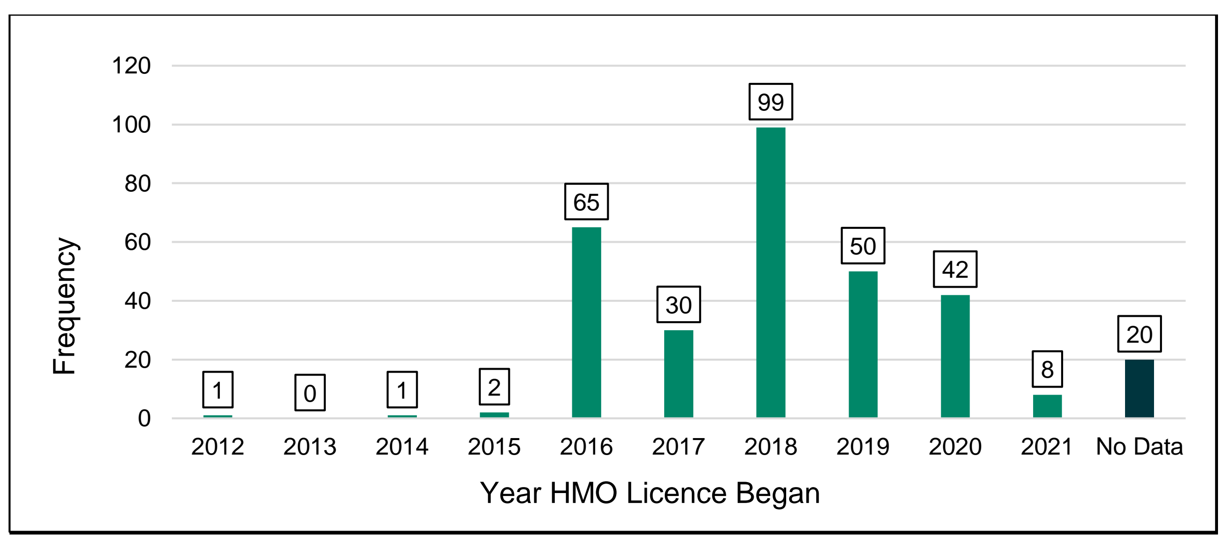
number of licences applied for in that year, which remained active in the most recent dataset (August 2022).

2.3.3 This is one of a number of important limitations with this data. The number of licences applied for per year does not simply represent new HMOs; because licences need to be renewed every five years, renewals of expiring licences represent a large proportion of new licences (and are not classified differently in the data). In addition, retrospective applications from HMOs functioning without a licence add to the total without adding new HMO stock in practice. Enforcement actions at EBC are understood to have created surges in retrospective applications at particular points in time (although is more relevant to planning permission than licensing). Given these flexibilities, it is difficult to draw clear conclusions about overall trends in the number of licensed HMOs from this data.

2.3.4 Figure 2-5 shows that the peak year of commencement for current HMO licences was 2018, with 99 licences. This is likely due to the change in national regulations in 2018 extending mandatory licensing to HMOs with fewer than 3 storeys. The two years following 2018 therefore saw an unsurprising 50% decline in the number of licences issued, dropping to 50 in 2019 and 42 in 2020 (though this may also reflect the Covid-19 pandemic). Finally, only eight licences were recorded as commencing in 2021. This may be a real decline or a reflection of a lag in new and renewed licences appearing on the register. The mean average number of new licences, noting the caveats above, is 49 per year between 2016 and 2021.

2.3.5 The reason that no (or very few) licences are shown as beginning prior to 2016 in the graph is that mandatory licensing is valid for a maximum of five years, so most of these older licensed properties will have since been renewed with a current licence post-2016 or have expired. The data for 2015 presented in the subsequent sub-section confirms that there were still many HMOs in existence prior to 2016.

Figure 2-5: Year of Commencement for Active HMO Licences in Eastbourne (2012-2021)



Source: EBC HMO Register

2.3.6 Similar trends are visible when reviewing more recent EBC data on the annual number of HMO licences issued per year (as opposed to the start date of current

licences, as discussed above). This data, summarised in Table 2-2 below, appears to suggest a slight decline in the annual number of licences issued in the most recent years. However, the two most recent annual totals are in fact very close to the annual average of 35 that is produced when the spike in 2018-19 is excluded. 2018 is 5 years after the first year in which licences were required and is thus likely to be particularly skewed by licence renewals (which cannot be disaggregated from new licences in this dataset).

Table 2-2: Number of HMO licences issued by year

Year	Number of licences issued
2016-17	39
2017-18	18
2018-19	101
2019-20	44
2020-21	43
2021-22	36
2022-23	32
Total	**313**
Annual average	**45**

Source: EBC HMO Register

HMO Register Comparison (2015 - 2021)

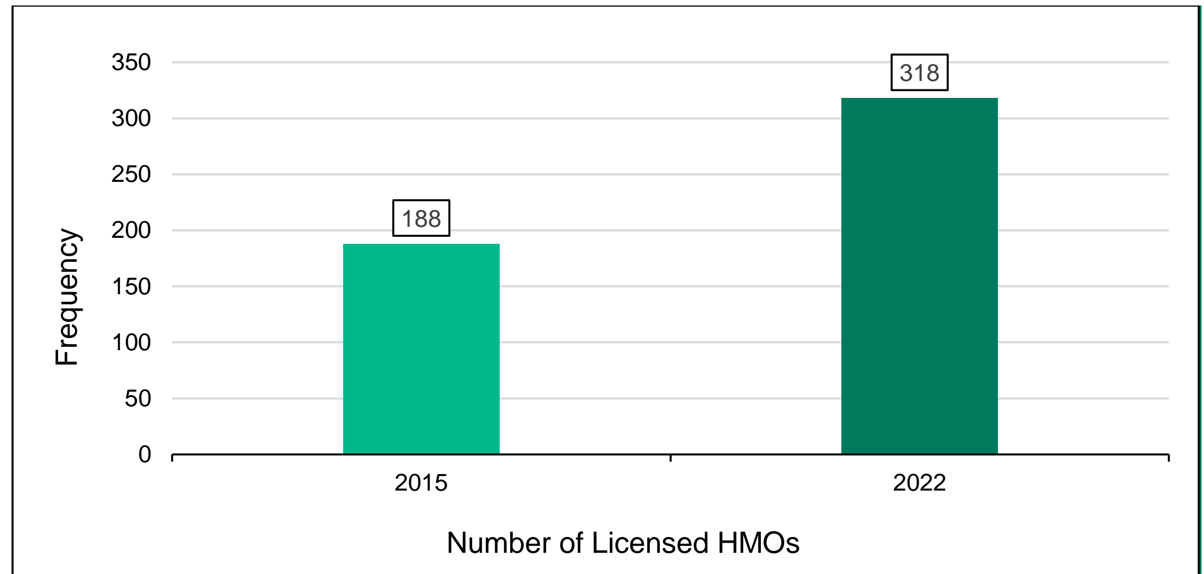
2.3.7 In addition to the most recent version of the register of licensed HMOs (August 2022, data to 2021), EBC also provided a snapshot of the register from October 2015. This sub-section explores the changes over time revealed by comparing the two datasets.

2.3.8 It should be noted that some HMOs are recorded as having ‘no data’ for different variables discussed below. Therefore, the analysis and figures below focus on HMOs with data available. The number of ‘no data’ entries are stated. A

Number of Licensed HMOs

2.3.9 Firstly, Figure 2-6 shows the total number of licences listed on EBC’s HMO register in 2015 and 2021. It reveals that the number of HMO licences active in the town has grown by approximately 70% over the observed period. This amounts to 130 additional properties over six years, or an annual average of 22 per year. This figure confirms that the average of 49 new licences per year discussed above is driven primarily by renewals of existing licences. However, as noted above, the 2015 dataset also predates 2018 changes that expanded mandatory licensing to HMOs with fewer than three storeys. This appears to have led to a step increase in the number of licensed properties in the newer dataset.

Figure 2-6: Number of Licensed HMOs in Eastbourne (2015 and 2022)



Source: EBC HMO Register

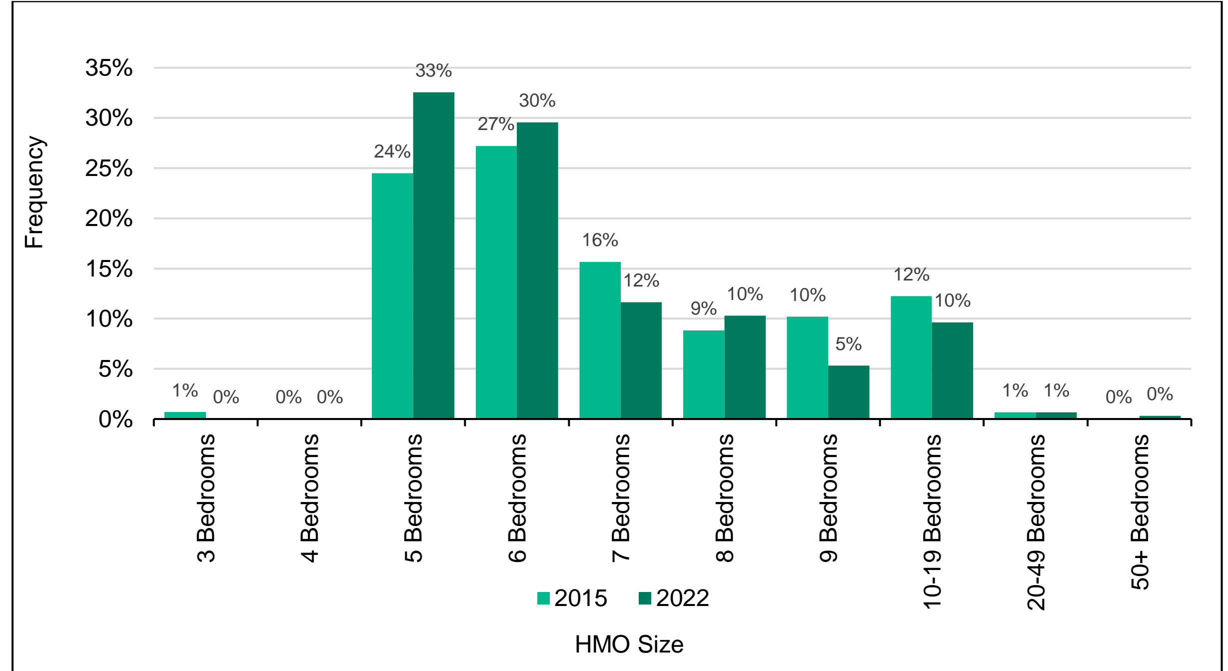
Number of Bedrooms

2.3.10 Moving on to the number of bedrooms per HMO, Figure 2-7 demonstrates that, at both points in time, the most common number of bedrooms are five and six. For both years, the median bedroom size was six and the average bedroom size was seven. This is to some extent pre-determined by the licensing conditions, given that licensing is not required for properties occupied by fewer than five individuals.

2.3.11 However, it is notable that Eastbourne currently has a slightly smaller HMO stock (in terms of size) than was apparent in the past: a higher proportion of HMOs have five or six bedrooms in 2022 (63%) compared with 2015 (51%). This is again likely a function of the regulatory change in 2018 that brought HMOs below three storeys under mandatory licensing, which are likely to be smaller properties with fewer bedrooms. Furthermore, it is difficult to compare the raw figures because far more HMOs on the 2015 register did not have bedroom data. However, that data suggests that new smaller HMOs do represent a majority of the new HMOs: the number with five bedrooms rose from 36 to 98, and with four bedrooms from 40 to 89.

2.3.12 In 2015 there were 41 HMOs with ‘no data’ for the number of bedrooms (22% of the total at the time). In 2022 there were 17 ‘no data’ entries (5% of HMOs at the time).

Figure 2-7: HMO Size in Eastbourne (2015 and 2022)



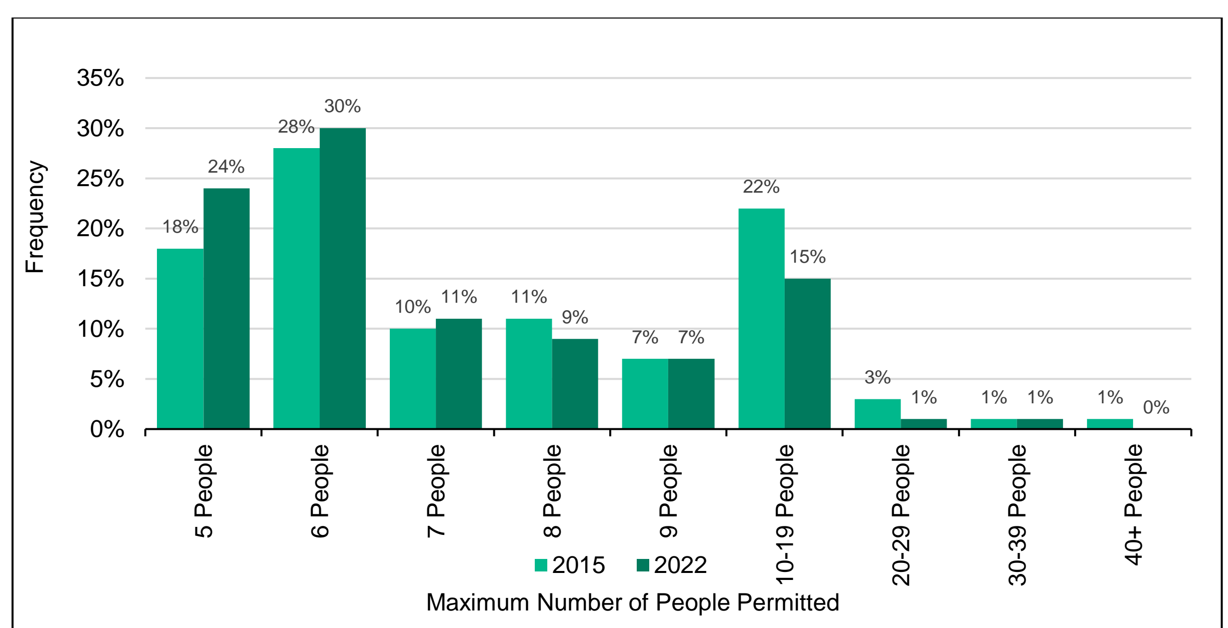
Source: EBC HMO Register

Maximum Number of People Permitted

2.3.13 Turning to the maximum number of people permitted per HMO, Figure 2-8 follows the trend in Figure 2-7, with values for this variable being slightly larger in 2015 when compared to 2022. This time, the shift is apparent in the median and average values, with the median for 2015 and 2022 falling from seven to six, and the average falling from nine to eight.

2.3.14 In 2015 there were 68 'no data' entries for this variable (36% of HMOs at the time). In 2022 there were 19 'no data' entries (6% of HMOs at the time).

Figure 2-8: Maximum Number of People Permitted Per HMO in Eastbourne (2015 and 2022)



Source: EBC HMO Register

2.4 Planning permission: trends over time

2.4.1 EBC's Development Management team provided anecdotal evidence about recent and future trends in the development and conversion pipeline for HMOs, along with data for HMO conversion planning applications for the past decade (see Table 2-3 and Table 2-4).

2.4.2 This information relates to planning applications for the creation of HMOs or conversions from other building uses. It therefore differs from the information reviewed above, which relates to the application for and granting of HMO licences. It should be emphasised that only a limited sub-section of HMOs require planning permission, as conversions from other residential uses are usually exempt under permitted development rights. This data therefore only provides a small window into conversion trends. In addition, not all functional HMOs (whether they have appropriate planning permission or not) have a licence: some may not need to be licensed due to their size and others may be operating illegally without one. Enforcement action is likely where the appropriate permissions and licences are not evident, which has helped to capture more HMOs in recent years. However, there are limitations with counting HMOs and fully understanding trends using these two discrete sources of information.

2.4.3 The evidence summarised below broadly corroborates the direction of travel apparent in the data reviewed above (noting the above caveat that it relates to planning applications rather than licensing, and it is possible for HMOs to have one but not the other). It also indicates that further new conversions are likely to persist in the near-term. The key points conveyed are as follows:

- Development Management are seeing an increasing number of HMO applications coming forward, especially since 2019. This aligns with the data on HMO applications, as presented in Table 2-3. It shows that since 2019, there has been an average of 13 HMO applications per year, whereas prior to 2019, the average was eight, a rise of over 50%. Additionally, the 15 applications submitted in 2022/23 was the highest annual number of applications in the past ten years. Many of these new HMO applications are 'change of use' conversions to which permitted development rights do not apply, particularly of smaller guest houses in the tourist accommodation area along the seafront.

- Planning officers note, however, that the recent uptick in the number of planning applications is at least in part a result of enforcement action that targeted HMOs with a licence but not the appropriate planning permission, which were required to apply for permission retrospectively to regularise the building use. The increasing number of planning permissions thereby creates a perception that the addition of HMOs is accelerating, but in fact more closely reflects the increasing visibility of existing HMOs.

- The HMO application data provided by EBC, presented in Table 2-4, suggests that new applications tend to be for properties in Devonshire ward; this has been the case throughout the ten-year period observed in the table. It is also notable that in the past few years Upperton ward has experienced a higher number of applications than in previous years; the eight applications in 2021/2023 equalled the total number of applications in the Ward for the preceding eight years.

- Applications to convert small terraces, formerly used for single family accommodation, were also identified as becoming more common for HMO applications. In some of these instances, properties are converted to the C4 use class under permitted development rights before the HMO licence is applied for.

- Another noted trend is in applications made for retrospective planning permission for larger properties (7 to 15 bedroom properties) following the enforcement efforts described above. In many instances, these properties are converted residential houses with all rooms converted to bedspaces. The existing policy, management and licensing arrangements do not include rules and standards that allow these proposals to be refused or meaningfully changed at planning application stage.

Table 2-3: HMO applications (1st April 2013 and 31st March 2023)

Year	Approved	Issued	Allowed on appeal	Refused	Withdrawn	Total
2013/14	3	2	0	0	1	**6**
2014/15	4	0	0	1	3	**8**
2015/16	3	2	1	2	3	**11**
2016/17	6	1	0	0	0	**7**
2017/18	4	0	0	2	1	**7**
2018/19	3	3	0	1	0	**7**
2019/20	11	2	0	0	0	**13**
2020/21	8	0	1	2	1	**12**
2021/22	9	2	0	1	1	**13**
2022/23	5	6	1	0	3	**15**

Source: EBC

Table 2-4: HMO Applications per Year by Ward (1st April 2013 and 31st March 2023)

Year	Devonshire	Meads	Old Town	St Anthonys	Upperton	Total
2013/14	3	2	0	0	1	**6**
2014/15	6	0	1	1	0	**8**
2015/16	9	0	0	1	1	**11**
2016/17	5	1	0	0	1	**7**
2017/18	4	0	0	1	2	**7**
2018/19	5	1	0	0	1	**7**
2019/20	10	1	0	0	2	**13**
2020/21	10	2	0	0	0	**12**
2021/22	9	1	0	0	3	**13**
2022/23	9	1	0	0	5	**15**

Source: EBC

2.5 Unlicensed HMOs

Section 257 Properties

2.5.1 Section 257 properties are buildings that have been converted into self-contained flats that are predominantly rented and where the conversion did not comply with relevant Building Regulations. They are not subject to mandatory licensing and therefore do not appear on the register or any other centralised record. They are, however, considered a type of HMO, and are generally considered to have the potential to bring the same potential impacts and challenges.

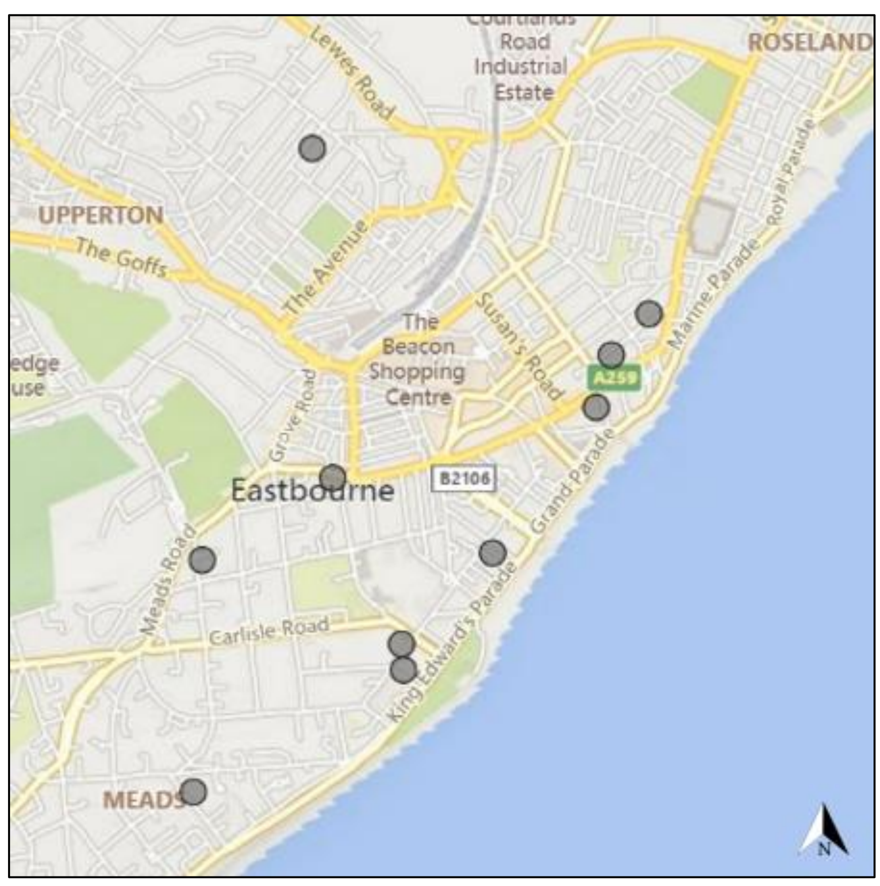
2.5.2 This is likely to depend on their size, quality of management and type of occupant: some Section 257 properties function more like blocks of self-contained flats, while others may facilitate anti-social behaviour due to their internal layout and a lack of appropriate support to vulnerable residents. Tangible impacts such as building condition, waste storage and parking may be similar to HMOs, but depend on the facilities associated with the property and its former use.

2.5.3 Given that Section 257 properties fall outside of licensing regimes and are not separately tracked in planning applications data (since they are classified as sui generis, along with a range of other potential building use categories), they are particularly difficult to quantify. Given the wide availability of former hotel and guesthouses in Eastbourne, it is likely that many Section 257 HMOs exist. However, it has not been possible to robustly identify or count them as part of this research.

2.5.4 An indication of their existence and distribution across the town is provided by an informal list of 10 probable Section 257 properties compiled by EBC officers who have visited them in the recent past. This list is not an attempt at an exhaustive tally, but simply provides anecdotal evidence of where a small sample are situated.

2.5.5 The properties are mapped in Figure 2-9 at a high scale to prevent identification. They cluster in broadly similar locations to the licensed HMOs mapped above, with particular concentrations along the seafront. This suggests that some may have been converted from large hotels. It should again be emphasised that this is likely to significantly under-represent the number of Section 257 properties and the distribution of this sample may not be representative of the actual picture.

Figure 2-9: Location of Section 257 Properties (Informal List)



Source: EBC

(Grey bubbles represent Licensed and potential unlicensed HMOs within a postcode. The larger the size of the bubble, the more HMOs within that postcode)

Schedule 14 Properties

2.5.6 A further category of large HMOs exempt from mandatory licensing is those controlled or managed by a local housing authority or registered provider of social housing. The exemption of such properties is provided for in Schedule 14 of the Housing Act.

2.5.7 This category is therefore similarly challenging to quantify. Registered Providers may be able to provide information on their existence, size and location, but this has not been possible as part of this study and may present an opportunity for targeted monitoring going forward.

2.5.8 It should be noted, however, that Schedule 14 properties are managed in a similar way to affordable rented housing, rather than by private landlords. As such, impacts associated with them may more appropriately sit in the context of affordable housing occupancy and management than the present assessment of HMOs.

Smaller Unlicensed HMOs

2.5.9 The other, larger category of unlicensed HMOs includes those occupied by fewer than five unrelated individuals (the threshold above which mandatory licensing would

apply). Following the planning system and Census definition, the minimum number of unrelated occupants for a property to qualify as an HMO is three. This category therefore covers HMOs with between three and five occupants.

2.5.10 While there is no official list of unlicensed HMOs within Eastbourne, making tallying them challenging, there are several indicators that may suggest that a property falls within this category across various EBC datasets. Example indicators include the Council Tax account holder having a different address to the property and the presence of four or more registered electors. Seven such indicators were identified in all.

2.5.11 On their own, these indicators are not sufficiently robust to indentify an HMO with a any degree of certainty. For example, many of the indicators used are strongly reliant on self-reporting processes (such as Council Tax registration) which present particular challenges for HMOs given the transient nature of occupant groups. There is also a degree of inconsistency and contradiction between the different datasets.

2.5.12 However, in combination, they can be used to generate a lower bound estimate of the potential number of smaller unlicensed HMOs. More importantly, they provide some understanding of their potential spatial distribution. Further detail on the indicators used and their limitations are provided in Appendix 2.1.

2.5.13 For the purposes of this study, if three or more indicators were satisfied for a property, it has been identified as a likely unlicensed HMO. It should be empahsised again that this is a deliberately conservative approach that is likely to significantly underestimate the number of properties. It is likely both to include mainstream residential properties that are not HMOs and to miss others that are HMOs. Though not even approximating a full estimate of their numbers or distribution, this approach represents a reasonable attempt to identify some of the relevant properties.

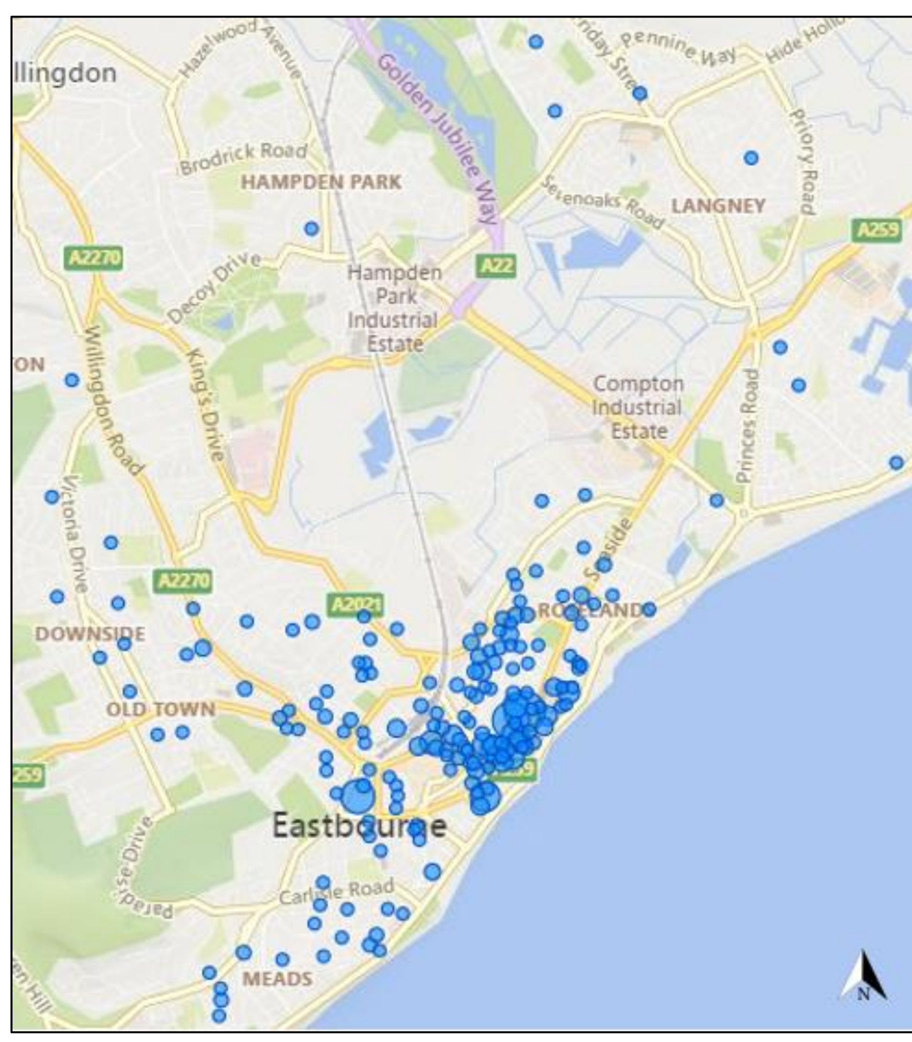
2.5.14 The approach results in the identification of a minimum of 72 smaller unlicensed HMOs in Eastbourne.

2.5.15 The spatial distribution of the sample of 72 potential unlicensed HMOs identified from this limited exercise is shown in added to the known licensed HMOs in Figure 2-10 to show the overall distribution of HMOs, noting again the significant limitations associated with the sample of unlicensed properties in particular. (Figure 2-3 is reproduced alongside for comparison with the distribution of licensed HMOs alone.)

2.5.16 Figure 2-10 shows that the potential unlicensed HMOs identified from the indicators are distributed very similarly to the licensed HMOs, although there are a few additional unlicensed HMOs scattered east of the A2290 in areas that are not known to have any existing licensed HMOs.

2.5.17 Given the way that this data on unlicensed HMOs and Section 257 properties has been gathered, it is not possible to make conclusions about trends over time beyond the anecdotal information from officers suggesting a growing trend in applications to convert both smaller terraced properties and guesthouses and hotels.

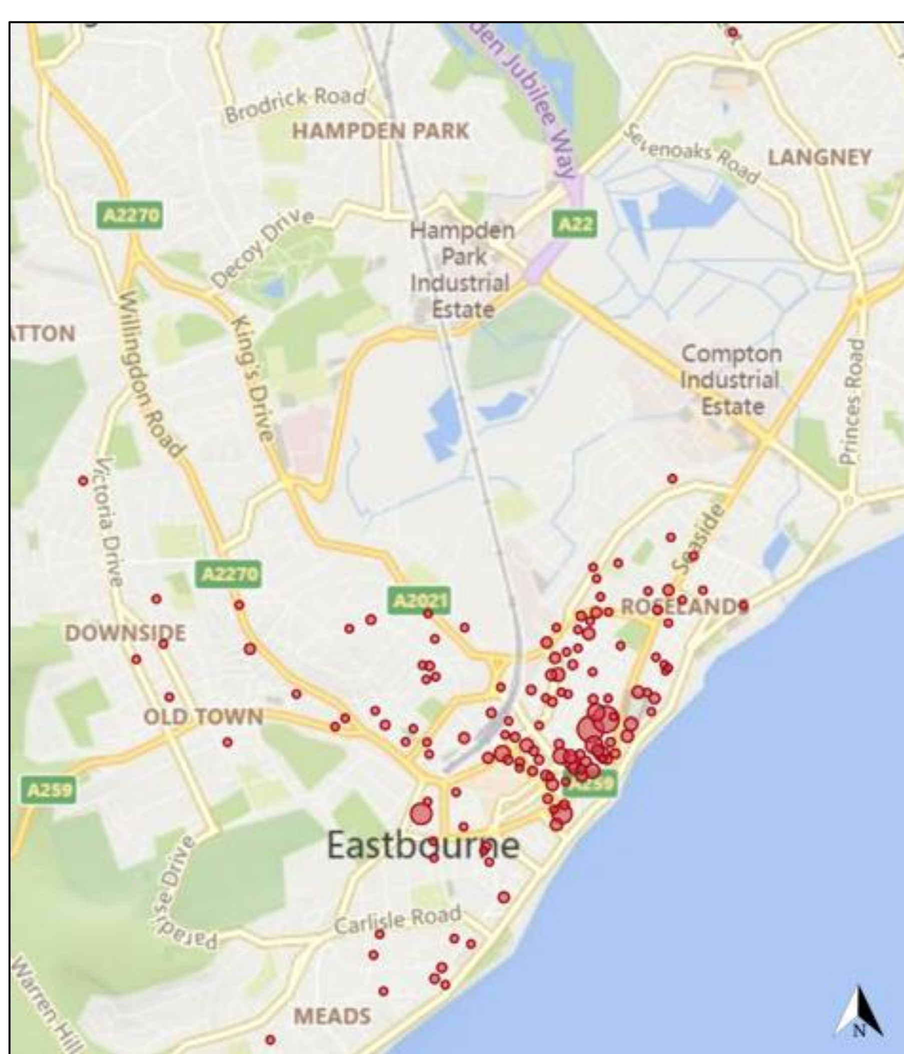
Figure 2-10: Location of Eastbourne's Licensed and Unlicensed HMOs



Source: EBC HMO Register / Council Tax / Electoral Register

(Blue bubbles represent Licensed and unlicensed HMOs within a postcode. The larger the size of the bubble, the more HMOs within that postcode)

Figure 2-3: Location of Eastbourne's Licensed HMOs



Source: EBC HMO Register

(Red bubbles represent Licensed HMOs within a postcode. The larger the size of the bubble, the more HMOs within that postcode)

2.6 Total Estimate of the HMO Stock and local authority comparison

2.6.1 This section has reviewed the current register of licensed HMOs and attempted to identify small samples of categories of HMO that are not tracked and are difficult to quantify. Combining these figures produces an overall lower-bound estimate of 400 HMOs in Eastbourne. This figure requires a strong caveat to emphasise that the unlicensed HMOs added to the licensed total (which is itself incomplete) do not represent a robust estimate, but only a limited sample of those able to be identified with a sufficient degree of confidence. This has been undertaken to establish their existence and (to a limited degree) their distribution. It is potentially misleading to sum these various lower-bound estimates, and has only been done here to provide an absolute minimum estimate of HMOs overall, which can be set in the context of the wider housing stock. It is highly likely that the number of the various types of HMO in Eastbourne far exceeds 400

2.6.2 This minimum sample represents approximately 0.8% of the total number of dwellings recorded in the 2021 Census. The individual breakdown of these HMO types is presented in Table 2-5.

Table 2-5: Combined lower-bound samples of the various components of Eastbourne's HMO Stock

	Licensed HMO	Unlicensed Smaller HMO	Section 257 Properties	Schedule 14 Properties
Count	318	72	10	-
Total		**400**		

2.6.3 By way of comparison, the 2021 Census, for the first time, includes an estimate of the number of HMOs in local authority areas. The figure for Eastbourne is 263, of which 80 are 'small HMOs' (defined as shared by 3-4 unrelated tenants) and 183 are 'large HMOs' (shared by 5 or more unrelated tenants). This is almost certainly an undercount given the number of licensed HMOs in the Borough is currently more than 280 as of August 2022. This inconsistency is not surprising given the likelihood of a lower and less consistent Census response rate among HMO occupants. However, this bottom-up count is useful in showing the potential number of unlicensed HMO properties, which further suggests that the conservative estimate given in Table 2-2 is likely to be a substantial undercount. This data is unfortunately not available for previous years, and is not able to be disaggregated to ward level or cross-referenced against address-specific EBC data.

2.6.4 Bearing these caveats in mind, the 2021 Census data does enable a comparison between local authority areas. Eastbourne's total ranks as the 110th highest of 318 local authorities, and is comfortably higher than the median count of 125 HMOs. However, the top local authorities are generally large cities, which would be expected to have high totals on any metric. Sorting the data by the percentage of all dwellings

that are HMOs gives Eastbourne a higher rank of 86th. Its percentage of 0.58% is nearly three times the median of 0.20%. Only 30 local authorities exceed 2% and only 59 exceed 1%. Most of the highest local authorities by percentage HMOs are London boroughs and university cities such as Oxford, Cambridge, Bristol and Nottingham. Brighton and Hove is the 12th highest and Hastings is actually lower than Eastbourne at 134th.

2.6.5 Although the tendency for this dataset to undercount HMOs is likely to be fairly consistent across locations, this data should be treated with a large degree of caution. For example, the review of precedents for intervention provided in Appendix 6.1 suggests that Hastings has closer to 2,800 HMOs – exceeding its Census estimate and available figures for Eastbourne by a significant extent. The other local authorities that provided an estimated total all exceeded the minimum count for Eastbourne (Doncaster: nearly 1,000; Portsmouth: 4,312; Bristol: 6,320; Northampton: 844). However, this sample is limited to examples that self-identify as having a 'problem' with HMOs. As such, while Eastbourne's count is lower than these examples, it is likely to be higher than the majority of other local authorities across the country. It is also important to note that the impact rather than the number of HMOs remains the key justification for action in most of the examples reviewed.

HMOs by Ward

2.6.6 Building on the licensed HMO ward data presented in Table 2-1, Table 2-6 presents the electoral wards in which all (licensed and unlicensed) HMOs are located in Eastbourne.

2.6.7 The addition of the lower-bound sample of unlicensed and Section 257 properties does not make a significant difference to the concentration revealed in Table 2-1. Devonshire remains the ward with the highest number of HMOs by a significant amount. The main difference is the wider geographical spread to wards with few licensed properties. The additional unlicensed properties slightly raise the proportion of the stock that is HMOs, to 3.6% in Devonshire and nearly 1% in Meads and Upperton.

2.6.8 It should be noted that whilst Table 2-1 includes a column for the 'number of rooms' within each ward, this same connot be provided in Table 2-6 as the data for the number of rooms in unlicensed HMOs and Section 257 properties was unavailable.

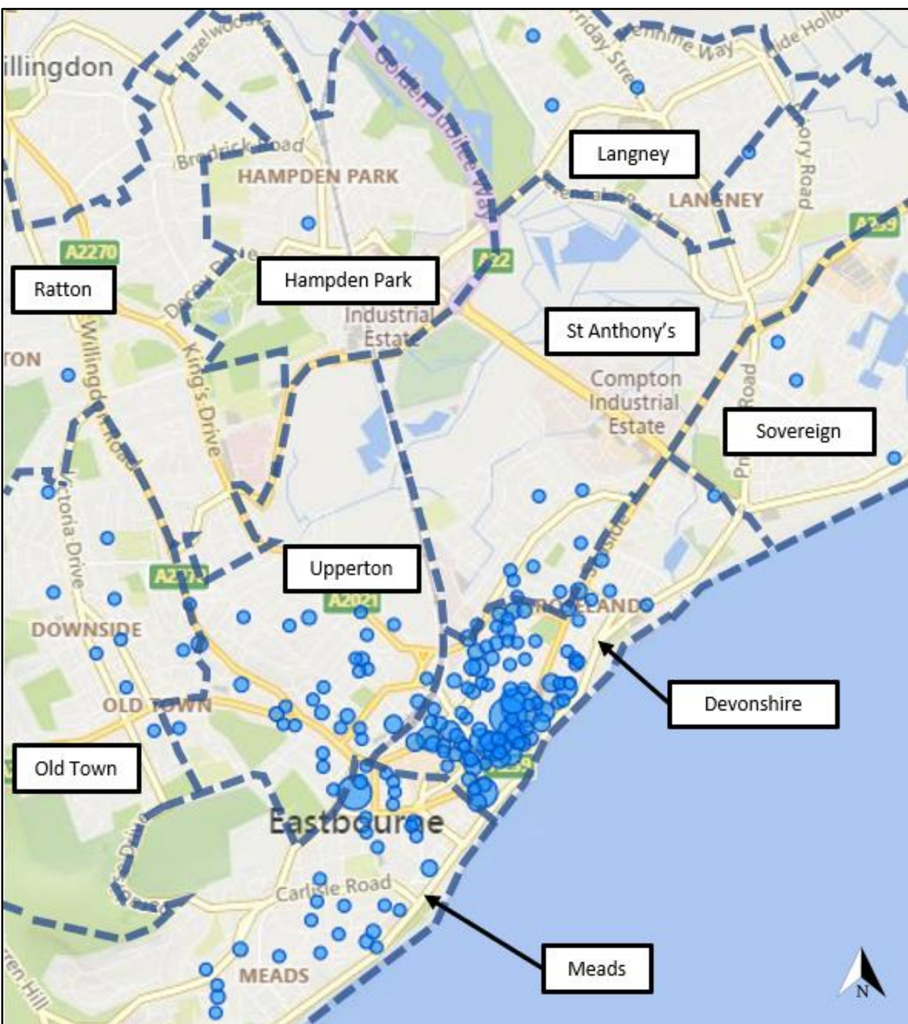
2.6.9 Figure 2-11 maps the estimated 400 HMOs in Eastbourne across ward boundaries. For comparison, Figure 2-12 has also been provided, which only maps Eastbourne's licensed HMOs.

Table 2-6: Location of Eastbourne's (Total) HMO Stock by Ward

Ward	Count	% of all HMOs	% of Stock
Devonshire	267	67%	3.6%
Hampden Park	1	0%	0.0%
Langney	3	1%	0.1%
Meads	57	14%	0.8%
Old Town	11	3%	0.2%
Ratton	2	1%	0.0%
Sovereign	3	1%	0.0%
St. Anthony's	15	4%	0.3%
Upperton	41	10%	0.7%
Total	**400**	**-**	

Source: EBC HMO Register

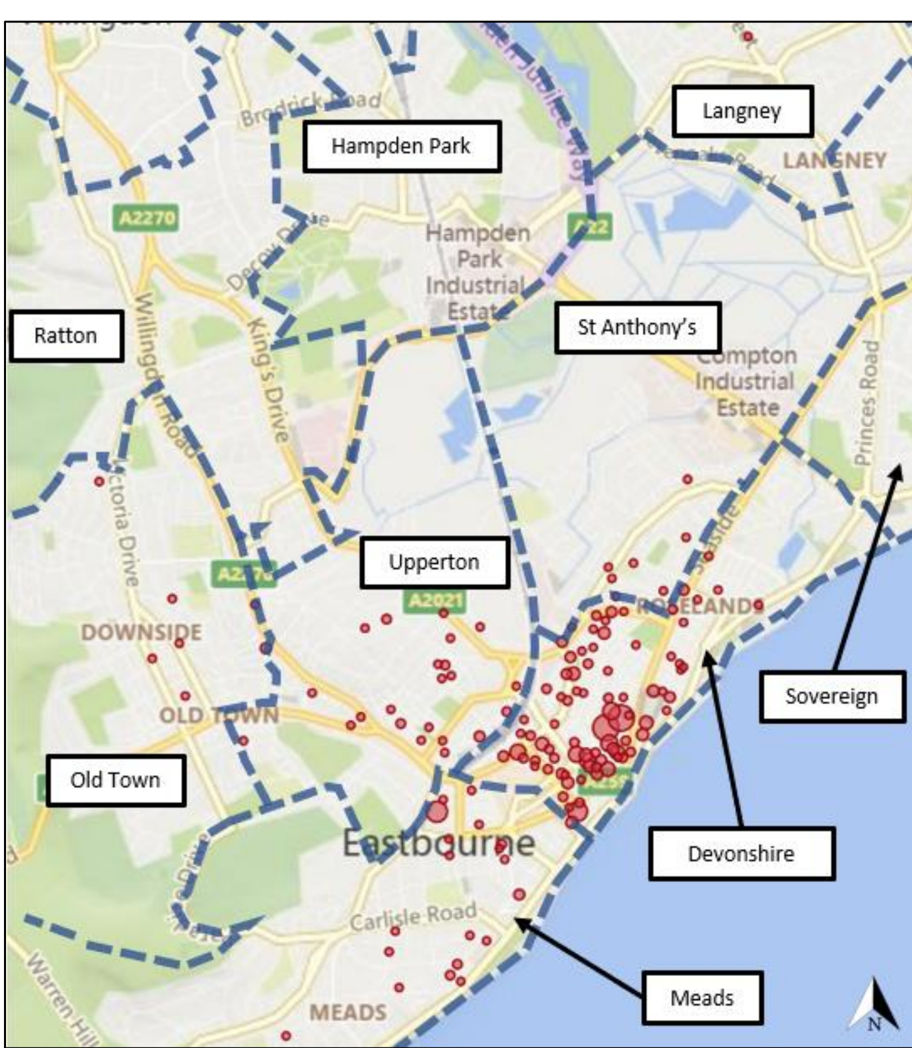
Figure 2-11: Location of Eastbourne's (Total) HMOs by Ward



Source: EBC HMO Register / Council Tax / Electoral Register

(Blue bubbles represent Licensed and non-licensed HMOs within a postcode. The larger the size of the bubble, the more HMOs within that postcode)

Figure 2-12: Location of Eastbourne's Licensed HMOs by Ward



Source: EBC HMO Register

(Red bubbles represent Licensed HMOs within a postcode. The larger the size of the bubble, the more HMOs within that postcode)

2.7 Summary

2.7.1 There are serious limitations with any estimate of the total number of HMOs in Eastbourne, as in most Local Authority areas where licensing and planning controls have not been expanded (a step that tends to allow for more accurate monitoring). This section has reviewed the available data to draw some conclusions about the scale, distribution and trends in the various types of HMO in Eastbourne.

2.7.2 There are 318 licensed HMOs recorded on EBC's register. The register of licensed HMOs is a reasonably accurate snapshot of the number of HMOs with five or more unrelated occupants, although it is possible that the register undercounts properties granted a licence in the past year due to a reporting lag. It is also relevant to note that any HMOs illegally operating without a licence are not reflected in this figure.

2.7.3 The 2021 Census count of HMOs by local authority clearly undercounts properties for a variety of reasons and cannot be used to produce accurate totals. However, it does enable comparison between local authorities. Eastbourne has the 110th highest number of HMOs by this metric (of 318 local authorities), and the 86th highest percentage of all dwellings that are HMOs. This percentage – 0.6% – is nearly three times the median of 0.2%. Eastbourne's number of licensed HMOs is the lowest of AECOM's review of precedents for intervention, although this sample by definition focuses on local authorities that have identified problems with the number or impacts of HMOs. It can be summarised that Eastbourne has a higher proportion of HMOs than most local authorities across the country, but lower totals than many of the authorities that have intervened in the market.

2.7.4 An attempt has been made to observe trends over time in the number and characteristics of Eastbourne's licensed HMOs using a historic snapshot of the register and the age of current licences. However, regulatory changes in 2018 that expanded mandatory licensing to cover HMOs with fewer than three storeys has a large apparent impact on the change over time. Likewise, the requirement for licences to be renewed every five years makes it difficult to separate new licences from renewals.

2.7.5 Bearing these caveats in mind, the data suggests that the mean average number of new or renewed licences granted in the years 2016-2021 is 49. This includes only those properties with licences that remain active in 2022. There has been a decline in new licences issued in recent years, from a peak of 99 licences in 2018 to 42 in 2020 and 8 in 2021. However, this reflects a spike in 2018 driven by the regulatory change as well as a lag in reporting in the latest year. The overall total number of licences in 2022 (318) is significantly higher than the total in 2015 (188). However, this does not express only the creation or conversion of completely new HMO properties. Rather, the figures again reflect the additional properties required to have a licence by the regulatory change in 2018 and enforcement actions increasing the visibility of existing HMOs.

2.7.6 The key finding from a review of this temporal data is that the actual number of licensed HMOs in Eastbourne is broadly increasing over time. However, the actual rate of growth is likely to be significantly lower than the perception created by headline

statistics, which conceal a number of contextual factors leading to the greater visibility of HMOs which may have been operating for some time.

2.7.7 In terms of their characteristics, almost 60% of Eastbourne's licensed HMOs have five or six bedrooms, with the remaining 40% mostly split between properties with 7-19 bedrooms. Though data is not available for unlicensed properties, it is likely that most of the smaller HMOs (i.e. those below the size threshold for licensing) have 3 - 4 bedrooms, and that the Section 257 properties have more than 10 bedrooms.

2.7.8 In terms of their spatial distribution, Eastbourne's licensed HMOs are heavily concentrated in the town centre. Nearly three-quarters of them are located in Devonshire Ward, 11% are in Meads Ward, 9% are in Upperton Ward, and no other ward is home to more than 4%. The proportion of the overall housing stock in each ward that are licensed HMOs remains small at 3% in Devonshire Ward, and around 0.5% in Meads and Upperton Wards.

2.7.9 The data on unlicensed HMOs is severely limited because they tend not to be centrally recorded for planning or licensing purposes. An indicative sample of smaller unlicensed HMOs (falling below the size threshold above which a licence is required) has been generated using a range of indicators detailed in Appendix 2.1. This process indicates that there are potentially many such properties across the town. Only a lower-bound sample of 72 properties that could be identified with a reasonable degree of confidence have been mapped. Their distribution is broadly similar to that of licensed HMOs. No information on their detailed characteristics (e.g. number of bedrooms) is available.

2.7.10 The methods available for identifying larger Section 257 and Schedule 14 properties are even more limited. No attempt to quantify these have been made, but an indicative sample of 10 probable Section 257 properties has been identifed through the local knowledge of EBC officers. This demonstrates their existance and, given the wide availability of former hotel and guesthouse accommodation in Eastbourne, suggests that many more are likely to be present in the town. Such properties may exert similar impacts to other HMO categories, particularly with regard to their external condition and effects on the streetscape, but the degree of behavioural impacts is likely to vary depending on the physical and management arrangements in place.

2.7.11 Though the count of HMOs given in the 2021 Census is not sufficiently reliable for understanding overall numbers, it does enable a reasonable comparison of the rate of HMO provision across local authorities. Eastbourne has the 86th highest proportion of properties that are HMOs by this measure, of 318 authorities across the country. Its percentage of 0.6% is nearly three-times the national median of 0.2%.

2.7.12 Finally, EBC data on planning applications for residential to 'sui generis' conversion (the only form of HMO conversion currently requiring planning permission) suggests that an average of 13 such HMOs have recieved permission in each of the last ten years. Though the data appears to show a significant uptick in the most recent four years, EBC officers note that this is likely to be a function of enforcement action requiring HMO licence holders without appropriate planning permission to apply retrospectively. As such, some of this growth again reflects the increased visbility of existing properties. Nevertheless, the new permissions among this small sub-set of

HMOs indicates that their numbers may be rising overall, and the EBC Development Management team have also observed a growing trend of converions from small terraced dwellings and tourist guest houses to HMOs.

3. Condition of HMOs

3.1 Introduction

3.1.1 This section is concerned with the physical condition of Eastbourne's HMOs. This is a feature of the age and construction of HMOs that also touches on the experience of living in and around them. As such, this topic bridges the gap between the characteristics of the current stock of HMOs reviewed in Section 2 and the analysis of potential HMO impacts to follow in Section 4.

3.1.2 Some secondary data helps to illuminate matters of building condition, but the key source of information for this section is a piece of fieldwork conducted by AECOM in Spring 2023. This involved the external inspection of a sample of 60 HMO properties by building surveyors. The sample of randomly selected addresses was controlled to give a broadly proportionate representation of licensed (40), smaller unlicensed (14) and Section 257 properties (6), and to reflect their spread across the Borough.

3.1.3 The purpose of this fieldwork was to establish whether HMOs are fit for purpose and serving their occupants well, and whether they are having any visible impacts on the surrounding locality. A copy of the inspection form is provided in Appendix 3.1. It covers the following three overarching categories:

- **Condition & Management:** an assessment of external features of each property, such as condition of the roof, garden, and windows.
- **Safety & Security:** covering health and safety issues of each property, as well as its surrounding area.
- **Surrounding environment:** an assessment of the conditions in the HMO's proximity.

3.1.4 Within these categories, a number of individual items were assessed. Each of these were assigned one of the following ratings:

- Green - good condition or minor deterioration;
- Amber – needs repair / decoration; or
- Red – needs replacement.

3.1.5 Unlike the doorstep surveys conducted to assess the perceived impacts of HMOs on their occupants and neighbours analysed in Section 4, the external inspections were not conducted on a control group of non-HMOs. Although this means that it is not possible to conclude whether HMOs are more likely to exhibit condition issues than the wider housing stock, the evidence remains useful in highlighting whether and what issues are present, as well as how widespread they appear to be. It is important to emphasise that the inspections represent a snapshot in time that may also not fully represent the longer-term picture, particularly around temporary issues such as waste and litter.

3.1.6 This section presents the results of this fieldwork and supplements with publicly available data which allows for greater comparison between the condition of HMOs and non-HMOs in Eastbourne.

3.2 AECOM Inspections Results

Condition & Management

3.2.1 For the Condition & Management category, the general conclusion across the individual inspection topics (a selection of which are presented in Figure 3-4 to Figure 3-7) was that most properties were rated green or amber.

3.2.2 The specific inspection topics 'roof condition' (Figure 3-6), 'external walls' (Figure 3-7), and 'boundary walls/fencing', received the least favourable ratings within the Condition & Management category, with all three topics having more amber ratings than green. However, on a positive note for these three topics, only two properties for all three of these topics were rated red.

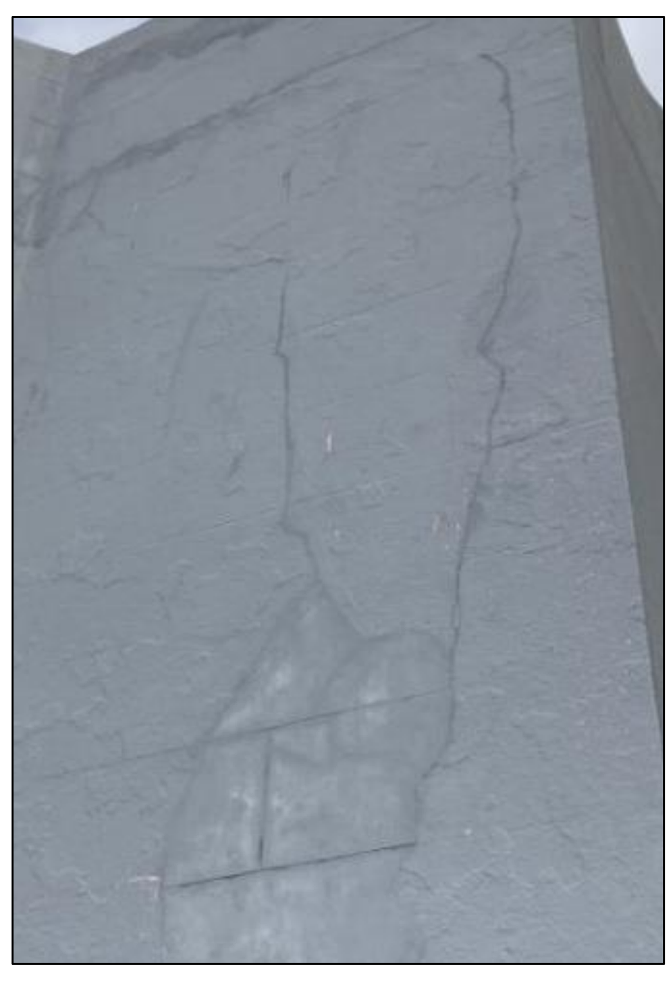
3.2.3 For the roof condition ratings, comments left by the inspection team suggested that the amber ratings were given for either 'missing tiles' or (more commonly) the need to clean moss from the roof (Figure 3-1).

Figure 3-1: An example of loose roof tiles and moss from AECOM inspection surveys

3.2.4 For the external walls rating, the inspection generally identified the need for 'redecoration', repairs due to 'spalling' (see Figure 3-2), and the need to repair 'hairline cracks'.

Figure 3-2: An example of external wall spalling from AECOM inspection surveys

Figure 3-3: An example of external wall hairline cracks from AECOM inspection surveys



3.2.5 For all other inspection topics within this category, the green ratings outweighed the amber ratings. These include structural damage (Figure 3-4), rainwater goods (Figure 3-5), garden areas, chimney condition, external doors condition, parking area, recent maintenance, bins, and post/mail facilities.

3.2.6 Of note, one of the best scoring topics within the Condition & Management category was the garden areas category, which saw 53 out of 56 properties receive a green rating.

3.2.7 In summary, this category suggests that the sampled HMO properties are generally in a reasonably good condition, although a fair proportion of properties could benefit from investment to repair certain aspects of each property, particularly the roof and property walls.

3.2.8 Of the properties surveyed, there did not appear to be any trends that stood out in relation to particular HMO types, with the distribution of scores being generally consistent across HMO types.

Figure 3-4: Structural Damage Inspection Rating

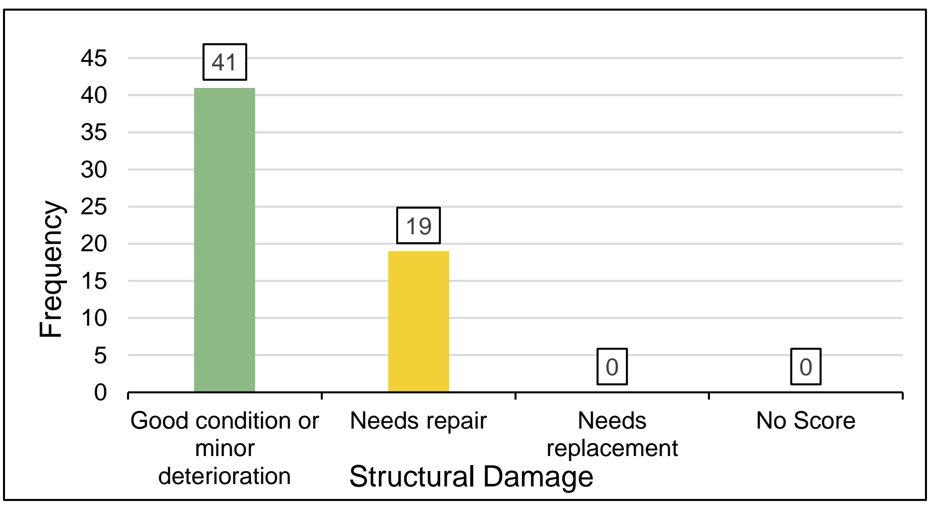


Figure 3-6: Roof Condition Inspection Rating

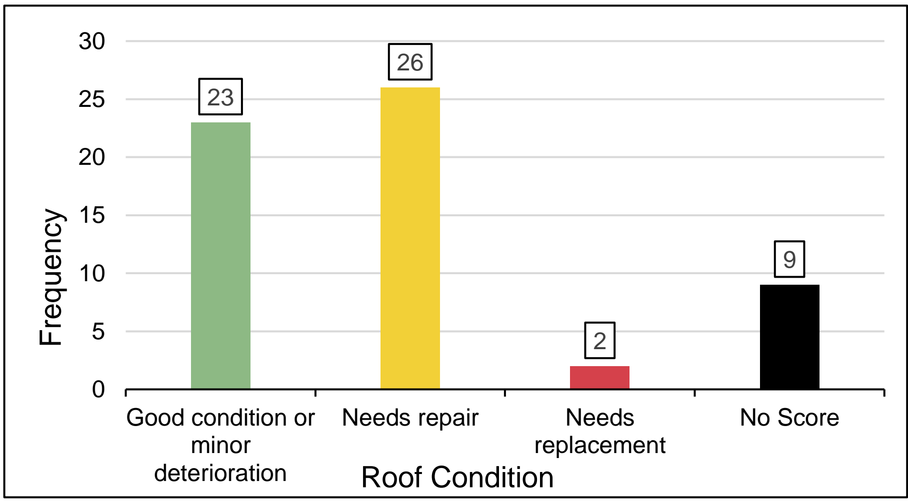


Figure 3-5: Rainwater Goods Inspection Rating

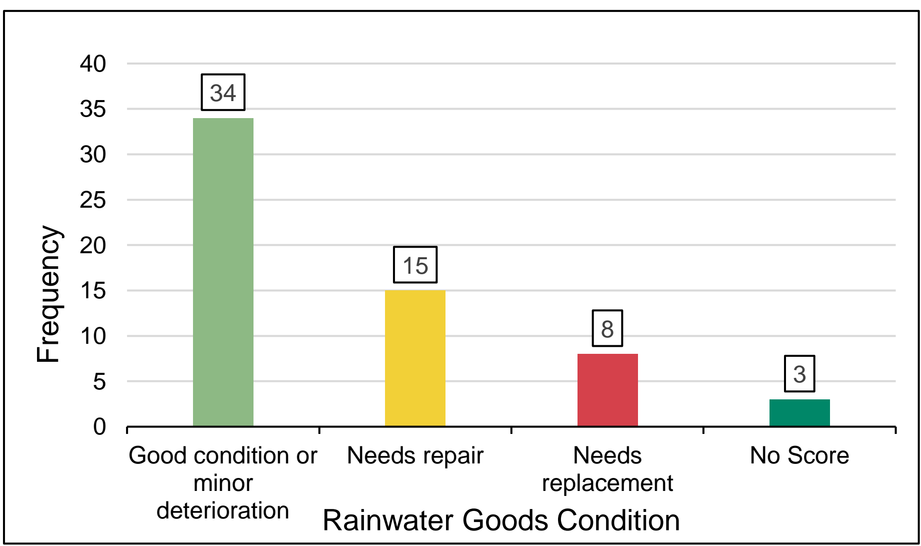
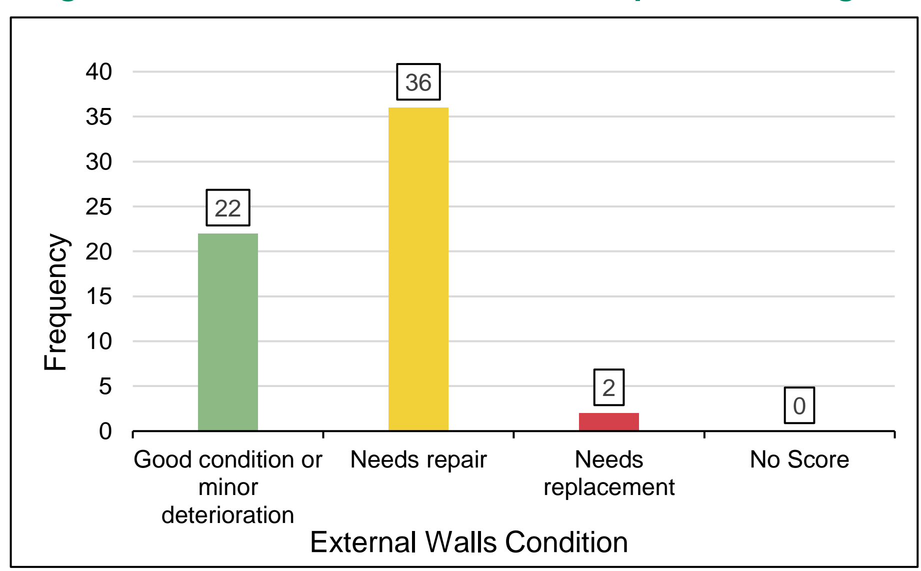


Figure 3-7: External Walls Condition Inspection Rating



Source for all: AECOM Inspection Data

Safety & Security

3.2.9 The individual inspection topics for this category are ‘suitable lighting’ (Figure 3-11), ‘safety issues’ (Figure 3-12), and ‘security issues’ (Figure 3-13).

3.2.10 Overall, the ratings within the Safety & Security category were positive, with the majority of dwellings returning a green rating in all of the inspection topics.

3.2.11 The few concerns related to this category were found in the ‘safety issues’ category, where 10 amber or red ratings were returned. These were generally related to ‘loose wires’ (see Figure 3-8), although there were three properties noted to have an ‘exposed gas main box’ (see Figure 3-9).

3.2.12 In the ‘security issues’ category only two negative ratings (both red) were returned. These ratings were awarded due to ‘open entry’ at one property and a broken door frame on another.

3.2.13 Of the properties surveyed, there was a higher concentration of negative scores for the licensed HMOs in the ‘safety issues’ category when compared to unlicensed HMOs and Section 257 properties. For the other categories, there did not appear to be any trends that stood out in relation to particular HMO types, with the distribution of scores being generally consistent across HMO types.

Figure 3-8: An example of a loose wire from AECOM inspection surveys

Figure 3-9: An example of an exposed gas main box from AECOM inspection surveys

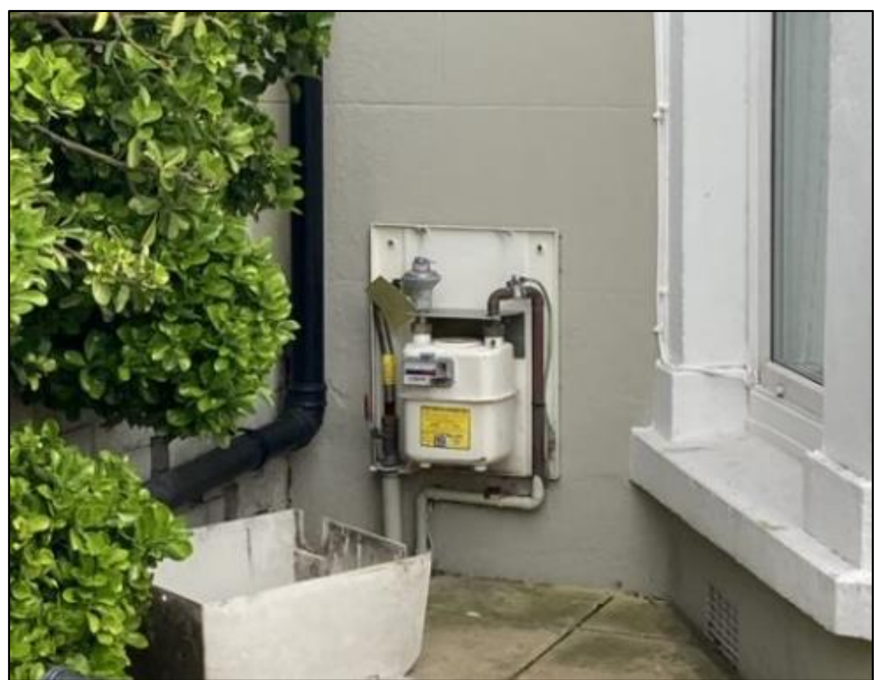


Figure 3-10: An example of a property with open entry from AECOM inspection surveys

Figure 3-11: Suitable Lighting Inspection Rating

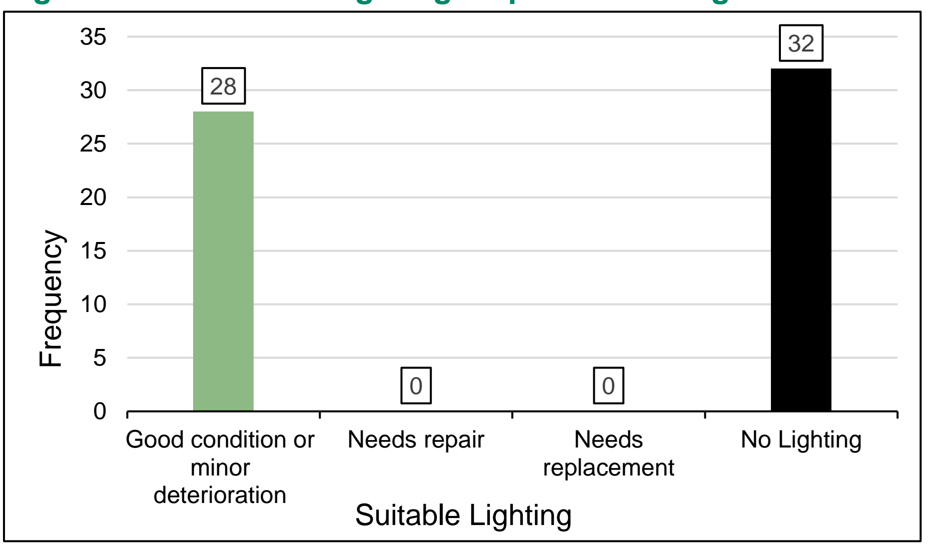


Figure 3-12: Safety Issues Inspection Rating

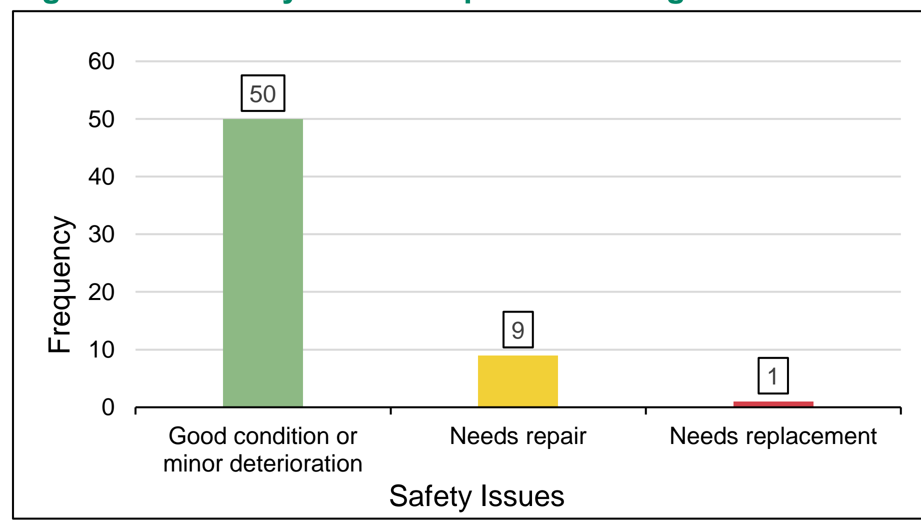
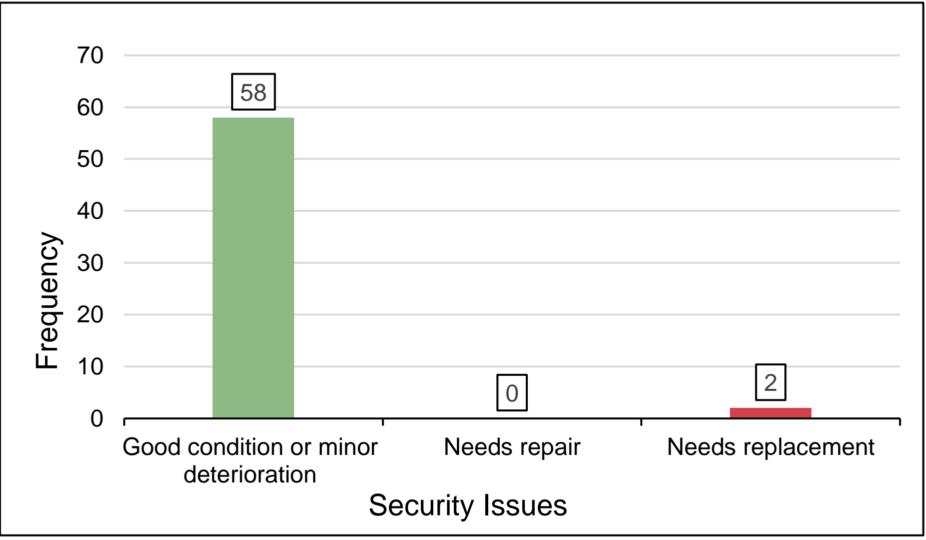


Figure 3-13: Security Issues Inspection Rating



Source for all: AECOM Inspection Data

Surrounding Environment

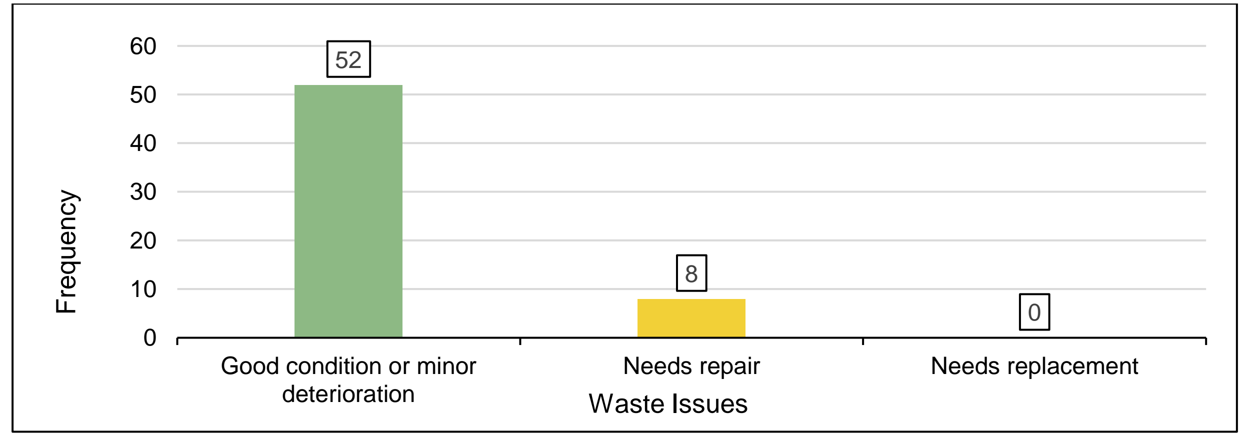
3.2.14 The individual inspection topics for this category are 'waste issues' (Figure 3-14), 'pest issues', vandalism issues', 'local character issues', 'tenant action issues' and 'other issues'.

3.2.15 Similar to the Safety & Security category, the majority of topics within the Surrounding Environment category for all inspected properties generally returned positive green ratings.

3.2.16 Only 'waste issues' returned more than five yellow ratings, where the ratings were awarded for five cases where there were no bins, and three cases of fly tipping waste in the back garden (see Figure 3-15).

3.2.17 Of the properties surveyed, there did not appear to be any trends that stood out in relation to particular HMO types, with the distribution of scores being generally consistent across HMO types.

Figure 3-14: Waste Issues Inspections Rating



Source: AECOM Inspection Data

Figure 3-15 : An example of fly tipping from AECOM inspection surveys

3.3 Energy Performance Certificate Data

3.3.1 This sub-section analyses publicly available data on Eastbourne’s dwelling stock to better understand the nature of physical issues associated with HMOs that may have a bearing on the quality of life of occupants or impact on the surrounding environment, and whether these are more common for HMOs than the wider housing stock.

3.3.2 The primary source of information that can shed light on the condition of properties in Eastbourne is the Energy Performance Certificates (EPC) data, which is publicly available on the Government website. EPCs provide an overall energy performance rating for a property which is determined through a survey of variables associated with energy efficiency. These certificates are mandatory for newly constructed, sold, or rented buildings. The data warrants a number of caveats:

- Not all HMOs have EPC data because they have not all been constructed or transacted since the introduction of EPCs in 2008. Data is available for 261 of the known 318 licensed HMOs (82% of licensed HMOs).
- EPC data sometimes has two (or more) entries for the same property if a test has been conducted more than once since 2008. The data has been filtered to include the most recent inspection data for every unique building reference number.
- Correlation does not necessarily mean causation. Therefore, throughout this sub-section, it should be understood that there may be wider drivers for the trends observed.

Overall Energy Performance Rating

3.3.3 Figure 3-16 presents the overall energy performance rating of dwellings in Eastbourne, comparing Eastbourne's licensed HMO properties to its non-HMO properties. It shows that:

- The average HMO in Eastbourne tends to have a lower energy rating than the average non-HMO.
- The proportion of Eastbourne’s non-HMO dwellings with energy ratings of A, B, and C are all higher than their equivalent proportions for HMO properties.
- Over half of the HMO properties have a current energy rating in Category D, whereas the equivalent proportion for non-HMOs is 39%.
- Finally, in the poorer performing rate categories (E, F, and G), HMOs and non-HMOs generally had similar proportions for each.

3.3.4 As such, the comparison suggests that HMOs are less likely to excel in their energy performance than non-HMOs, but are no more likely to have very poor performance ratings.

Figure 3-16: Overall Energy Performance Rating for Eastbourne's HMOs and Non-HMOs

Current Energy Performance Rating	HMO	Non HMO
A	0%	0%
B	2%	7%
C	18%	36%
D	60%	39%
E	15%	14%
F	2%	3%
G	3%	1%

Percentage of Total

Source: EPC Data

3.3.5 In addition to providing an overall energy performance rating, EPC datasets include a record of variables such as the type of window glazing and the energy efficiency of light fixtures. These variables are potentially relevant here because they provide an indication about whether properties are being looked after.

Windows

3.3.6 Figure 3-17 and Figure 3-18 present the data for window glazing type and overall window energy efficiency for properties in Eastbourne's licensed HMO and non-HMO properties.

3.3.7 Beginning with glazing type, around 90% for both HMO and non-HMO properties had some form of double glazing or secondary glazing. The majority of the remaining dwellings had no data, leaving only a small proportion (1% or under) with single or triple glazing for both HMO and non-HMO properties.

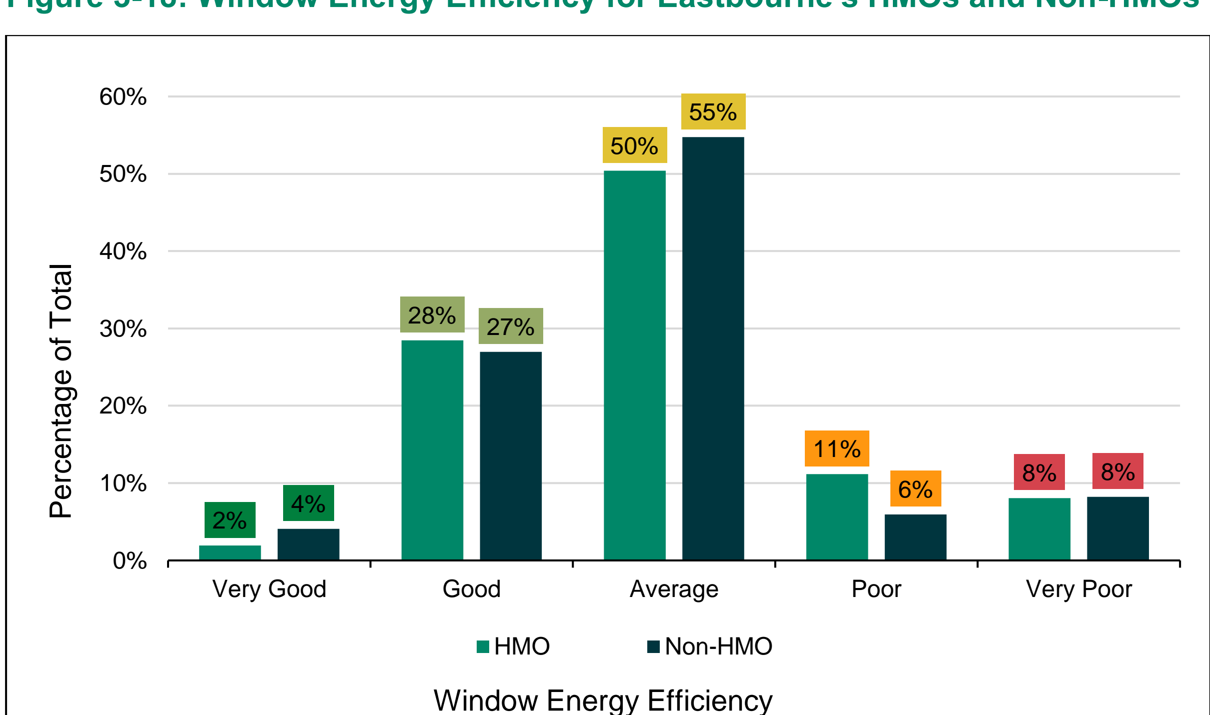
Figure 3-17: Glazing Type for Eastbourne's HMOs and Non-HMOs

Percentage of Total
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
0%
0%
89%
87%
0%
1%
10%
12%
Triple Glazing
Double Glazing / Secondary Glazing
Single Glazing
No Data
HMO
Non-HMO
Glazing Type

Source: EPC Data

3.3.8 Turning to the overall window energy efficiency variable, Figure 3-18 shows that there is not much difference between HMO and non-HMO properties, especially at the extremes of the scale (for very good, good, and very poor, their equivalent proportions are within 2% of each other). At the average and poor ratings, there is a 5% difference in percentage points between the two datasets, with non-HMOs having the extra 5% in the (more favourable of the two) average category, whereas HMOs had 5% more in the (less favourable of the two) poor category.

Figure 3-18: Window Energy Efficiency for Eastbourne's HMOs and Non-HMOs

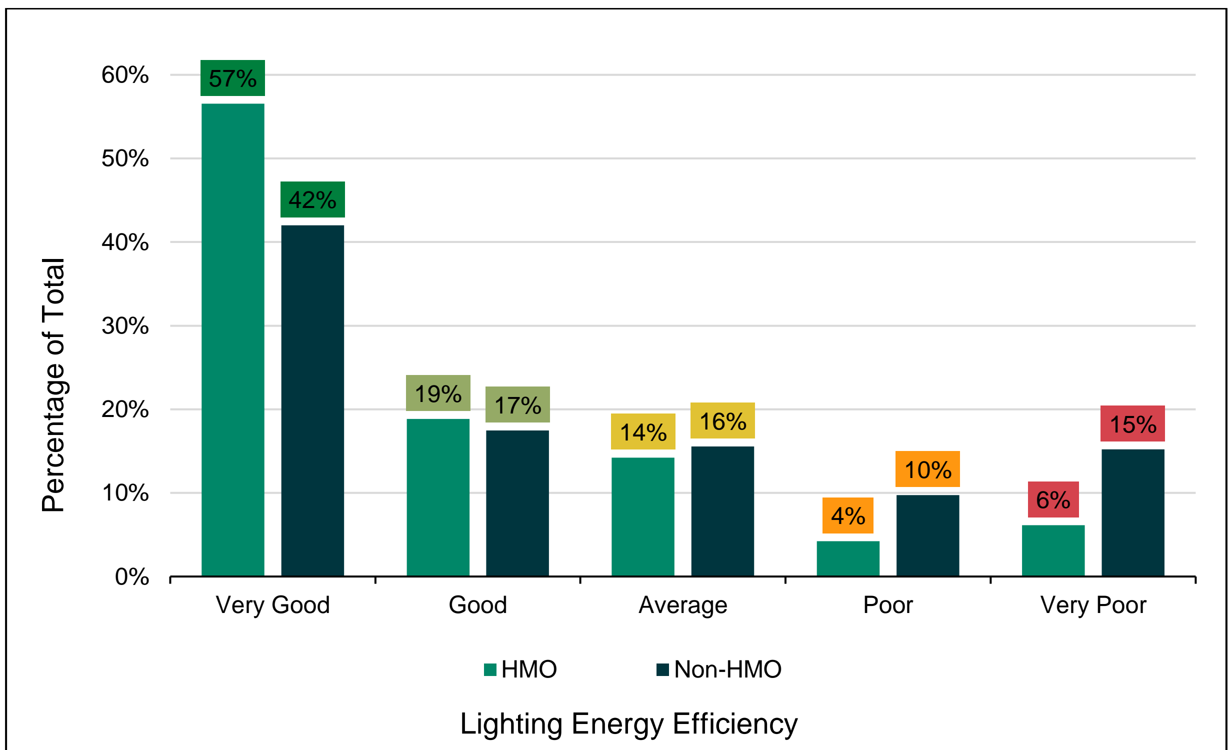


Source: EPC Data

Lighting

3.3.9 Figure 3-19 presents the lighting energy efficiency rating for Eastbourne's HMO and non-HMO properties. It shows that, on average, Eastbourne's HMO properties are more efficient when compared to Eastbourne's non-HMO. All of the 'positive' ratings (very good and good) have a higher proportion for the HMOs, whereas the proportion of HMOs with a 'negative' (poor and very poor) or Average rate is lower for HMOs. This may be because tenants of HMOs tend to have bills included in their rent, meaning that landlords are incentivised to save on utilities where possible.

Figure 3-19: Lighting Energy Efficiency for Eastbourne's HMOs and Non-HMOs



Source: EPC Data

3.4 Summary

3.4.1 The results of fieldwork conducted by AECOM in Spring 2023 to assess the external condition of a representative sample of Eastbourne HMOs provide the following key findings. The sample was limited in size and represents a single snapshot in time, so the results may not be representative of all HMOs or of the condition of the HMOs assessed over the log-term. Indeed, anecdotal evidence from EBC officers suggest that problems are more widespread than indicated by this element of the research.

- **Condition & Management**: the most common issues related to the condition of property roofs, external walls and boundary walls/fencing. More properties within the HMO sample were rated as showing deterioration and requiring repair in these areas than being in good condition. Although such issues are widespread, the specific problems identified are relatively minor. They include

missing roof tiles, spalling (weathering) and hairline cracks. On the more serious topic of structural damage, less than a third of properties required light repair and none required more serious attention. Perhaps surprisingly, and which possibly indicative of attentive management, the sample received positive ratings for issues related to bins in or clearly associated with a given property boundary, post/mail facilities and garden maintenance.

- **Safety & Security**: the majority of HMOs inspected received a positive rating across all of the categories considered. The concerns raised were concentrated in the topic of safety issues, with 10 properties identified as requiring attention – mostly related to loose wires and exposed gas mains. There were very few security issues highlighted; the two that were identified related to broken or open entryways that are considered significant impacts on occupant safety.
- **Surrounding Environment**: this category sought to assess the knock-on impacts of HMOs on their immediate surroundings, although most of the evidence gathered would be circumstantial (i.e. it is not clear that the HMOs directly cause issues of local character such as vandalism). The majority of HMOs received positive ratings on the various sub-topics. Only waste issues presented more than five non-positive ratings. These cases involved a lack of bins or of waste resembling fly tipping in the back garden.

3.4.2 To summarise the inspections findings, it is observed that Eastbourne's HMOs are for the most part free of issues relating to their security and environment. The inspection for the condition of HMOs did reveal wider concerns related to the state of roofs, external walls, and boundary walls in over half of the properties surveyed. However, these concerns were noted to need repair, rather than replacement. This might imply similar issues of condition internally (as AECOM's inspections were external only) but this cannot be confirmed in this study.

3.4.3 Issues of higher concern were identified in the inspection for only a small number of properties. The specific issues were broken entryways, significant waste in the garden, and matters requiring structural repair.

3.4.4 Overall, the story of the inspections data is one of a small number of problem properties rather than of widespread issues; although Eastbourne's HMO stock could generally benefit from some form of maintenance to improve the condition of the properties. It can also be concluded that most of the more significant physical and visible issues are of greater concern to HMO occupants than to the wider streetscape and community. The potential impacts affecting the latter may be more a function of the activities of occupants than of the physical presence of HMO buildings and their condition. This will be tested in Section 4.

3.4.5 EPC data suggests that HMOs are generally less efficient than the non-HMO housing stock, but this is predominantly because fewer HMOs excel in their energy performance than other homes in the mainstream stock. HMOs are no more likely to have an extremely poor energy rating than the wider stock. This relationship holds true when comparing specific categories such as window and lighting quality and efficiency.

4. Impacts

4.1 Introduction

4.1.1 As noted in Section 1 of this report, research literature and the experience of other local authorities suggests that HMOs have the potential to exert a wide range of impacts on residents and communities. Section 3 considered physical issues arising from the condition and use of HMO properties and any impacts on the surrounding streetscape. Section 5 explores the role of HMOs in the wider property market. This section seeks to understand various other impacts that may be present in Eastbourne, so far as these can be measured. The topics presented are summarised below, with caveats about their limitations:

4.1.2 The first sub-section presents the results of a series of doorstep interviews conducted in Eastbourne in Spring 2023 that capture the intangible effects of HMOs on resident wellbeing and the local community. Although clear conclusions emerge when comparing areas of high and low HMO concentration, there are inherent uncertainties about whether HMOs have a direct or contributory impact on the issues identified. Qualitative responses provide a further sense of community perceptions about the role of HMOs in local issues.

4.1.3 The next sub- section reviews secondary data relating to deprivation and crime, which supplements the survey results on those topics. Again, it should be noted that this information can only demonstrate correlation between the presence of HMOs and the presence of suspected impacts, and not a direct causal relationship. The findings could be supplemented by EBC data on noise complaints, police call outs and inspection reports if this information becomes available in future.

4.1.4 The final sub-section considers the knock-on impacts of HMOs on Eastbourne's tourist economy, in terms of the loss of hotels to HMO conversion and the effects of HMO concentration on local businesses. The evidence on the former point uses robust secondary data but again cannot prove a direct causal link, while the latter point is largely anecdotal, drawn from conversations with key local stakeholders.

4.2 Survey Evidence

4.2.1 EBC commissioned AECOM to undertake primary research to gather evidence on the potential impacts HMOs are having on residents and surrounding neighbourhoods. The results provide robust data on the intangible impacts experienced by local people and an additional source of local insight about the other issues considered in this study.

Methodology

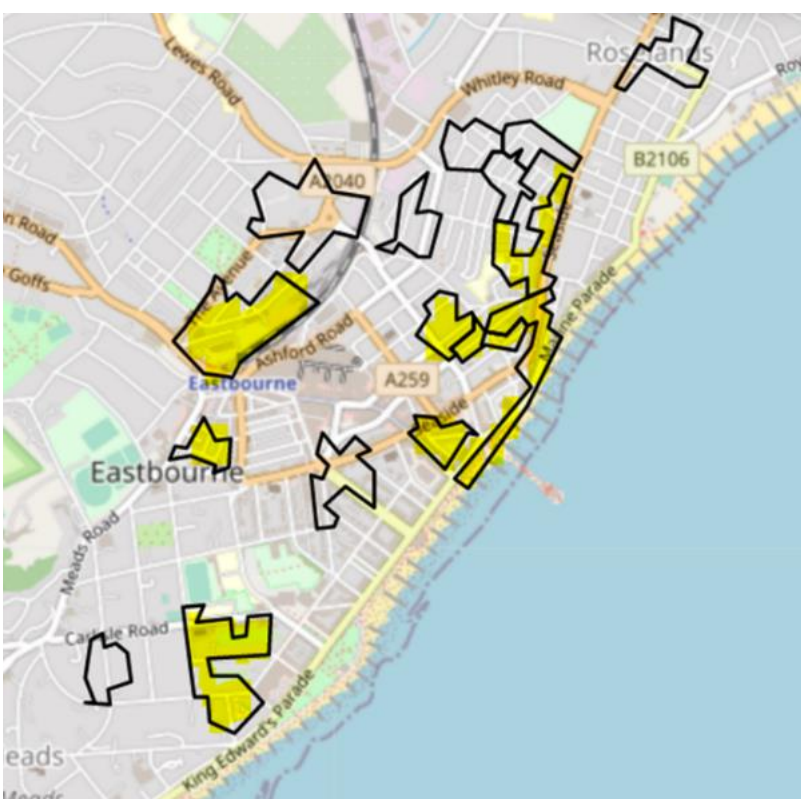
4.2.2 The fieldwork consisted of a series of doorstep interviews of Eastbourne residents, undertaken between 13th March and 23rd April 2023. A survey questionnaire was devised to capture respondents' views about their area across a number of relevant

themes (closed questions), as well as any broader issues they wished to raise (open questions). A blank copy of the full survey questionnaire is supplied in Appendix 4.2.

4.2.3 The interviews were conducted in areas of high HMO concentration (the core sample) as well as otherwise similar areas of low HMO concentration (the control sample) in order to compare findings. The control areas are within the same close radius around the town centre as the core areas and have similar rates of private renting and IMD scores. They are not outlying suburbs.

4.2.4 A total of 426 interviews were completed; 224 were from the core area and 202 from the control area. Details of the specific areas targeted are presented in Figure 4-1 below, and the rationale for their selection is provided in Appendix 4.1.

Figure 4-1: Survey Areas - Core Areas (in yellow) and Control Areas (no highlight colour)



4.2.5 In addition to the comparison of the core and control sample, the responses of HMO occupants themselves can be isolated where appropriate to identify any specific impacts they face and whether they hold different views to the wider community. In total 52 of the respondents (all in the core sample) lived in HMOs. This was asked by the surveyor in order not to lead responses, but was categorised after the fact using the property address. Because of this relatively small sub-sample, the results should be treated with caution. Because HMOs are not necessarily unified households, in some cases multiple occupants completed the survey. The 52 HMO respondents occupied 42 HMOs. For non-HMO households, one member of the household was asked to complete the survey.

4.2.6 To ensure an unbiased interpretation of the responses received, AECOM were appointed to carry out the following tasks:

i. Quantitative analysis of the closed questions and demographic questions;
ii. Thematic coding and analysis of open-end questions; and
iii. Cleaning and analysis of location data provided.

4.2.7 All free-text responses were grouped into themes to allow meaningful analysis. A code frame outlining the themes allowed for quantitative analysis of the responses.

4.2.8 Percentages shown for the open-ended comments are of those who provided a comment.

4.2.9 Statistical significance testing was completed. Where results are reported as different between sub-samples, this means those differences are statistically significant from each other. Only data which is statistically significant has been reported. This is particular relevance to the sample of HMO occupants, which is only represented in some graphs where its results can be isolated with a sufficient level of statistical significance.

Respondent demographic profile

4.2.10 Over half of the respondents were aged 35 to 64 (55%), with 21% being aged 65 and over and 24% aged 16 to 34. There was also a greater proportion of those who were working compared to those who are not working (65%, 35% respectively).

Figure 4-2: Demographic data

Age	16-34	All respondents	24%
		Census	24%
	35-64	All respondents	55%
		Census	46%
	65+	All respondents	21%
		Census	30%
Gender	Male	All respondents	50%
		Census	47%
	Female	All respondents	50%
		Census	53%
Work	Working	All respondents	65%
		Census	52%
	Not working	All respondents	35%
		Census	48%

Base: All respondents (426)

4.2.11 When comparing with the Census 2021 data for the entire Borough, a higher proportion of respondents aged 35-64 were interviewed (55%) compared to 46% of 35-64 recorded during the Census 2021. In addition, a higher proportion of working respondents (65%) were interviewed compared to 52% recorded in the Census 2021.

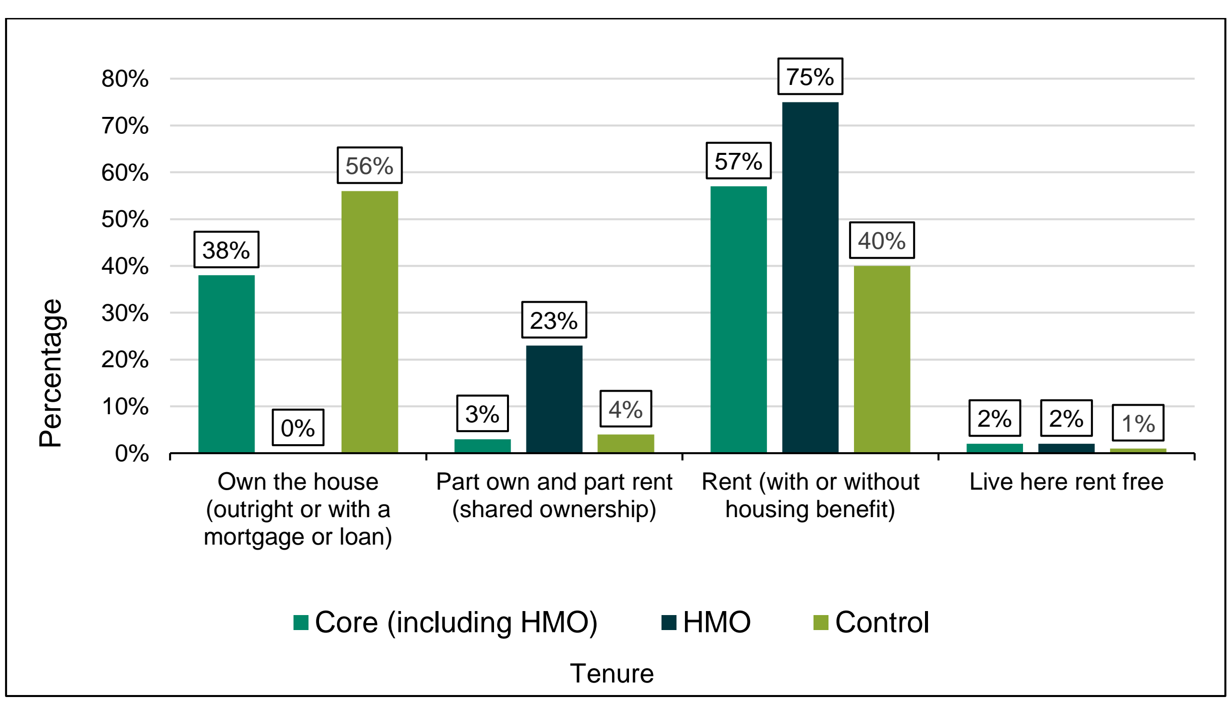
Tenure

4.2.12 Overall, around half of respondents rented their home (49%) and half owned (46%), with the remainder in shared ownership or living rent free. Those living in HMOs were all renting or said they lived in shared ownership. Given that HMOs are rented by definition and it is not possible to part own unless you are the landlord and occupant (or, for instance, a family member of the landlord), it is likely that this represents some misunderstanding of the available categories.

- Over half of those in the control sample own their house compared to two fifths of those in the core sample (56% and 38% respectively)
- More respondents in the core area rented; Seventy five percent of the respondents who rent (with or without housing benefit) lived in HMOs.

4.2.13 Of those that rent, 83% said their landlord was a private landlord or letting agency whilst 2% were housing association, housing cooperative, charitable trust or registered social landlord. The remaining were either employer, household member, relative or friend.

Figure 4-3: Property tenure



Base: Core including HMO (224), HMO (52), Control (202)

**Note the small base for HMOs*

Rating of the neighbourhood

4.2.14 All respondents were asked to rate the area they live in from 0 to 10, with 0 being very dissatisfied and 10 being very satisfied. The average satisfaction rating given by control respondents was 7.99, whereas the average rating of core respondents (including HMO respondents) was slightly lower at 7.74. Those living in HMOs were the least satisfied with an average score of 7.50.

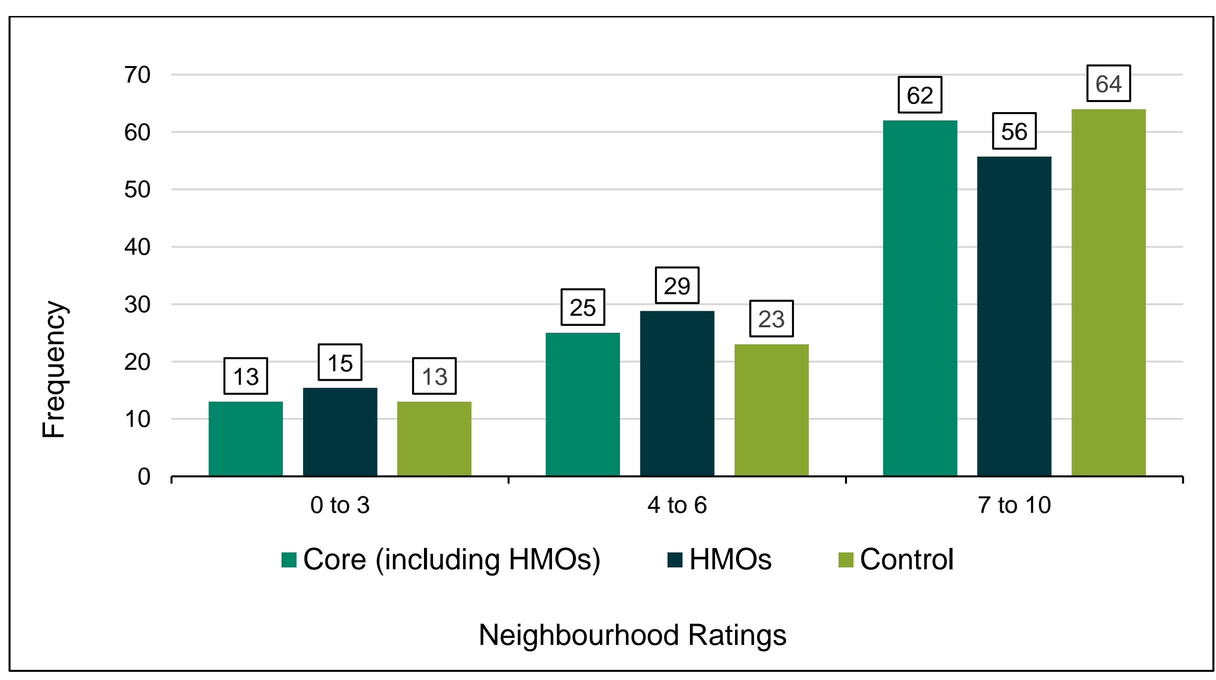
Table 4-1: Average ratings (0-10) of respondents who are satisfied or dissatisfied with neighbourhood

Satisfaction	Core (including HMOs)	HMOs	Control
Mean	7.74	7.50	7.99
Median	8.00	8.00	9.00
Mode	9.00	9.00	9.00
Total	**224**	**52**	**202**

4.2.15 Figure 4-4 shows that there is relatively little difference in satisfaction ratings of neighbourhoods between the Core and Control sample, although the broad pattern is toward very slightly lower satisfaction near to HMOs and slightly lower again within HMOs themselves.

4.2.16 The graph also highlights how the averages in the table above mask some strongly negative responses, with up to 15% of respondents rating their neighbourhood below 3 out of 10. Just under half of HMO respondents rated their neighbourhood below 7.

Figure 4-4: Neighbourhood ratings



Base: Core including HMOs (224), HMOs (52), Control (202)

Safety

4.2.17 There were no significant differences in feeling of safety between the two areas during the day (73% and 78% safe or very safe respectively). Although the control area had around twice the proportion of respondents who felt very safe, it also had a slightly higher proportion of respondents who felt very unsafe.

Figure 4-5: Safety during the day

	Very safe	Safe	Neither	Unsafe	Very unsafe	Don't know
Core including HMOs (n=224)	18%	55%	12%	11%	4%	
Control (n=202)	37%	41%	9%	6%	6%	1%

Base: All respondents (426)

4.2.18 Similarly, there were no significant differences in feeling of safety between the two areas during the evening. 54% and 49% of respondents in the control and core samples respectively felt safe or very safe, while 24% and 28% respectively felt unsafe or very unsafe. However, when isolating the HMO respondents, only 35% felt safe or very safe while 29% felt unsafe or very unsafe and a much larger proportion than the wider samples responded 'neither safe nor unsafe'.

4.2.19 It is clear when comparing the night to day time data that safety issues are more prevalent in the evening and night.

Figure 4-6: Safety during the evening / at night

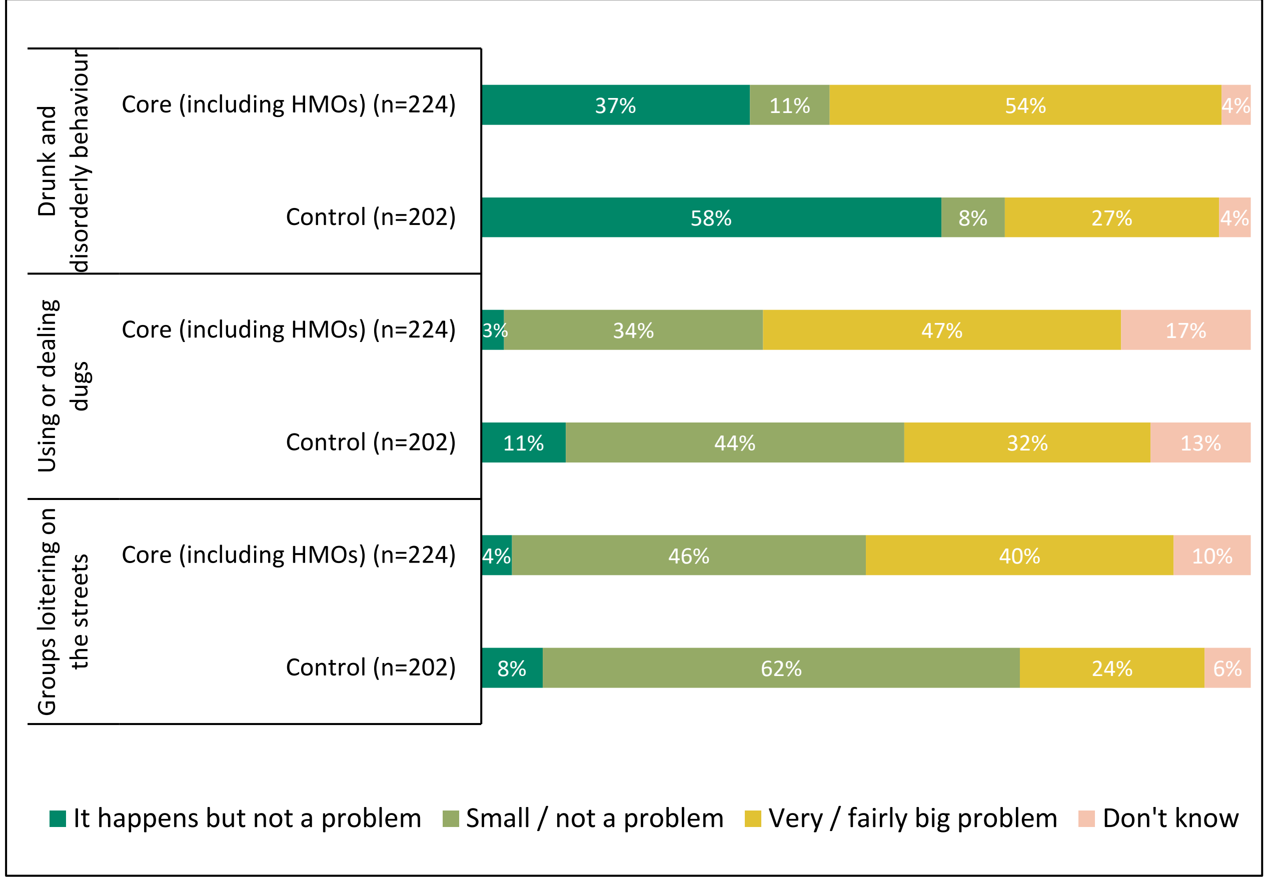
	Very safe	Safe	Neither	Unsafe	Very unsafe	Don't know
Core including HMOs (n=224)	14%	35%	17%	23%	5%	5%
HMOs (n=52)	10%	25%	31%	23%	6%	6%
Control (n=202)	21%	33%	17%	15%	9%	5%

Base: All respondents (426)

4.2.20 Figure 4-7 shows the proportion of respondents who did or did not state there is a problem with various forms of anti-social behaviour in the neighbourhood. Anti-social behaviour encompasses drunk and disorderly behaviour, drug use, racial discrimination, troublesome neighbours and similar issues. The core survey area had significantly more respondents than the control area stating they had issues with:

- **Drunk or disorderly behaviour** in public places: (54% said there is a fairly / very big problem in the core area compared to only 27% in the control)
- **Using or dealing drugs** (47% said there is a fairly / very big problem in the core area compared to only 32% in the control)

Figure 4-7: Extent anti-social behaviours are a problem



Base: All respondents (n=426)

4.2.21 However, there were lower concerns regarding some of the issues (for which graphs have therefore not been provided) including:

- Respondents in the core sample are more likely to state that **groups loitering on the streets** is a very big to fairly big issue in the neighbourhood compared to those in the control sample (40% and 24% respectively)

4.2.22 There was no significant difference between the core and control sample for the following statements:

- **Racial discrimination:** a similar but small proportion of the core and control stated the issue is fairly big (11% and 16% respectively)
- **Troublesome neighbours:** there was no significant difference between the core and control sample, both of which had modest proportions identifying a problem (17% and 16% respectively)

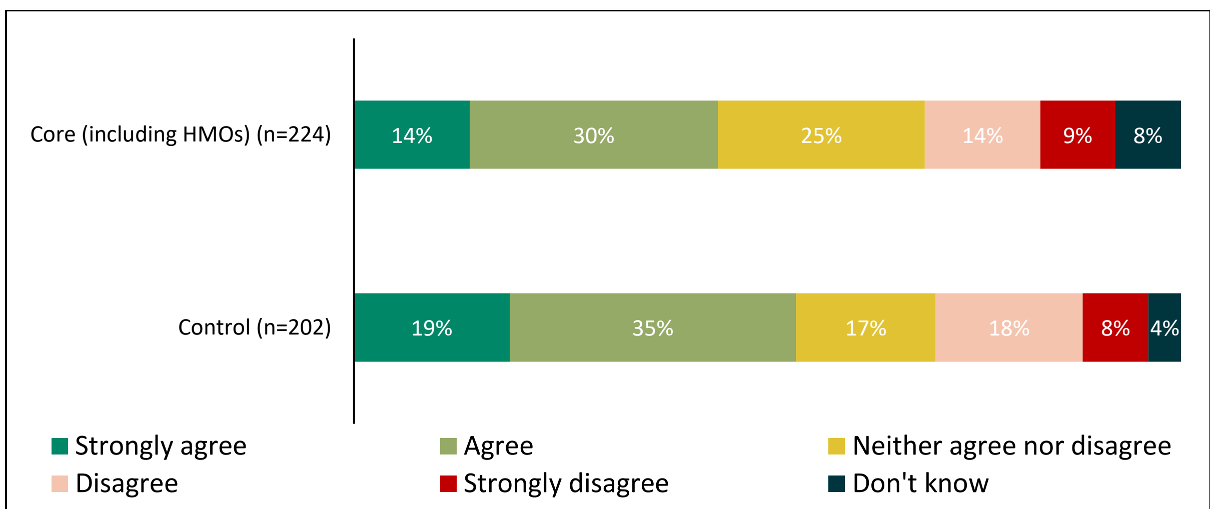
Sense of community

4.2.23 The following sub-section details different indicators of the sense of community felt across the core and control samples. This includes:

- Sense of community in general
- How likely something lost would be returned
- Duty of care
- Parking in the area

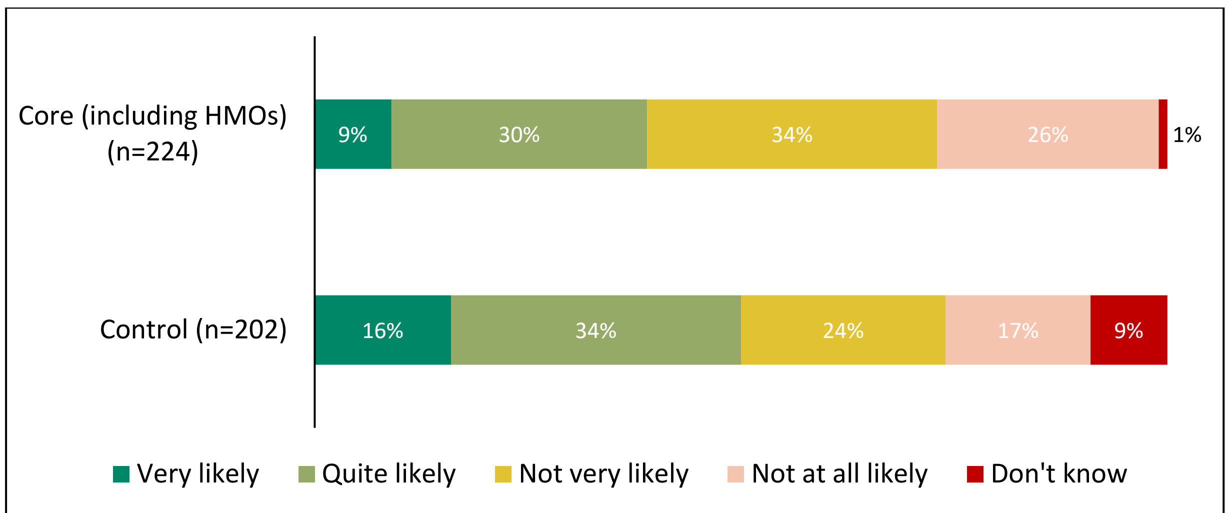
4.2.24 Half (53%) of the control sample either strongly agree or agree there is a sense of community in the area compared to 44% living in the core area. However, this represents more of a difference in the absence of strong community feeling, as there is no discernable difference between the proportion of respondents saying they disagree or strongly disagree (23% in the core area and 26% in the control area).

Figure 4-8: General sense of community



4.2.25 Figure 4-9 indicates how likely or unlikely something lost would be returned between the core and control sample. More of those in the core sample (60%) felt their belongings would not be very likely or at all likely to be returned if lost, compared to 41% of those in the control sample. 50% of those in the control sample are confident their belongings would be returned if lost, compared to 38% of the core sample.

Figure 4-9: How likely something lost would be returned



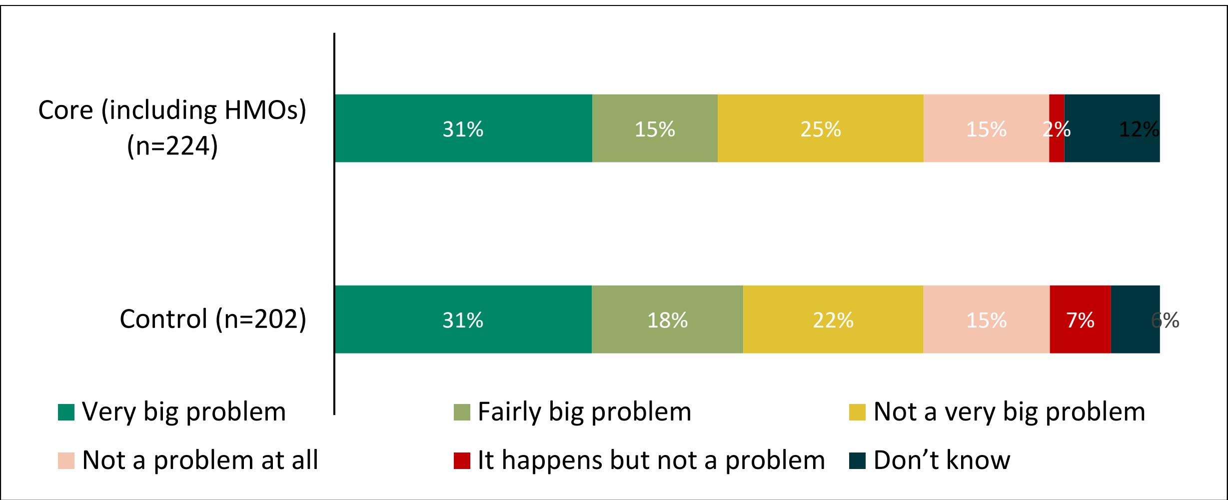
4.2.26 On other measures within the community topic:

- There was a small difference between the core and control sample regarding whether people in their neighbourhoods help one another, with 31% compared to 27% stating people help each other respectively
- The difference between the core and control sample on issues related to parking was not significantly different, with 42% stating it is not a problem compared to 45% (core and control respectively). It is notable, however, that only a minority in all areas think parking is not an issue – suggesting discontent on this topic is widespread and not specific to areas with higher concentrations of HMOs, even if they are sometimes blamed for parking pressures by neighbours.
    - It is useful here to note broader patterns of car ownership revealed in the Census. While no robust data exists on this point for HMO occupants specifically in the Census or elsewhere, it is available for the relevant categories of private renters and 'other' households (containing multiple families or unrelated individuals).
    - The data suggests that renters have the lowest levels of car ownership of all tenures in Eastbourne: only 20.6% and 22.5% of social and private renting households respectively have 2 or more vehicles, compared to 41.3% for all households and 54.6% for homeowners. In contrast, 'other' households are more likely to have 2 or more cars than other categories, at 40.7% compared to 37.5% for families. (This data is for Eastbourne in 2011 given limitations in the multivariate data presently available for 2021 and the anomalies discussed in Section 5[25])
    - This suggests that HMOs do not necessarily bring more cars to a neighbourhood: though more occupants tend to mean more cars, the most common types of HMO occupant (private renters, students, those on benefits) tend to be less likely to be car owners. An owner-occupier

[25] For example, the 2021 data comparing car ownership to household composition only distinguishes between households with and without vehicles, rather than between 1 and 2 or more vehicles.

household of a 4+ bedroom dwelling is potentially just as likely to own more than 2 cars – for example one for each working adult plus additional cars for older children. A key limitation of this data is that the Census counts only up to 2 or more vehicles, meaning that the number of properties with many cars cannot be distinguished from those with only 2.

Figure 4-10 Are there issues with parking?

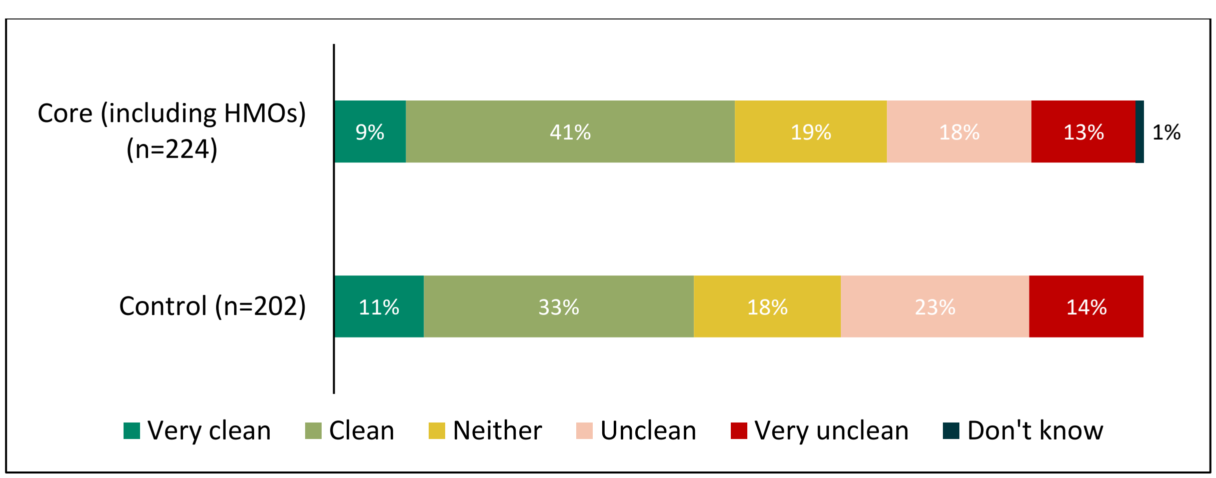


Community cleanliness and maintenance

4.2.27 This sub-section details different aspects of cleanliness and maintenance of the community, including: general cleanliness, littering, and vandalism and graffiti.

4.2.28 Figure 4-11 shows the responses given around the general cleanliness and maintenance of the neighbourhood. Interestingly, the core sample where HMOs are concentrated received a higher cleanliness score than the control area. In the control area 37% of respondents feel the area is unclean or very unclean compared with 31% for the core area.

Figure 4-11: General cleanliness



4.2.29 Additional findings suggest the following:

- In relation to vandalism and graffiti in the area, there was not a great difference between the core and control sample. 26% and 23% of respondents respectively felt that this was either a very big or fairly big problem in the community. Almost three quarters of the respondents in each sample did not believe vandalism and graffiti to be a problem in their neighbourhoods.
- On the contrary, around half of both the core and control sample believed issues to do with street litter were either a very big or fairly big problem (53% and 49% respectively).

Further Comments

4.2.30 In the questionnaire, respondents were asked two open questions, where they could provide more detail to their answers. These questions were:

- What causes the issues in the area?
- Do you have any further comments on where you live, your residence or anything else discussed in the questionnaire?

4.2.31 Not everyone answered these questions. All responses provided were read and grouped into themes.

- When asked what causes the issues in the area, 26% (n=111) respondents provided a comment as to why.

4.2.32 The main issues mentioned included:

- Parking issues (Lack of parking / too many cars/ non-residents parking to avoid charges in town) 50% (n=56)
- Dog mess on the pavements (23%, n=26)
- Issues with drugs (21%, n =24)
- Rubbish (fly tipping, dumping in alleys, left by houses) (21%, n=24)

4.2.33 Only nine comments specifically (8%) mentioned HMOs as a reason for the cause of these issues. These were almost exclusively given in the core area where HMOs are concentrated. Comments included the following, that often linked HMOs with wider social issues:

- “Bad parking because of a lot of HMOs” (core)
- “Cars have got bigger and most households have more than 1 car and lots of HMOs in the area now” (control)
- “Everything is just awful and too many houses being turned into HMOs” (core)
- “HMOs, overcrowding, drugs, drink” (core)

- “HMOs where people don’t care and unemployment causing rough sleeping and drug dealing and drunkenness” (core)
- “Lot of HMOs in the area and street drinkers passing through and hanging around” (core)
- “Lots of HMO conversions so just too many people” (core)
- “Mainly alcohol problems and I can’t believe the amount of alcohol we sell in the Sainsburys and also too many HMOs” (core)
- “Too many HMOs and too many students too many cars parked by people walking into town etc.” (core)

4.2.34 When asked if they had any further comments, 25% (n=108) of respondents provided a comment.

4.2.35 Eleven percent of respondents (n=12) provided positive comments about the area and said it was a nice area to live. Most of these positive comments were received in the control area where HMOs are less common.

- “It's a lovely community here” (control)
- “It's pretty good overall” (control)
- “Love the area” (control)
- “No I'm really happy here” (core)
- “Thank you for cleaning up the park in Upperton Gardens, it’s helped keep it a better place and less trouble” (core)
- “The people are nice with a community spirit” (control)

4.2.36 Of the other comments provided:

- 21% of comments (n=23) related to parking issues and lack of parking in the area, which is consistent with the previous comments provided
- 9% made comments about an issue with their property or maintenance of the building in which it sits
- 9% made comments related to rubbish being left nearby, in alleyways, on the roads
- 7% suggested they want more police presence in their area

4.3 Index of Multiple Deprivation Data

4.3.1 The Index of Multiple Deprivation (IMD) is a measure used in the United Kingdom to assess and rank Lower Super Output Areas (LSOAs) based on their level of deprivation. The IMD provides a rank for each LSOA for seven individual indicators, as well as a combined overall deprivation score.

4.3.2 Some of these indicators are relevant to the impacts attributed to HMO concentration and provide a sense of their spatial distribution in the absence of more targeted

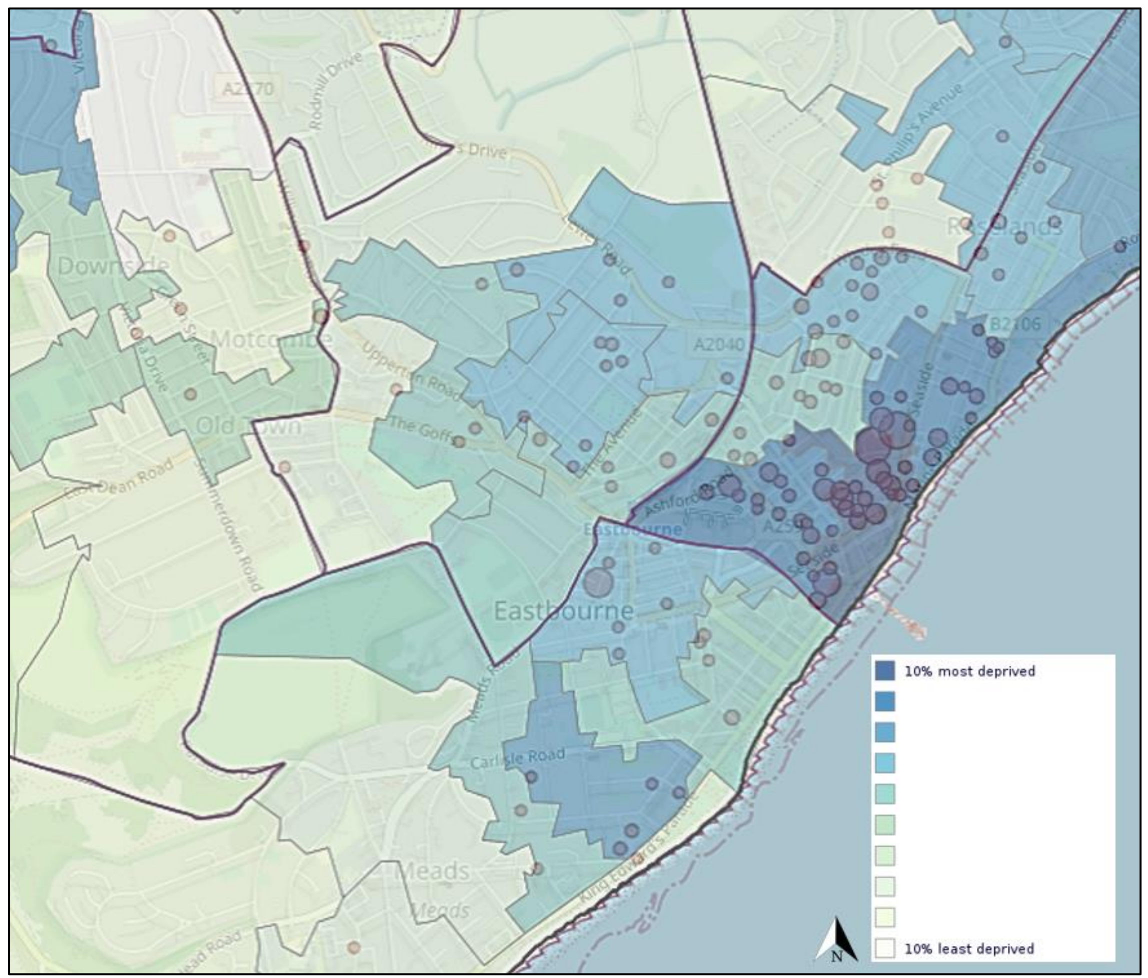
evidence (e.g. from police and complaints data), although direct causal connections can only be interpreted with a high degree of caution.

Overall IMD Rank

4.3.3 Figure 4-12 overlays the location of Eastbourne's HMOs with the overall IMD rankings of the town centre's LSOAs. It shows that the majority of HMOs are located in Eastbourne's more deprived (darker shaded) areas.

4.3.4 It is important to emphasise HMOs do not cause deprivation, although they may attract more deprived people into an area. Instead, the map shows that the presence of HMOs is correlated with higher deprivation. The causal link can go in both directions, and there may be a third factor that drives both deprivation and the presence of HMOs, such the lower attractiveness of an area for residential use, or the higher rates of crime and greater distance from health and education services experienced in town centres.

Figure 4-12: Eastbourne's HMOs and Index of Multiple Deprivation Rank (Overall) (2019)



Source: EBC HMO Register / IMD Data

(Red bubbles represent Licensed HMOs within a particular postcode. The larger the size of the bubble, the more HMOs within that postcode)

Crime Domain and Living Environment Deprivation Domains

4.3.5 It is also worth highlighting trends in the individual IMD indicators. Two of particular interest to this study are 'Crime Domain' (CD) and 'Living Environment Deprivation Domain' (LEDD).

4.3.6 The CD measures the level of crime and the fear of crime within an LSOA, whereas the LEDD measures the quality of the physical and built environment within an LSOA.

4.3.7 As can be seen in Figure 4-13 and Figure 4-14, like the overall IMD trend, HMOs are generally found in areas of Eastbourne with higher levels of deprivation for both the CD and the LEDD.

Figure 4-13: Eastbourne's HMOs and Index of Deprivation Rank (Crime) (2019)

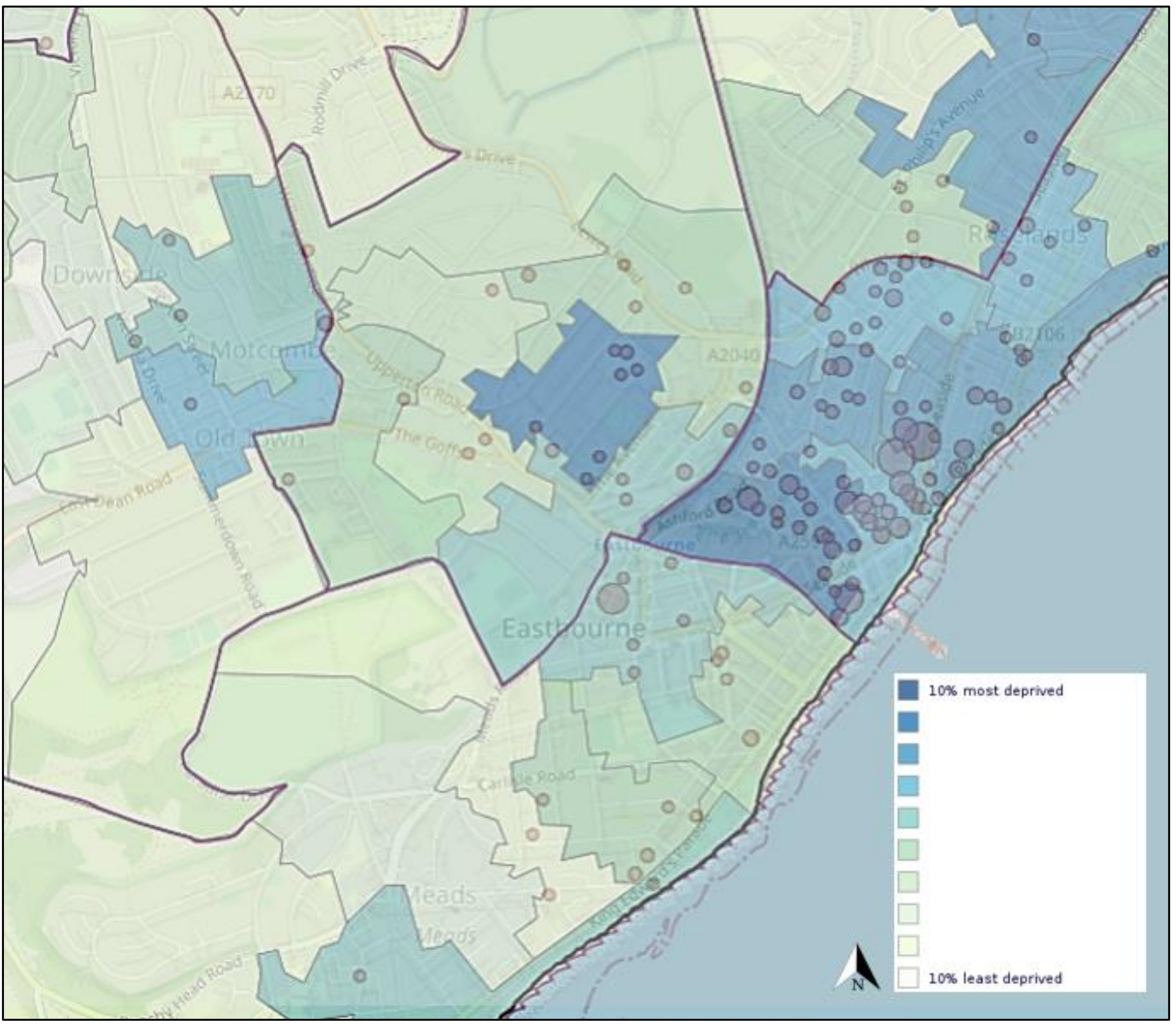
Source: EBC HMO Register / IMD Data

(Red bubbles represent Licensed HMOs within a particular postcode. The larger the size of the bubble, the more HMOs within that postcode)

4.3.8 Here the causal link may be stronger. The inspection of HMOs in Eastbourne reported in Section 3 suggests that they tend to have some issues of poor structural condition and other visible impacts, although perhaps not as much as is widely perceived. This

would contribute to a lower quality of living environment where they are concentrated in large numbers (as in Devonshire Ward). Section 4 discusses the potential for mental health, substance use and other issues to be amplified when vulnerable people are placed together without support in HMOs, which could be a catalyst of crime and fear of crime. However, the correlation is probably more attributable to low incomes, which are associated with both crime and HMO occupation.

Figure 4-14: Eastbourne's HMOs and Index of Deprivation (Living Environment Deprivation Domain) (2019)



Source: EBC HMO Register / IMD Data

(Red bubbles represent Licensed HMOs within a particular postcode. The larger the size of the bubble, the more HMOs within that postcode)

4.4 The Hotel Market in Eastbourne

4.4.1 This sub-section will explore the relationship between HMOs, hotels, and the tourism sector within Eastbourne over the past 10 years.

4.4.2 When reading this sub-section, it is important to keep in mind the following points:

- The data available for analysis, which is drawn from CoStar (a provider of commercial property analytics) unless otherwise stated, provides no direct link between hotels and HMOs. Consequently, there remains a level of uncertainty about whether there is a correlation between the closure of hotels and the growth in number of HMOs. Other factors, such as the impact of Covid-19 on the hospitality sector, may have driven these trends. It is also important to note that the CoStar data is limited to larger hotels and therefore cannot be used to fully investigate the potential links between HMOs and Eastbourne's large sector of smaller guesthouses and B&Bs, which may in fact be more common targets for conversion.
- Some hotels in Eastbourne are functioning as asylum seeker accommodation for the Home Office. The formal use class associated with this function is a subject of ongoing debate, with a recent EBC enforcement notice (which was upheld at appeal) affirming that it represents a change from hotel (C1) to hostel (sui generis). In the case of the enforcement notice and appeal decision, the current use was therefore found to be unauthorised. The use of former hotels for this purpose complicates the picture around HMOs because this may be an intermediate step on the pathway from hotel to HMO use in future (depending on the ongoing demand for asylum seeker accommodation) and because there are overlaps in the perceived impacts creased by the cohabitation of vulnerable people in HMOs and asylum seeker accommodation.
- Similarly, it is understood that some B&Bs and guesthouses in Eastbourne provide long-term temporary accommodation placements, thus functioning more like a HMO than tourist accommodation. EBC note that there are around 13 hotels / B&Bs / guesthouses that are currently understood to be being used as HMOs, and are not taking regular guests.

4.4.3 Eastbourne is a well-known and historic holiday destination, attracting visitors throughout the year to its promenade, pier, and sandy beaches. The town is also close to South Downs National Park, which makes it a popular destination for hikers and nature lovers. Conferences and business events are also a key element of the local economy. To accommodate Eastbourne's visitors and their varied needs and budgets, the town has a wide variety of hotel, guesthouse and bed & breakfast accommodation. As of January 2023, there were 53 registered hotels in Eastbourne listed as 'open', of varying sizes and class types, according to CoStar. This unfortunately does not include numerous smaller guesthouses, bed & breakfasts and holiday lets, which anecdotal evidence from EBC officers and councillors suggests are more frequent targets for conversion to HMOs. Looking at the data over time suggests that the designation 'open' means generally operational (i.e. even if closed over the winter).

4.4.4 The hotel sector in Eastbourne is relevant to this study because tourist accommodation can be easily converted into HMOs. There is little data about the actual number of hotels that have been converted to HMOs, although it is clear from AECOM's inspections that a number of the properties visited (particularly Section 257 properties) are former hotels. A high-level review of planning application data undertaken by EBC indicates at least 12 applications for change of use from tourist accommodation to HMO between 2013 and 2022, all but two of which were in Devonshire Ward. 5 of these 12 applications were approved, 6 refused and 1 withdrawn. One of the (refused) applications was for retrospective planning permission and another was a second application for a property for which permission was previously refused.

4.4.5 This trend is established in Eastbourne to the degree that the Local Plan explicitly protects hotels from conversion to HMOs within a defined tourist accommodation area. Yet the conversion of hotels to HMOs remains a risk outside of that defined area and a cause of concern to local stakeholders, including elected members and representatives of local businesses. The following sub-section summarises the anecdotal evidence provided by their views. Subsequently, data about wider trends in the Eastbourne hotel sector will be reviewed.

Anecdotal evidence of the impact of HMOs on the hotel sector

4.4.6 Demand patterns in the tourism market are reported to be rapidly changing, especially following the Covid-19 pandemic. Although other draws such as business conferencing represent new demand streams, Eastbourne is a less popular domestic tourism destination than it was historically. As such, some change in hotel provision is accepted, and this includes the loss of holiday accommodation that no longer meets modern standards (e.g. en-suite rather than shared bathrooms).

4.4.7 However, these changes would ideally be subject to some level of planning rather than subjected to near-term market changes during a volatile period. The option to convert tourist accommodation to HMOs can be financially attractive to individual owners but given the limited planning powers to assess or prevent conversions, the large-scale loss of hotels in this way could impact on the ability of Eastbourne to offer a range of accommodation options and price points. Because the tourist economy feeds into the wider economy (e.g. the retail and hospitality sectors), the implications of this could be far reaching.

4.4.8 Beyond the economic impact of the loss of hotel accommodation to HMO uses lies a further risk, described by local stakeholders as a potential domino effect or spiral of decline. This involves the introduction of large HMOs to areas with high concentrations of tourist accommodation. The perceived impacts of the HMOs, such as anti-social behaviour, have led to complaints from the guests of the nearby hotels. Over time this is understood to cause a decline in popularity of those hotels, leading them to become less financially viable and thereby increase the incentive to themselves be converted to HMOs. As more hotels in the area become HMOs there is a greater likelihood that others will follow. This knock-on impact also applies to the wider hospitality economy, with representatives of other types of business (such as restaurants and shops) noting challenges arising from the combination of a loss of tourist customers and behavioural impacts arising from HMOs.

4.4.9 The Eastbourne Tourist Accommodation Retention SPD[26] notes that HMOs are a '*…significant threat to the attractiveness of the seafront. The presence of HMOs in the prime tourist areas does not portray a positive image of the destination, and could adversely impact the visitor experience*'. For these reasons, Eastbourne has a designated Tourist Accommodation Area (see the Tourist Accommodation Retention SPD)[27] along the seafront, which protects this area from the perceived negative impacts of HMOs by limiting their existence.

4.4.10 It is relevant to note that similar impacts are perceived to be generated by the use of hotels to house asylum seekers. However, this occurs through block bookings made by the Home Office, meaning that the hotel retains a business use (whether as a hotel or, as recent enforcement action has demonstrated, as a 'sui generis' hostel) rather than becoming an HMO. There is also onsite support that helps to mitigate problems experienced by its vulnerable occupants, in contrast to HMOs used for temporary accommodation placements.

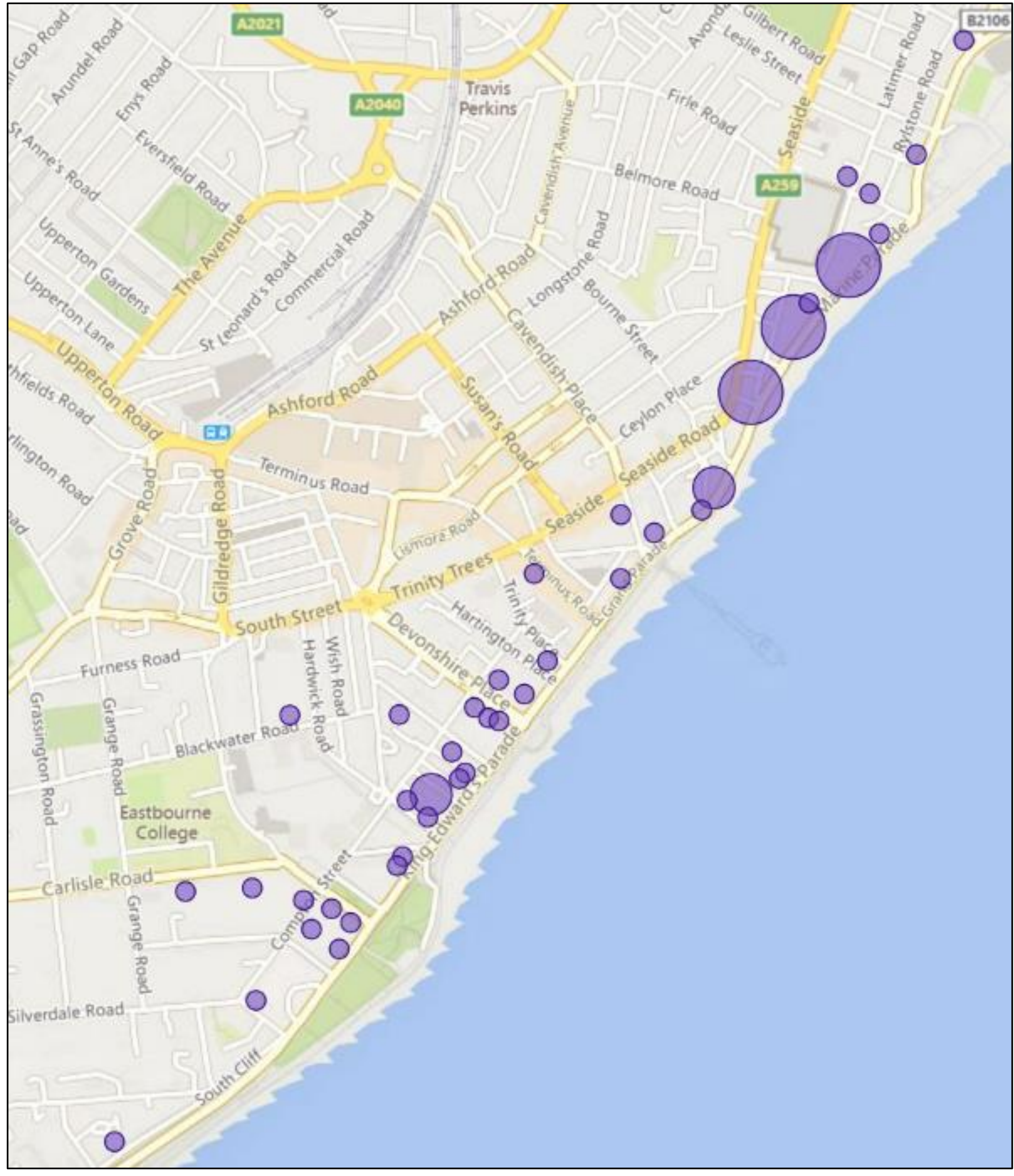
[26] Available at: https://planningpolicyconsult.lewes-eastbourne.gov.uk/TAR_SPD/viewCompoundDoc?docid=8089684

[27] Available at: https://planningpolicyconsult.lewes-eastbourne.gov.uk/TAR_SPD/viewCompoundDoc?docid=8089684&sessionid=&voteid=&partId=8090548

Hotel sector data

4.4.11 The location of Eastbourne's existing stock of hotels is provided in **Error! Not a valid bookmark self-reference.** and Figure 4-16. It can be seen that the majority of the town's hotels are located in the Seafront area.

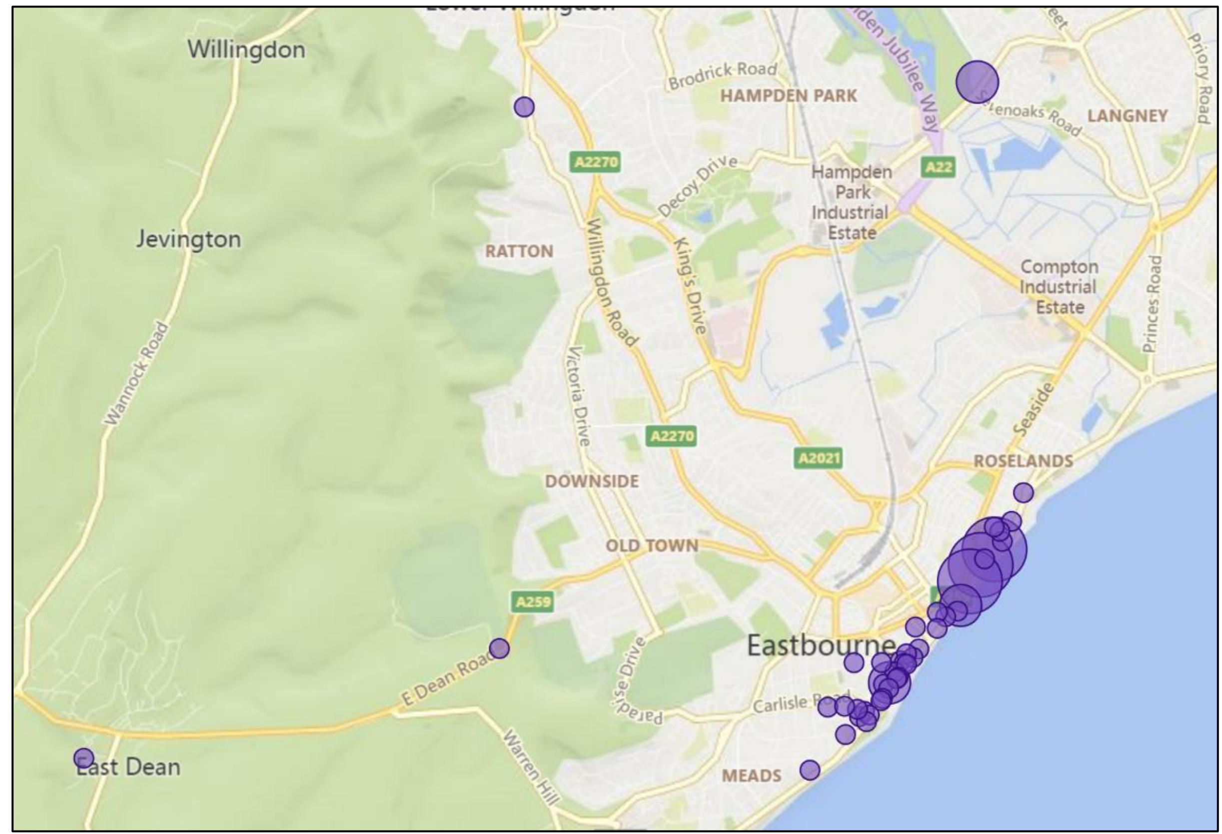
Figure 4-15: Eastbourne Seafront Hotels



Source: CoStar

(Purple bubbles represent open hotels within a postcode. The larger the size of the bubble, the more hotels within that postcode)

Figure 4-16: Eastbourne Hotels (All)



Source: CoStar

(Purple bubbles represent open hotels within a postcode. The larger the size of the bubble, the more hotels within that postcode)

4.4.12 Despite Eastbourne's many hotels, closures in recent years have raised concerns about the potential negative impact this has had on the local tourism economy, as noted above.

Hotel Trends in Eastbourne

General Trends

4.4.13 Table 4-2 presents four key datasets related to Eastbourne’s hotels from 2013-2020 from CoStar.

4.4.14 When interpreting this data, one should be aware that the figures after 2019 are heavily influenced by the Covid-19 pandemic and the knock-on financial pressures it imposed on the tourism and hospitality industry.

4.4.15 The following key messages can be read from Table 4-2:

- **Existing buildings**: The number of hotels in Eastbourne remained relatively unchanged between 2013 and 2019, at around 60 premises. However, since 2019, there has been a slow but steady decline in the number of hotels.
- **Supply and demand for hotels:** Between 2013 and 2019, both the supply and demand for hotel rooms experienced an overall positive trend of growth.

However, both variables saw a sharp fall in 2020 as a result of the Covid-19 pandemic. In 2021 and 2022, both variables showed signs of growth, but remained below their respective pre-pandemic levels.

- **Occupancy**: As with the supply and demand variables, occupancy saw positive growth before a significant decline in 2020. However, unlike the supply and demand variables, occupancy recovered to its pre-pandemic rate.

Table 4-2: Supply, Demand, and Occupancy Data for Eastbourne's Hotels (2013-2022)

Period	Existing Buildings	Change (no. of buildings)	Supply (no. of rooms)	% Change	Demand (no. of rooms)	% Change	Occupancy	% Change
2013	**59**	-	**1,050,657**	-	**737,282**	-	**70%**	-
2014	**60**	+1	**1,054,585**	+ <1%	**770,511**	+5%	**73%**	+3%
2015	**60**	0	**1,053,631**	- <1%	**779,777**	+1%	**74%**	+1%
2016	**60**	0	**1,062,023**	+1%	**799,267**	+3%	**75%**	+1%
2017	**59**	-1	**1,077,257**	+1%	**798,865**	- <1%	**74%**	-1%
2018	**59**	0	**1,072,370**	-1%	**804,853**	+1%	**75%**	+1%
2019	**59**	0	**1,074,195**	+ <1%	**774,129**	-4%	**72%**	-3%
2020	**57**	-2	**944,907**	-12%	**428,105**	-45%	**45%**	-37%
2021	**56**	-1	**947,275**	+ <1%	**582,657**	+36%	**62%**	+27%
2022	**53**	-3	**971,264**	+3%	**706,066**	+21%	**73%**	+11%

Source: CoStar.

Note: it is unclear how the 'Demand' indicator is calculated by CoStar

Occupancy of hotels by class since 2013

4.4.16 Observing the occupancy rates for hotels by class type reveals that the higher end hotels have seen a decline in their occupation percentage, whereas the economy options have experienced an increase in their occupation rate. This trend is likely due to the impact of Covid-19 and the economic downturn that has followed the easing of lockdowns as well as the more recent cost-of-living crisis. It is also apparent that some of the lower end hotels are being block booked for asylum seekers, which may be supporting their viability in the near-term. This may change in the context of March 2023 national changes exempting HMOs and other private rented properties from licensing and other requirements if used to house asylum seekers, the intention of which is to reduce the use of expensive hotel accommodation to house them.

Table 4-3: Occupancy of hotels by class since 2013 (%)

Period	Luxury & Upper Upscale (L/UU)	Upscale & Upper Midscale (U/UM)	Midscale & Economy (M/E)	Class Type with highest occupation
2013	75.14%	71.38%	69.50%	L/UU
2014	76.93%	73.52%	72.65%	L/UU
2015	80.10%	75.40%	73.20%	L/UU
2016	74.99%	77.06%	74.86%	U/UM
2017	75.15%	77.74%	73.25%	U/UM
2018	77.17%	79.00%	73.97%	U/UM
2019	77.82%	78.24%	70.19%	U/UM
2020	40.36%	37.72%	47.54%	M/E
2021	54.60%	44.12%	66.64%	M/E
2022	60.91%	69.35%	74.62%	M/E
Change (2013-2022)	**-14.2%**	**-2.03%**	**+5.12%**	

Source: CoStar

HMO and Hotel Location

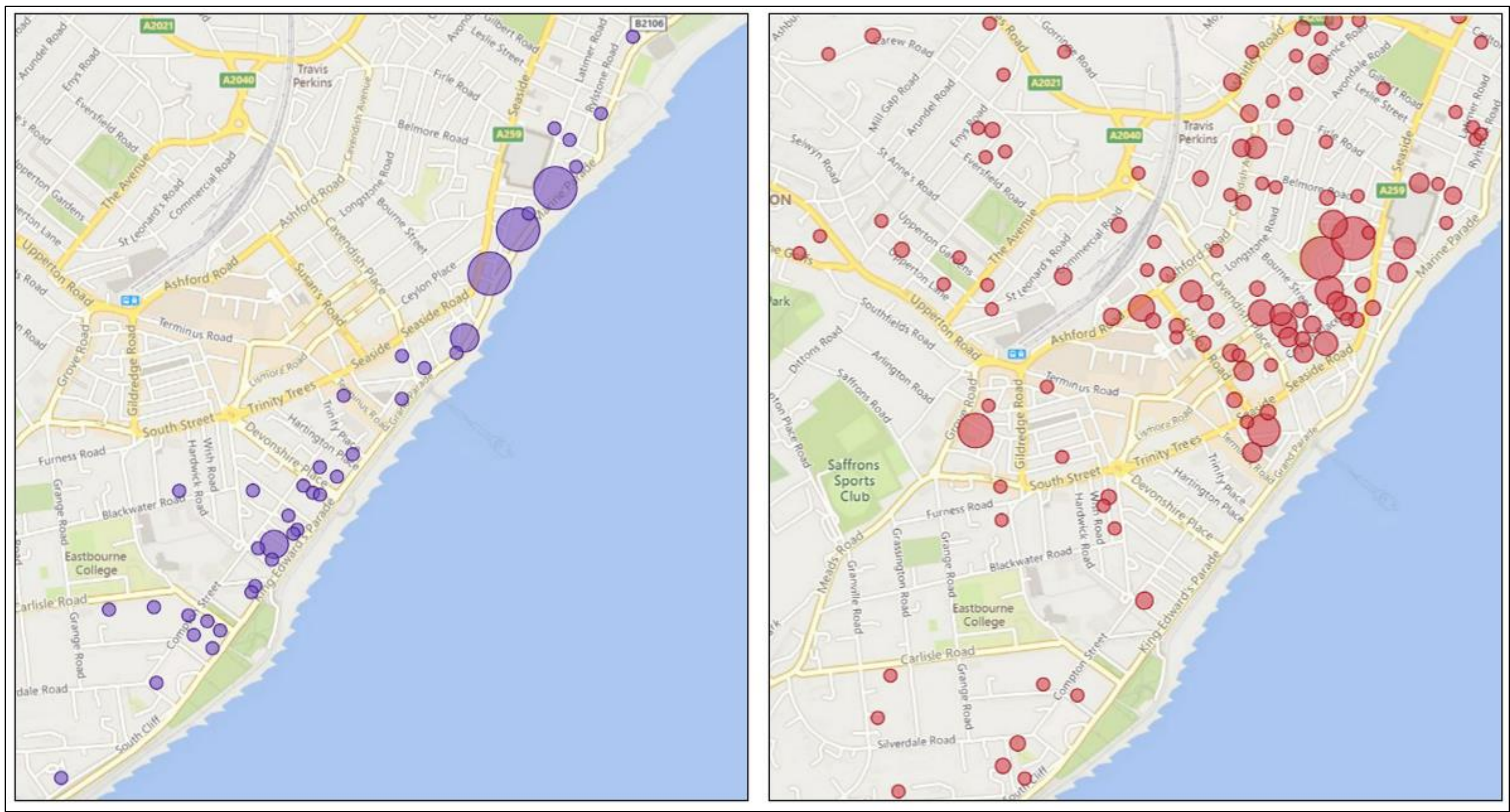
4.4.17 Figure 4-17 compares the location of hotels and HMOs within central Eastbourne. It reveals that Eastbourne's hotels are mostly found on the Seafront, commonly along (or off) Grand Parade and Royal Parade. HMOs, by contrast, are spread out over a wider area, covering the majority of central Eastbourne, but generally avoiding the Seafront area where the hotels are located. The absence of HMOs in the Seafront area is a result of protections afforded to hotels in the area through its designation as a Tourist Accommodation Area (TAA) (refer to Tourist Accommodation Retention Supplementary Planning Document for more information).[28]

4.4.18 It is relevant to note that the TAA was reduced in size in 1998, removing its protection from areas such as Langney Road and Jevington Gardens. These 'former TAA' areas now contain many HMOs, which are understood to have been converted from old tourist accommodation once the restrictions were lifted. Whilst this demonstrates that the TAA offers important protection for Eastbourne's stock of tourist accommodation, there are examples known to EBC officers of hotels and guesthouses within the existing TAA gradually functioning more like a HMO while still formally operating as a tourist accommodation business, which makes their identification and enforcement action difficult.[29] Therefore, the conversion of hotels to HMOs in the Seafront area remains a controversial issue in Eastbourne, despite most of the hotels in Eastbourne being located within the TAA.

[28] Available at: https://planningpolicyconsult.lewes-eastbourne.gov.uk/TAR_SPD/viewCompoundDoc?docid=8089684&sessionid=&voteid=&partId=8090548

[29] Available at: https://acp.planninginspectorate.gov.uk/ViewCase.aspx?caseid=3274954

Figure 4-17: Location of Hotels (Purple) and HMOs (Red) in Central Eastbourne (Winter 2022)



Source: EBC Data / CoStar

(Purple bubbles represent open hotels within a postcode. Red bubbles represent HMOs within a postcode. The larger the size of the bubble, the more hotels/HMOs within that postcode)

Hotel Closures

4.4.19 The CoStar 2023 hotel register lists nine hotels as permanently closed, and one additional hotel as temporarily closed. Table 4-4 provides data on these hotels.

4.4.20 It is worth noting that a sense check has revealed that some of these hotels listed as closed by CoStar are still in operation. EBC have provided notes to clarify the status of these hotels, which are presented in the final column of Table 4-4.

Table 4-4: Permanently or Temporarily Closed Hotels in Eastbourne (2023)

	Building Name (CoStar)	Address (CoStar)	Rooms (CoStar)	Class (CoStar)	Scale (CoStar)	Operation Status (CoStar)	Additional Local Information Provided by the EBC
1	Alfriston Hotel	16 Lushington Road, BN21 4LL	13	Midscale	Independent	Permanently Closed	-
2	Arundel Private Hotel	43-47 Carlisle Rd, BN21 4JR	30	Midscale	Independent	Permanently Closed	-
3	Fairlands Hotel	15-17 Lascelles Terrace, BN21 4BJ	27	Midscale	Independent	Permanently Closed	Currently being used as an HMO/hostel. Not accepting holiday makers.
4	Mansion Lions Hotel Eastbourne	Grand Parade, BN21 3YS	108	Economy	Independent	Permanently Closed	-
5	Savoy Court Hotel	11-15 Cavendish Place, BN21 3EJ	29	Economy	Independent	Permanently Closed	Permission granted for Change of Use (CoU) to residential; permission refused and dismissed on appeal for CoU to HMO. Currently used as hostel, following enforcement notice upheld at appeal, and not accepting holiday makers.
6	So Eastbourne Hotel	12-20 Lascelles Terrace, BN21 4BL	47	Midscale	Independent	Permanently Closed	Now known as the View Hotel - open and operating as a hotel.
7	Southcroft Guest House	15 South Cliff Avenue, BN20 7AH	6	Midscale	Independent	Permanently Closed	-
8	The Berkeley Hotel	3 Lascelles Terrace, BN21 4BJ	13	Economy	Independent	Temporarily Closed	Understood to be open and operating.
9	The Palm Court Hotel	15 Burlington Place, BN21 4AR	38	Economy	Independent	Permanently Closed	Currently being used to house asylum seekers.
10	The Sherwood Guest House	7 Lascelles Terrace, BN21 4BJ	13	Midscale	Independent	Permanently Closed	-

Source: CoStar, EBC

4.4.21 While the commentary above (see Table 4-3) suggests that the higher-end hotels are struggling in comparison to mid to lower end hotels, the CoStar data presented in Table 4-4 presents a different story. All of the listed hotel closures are midscale or economy class hotels. Additional data with the year of closure would be useful to understand why they closed, and whether it can be linked to other data analysed within this section.

4.4.22 Figure 4-18 provides a map of the location of the closed hotels, showing that the majority of the closures have been in hotels towards the south-west of the town centre.

Figure 4-18: Location of Hotels Listed as Permanently or Temporarily Closed

Source: EBC, OpenStreetMap

(Orange bubbles represent closed hotels within a specific postcode. The larger the size of the bubble, the more hotels within that postcode. Overlapping bubbles indicate neighbouring postcodes. Place name labels (e.g. Arts District) are from the base map in OpenStreetMap)

Section 257 Properties

4.4.23 EBC has provided an indicative sample of potential Section 257 properties (large HMOs that do not appear on the register). While there is no available data to suggest whether or not these properties were former hotels, mapping them and comparing their location to Eastbourne's other hotels may provide an indication as to whether or

not hotels are being converted into HMOs. The location of the indicative sample of potential Section 257 properties is provided in Figure 4-19. It should be further emphasised that this is likely to be a significant underrepresentation of the number of Section 257 properties and, as such, conclusions about their distribution and former use should be taken with caution.

Figure 4-19: Section 257 Properties in Eastbourne

Source: EBC, OpenStreetMap

(Grey bubbles represent a small indicative sample of potential Section 257 properties within a specific postcode. The larger the size of the bubble, the more potential section 257 properties within that postcode)

4.4.24 Figure 4-19 shows that the indicative sample of Section 257 properties are distributed across a wider area within central Eastbourne when compared to the location of hotels. Because of this, there is no clear link between the location of these HMOs and where hotels are usually located (found to be close to the seafront, see Figure 4-17). There may be a case to suggest that the Section 257 properties by the 'Arts District' and 'Seafront' on the map may be former hotels due to their location. Further investigation would be needed to confirm this.

Hotel Sector Data Summary

4.4.25 Whilst all hotel value classes in Eastbourne have been negatively impacted by Covid-19, upscale hotels have suffered more in terms of occupancy, while midscale and economy hotels are more likely to have been listed as closed (though some of this reflects authorised or unauthorised use changes, such as to accommodate asylum seekers). While the CoStar data suggests that hotels may be at risk of closure (and being replaced by HMOs), the guesthouses and B&Bs not covered by that dataset are considered more likely targets for conversion by EBC officers.

4.4.26 Mapping Eastbourne's hotels alongside known licensed HMOs shows that the two tend to occupy broadly the same area of the town centre but rarely exactly the same roads. This is potentially due to the shrinkage of the Tourist Accommodation Area over time, as no-longer protected accommodation coverts to HMOs.

4.4.27 However, the data from the past 10 years may indicate that the risk of hotel closures is less than it was two or three years ago, as hotel closures may be linked to occupancy rates and overall revenues, rather than demand for HMOs. This reflection is based on the data in Table 4-2, which reveals that more hotels may be more likely to close when the town's overall occupancy rate falls below 70%, which was the case in the years immediately after the pandemic. Eastbourne's occupancy rate has since rebounded in 2022 to around 73%, which may suggest that hotel closures (and subsequently, their potential conversion into HMO properties), may not be a major risk. That said, financial incentives remain for struggling businesses to provide accommodation for asylum seekers, which requires fewer staff, and the likelihood of such properties returning to hotel use subsequently is considered to be low.

Eastbourne Borough: Retail & Leisure Study Report Findings[30]

4.4.28 The analysis of Eastbourne's hotel market presented within this chapter broadly aligns with that presented in the Retail & Leisure Study Report ('the Report'); both suggest that Pandemic had a significant impact on Eastbourne's hotel market in 2019, before recovering well since the lifting of restrictions.

4.4.29 The Report provides an additional insight into the impact of the pandemic, suggesting that '…a*t its worst, hotel occupancies in Eastbourne dropped to a monthly average rate of c. 22% of room*'.

4.4.30 There was a slight difference between the total number of hotels reported in the Report and the CoStar figures (66 compared to 53 in 2022, respectively), although both quote similar, healthy occupancy rates (72% to 73%, respectively).

4.4.31 Finally, an additional useful insight provided by the Report is that (at the time of writing) there were no hotels under construction '*…within Eastbourne itself, and in fact in the previous ten years the amount of stock within Eastbourne has contracted as demolition/ repurposing has outpaced new construction*'.

[30] Cushman & Wakefield (2022). *Eastbourne Borough: Retail & Leisure Study*. Available at: https://www.lewes-eastbourne.gov.uk/media/2517/Eastbourne-Retail-and-Leisure-Study-March-2023/pdf/Eastbourne_Retail_and_Leisure_Study_March_2023.pdf?m=638211368324170000

4.5 Summary

Intangible Impacts

4.5.1 A survey of Eastbourne residents was carried out in Spring 2023 to capture the intangible impacts of HMOs on occupants, their neighbours and the wider community. 426 interviews were conducted, split across a core sample of residents in areas of high HMO concentration and a control sample of residents in areas of low concentration (but that were otherwise similar on key metrics). Some datapoints have a sufficiently robust sample to isolate the responses of those actually living in HMOs, although those conclusions should be treated with more caution. The key findings of the survey are as follows:

- Generally, survey respondents are satisfied with their neighbourhoods. Across all samples the most common satisfaction score out of 10 was 9 and the mean average ranged from 7.5 (among occupants of HMOs) to 8 (among the control sample with few HMOs in the area). However, a modest proportion of respondents gave low scores: at least 13% gave 3 or below across all samples. 44% of HMO residents gave scores below 7 compared with 36% for the control group. The median satisfaction rate was 8 for the core sample, 8 for HMO occupants, and 9 for the control sample.

- Residents of areas with high concentrations of HMOs are less likely to feel very safe in the daytime than in control areas, but no more likely to feel unsafe. However, the feeling of safety is lower at night across all groups. This is particularly true among HMO occupants – only 35% of whom feel safe or very safe at night, compared to 49% in the core sample and 54% in the control sample.

- The biggest differences between the core and control samples were found in relation to antisocial behaviour. 54% of respondents in the core sample reported that drunk or disorderly behaviour was a problem in the neighbourhood, compared with only 27% in the control area. The respective figures for issues with drugs were 47% and 27%, and this issue featured strongly in respondents' additional comments. For groups loitering on the streets they were 40% and 24%. However, issues with troublesome neighbours were of concern to few respondents in either sample.

- There was reported to be only a slightly stronger general sense of community and sense of mutual helpfulness in the control than the core areas. However, a greater distinction was found when respondents were asked whether they would expect a lost item to be returned: only 39% of core sample residents expected a returned item, compared to 50% in the control group.

- Perhaps surprisingly, given that parking was by far the most common issue raised during the part of the survey inviting further specific comments (a number of those qualitative responses linked parking to HMOs), there was little statistically significant difference in the proportion of people viewing parking as a problem between the core and control areas. That said, a majority of respondents in both samples saw this as an issue.

- Similarly, littering and cleanliness are widespread issues but do not vary significantly between areas with more or fewer HMOs. Issues with vandalism and graffiti are less widespread and again not a greater concern where there are higher concentrations of HMOs.

- 8% of respondents who opted to provide additional comments at the end of the survey raised HMOs explicitly (almost all in the core sample area). These comments mentioned the fast growth in the number of HMOs, overcrowding and parking issues, and linked HMOs to broader social issues including drugs and alcohol.

4.5.2 In summary, the survey found a slight negative correlation between the concentration of HMOs and residents' satisfaction with their neighbourhood as well as the general sense of community. Some of the most common reasons for dissatisfaction, such as parking, appear to be widespread but not worse in areas with many HMOs. The strongest contrasts between the core and control sample were found in relation to the behaviour of people in the neighbourhood, particularly around alcohol, drugs, loitering groups, and safety at night. This correlation does not necessarily imply causation, but the perception among those who opted to provide further comment is that HMOs are linked to various social issues. It is also interesting to note that residents of HMOs themselves often provided the most negative responses, suggesting that the impacts of their living conditions are felt most strongly by occupants themselves.

4.5.3 Index of Multiple Deprivation (IMD) data shows that most of Eastbourne's HMOs are located in the Borough's more deprived areas overall. Rather than HMOs causing deprivation or vice versa (although occupants do tend to have lower incomes), there may be a third factor that drives both deprivation and the presence of HMOs, such as the lower attractiveness of an area for residential use or the higher rates of crime common in town centres. Indeed, in a pattern familiar across the country, the correlation is equally strong for the indicators of crime and the quality of the living environment.

The Hotel Market

4.5.4 The hotel market in Eastbourne is relevant to this study because tourist accommodation can be relatively easily converted into HMOs because most of the space is already in the form of self-contained bedrooms. There is little data about the actual number of hotels that have been converted to HMOs, although it is clear from AECOM's inspections that a number of the properties visited (particularly potential Section 257 properties) are former hotels. This trend is established in Eastbourne to the extent that the Local Plan explicitly protects hotels from conversion to HMOs within a defined tourist accommodation area. Yet this remains a risk for the wider town.

4.5.5 Conversations with local stakeholders emphasise the growing incentive to convert hotels and guesthouses to HMOs during the current volatile market, as well as the implications on the tourist and wider economy if too much hotel accommodation is lost. In addition, local businesses have reported that the social impacts associated with HMOs (such as those reviewed above) have a deterrent effect on hotel guests that can lead to low occupancy and further potential HMO conversions.

4.5.6 The Eastbourne Tourist Accommodation Retention SPD notes that HMOs are a '…significant threat to the attractiveness of the seafront. The presence of HMOs in the prime tourist areas does not portray a positive image of the destination, and could adversely impact the visitor experience'. For these reasons, Eastbourne has a designated Tourist Accommodation Area (TAA) along the seafront, which protects this area from the perceived negative impacts of HMOs by limiting their existence. HMOs and hotels occupy broadly the same region of the town centre near to the coastline but, due to the TAA, rarely exactly the same roads.

4.5.7 Although the increase in HMO numbers and gradual loss of hotels are both clearly established in the data, a causal connection is difficult to establish given the impact on hotel revenues of the COVID-19 pandemic, energy costs and wider cost-of-living pressures. The hotel market has broadly recovered to pre-pandemic occupancy rates but at the cost of a modest decline in operational properties – particularly since 2019. A small number of properties no longer functioning normally as tourist accommodation now house asylum seekers in the form of hostels, which may have similar implications for the wider community as HMOs housing vulnerable people. This particular trend may also increase demand for HMO accommodation from such groups in the near term due recent enforcement notices affirming that hotels used for this reason fall into a different planning use class, combined with a national regulatory change exempting HMOs from licensing requirements for a temporary period if used to house refugees and asylum seekers (intended to reduce reliance on hotels).

4.5.8 CoStar data suggests that declining revenues in economy and midscale hotels makes them more vulnerable for conversion to HMOs or asylum seeker accommodation, but this may in fact be a greater risk for Eastbourne's many guesthouses and B&Bs, which may change use more gradually and are harder to identify.

5. Market Dynamics

5.1 Introduction

5.1.1 This section seeks to describe the role that HMOs play in the Eastbourne housing market. This involves asking three inter-related questions: Who lives in HMOs and why? What do HMOs offer that other housing options do not? And which other forms of housing are impacted by the presence and addition of HMOs in the market? The characteristics that distinguish HMOs and their occupants can be grouped into four key areas, which structure the analysis to follow:

- **Size**: rooms in HMOs are usually the smallest type of accommodation in the market, yet they are generally found in the largest properties.
- **Household composition**: occupants are typically unrelated adults sharing facilities, either through financial necessity or lifestyle choice.
- **Tenure**: HMO accommodation is privately rented, but many occupants rely on housing benefits or are placed there as a form of temporary accommodation.
- **Affordability**: rooms in HMOs tend to be the lowest-cost rental option in the private housing market.

5.1.2 A key overarching feature of HMOs, then, is flexibility: they house a wide range of occupants, span tenure categories at the lower-cost end of the market, and provide an alternative use for larger homes and other buildings (such as hotels and guesthouses). In theory, they provide a useful function in any housing market and can be added or removed without new development through conversion from (and back to) single-family dwellings through permitted development rights. However, in high concentrations and in relatively unusual markets – both true of Eastbourne – they can have other, more complex effects.

5.1.3 The following sub-sections present evidence about how HMOs currently operate in Eastbourne and across its constituent wards. Trends over time, anecdotal evidence from local stakeholders and findings from the Eastbourne Local Housing Needs Assessment 2023 (LHNA) are also drawn upon to understand how and to what extent HMOs are currently meeting different segments of housing need or having adverse effects on the market.

5.1.4 There is no established or reliable method for estimating the future need for HMO accommodation. This is because occupant groups are so diverse, each theoretically have alternatives, and no relevant projections for them exist. Instead, it is helpful to consider the identified need for other forms of housing through the lens of HMOs. The picture that emerges will illustrate the balance of positive effects, opportunity costs and knock-on impacts that further HMO provision might bring in Eastbourne.

5.2 Size

5.2.1 HMOs are usually large houses and are recorded in the Census and other datasets as such. However, in practice they tend to function as, and meet some of the need for, small dwellings. Rooms in HMOs provide the smallest accommodation on the market: the bedroom is the only private space, while living rooms and other facilities are usually shared. HMOs therefore tend to accommodate those who need less space or cannot afford more. This typically means single individuals, though couples and occasionally children also reside in HMOs. Generally speaking, the availability of this option at the smallest and cheapest end of the housing market plays an important role in overall housing diversity and its ability to meet the full range of local needs. It also reflects the general high cost of housing and poor affordability which means that lower income people and households seek or are forced to share housing because it is the only option they can afford.

5.2.2 However, the value brought by HMOs depends on the range of other options available. For example, in areas where plenty of studio and 1 bedroom housing units exist and are not significantly more expensive, HMOs provide less additional value. Furthermore, where the supply of large family dwellings is below demand, the conversion of such properties to HMOs worsens this imbalance and conflicts with the needs of other groups. Both of these dynamics appear to be present in Eastbourne.

Existing mix and recent trends

5.2.3 Eastbourne is notable for its high proportion of small dwellings. 2021 Census data shows that half of homes in the Borough have 1-2 bedrooms. At 17%, the percentage of dwellings with 1 bedroom in Eastbourne is much higher than the East Sussex average of 12%. (Note that for the purpose of the Census and the LHNA, studios and bedsits fall within the 1 bedroom category.) Eastbourne's weighting toward the smaller end of the size spectrum corresponds with its high proportion of flats, which constitute 37% of all homes compared to 24% for the wider County.

5.2.4 These characteristics vary across the Borough. The town centre wards of Devonshire, Meads and Upperton have the greatest concentration of 1 bedroom properties at 29%, 26% and 33% respectively. They are also home to the highest concentrations of licensed HMOs, meaning that a moderate proportion of the relatively few 4+ bedroom properties in those locations[31] (between 11% and 15%) are operating as HMOs and functioning in practice as additional smaller units. It is fairly typical and not necessarily problematic for town centre locations to host high proportions of transient single people, who tend to be attracted to employment opportunities and access to local services. However, fewer HMOs and more family houses could increase choice and demographic balance in these areas with particularly high proportions of 1 bedroom homes.

5.2.5 2021 Census data reveals a related trend of rising population densities. The number of people per hectare in Eastbourne has risen from 20.3 in 2001 to 22.5 in 2011 and 23.0 in 2021 – an increase of 13% over the last 20 years. Devonshire Ward, home to

[31] The proportion of 4+ bedroom homes is 12% in Devonshire, 11% in Meads and 15% in Upperton, which are at or below the Eastbourne average of 15%. Note that the East Sussex average is 23%.

the greatest concentration of HMOs, has by far the highest density in the Borough at 84.6 people per hectare, and the second highest 20-year growth rate at 26%.

5.2.6 The Eastbourne Core Strategy supports residential densification in the Borough's sustainable neighbourhoods, which include Seaside (in Devonshire Ward) alongside the other key HMO wards of Meads and Upperton. Conversion to HMOs can generally be assumed to increase population density because of the incentive to maximise occupancy in all of the available living space, which is less present for large or wealthy families. It is difficult to disentangle the role of HMOs in rising densities from the more significant driver of new construction and its bias toward smaller units, but the modest part they play is relevant to note.

5.2.7 The latest Census statistics on density and the dwelling size mix reflect the pattern of recent completions across Eastbourne overall; data summarised in the LHNA (Table 6-14) show that a combined 81% of new homes built between 2011-12 and 2020-21 were 1-2 bedroom dwellings (44% were 1 bedroom dwellings and 37% were 2 bedroom dwellings). New construction is therefore exaggerating the historic over-representation of smaller homes. This trend is likely to persist due to the limited availability of land in Eastbourne and the ongoing tendency for new residential completions to come about through conversion and change of use, which favour flatted development. The LHNA acknowledges that this characteristic is not necessarily a problem because the Borough operates within a wider housing market area where larger family housing is readily available (e.g. in Wealden). However, this larger housing in the wider market area is not accessible to all households since it depends on the ability to afford it and/or to be able to move to a different area with potential implications for travel to work and other activities.

Future need

5.2.8 Nevertheless, in terms of future need the LHNA (Table 5-7 in the LHNA, replicated below as Table 5-1) finds that Eastbourne's dwelling mix would benefit from diversification toward family-sized housing where possible. The future need for 1 bedroom properties by 2038 is estimated at around 16% of all new housing. This is far lower than the 44% seen in recent completions. However, it is worth emphasising that the need identified in the LHNA is based on projected demographic change and the imperative to diversify the market rather than the availability of suitable development sites, which is a clear practical limitation.

Table 5-1: Dwelling Size Mix, Eastbourne

Number of bedrooms	Current Mix	New Build Need – Market (Rented and Ownership)	New Build Need - Affordable Rented	New Build Need to 2038 - Overall
1 bedroom	17%	9%	70%	16%
2 bedrooms	33%	41%	22%	38%
3 bedrooms	35%	38%	9%	35%
4+ bedrooms	15%	12%	0%	11%

Source: Census 2021, LHNA Table 5-7

5.2.9 The general thrust of this evidence is that 1 bedroom properties are already abundant in Eastbourne and the future need for them is relatively limited. There is, correspondingly, higher demand pressure on mid-sized and larger family housing. Local agents note that this high demand for mid-sized and larger properties exists in the PRS as well as the ownership market, and that conversions are driven by investment yields as opposed to declining demand as family homes.

5.2.10 The addition of further HMO accommodation, which functions as small units of accommodation, would appear to be at odds with the evidence presented in the LHNA, particularly if achieved through the loss of existing large family homes. New HMOs arising from the conversion of residential properties simultaneously add to the 1 bedroom equivalent stock and deplete the 3+ bedroom stock, thus reinforcing the longstanding size imbalance in the market and increasing the need for new larger homes for which little suitable land is available.[32]

5.2.11 This conclusion applies especially in the town centre wards where the dwelling mix is imbalanced to a greater degree and development land even more scarce. That said, the goal of diversity in the housing stock does not necessarily need to be achieved at the scale of individual wards, and there is an equally valid imperative to preserve the distinctive identity and high density of the town centre. In addition, many new HMOs in the relevant wards are conversions from hotel rather than residential uses, thereby limiting the knock-on effect on family housing. The impact on the hospitality sector is considered elsewhere in this report.

5.2.12 A further important caveat to this analysis is the fact that a studio or 1 bedroom dwelling is not equivalent to a room in an HMO: although both could suitably accommodate a single person, there are key differences of affordability, lifestyle and tenure. It is therefore relevant that the LHNA suggests robust continued need for 1 bedroom accommodation in the affordable sector, which has a high degree of overlap with HMOs because many people eligible for affordable rents live in shared housing using benefits. As such there is additional value to the existence of HMOs for smaller households in need of affordable or benefit-supported accommodation. The factors of lifestyle, tenure and affordability are considered further in the subsequent sub-sections.

5.3 Household composition

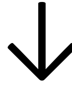
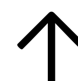
5.3.1 A room in an HMO is a different lifestyle proposition to a self-contained studio or 1 bedroom flat. For some, the sharing of facilities and living accommodation is the specific attraction. This is primarily the case among students and groups of friends house sharing, but community and social contact are also sometimes valued by individual occupants without pre-existing relationships.

[32] Although the conversion of HMOs back to single-family housing is possible, issues of condition and the cost of renovation (e.g. removing kitchenettes and other adaptations) tend to be prohibitive. This point was emphasised by local agents and is reflected in the marketing of HMO properties for sale, as explored in the Affordability sub-section below.

5.3.2 As HMO occupants are not a homogenous group, it is difficult to align them with specific lifestyle, employment or other trends to understand how demand may change in future. However, to understand the role that HMOs play in Eastbourne, it is useful to consider the broad market segments they tend to accommodate and any qualitative evidence about whether their needs may be growing or declining. These are loosely defined in the table below. Note that these categories are not exhaustive or exclusive: many properties will house a mix of people with different circumstances.

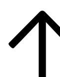
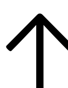
5.3.3 The overall direction of travel suggested by this high-level analysis is toward increasing demand for HMO accommodation, driven primarily by economic factors, limitations in the supply of affordable housing and policy changes around homeless people and asylum seekers. This is counterbalanced to some extent by an expected drop in demand from students – a group considered in further detail later in this Section. It should be noted, also, that this combination of trends will have a significant impact on the mix of people occupying HMOs in addition to overall levels of demand: generally speaking, students are likely to be replaced by vulnerable people and key workers on low incomes. This is likely to have a knock-on impact on the kinds of effects the concentration of HMOs in Eastbourne exerts on the wider community.

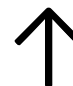
Table 5-2: HMO Market Segments

Market segment		Direction of travel and justification
Students at college or university living together, for whom cohabitation has a social appeal. Leases are likely to be taken out for a whole property rather than each party individually contracting with the landlord. Bedrooms may not be lockable and shared living space is likely to be desired.		The closure of the Eastbourne campus of the University of Brighton is likely to significantly reduce student numbers and demand from this group, and to increase the available supply of HMOs from departing students.
Young professionals living together, either with or without pre-existing relationships, but may be like-minded and appreciate the social benefits from cohabitation. Shared living space is likely to be sought. Rooms may be sub-let under a single tenancy agreement.		The national unemployment rate remains historically low at under 4%,[33] while inflation has only slightly eased from a 40-year high to 9%.[34] At the time of the 2021 Census Eastbourne's unemployment rate was consistent with the national average at 3.5%, and the latest earnings data show Eastbourne's individual lower quartile wage slightly sits above the East Sussex but well below the South East and national averages. This suggests that demand for low-cost accommodation for those in work is unusually robust and likely to persist in the near-term. Current rental listings and anecdotal evidence from local agents also points to an increase in the number of HMOs presented as well-equipped and

33 https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/employmentintheuk/latest

34 https://www.ons.gov.uk/economy/inflationandpriceindices/bulletins/consumerpriceinflation/april2023

Market segment		Direction of travel and justification
		high-standard lifestyle accommodation, some of which are new conversions. However, the LHNA suggests a slightly declining and relatively low 16–44-year-old population in Eastbourne (compared to wider averages).
Independent working individuals who are not known to each other and would each contract separately with the landlord. The social aspect is likely to be less important than the low cost and the proximity of the property to employment. Rooms are likely to be individually lockable and shared living space may not be required. Occupant churn may be high as circumstances change.		As above. Local agents suggest that tightness in the PRS overall means that those looking for 1 bedroom rental properties often accept HMOs as an alternative when the stock is limited. They also indicate a large proportion of local demand is from care sector workers. Human health and social work activities represent 22% of employment by industry in Eastbourne compared to 14% across the South East (2021 Census). This is likely to persist given the ageing population identified in the LHNA.
Benefit-funded individuals in inconsistent or low-income employment, or who may not be able to work. Their accommodation is partly or fully funded through housing benefit and/or universal credit. Again the focus is on minimising costs, and churn may be high. If under the age of 35, they are only entitled to the single room rate under Housing Benefit and so will have to live in shared housing unless they can find additional funds to afford self contained accommodation.		The LHNA shows a large number of Eastbourne households claim benefits and/or are waiting for affordable rented housing. The LHNA anticipates that need will continue to outstrip supply in the coming years, with the private rented sector picking up much of the slack.
Vulnerable people who are living in HMO accommodation as a transitional arrangement, placed by a Local Authority (which may or may not be Eastbourne), the County Council and third-sector organisations. Shared living space is likely to be less of a focus. There may be frequent interactions with social and care services.		Homelessness and mental health problems can be expected to rise as the cost of living increases, leading to additional emergency accommodation placements. Homelessness prevention initiatives, particularly from other local authorities, resulted in a spike in cross-border placements during the Covid-19 pandemic, but numbers have since stabilised in Eastbourne. Refugees from Ukraine and elsewhere are present in abundance and may require follow-on accommodation funded by benefits.
Those experiencing relationship breakdown who require transitional accommodation upon ending a cohabiting relationship.		This is anecdotally understood to be a notable segment of demand for HMOs, and may be growing due to the pressure on relationships exerted by cost of living

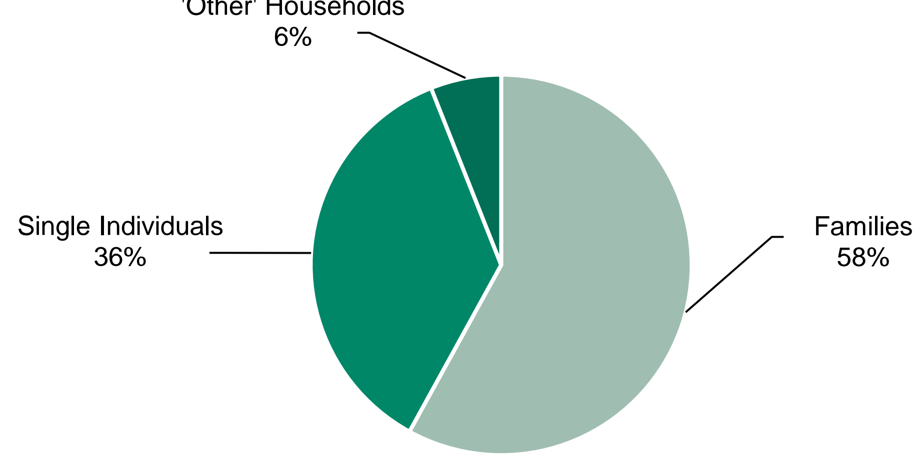
Market segment		Direction of travel and justification
		issues combined with broader trends away from traditional family structures.
Asylum seekers who may occupy rooms in HMOs on a temporary or long-term basis as move-on accommodation.		Temporary national licensing changes in March 2023 incentivise HMO and other landlords to house asylum seekers through the relaxation of licensing requirements for a two-year period. Given the current use of hotel and guesthouse accommodation by the Home Office in Eastbourne, it is likely that demand from asylum seekers for HMO rooms will rise in the context of this policy change.

5.3.4 The nuances of these market segments are not present in the limited secondary data shedding light on HMOs. However, overall statistics on the composition of households are newly available from the 2021 Census and are worth reviewing. Subsequently, the two market segments with the strongest trend patterns – students and people placed in temporary accommodation – will be explored in greater detail.

Census data

5.3.5 The most important Census dataset capturing trends in HMO occupancy (as opposed to the actual number of properties) relates to household composition, meaning the combination of relationships among people living together in dwellings. As shown in Figure 5-1 the vast majority of households in Eastbourne in 2021 were either families (58% of households) or single individuals (36%). The remaining 6% are classified as 'other' households, which are comprised of multiple families or unrelated individuals. This totals 2,791 as of the 2021 Census.

Figure 5-1: Household Composition in Eastbourne (2021)



Source: 2021 Census

5.3.6 The definition of the 'other' category has much in common with definitions of HMOs: "A group of people (not necessarily related) living at the same address who share cooking facilities and share a living room or sitting room or dining area". These include "unrelated adults sharing, student households, multi-family households and households of one family and other unrelated adults".[35] Note that people living in care homes, prisons and other communal establishments are counted separately in the Census.

5.3.7 However, this category does not only include HMO occupants. When cross-tabulated with tenure data, it is apparent that only 1,061 households (38% of all 'other' households) in Eastbourne live in the private rented sector (which is a defining characteristic of HMOs). Of these households, 289 live with dependent children. Other than single parents with small children, this is fairly unusual for HMO occupants, suggesting that some of these may be multi-generational or multi-family households in other private rented accommodation, and that 772 is a more realistic upper-bound estimate.

5.3.8 That said, there are additional uncertainties about the accuracy of this data that point toward undercounting of HMOs. For example, without careful attention to the question, occupants of HMOs may assume that their private bedroom space is its own dwelling, particularly if it has en-suite or kitchenette facilities. Furthermore, the groups most likely to reside in HMOs may not be strongly incentivised to complete the Census or may face additional challenges such as language barriers. As such, some HMOs may not be captured at all or be captured incorrectly (most likely as single-person households), meaning this data should be treated with caution.

5.3.9 Census data suggests that around 772 Eastbourne households in 2021 reside in HMOs, equating to around 1.6% of the total, but it is not possible to be precise because the alternative possibilities (purpose-built student accommodation, multi-generational families and other living arrangements) are not fully or consistently disaggregated in the Census.

5.3.10 Nevertheless, the trend in privately renting 'other' households is a highly relevant indicator of changes in HMO occupancy over time. In Eastbourne this category has followed an interesting trajectory over the past 20 years. As shown in Figure 5-2 the total was 729 in 2001, rising sharply to 1,392 in 2011 – an increase of 91%. However, in the 2021 Census this figure has fallen back to 1,061 – a decrease of 24% from 2011, leaving the current total 46% higher than in 2001. Interestingly, Eastbourne experienced a higher increase to 2011 and a greater decrease to 2021 than East Sussex, the South East or England overall.

5.3.11 The breakdown by ward is also shown in Table 5-3 below. This aligns with the concentration of HMOs to some degree, with privately renting 'other' households particularly prevalent in Devonshire and Meads Wards, where they form nearly two thirds of 'other' households and a higher proportion of all households than the Borough-wide average.

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35 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/articles/householdsandhouseholdcompositioninenglandandwales/2014-05-29

Figure 5-2: 'Other' Households in Eastbourne (2001 to 2021)

Source: 2021 Census

Table 5-3: Privately rented 'other' households, Eastbourne and Wards, 2021

	Count	% of 'other' households	% of all households
Eastbourne	**1,061**	**38.0%**	**2.3%**
Ward			
Devonshire	373	60.7%	5.6%
Hampden Park	56	22.3%	1.3%
Langney	40	14.8%	0.9%
Meads	173	59.0%	3.0%
Old Town	58	20.6%	1.3%
Ratton	49	22.3%	1.2%
Sovereign	105	38.9%	1.9%
St Anthony's	63	22.3%	1.3%
Upperton	145	46.6%	2.6%

Source: Census 2021

5.3.12 If HMOs are indeed a majority of privately renting 'other' households, the recent decrease appears to conflict with Section 2 of this study, which establishes that the number of HMOs in Eastbourne has continued to rise over the last decade – albeit partly driven by changes that have made existing HMOs more visible, making it difficult to draw precise conclusions about the potential rate of growth.

5.3.13 Part of the explanation for this could be that the 2021 Census was taken at the height of the Covid-19 pandemic, during a lockdown, and respondents were instructed to state their living arrangements accurately as of Census day, rather than what they were usually or previously like. Consequently, the results to some degree reflect an anomaly rather than a longer-term trend. It is not possible to tell whether the number of privately renting 'other' households would have continued to rise as between 2001 and 2011 or was in fact receding anyway. However, other Census datasets do suggest that much of the contraction is explained by Covid-19 – particularly its impacts on students.

Students

5.3.14 Across Eastbourne the number of people recorded as being full-time students (aged 16+, economically active or not) followed a very similar trajectory to the number of 'other' households: the rise between 2001 and 2011 was 39% and the decline from 2011 to 2021 was 15%.[36] (The respective figures for all 'other' households were a 33% increase followed by a 18% decrease). Because of this close correlation, it is possible to conclude with reasonable confidence that temporary changes in the student population drove the apparent change in the number of 'other' households – particularly in the PRS.

5.3.15 At the time of the 2021 Census, on 21 March of that year, the third national lockdown was being phased out, with primary and secondary schools reopening on 8 March.[37] Universities had generally transitioned to remote classes and did not respond as quickly, instead following their existing plans through the remainder of the academic year. Many students had returned to their family homes in 2020 for health and financial reasons. When the Census was conducted there would therefore be more than usual family households and fewer than usual 'other' student households than would otherwise have been the case. (It is worth emphasising that non-student HMO households may have also temporarily disbanded for health and employment reasons, notably cohabiting working adults with alternative living arrangements.).

5.3.16 The trend in Eastbourne followed that of East Sussex as a whole, where the number of students also declined by 5% compared with 2011 (after a 31% increase from 2001 to 2011). Conversely, across England the number of students continued to rise, by 4%, following a 40% increase the previous decade. However, the number of students across England did not decrease, probably because most of the students who moved home remained in England. The number of students in East Sussex dropped by less than in Eastbourne because some of the home-bound students likely moved from places of learning to family homes that were both within East Sussex. Eastbourne probably saw a sharper decline due to its smaller scale and character as a single urban area, making it less likely that both a student's term-time accommodation and family home would be in the same town. Even those students who moved from

[36] The totals are 4,468 in 2001, 6,220 in 2011 and 5,301 in 2011. Note that these are individuals rather than households, and cannot be used to derive the number of student HMOs because of that difference, the fact that some students live at home or in purpose-built accommodation, and the difficulty of knowing how many students live together in each HMO or on average. In the 2011 Census the 'other' household category was broken down further but just 8% of other households were 'all full-time students'. The category suggests that every single person in the household needed to be a full-time student for this to apply, which is not as common as households of mostly or partly students, or some non-full time students.

[37] https://www.instituteforgovernment.org.uk/data-visualisation/timeline-coronavirus-lockdowns

Eastbourne to family homes in the surrounding towns and villages would have appeared in a different Local Authority area for the purpose of the Census. Indeed, it is interesting to note that the student populations of Wealden and Lewes, which surround Eastbourne and are more rural in character, saw modest increases in the student population in the same period (of 2% and 3% respectively).

5.3.17 If the latest Census data on students in Eastbourne can be considered an anomaly due to Covid-19, it is worth considering what the true number is likely to be, now that in-person learning has resumed. Using Census data for simplicity and consistency, the lower end of the range is the 2021 Census figure of 5,301 full time-students over the age of 16. The 2011 Census provides an alternative scenario in which student numbers did not decline at all in practice (but also did not grow). In 2011 there were 6,220 students in Eastbourne. Finally, there is a possibility that the student population continued to grow in 2011-2021 at the same rate is it did in 2001-2011. Under that scenario there could be as many as 8,659 students in Eastbourne. The produces a wide approximate range of 5,500 to 8,500 full-time students, of which the mid-point and an appropriate ballpark figure for the purpose of this analysis is 7,000.

5.3.18 If this is the usual number of students in Eastbourne, it suggests that around 1,500 students left the Borough during the pandemic. This is roughly the same number of students studying at the Eastbourne campus of the University of Brighton, who would be among the most likely to relocate at that time. The majority of other full-time students aged over 16 would be sixth-form students, who tend to remain in the family home. There were 3,284 16-18 year olds recorded in the 2021 Census. Another unspecified segment of the student total would be adult learners, some of whom may live in HMOs while others live alone or in family groups.

5.3.19 The next question is how many Eastbourne HMOs are normally occupied by students. Nationwide data gathered by Higher Education Statistics Agency (HESA), which is not available for the Borough specifically, suggests that the percentage of full-time higher education students living in the private rented sector in the 2021/22 academic year is 27%, having declined slightly from 29% in 2019/20 and above 30% in 2015/16.[38] This is consistently the largest accommodation category, although it also includes people living in smaller groups (i.e. alone or with one or two others), so does not only represent HMO accommodation. The next most common category is the parental home at 20%, followed by own residence at 19% and halls of residence at 16%.

5.3.20 The number of higher education students in Eastbourne is between 1,500 (known student total at University of Brighton campus) and approximately 4,000 (7,000 total estimate minus sixth-form students). If up to 27% of this range rent privately this implies a potential market size of 405-1,080 students in the private rented sector overall. It is not possible to accurately estimate the share of that market residing in HMOs. However, if the most common number of rooms in an HMO is 5 (EBC licensed register), potentially around 80-220 HMOs in Eastbourne might normally be occupied mostly or entirely by students. This is a fairly significant proportion of the estimated total (20-55%).

[38] https://www.hesa.ac.uk/data-and-analysis/students/chart-4

5.3.21 Finally, it is worth considering the future trajectory of the student market for HMO accommodation. As discussed above, long-term trends in student numbers are not a reliable basis for forward projections due to recent circumstances. A more relevant indicator is provided by changes in the provision of higher education in Eastbourne and in the provision of purpose-built student accommodation. By far the most significant change in this case is the impending closure of the Eastbourne campus of the University of Brighton.

5.3.22 The University of Brighton will close its three sites in Eastbourne (Hillbrow, Darley Road and Leaf Hospital) by the start of the 2024/25 academic year.[39] The current (or usual) number of University of Brighton students based in the town is approximately 1,500. This alone could therefore reduce the student population by more than one fifth, to around 5,500 (from the loose current estimate of 7,000). Applying the HESA rate of 27% to the University of Brighton population suggests around 405 individuals are privately renting, an unknown but probably large number in HMOs. If 5 rooms is again taken as the HMO average, this suggests a direct reduction of 81 HMOs mostly or entirely occupied by students that could be vacated.

5.3.23 This would create a significant number of vacancies in HMOs across the Borough, with impacts on rent levels and the accommodation options of other groups profiled at the start of this section. That effect could be magnified if any of the University of Brighton's purpose-built student accommodation is repurposed as mainstream residential housing.[40] Local agents express a high degree of confidence that capacity created by vacating students will be absorbed as rooms are re-occupied by non-students, with carers identified as a key source of ongoing demand.

5.3.24 There are, however, a number of uncertainties here. For example, some students may continue to live in Eastbourne and commute to Brighton for affordability or continuity reasons, which could moderate the expected drop in demand for HMOs. If demand from non-students does not rise to fill the vacancies created through this process, a number of possibilities arise. Some HMO landlords might compete for occupants by improving their properties, while other properties with persistently vacant rooms may deteriorate due to a lack of funds for investment. If underoccupancy persists long-term, some HMOs may be converted to other uses, such as single-family housing. However, it is also possible that the increased availability of low-cost accommodation in Eastbourne will have the effect of drawing occupants from beyond Eastbourne's borders. This may include vulnerable people placed in temporary accommodation.

Temporary accommodation

5.3.25 The variety of groups considered vulnerable or in need of temporary housing support includes those at risk of homelessness, leaving care, facing mental health challenges, involved with the justice system, at risk of domestic violence, and seeking refugee status. Temporary accommodation placements are made by a range of organisations:

[39] https://www.bbc.co.uk/news/uk-england-sussex-60166035

[40] The University of Brighton did not respond to requests to comment on the current level of purpose-built student accommodation provision and their future plans for repurposing their Eastbourne campus buildings.

- EBC has a statutory duty to prevent homelessness. The placements it makes for this reason are the most common source of demand for temporary accommodation in the Borough. EBC does not, however, have a duty to house any other groups, nor to directly provide follow-on care for placed households other than to address the needs that are driving their risk of homelessness.
- Other Local Authorities can house people at risk of homelessness outside of their administrative boundaries. This may be driven by a lack of suitable accommodation in the source authority or for specific reasons such as providing geographical distance for those at risk of domestic violence. At any time Eastbourne is both hosting placements arising from other authorities and itself placing households elsewhere.
- ESCC places households who are at risk of homelessness and have children, and other groups such as those leaving care (e.g. for mental health reasons).
- Other organisations make placements for other vulnerable groups, such as the probation service, drug and alcohol support services, and other charities with specific remits. Some own and manage accommodation, while others help households source their own housing. Neither form of placement is centrally recorded, meaning it is difficult to ascertain numbers and changes over time.
- Through private contractors, the Home Office also takes out block bookings of hotels for refugee and asylum seeker accommodation in Eastbourne and elsewhere. This is not considered HMO accommodation but is worth mentioning as some of the demand streams and impacts overlap. This is particularly so given the March 2023 changes incentivising HMO landlords to house asylum seekers by relaxing licensing requirements. The use of at least 6 hotels, guest houses or hostels in Eastbourne to house these groups may lead to an uptick in demand for HMO accommodation in light of the recent changes.

5.3.26 Temporary accommodation comes in a variety of forms. Rooms in HMOs represent only one segment of the sector, chiefly accommodating single people. Other forms include self-contained flats and houses, guesthouses and hotels, although the latter tend to be seen as transitory or backup arrangements.

5.3.27 EBC sometimes discharges its duties directly with PRS landlords, including those operating HMOs, but primarily procures temporary accommodation from private providers that own properties or otherwise source them as needed. These providers operate some buildings (including HMOs) themselves, but also have relationships with private landlords in the wider PRS. Placements of this kind are spot purchased by EBC. However, they are indirectly funded through housing benefits (rather than Universal Credit) under a separate subsidy scheme, which is claimed back by the Council at 2018 LHA rates – though this leaves a significant shortfall. It is interesting to note that the funds recuperated in this way are lower for shared accommodation than self-contained dwellings. This means that EBC is financially incentivised to make placements into the latter, even though the former is theoretically lower cost.

5.3.28 Most temporary accommodation placements by the Council are concentrated in specific buildings and areas rather than relevant individuals being mixed in with self-funding HMO occupants. Although the concentration of people with similar issues and life challenges can amplify those issues, it is preferable from the perspective of management and the provision of social and other care services. The other organisations referenced above can use the same providers but may also have their own relationships with other landlords.

5.3.29 As of May 2023, EBC houses 255 households in temporary accommodation. 104 of these are single people (two-thirds of whom are male). Though this is the key segment of need suitable for HMO accommodation, an additional 12 households are assessed as needing only a single bedroom. Of the 116 households eligible for a single bedroom, 89 are presently housed in shared accommodation. Shared accommodation is likely to mean HMOs in most instances, but may also include guest house accommodation.

5.3.30 Lewes District is currently housing 24 households who are eligible for a single room, 22 of whom are in shared accommodation. A high proportion of these households are placed in Eastbourne. This is not uncommon given the joint working arrangements of the two Councils along with Eastbourne's larger PRS and greater availability of smaller homes. Placements from South Wealden are also not uncommon because of the overlapping school catchments and other links across the two authorities' shared urban area.

5.3.31 It is not known exactly how many placements are currently active from other local authorities because notification processes are not always followed consistently. In the past there have been large net inflows to Eastbourne, notably following Brighton and Hove City Council's implementation of the Covid-19 'Everyone In' programme, which resulted in around 200 placements in Eastbourne in a short time period, including some individuals with particularly severe complex needs and others with injunctions banning them from other town centres. However, the EBC Housing Needs team suggests that there are currently around 10-15 people placed from Brighton, and that overall inflows and outflows are in balance. That said, this experience had multiple impacts that continue to influence perceptions of placement arrangements and HMOs.

5.3.32 In addition to emergency temporary accommodation placements, the Councils house single people with multiple complex needs through the Rough Sleeper Initiative (RSI). Eastbourne houses 50 such individuals and Lewes houses 11. These are less likely to involve HMO accommodation.

5.3.33 In total, it can be concluded that around 90-125 households at risk of homelessness are currently in temporary shared accommodation including HMOs. Using the average HMO size of 5 rooms, this implies around 18-25 HMOs might be occupied by this group, which represents 4.5-6% of the total.

5.3.34 The temporary accommodation provided by ESCC would be unlikely to draw on HMO accommodation. It typically involves specialist accommodation schemes managed by registered providers that include ongoing support, into which EBC nominates households. Upon exit from such schemes, typically in six months to a year,

households can present themselves to EBC for housing. A relevant challenge is the undersupply of suitable move-on accommodation for such people.

5.3.35 ESCC note that these specialist schemes are generally commissioned through a framework, which providers can apply to join and take up opportunities advertised by ESCC and EBC. The ability to commission additional accommodation in this way is open to EBC and other statutory services, and may offer a longer-term alternative to higher cost and lower support spot purchasing arrangements. A potential limitation is the availability of suitable and regulatorily compliant buildings, so a further option might be to allow planning permission to convert vacant commercial and public buildings to that purpose through dialogue with trusted developers and providers.

5.3.36 An early-stage example of this is a scheme being explored by the EBC Property and Development team to utilise national government funding earmarked for Eastbourne through the Single Homeless Accommodation Programme (SHAP). This is required to target people with multiple complex needs who are currently unhoused. It would involve the acquisition of a building to provide accommodation with significant wrap-around support, as well as communal space that could help to meet severe weather emergency housing duties. In addition to funding for the building acquisition, EBC would be able to reclaim significantly higher ‘hostel rents’ from central Government for each placement. The opportunity currently under consideration would re-purpose a former private-sector community organisation space that has received interest from private HMO landlords to house and support 11-13 people that are predominantly living on the street in central Eastbourne. It would be classed as an HMO but function more like purpose-built temporary accommodation.

5.3.37 Demand for temporary accommodation is primarily driven by tenure insecurity, rising housing and living costs, a lack of regulated supported housing and social schemes, and an undersupply of new housing – especially in affordable tenures. As these trends evolve it is likely that needs will rise within Eastbourne. However, because of the range of alternative options and commissioning approaches, the impact on demand for mainstream HMO accommodation is difficult to predict.

5.3.38 Although HMOs are generally preferable to rooms in guesthouses and hotels in terms of the experience of occupiers and value for money for the commissioning organisation, the preferred form of accommodation is specialised and/or self-contained. There is little financial incentive for commissioners to place households in HMOs over other options, but HMO accommodation does provide a helpful backup source of supply.

5.3.39 Because of these complex dynamics, a direct causal relationship between rising emergency needs and demand for HMO accommodation is difficult to establish. Likewise, an increase in the supply of HMOs through conversion of family housing and hotel accommodation cannot be easily absorbed by this potential demand stream. For this to occur, providers would need to source and offer that accommodation either to replace or add to its existing stock. While there is a perception among the public that Eastbourne is viewed as a destination authority for vulnerable people due to the ready availability of HMO and hotel accommodation, current evidence suggests this has a minimal impact on the market. The availability of low-cost single-person accommodation may make Eastbourne a more attractive

target from source authorities but this relationship is not direct or immediate, and the out-placement of households depends on a range of other factors in the source authority.

5.3.40 It is likely, however, that lower income single people and households move to Eastbourne and other coastal areas where there is better availability of cheaper housing, including HMOs. This flow is long-standing and common to most urban areas. It generally happens without the intervention of public authorities.

5.3.41 In summary, HMO accommodation plays a role in the provision of temporary accommodation for Eastbourne and, in a limited way, other authorities. However, this occurs at a relatively small scale and tends to be viewed by commissioners as a non-preferred option. As such, trends in the need for temporary accommodation and in the availability of HMOs have a relatively small and indirect relationship.

5.4 Tenure

5.4.1 By definition, HMO accommodation is part of the private rented sector (PRS). It is not possible to own rooms in HMOs: the equivalent arrangement would be a co-housing or co-operative residential scheme, which would not require an HMO licence or share many of its defining features. HMO rooms are instead generally rented out on the open rental market by private landlords, and often have shorter or more flexible tenancies than self-contained rental properties. The low cost and relative flexibility tends to attract self-funding individuals in lower-wage employment as well as groups of cohabiting friends and students, as described in the previous sub-section.

The private rented sector (PRS)

5.4.2 Tenure data from the 2021 Census shows a clear upward trend in private renting in Eastbourne over the past 20 years. The sector experienced a 91% expansion in that time, growing from 16% to 27% of the total housing market. The three highest rates of private renting by ward in 2021 are also the three wards with the highest concentrations of licensed HMOs: Devonshire (47% private renting), Meads (37%) and Upperton (37%). This is unsurprising: private renting is usually more common in town centres where populations tend to be more transient and influenced by employment, and where smaller homes (such as 1-2 bedroom flats) tend to predominate.

5.4.3 It is unclear whether the upward trend in private renting across Eastbourne primarily reflects increasing demand or supply. Though demand is likely to be rising given the worsening affordability of home ownership (established in the LHNA), there are also supply-side reasons for growth in the PRS, such as the continued availability of former commercial properties for conversion to residential – such as closing hotels in the case of HMOs.

5.4.4 However, it is important to stress that HMOs only form a minor share of the PRS overall. Only 8.7% of private renters, representing 2.3% of all Eastbourne households, fall into the ‘other’ category discussed above. When broken down by ward these statistics again align with the concentration of licensed HMOs: only

Devonshire, Meads and Upperton have higher proportions of ‘other’ PRS households than the Borough as a whole, at 5.6%, 3.0% and 2.6% respectively.

Benefit arrangements and affordable housing need

5.4.5 Though all HMO occupants would formally be classified as private renters, in practice many occupants cover their rent using housing benefits (or Universal Credit). For example, individuals aged under 35 applying for Local Housing Allowance are only eligible to receive the allowance rate for a room in shared housing. Department for Work and Pensions (DWP) data for August 2022 suggests that 44% of Eastbourne households claiming housing benefit or universal credit (which includes those living in affordable rented accommodation) live in the PRS. Interestingly, three of the four wards that exceed 50% are Devonshire (56%), Meads (61%) and Upperton (52%). HMOs and the wider PRS therefore provide the additional function of accommodating households who may be eligible for affordable rented housing provided by the Council or a Housing Association, but are yet to be housed due to the present backlog or fall into low-priority bands.

5.4.6 Eastbourne Borough Council’s affordable housing waiting list totalled 1,118 households in 2021 (LHNA Figure 8.3), of which 471 applicants were eligible for a 1 bedroom property only.[41] It is likely that some if not most of these people live in HMOs using some form of benefit arrangement, and that further households who would be eligible are not registered. DWP data for August 2022 indicates that 50% of Eastbourne households on housing benefits or Universal Credit (where bedroom eligibility is recorded) are eligible for 1 bedroom or fewer. The only wards that exceed this figure are Devonshire (65%), Meads (83%) and Upperton (73%), due to their smaller housing stock (including HMO accommodation), meaning that a higher proportion of single-person households live there. The provision of additional affordable rented housing could therefore theoretically reduce the demand for HMOs.

5.4.7 The reverse, however, is not true: the same number of households would remain eligible for, and likely better served by, affordable rented housing even as more HMO accommodation becomes available. Although Government endorses the use of the PRS to meet housing needs through the administration of housing benefit and to discharge local authorities’ homelessness duties, purpose-built affordable rented housing offers the occupant a lower-cost and more secure form of tenancy. The LHNA notes: “Discussions with EBC housing officers suggests the PRS in Eastbourne is struggling to meet local needs. Officers specifically raised the issue of a gap between PRS rents and what households can claim in housing benefit under Local Housing Allowance (LHA) rates. This leaves many households needing to top up their rent, stretching themselves further financially and reducing disposable income for other essentials such as food and energy costs. Related to these pressures, EBC became the first local authority to declare a cost-of-living emergency after the Trussell Trust revealed the borough had the highest reliance on food banks in the country. The Council also cited the rising cost of energy bills.” DWP data for August 2022 confirms

[41] Vacancies in affordable rented housing are also higher in 1 bedroom properties because they are numerous and the cohort (which includes couples) tends to be more transient and may need a different size of dwelling when, for instance, having children. 65% of lettings in 2018-19 (latest available year) were 1 bedroom properties. Though there is a high absolute need for smaller properties there is less demand pressure because of the size of the stock.

that for 56% of those on Universal Credit in Eastbourne, the available LHA rate does not cover their rent.

5.4.8 Despite the seriousness of this challenge, the reality – in Eastbourne and across the country – is a large and persistent undersupply of affordable rented accommodation. The current and future need for affordable rented accommodation is therefore a relevant consideration when thinking about the function of HMOs. The LHNA suggests a backlog of a similar size is likely to persist into the future without a significant injection of new supply. After turnover through relets and other factors are taken into account, the LHNA estimates an overall net shortfall for affordable rented housing of 169 households per year, or 3,388 in total over the 20-year Local Plan period. EBC officers note that the need could also increase further in the short-term as Ukrainian refugees currently accommodated with local families reach the end of their initial hosting periods and require move-on accommodation of their own.

5.4.9 In this context of limited affordable rented housing, HMO accommodation provides the next lowest-cost alternative for relevant households and arguably prevents homelessness to some degree. It may play a productive, ongoing role in absorbing the unmet need for 1 bedroom affordable rented housing as it persists and fluctuates in the coming years.

Temporary accommodation

5.4.10 As noted in the previous sub-section, a third way that HMO accommodation can be accessed is through temporary accommodation placements. Most such people would also be eligible for social or affordable rented housing. However, the turnover of affordable rented housing is relatively modest and tends to accommodate transfers from existing occupants and others on the waiting list in accordance with the approved priority banding system. It is therefore more common for homelessness and associated issues to be addressed through emergency temporary accommodation in the short term than through the social and affordable rented sector. Because temporary placements are indirectly funded through housing benefits, occupants are theoretically still in the PRS, although due to the complexity of the situation there may be a lack of consistency in how they self-report their tenure situation in the Census. As discussed in the previous sub-section, the ability of HMOs to serve fluctuating levels of unmet need for temporary accommodation is broadly beneficial in the context of wider housing supply and funding challenges, although this function is small in scale relative to the other uses noted here.

Summary

5.4.11 In summary, the market for HMOs includes people who cannot afford market rents as well as those who can. While all HMO occupants are theoretically living in the PRS, their funding and management arrangements vary, producing a different experience in practice. There are also clear overlaps with groups that may be better suited to other tenures, notably affordable renting and purpose-built supported accommodation. As such, HMOs play a flexible role in the housing market by accommodating unmet demand from other tenure categories and providing an intermediate step for households transitioning between other forms of housing.

5.5 Affordability

5.5.1 Within the mainstream (i.e. non-subsidised) housing market, rooms in shared accommodation tend to be the lowest cost form of housing available. This is because of the small amount of floorspace per household and the sharing of kitchen, bathroom and other facilities. As noted in the previous sub-sections, this makes HMOs an attractive option to groups of students and house sharers, but also to individuals who are unable to access other options in the market or who prioritise affordability over other considerations. This sub-section sets HMOs within the broader context of housing affordability in Eastbourne and identifies what income groups rely on them.

HMO rental costs

5.5.2 It is first important to establish the rental prices of HMO accommodation. Table 5-4 below shows average rents in Eastbourne in the year to September 2022 from ONS private rental market data. Rooms in shared houses offer a significantly lower cost option than 1 bedroom properties.

Table 5-4: Rental Costs, Eastbourne [42]

Size	Count	Mean	LQ	Median	UQ
Room	**40**	**£434**	**£400**	**£500**	**£542**
Studio	40	£569	£500	£575	£650
1 bedroom	390	£731	£667	£725	£795
2 bedroom	510	£929	£835	£925	£1,000
3 bedroom	210	£1,146	£995	£1,134	£1,280
4+ bedroom	50	£1,392	£1,250	£1,400	£1,595
Overall	1,250	£898	£725	£875	£1,000

Source: ONS Private Rental Market Data, 2022

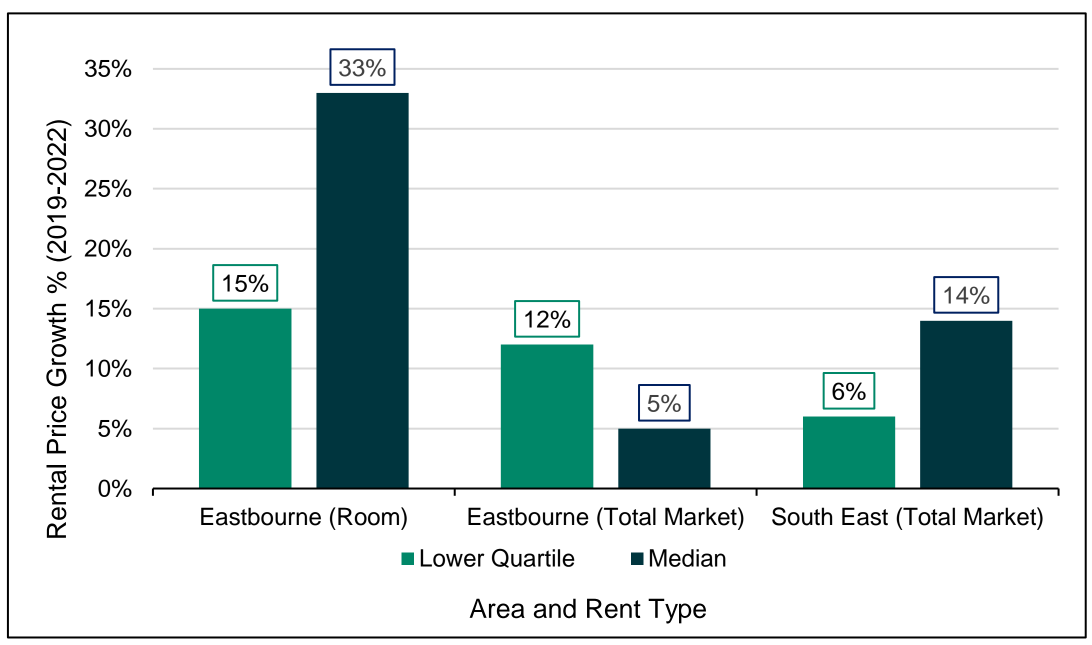
5.5.3 The same dataset shows that median room rental price in Eastbourne is higher than that of East Sussex (£450), the South East (£468) and England (£438). The lower quartile averages are all similar. Eastbourne falls below the South East (£412) but above East Sussex (£395) and England (£390). In terms of the count of room rents recorded, which can be seen as a proxy for the extent of HMO accommodation, Eastbourne had a count of 40, which is slightly lower than Hastings at 50, but significantly higher than any of the other East Sussex authorities. In fact, Eastbourne and Hastings together represented 90% of all room rents recorded in the county.

5.5.4 The ONS private rental market data presented in the table above has been recorded since 2019. This historic data highlights the rapid increase in rental prices, of 15.3% for lower quartile room rents and 33.3% for median room rents over the last four years

[42] https://www.ons.gov.uk/peoplepopulationandcommunity/housing/datasets/privaterentalmarketsummarystatisticsinengland

(as presented in Figure 5-3). These are higher rates of increase than for the Eastbourne rental market overall, at 11.5% for the lower quartile and 5.1% for the median, as well as for the room rate averages for the South East, at 5.6% for the lower quartile and 13.6% for the median. (Note that East Sussex averages for rooms in shared houses are less useful for comparison because Eastbourne makes up nearly half of the sample.) It can be concluded that room rents are rising unusually fast in Eastbourne compared to other property sizes and comparison areas. Rising rents reflect the ability of local market demand to absorb the increasing stock of HMOs.

Figure 5-3: Rental Price Growth in Eastbourne and South East (2019-2022)



5.5.5 The ONS statistics for current rents in Eastbourne can be sense-checked and fleshed out using current listings on Rightmove. A sample of listings (including let agreed) as of February 2023 found 11 HMO rooms for rent, ranging from £400 to £760 per month. The median monthly rent in this sample is £530. This exercise reveals two fairly distinct segments of the market in Eastbourne:

- Purpose-designed, refurbished and usually smaller HMOs, some of which are marketed specifically as co-housing for professionals. Rooms are advertised for £595 to £760 per month. The £760 listing is an outlier: the next highest is £600. Such properties represented 45% of the Rightmove sample. The median price of this sub-sample (and the upper quartile overall) is £600 per month.
- More traditional options with greater variation in condition and often a larger number of rooms in the property. Monthly rents range from £400 to £530, representing 55% of the Rightmove sample. The median price of this sub-sample (and the lower quartile overall) is £485 per month.

5.5.6 Being both higher and more recent than the ONS data, the Rightmove statistics potentially indicate an uptick in prices in the past year (when the cost of living has been rising generally). However, they are based on a much smaller sample and may

be skewed by some unrepresentative outlying examples. The Rightmove data broadly corroborates the ONS lower quartile and median monthly prices, but also usefully extends the full range of prices at the higher end of the market beyond the ONS upper quartile figure of £542 per month. Four of the 11 rooms listed on Rightmove were advertised at £600 per month, suggesting this is a common offering that needs to be captured when thinking about HMO rents.

5.5.7 It is therefore possible to summarise that HMO rooms in Eastbourne generally cost between £400 and £600 per month, with many listings clustering at each end of the range. The overall median is consistently around £500 per month.

Housing benefits / Universal Credit

5.5.8 As noted in the previous sub-section, many occupants of HMOs cover their rental costs in part or in full using housing benefits or Universal Credit. The maximum claimable amount is known as the Local Housing Allowance (LHA) rate. This is split into different category rates, which are fixed across Broad Rental Market Areas (BRMAs). The relevant BRMA for Eastbourne covers the whole Borough plus Seaford and the south part of South Wealden district (to Heathfield). The relevant rate category for HMOs is Category A, defined as shared accommodation with exclusive use of one bedroom and shared facilities (e.g. kitchen, bathroom).

5.5.9 Effective from April 2023, the Category A LHA rate for housing benefits in Eastbourne is £74.81 per week or £323.93 per month (weekly x 4.33). The equivalent rate for Universal Credit, effective for 2022-23, is £325.07 per month.[43]

5.5.10 Housing benefits and Universal Credit therefore cover around £325 per month for eligible households, leaving a minimum £75 per month shortfall (on the cheapest available rooms) to be topped up through earnings (where individuals are working) or other benefit entitlements. Recent research has revealed Eastbourne to be among the local authorities in the country with the biggest gap between LHA rates and effective local rents, highlighting that 0% of shared accommodation rents in particular are affordable to those reliant on LHA rates, compared to a national average of 16%.[44]

Comparison of rental costs

5.5.11 Following the approach taken in the LHNA for all forms of housing, Table 5-5 on a subsequent page assesses the affordability of HMO rooms relative to local incomes and the relevant alternatives. A key assumption used in these calculations, consistent with the LHNA, is that a household can be said to 'afford' a rented housing option when spending no more than 30% of their income on rental costs. The costs of home ownership are not included here as there is no owned equivalent of an HMO room and the target markets for ownership and HMOs are likely to be far removed from one another. However, it is worth noting that the rising cost of market housing is a

[43] https://www.gov.uk/government/publications/local-housing-allowance-lha-rates-applicable-from-april-2023-to-march-2024; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1060512/england-rates-2022-to-2023.csv/preview

[44] https://www.jrf.org.uk/report/government-must-raise-housing-benefit-crisis-deepens-private-renters

driver of price pressures in the PRS overall. In Eastbourne in the decade to 2021 the lower quartile house price (to purchase on the open market) rose by 53%, or an additional £71,000 in absolute terms (LHNA Table 7-1).

5.5.12 For an average HMO room, an occupant will need an annual income of around £20,000 to afford the annual rent of £6,000. A minimum income of £16,000 is needed to afford room at the lower end of the market, and an income above £24,000 would provide access to higher-value options.

5.5.13 This can be compared to the income needed for affordable rented housing and self-contained accommodation in the PRS. Drawing on calculations from the LHNA (Table 7-12), the income required for a social rent bedsit or 1-bedroom in Eastbourne is similar to lower cost HMOs at £15,500 to £16,000. For affordable rent a 1-bedroom property requires £17,500. The income required for a private rented studio and 1-bedroom flat is comparable to higher-value HMO rooms, at £22,000 and £27,000 respectively.

5.5.14 It can therefore be concluded that HMOs primarily serve individuals earning (or with incomes of) between £17,500 and £22,000 per year. In theory, lower earners will need affordable rented housing and higher earners can afford self-contained rented accommodation. However, in practice the potential market is much larger, including anyone earning below £22,000 but unable or waiting to access affordable rented housing, and some people earning above £22,000 who seek out HMOs by choice for financial, social or other reasons.

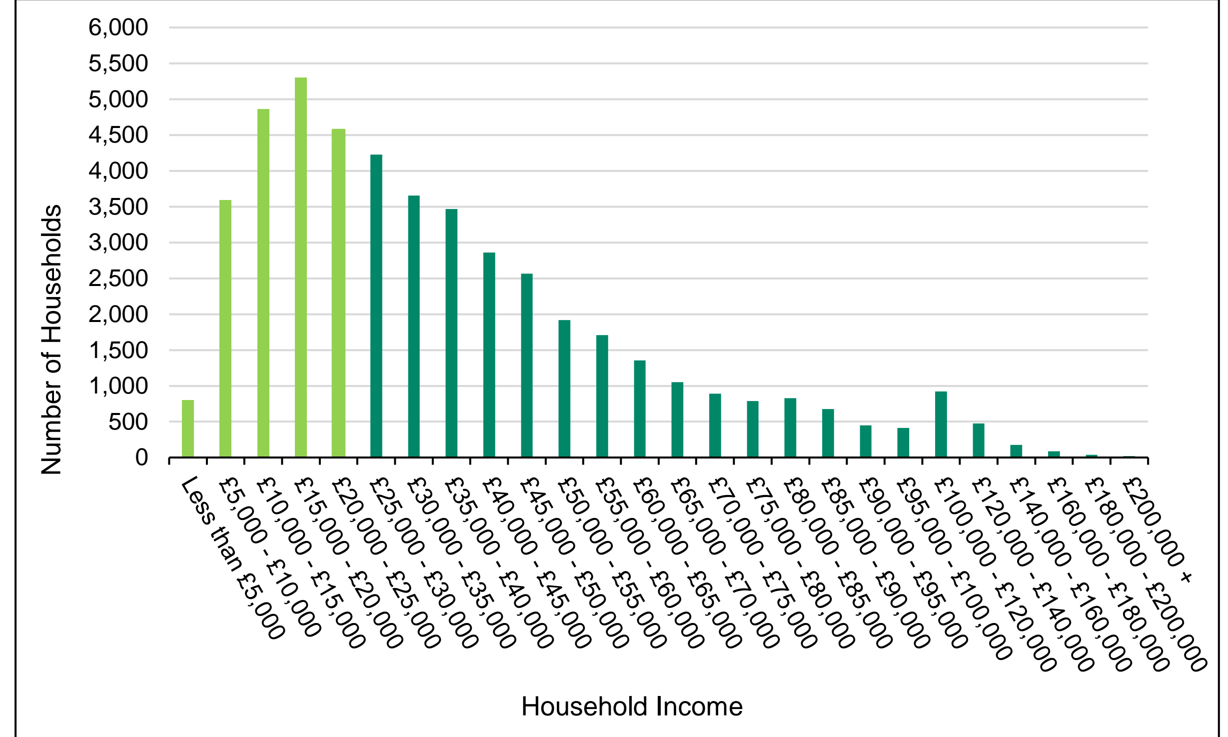
5.5.15 As explored in the previous sub-section, there is a particularly large degree of overlap between those eligible for affordable rented housing and those using housing benefits to live in the PRS. The maximum LHA rate noted above would cover most of the cost of a lower-value HMO room, leaving a shortfall of around £1,000 to £2,000 that could be met with an annual income of £3,000 to £7,000 or additional benefit entitlements. By contrast, housing benefits and Universal Credit cover the entire cost of affordable rents with no shortfall. For unemployed households, even those receiving the maximum LHA allowance, HMO accommodation may still present significant affordability challenges. In practice, many HMO occupants will be spending more than 30% of their income on rent to be able to afford their accommodation.

Affordability on local incomes

5.5.16 According to CACI household income data for Eastbourne in 2021 (presented in Figure 5-4 below), approximately 4,480 households (9.4% of the total) have incomes between £17,500 and £22,000 per year.[45] The light green bars in the graph represent those most likely to make use of HMOs, depending on their circumstances.

[45] CACI data is divided into £5,000 income bands, so to estimate how many people in the £20,000 to £25,000 income band earn £20,000 to £22,000 the number of people in the band is divided by two-fifths.

Figure 5-4: Household incomes, Eastbourne



Source: CACI Paycheck 2021

5.5.17 The number of households with incomes below £22,000, who all theoretically fall within the target market for HMOs, e.g. when using housing benefits, is 16,480, or 34.3% of the total. However, because people in these income bands cannot afford any form of market housing, many of them will be eligible for affordable rented housing. (Note that this data does not account for assets; the lower bands include older home owners with higher wealth but low incomes). As of the 2021 Census, 5,940 Eastbourne households lived in social rented tenures. The potential target market for HMOs net of affordable rented housing occupants is 10,540, or 22.1% of the total.

5.5.18 This is a rough, upper-bound estimate because it is not possible to exclude the potentially large number of low-income households composed of more than one or two individuals, for whom a room in an HMO would not be an appropriate housing solution. Generally speaking it can be concluded that between a tenth and a fifth of households in Eastbourne could benefit from the availability of HMOs from an affordability perspective. It is not possible to correlate this figure with Census statistics because of the different way that households are counted in the two datasets.

5.5.19 Table 5-5 below compares HMO costs to other forms of housing and three measures of local incomes.

- It is apparent that median earning single individuals cannot necessarily afford a 1 bedroom private rented home and may therefore rely on HMO rooms and self-contained studios.

- Lower income households can potentially afford the lowest-cost HMOs only, but some of these households will include two or more people and consider HMO rooms to be unsuitable.
- Lower earning single-person households appear unable to afford any form of housing in Eastbourne and will therefore be likely to rely on affordable rented housing or housing benefits. With housing benefits or Universal Credit they may be able to access rooms in HMOs, but because of the variation in how eligibility and benefit levels are calculated for individuals, it is not possible to generalise further.

Table 5-5: Affordability comparison of HMOs to other market and affordable rental options

Tenure	Annual rent	Annual income required	Affordable on median individual earnings? £24,153	Affordable on LQ household incomes? £17,523	Affordable on LQ individual earnings? £14,935
Market 1 bedroom	£8,100	£27,000	No	No	No
Market studio	£6,600	£22,000	Yes	No	No
Upper-range HMO room	**£7,200**	**£24,000**	**Marginal**	**No**	**No**
Mid-range HMO room	**£6,000**	**£20,000**	**Yes**	**No**	**No**
Lower-range HMO room	**£4,800**	**£16,000**	**Yes**	**Yes**	**No**
Affordable rent 1 bedroom	£5,245	£17,500	Yes	Marginal	No
Social rent 1 bedroom	£4,672	£15,500	Yes	Yes	No
Social rent bedsit	£4,805	£16,000	Yes	Yes	No

Source: LHNA, AECOM modelling, SDR tables, ONS and Rightmove HMO price data, CACI Paycheck income data and ASHE earnings data.

The investment market for HMOs

5.5.20 In terms of the potential incentive to supply more HMO accommodation it is also worth reviewing the cost of HMOs to purchase for investment and the potential returns available.

5.5.21 Although in theory any 5+ bedroom home could be converted to an HMO subject to the necessary permissions, it is more relevant to focus on the smaller sample of properties currently listed for sale that either already hold an HMO licence or specifically listed as having potential for conversion (due to previous use as an HMO, extant planning permission, use as a bed and breakfast, or other reasons).

5.5.22 At the time of search in February 2023, there were 9 listings of operating HMOs and a further 6 of potential HMOs. Detailed data is provided in Table 5-6 below, and a few key findings are worth noting:

- Both the potential income and the purchase price are strongly, if not perfectly, correlated with size in terms of the number of rooms. The implied room rate is broadly in line with the averages in the review of advertised rents noted above.
- The average potential annual gross return (of the operating HMOs) is 9.5%, and in no cases falls below 8.5%.
- In line with this potentially attractive rate of return, all but three of the total sample of 15 are either sold subject to exchange of contracts or under offer, implying robust demand from potential purchasers.
- It should be noted that the potential return is based on the listing rather than the eventual transaction price, an annual income that is not verified and is often quoted as ‘when fully occupied’, which may not always be the case, and that some of the properties require maintenance or refurbishment to realise the potential return cited.
- It is not possible to estimate the return for the properties with permission to convert because the cost of conversion and refurbishment is unknown.
- Note also that gross return (annual potential income divided by the purchase price) does not reflect stamp duty, tax on the income, insurance, maintenance and management costs, or other items that will in practice reduce this gross rate of return to a net figure.

5.5.23 In summary, there appears to be fairly high churn of existing HMOs and a modest pipeline of potential future HMOs, with robust appetite for both from investor-purchasers. This reflects an attractive gross rate of return, although there is large variation in the rents commanded, level of refurbishment required and management approach.

Table 5-6: HMOs and Potential HMOs for Sale

Listing price	Street	Rooms	Annual income	Sale status	Income per room	Implied monthly room rate	Potential gross annual return
Operating HMOs							
£300,000	Ashford Road	6	£35,000	Sold	£5,833	£486	11.7%
£317,500	Seaside	5	£28,140	Listed	£5,628	£469	8.9%
£350,000	Willowfield Square	5	£33,000	Listed	£6,600	£550	9.4%
£379,950	Cavendish Avenue	5	£33,600	Sold	£6,720	£560	8.8%
£420,000	Whitley Road	6	£36,000	Offered	£6,000	£500	8.6%
£430,000	Marine Road	8	-	Sold			
£550,000	Marine Road	8	£55,000	Sold	£6,875	£573	10.0%
£599,950	Enys Road	10	£57,840	Offered	£5,784	£482	9.6%
£750,000	Whitley Road	11	£69,300	Offered	£6,300	£525	9.2%
Potential HMOs							
£325,000	Commercial Road	5		Sold			
£325,000	Bourne Street	5		Sold			
£350,000	Ceylon Place	6		Sold			
£350,000	Cavendish Place	5		Sold			
£425,000	Upperton Road	9	£82,000	Listed			
£480,000	St Aubyns Road	7		Offered			

Source: Rightmove, February 2023

5.6 Summary

5.6.1 This section describes how HMOs currently function in Eastbourne and reflects on the trajectory of supply and demand going forward.

5.6.2 HMOs play a valuable and distinctive role in the Eastbourne housing market (and the wider multi-authority housing market area) by providing the smallest and lowest cost accommodation available. This attracts various occupant groups, from students and professional house sharers to low-income workers, single people relying on housing benefits and individuals placed in emergency temporary accommodation. However,

when HMOs are created through the conversion of Eastbourne's relatively scarce and much-needed family housing, these market segments are served (and sometimes not optimally served) at the expense of other groups.

5.6.3 Demand for HMO accommodation in Eastbourne also depends on market conditions and trends that could interact in unpredictable ways in future years. These include:

- Demand trends in the wider private rented sector (PRS), including the availability and costs of self-contained accommodation.
- The future delivery and availability of affordable rented housing.
- Changing employment and immigration levels affected by the cost-of-living crisis, wider economic trends (notably interest rates) and evolving Government policy (such as the Rent Reform Bill).
- The expected decline in student numbers associated with the closure of the University of Brighton campus.
- Homelessness prevention initiatives in Eastbourne and neighbouring authorities.
- The recovery of tourism following the Covid-19 pandemic, impacting hospitality employment as well as the viability of guesthouses that could be converted to HMOs.

Size

5.6.4 HMOs are usually large houses but tend to function as the smallest dwellings in the market. Whether this is a beneficial and efficient use of such properties depends on the availability and need for homes at both ends of the size spectrum.

5.6.5 Eastbourne is notable for its high overall proportion of 1-2 bedroom and flatted dwellings compared to the County and national averages. This feature of the housing stock has been exaggerated by recent development (81% of new homes built in the last decade have 1-2 bedrooms) and is likely to persist due to the limited availability of land. This imbalanced housing mix is not inherently problematic: the Eastbourne Core Strategy broadly supports residential densification in appropriate locations, and the LHNA emphasises that the Borough operates within a wider housing market area where a wider range of options, including large family homes, exists.

5.6.6 Yet the LHNA also finds that demand pressure in Eastbourne is highest for mid-sized and larger family housing, and that the future need for the smallest dwellings is limited. The availability of residential land in the Borough is a clear practical limitation to building larger homes in future. In this context, halting the conversion of existing houses to HMOs (which simultaneously add to the 1 bedroom equivalent stock and deplete the 3+ bedroom stock) would help to mitigate Eastbourne's worsening dwelling size imbalance. Because the conversion of residential homes to HMOs currently does not require planning permission, it is difficult to establish the precise rate at which this is taking place and therefore the scale of the impact exerted by HMOs.

5.6.7 The dominance of small dwelling units is particularly apparent in the town centre wards, where population densities are rising and 25-33% of homes have 1 bedroom. That these are also the wards with the highest HMO concentrations suggests that a proportion of the few 4+ bedroom properties in those areas are in practice functioning as even more small units. (Note that many of the town centre HMOs, especially in Devonshire, are converted from hotels and guesthouses rather than residential homes.) Although diversity in the housing stock does not need to be achieved at the scale of wards, and it is natural for a town centre to have dense housing and a high transient population, there may be benefits to improving housing choice, promoting balanced communities and avoiding HMO concentrations in the town centre specifically.

Household composition

5.6.8 The Census considers an HMO to be occupied by a single 'other' household (i.e. neither of the two main alternatives of single individuals and family groups). As of 2021, 1,061 or 2.3% of all Eastbourne households both fall into this category and rent from a private landlord. Although these households do not necessarily occupy HMOs, the three wards that exceed the Borough average on this metric are those with the highest HMO concentrations: Devonshire (5.6%), Meads (3.0%) and Upperton (2.6%). The number of such households across Eastbourne overall rose by 91% between 2001 and 2011 but fell back by 24% between 2011 and 2021. The recent decline is explained in part by the timing of the Census during the Covid-19 pandemic, particularly its impact on students – the number of whom followed a similar trajectory.

5.6.9 The type of households that HMOs tend to accommodate can be broken down into several broad market segments, each with their own indicators of future demand, described below.

5.6.10 The overall direction of travel suggested by this high-level analysis is toward increasing demand for HMO accommodation, driven primarily by economic factors, limitations in the supply of affordable housing and policy changes around homeless people and asylum seekers. This is counterbalanced to some extent by an expected drop in demand from students. It should be noted that this combination of trends will have a significant impact on the mix of people occupying HMOs in addition to overall levels of demand: generally speaking, students are likely to be replaced by vulnerable people and key workers on low incomes. This is likely to have a knock-on impact on the kinds of effects the concentration of HMOs in Eastbourne exerts on the wider community.

- **Students**, cohabiting for social or financial reasons. Future demand from this household type is expected to strongly reduce following the imminent closure of the University of Brighton Eastbourne campus, potentially equating to vacancies in 20% of Eastbourne's HMOs.
- **Young professionals**, cohabiting for social or financial reasons. Demand for this household type is expected to remain robust in the near-term due to low unemployment and high inflation.
- **Low-income workers**, sharing for financial reasons and access to employment. As with young professionals, low-income demand for HMOs

from low-income workers is likely to remain high, driven by cost-of-living concerns coupled with robust employment in high-demand sectors such as care.

- **Benefit-funded individuals**, limited in their housing choices by Local Housing Allowance rates (which limit certain groups to shared accommodation only). HMO occupation by benefit-funded households is likely to remain common and possibly to increase given the persistent backlog on the affordable housing waiting list and the projected newly arising need over the Local Plan period, alongside wider cost-of-living pressures.
- **Those experiencing relationship breakdown**, requiring transitional and low-cost accommodation when they cease to cohabit with partners or families. This segment may grow in response to broader economic challenges and trends in family structures.
- **Vulnerable people**, placed in HMOs by local authorities and other organisations as a temporary measure. The number of such placements has stabilised at a modest proportion of the HMO stock following a temporary spike during the Covid-19 pandemic. It is expected to remain at current levels or to rise slightly due to the present economic climate and as refugees from Ukraine begin to require follow-on accommodation from host families.
- **Refugees and asylum seekers**, currently predominantly housed by host families or in hotels and hostels. This is likely to be a key near-term driver of demand for HMO accommodation due to temporary national regulatory changes that incentivise HMO and other landlords to house asylum seekers through the relaxation of licensing requirements for a two-year period.

Tenure

5.6.11 HMO accommodation is by definition part of the PRS, tending to offer lower rental costs as well as shorter minimum tenancies than self-contained rented accommodation. The PRS has expanded significantly in Eastbourne in recent years, nearly doubling from 16% to 27% of the housing market overall between the 2001 and 2021 Censuses. Rising rates of renting are driven by demand linked to affordability as well as supply from an expanding buy-to-let sector and HMO conversions. The highest rates of renting are found in the town centre wards where HMOs are most common: Devonshire (47% private renting), Meads and Upperton (both 37%). As noted above, however, HMOs represent a relatively small proportion of the PRS.

5.6.12 The Census classifies all HMO occupants as private renters, many of whom cover their rent payments through housing benefits or Universal Credit. 44% of Eastbourne households receiving some form of housing benefit (and over 50% in the town centre wards) live in the PRS rather than affordable or social rented housing. In addition, a majority of all benefit-funded households in the Borough (and up to 83% in Meads ward) are only eligible for a 1 bedroom property. As part of the PRS, HMOs therefore provide the additional function of accommodating single-person households who cannot afford to rent on the market without support, or who are on the waiting list for affordable rented housing. The Eastbourne waiting list stood at 1,118 households in

2021, of which 471 applicants are eligible for a 1 bedroom property. This suggests a large volume of households on the waiting list are using HMO accommodation in lieu of allocated affordable rented housing.

5.6.13 The provision of additional affordable rented housing, which offers the occupant a lower-cost and more secure form of tenancy, could therefore theoretically reduce the demand for HMOs. However, the opportunities for new supply in Eastbourne are limited. The LHNA suggests the need for an additional 169 social/affordable rented units per year to meet the existing backlog and meet newly arising needs. In this context, HMO accommodation usefully, if imperfectly, addresses some of Eastbourne's unmet need for 1 bedroom affordable rented housing.

Affordability

5.6.14 Rooms in HMOs generally offer the lowest-cost non-subsidised housing option in the market. ONS statistics suggest that Eastbourne's median monthly room rate of £500 is 31% cheaper than the median 1 bedroom rent (£725). Monthly prices for a room in a HMO tend to range from £400 to £600. A closer analysis of current rental listings reveals two fairly distinct segments of the HMO market: purpose-designed, refurbished and usually smaller HMOs, sometimes marketed as co-housing for professionals; and more traditional shared housing, often with a larger number of rooms in the property and sometimes in poorer in condition.

5.6.15 Although HMOs are cheaper than other options, the current median room rent in Eastbourne is higher than that of East Sussex, the South East and England, and has risen by a third in the last four years – a fact corroborated by local agents. This is a significantly higher rate of increase than was experienced for the PRS in Eastbourne overall in the same period, and reflects the ability of local market demand to absorb the increasing stock of HMOs in recent years. Eastbourne's affordability context is similarly challenging across other tenures, as established in the LHNA, with 53% price growth in lower quartile market housing to purchase in the decade to 2021.

5.6.16 For the current median HMO room in Eastbourne, an occupant will need an annual income of around £20,000 to afford the annual rent of £6,000. A minimum income of £16,000 is needed to afford room at the lower end of the market, and an income above £24,000 would provide access to higher-value options. The range of incomes required overlaps with affordable rented housing at the low end and self-contained rental accommodation at the high end.

5.6.17 HMOs in Eastbourne primarily serve households with incomes of between £17,500 and £22,000 per year, which is around 4,480 households or 9% of the total. In theory, households with lower incomes will need affordable rented housing and those with higher incomes can afford self-contained rented accommodation. However, in practice the potential market is much larger, including anyone with an income below £22,000 but unable or waiting to access affordable rented housing, and some people/households with incomes above that level who nevertheless seek out HMOs by choice for financial, social or other reasons. The potential target market for HMOs is approximately 10,540 households or 22% of the total. This represents all households with incomes below £22,000 minus the number of households living in affordable rented housing. It therefore is an upper bound estimate that includes larger households for whom single rooms are not appropriate and older households with

low incomes but who own their homes and have more limited outgoings. It is important to remember that income alone does not determine the scale of need for HMOs.

5.6.18 There is a particularly large degree of overlap between those eligible for affordable rented housing and those using housing benefits to live in the PRS. Housing benefits and Universal Credit cover around £325 per month for households eligible for a room in a shared house, leaving a minimum £75 per month shortfall (on the cheapest available rooms) to be topped up through income or other benefits arrangements. This finding corroborates the DWP statistic that local housing allowance (LHA) rates do not cover the rent of 56% of those on Universal Credit in Eastbourne. For unemployed households, even those receiving the maximum LHA allowance, HMO accommodation may still present significant affordability challenges, resulting in limited funds for other essentials such as food and transport costs.

5.6.19 Finally, it is worth noting from property market listings that there appears to be fairly high turnover of existing HMOs listed for re-sale as well as a modest pipeline of potential future HMOs advertised as such. Offers are in place for the vast majority of current listings, indicating robust appetite from potential purchasers, based on the potentially attractive gross rate of return above 8.5% of the purchase price.

Key points

- Rooms in Eastbourne HMOs cost between £400 and £600 per month, which is significantly cheaper than self-contained alternatives, but higher than the regional and national average. Between 10% and 25% of Eastbourne households potentially benefit from the availability of relatively more affordable HMO accommodation. This includes single people aged under 35, for whom housing benefits extend only to shared housing.

- The median room rent has risen by a third in the past four years, making this option slightly less affordable over time because demand has remained higher than supply. This reflects the market's ability to absorb additional HMO conversions – a point echoed by local agents.

- By offering a flexible and low-cost option in the private rented sector (PRS), HMOs accommodate a range of self-funding household types, but are also able to serve unmet demand for affordable rented housing and those requiring temporary accommodation placements.

- Students potentially occupy 80-220 HMOs in Eastbourne (with the remainder living in student halls, family homes and self-contained rental accommodation). The imminent closure of the University of Brighton Eastbourne campus could reduce this figure by 80, or 20% of the total.

- Demand from low income working people is likely to remain robust due to low unemployment, high inflation and the health of key market segments such as care workers.

- In the context of limited affordable rented accommodation and rising numbers of benefit recipients, demand from single people reliant on benefits is expected to remain stable or gradually increase. However, it is noteworthy that the maximum housing benefit level that can be claimed for a room in a shared house in Eastbourne is substantially below actual rental costs. Households reliant on benefits therefore need to find additional funds to cover their rent.

- Temporary accommodation placements into HMOs are rarer than widely believed due to the visibility of associated impacts. This demand stream has stabilised following the pandemic at the equivalent of around 18-25 HMOs (though their occupants may be spread across more properties, mixing with other occupant groups in practice). However, it may rise again due to nationwide drivers of housing vulnerability and local homelessness prevention initiatives.

- HMOs effectively add to the 1 bedroom equivalent stock that is already plentiful in Eastbourne and, if converted from other residential uses, do so at the expense of the Borough's more limited larger family housing. It is not possible to gauge the extent of this trend because conversions take place without planning permission under permitted development rights.

- The town centre wards of Devonshire, Meads and Upperton, where HMOs are concentrated, exhibit many of the dwelling stock and demographic characteristics associated with this type of housing in heightened ways. These include Eastbourne's bias toward smaller homes, increasing rates of private renting and high levels of benefit recipients in the mainstream housing market.

- There appears to be relatively high turnover in the ownership of HMOs and a modest pipeline of planned conversions, with robust appetite from purchasers attracted by high investment yields.

6. Options for Intervention

6.1 Introduction

6.1.1 This chapter brings together evidence on the impacts of HMOs observed in Eastbourne and the courses of action available to the Council to mitigate them. Its three sub-sections are as follows:

- First, various interventions pursued by other local authorities are reviewed to capture the full spectrum of options available and establish the standard of justification underpinning them.
- Next, for each of the impacts identified in Eastbourne, the evidence for and against intervention is summarised.
- Finally, the justification for each potential course of action is assessed, with discussion of their advantages and disadvantages.

6.1.2 It is beyond the scope of this study to make a final recommendation for the specific actions, if any, the Council might take. Any decision by EBC requires consideration of the political and resourcing implications of the available options, any additional evidence required, and the Borough's broader planning and housing strategies relevant to this issue.

6.2 Precedents for intervention

6.2.1 The Table in Appendix 6.1 identifies the action taken to manage the spread and quality of HMOs (beyond mandatory licensing) by a number of local authorities, and notes the form and scope of supporting evidence cited.

6.2.2 Of the 8 local authority interventions reviewed, 7 included Article 4 Directions removing permitted development rights and requiring planning permission for a change of use from Use Class C3 (dwelling house) to Use Class C4 (HMO). The geographic coverage of the Article 4 Direction varies across these examples, with some applying to specific wards, while others cover the entire local authority. They generally do not appear to be time limited, with some coming into force over 10 years ago.

6.2.3 Additional licensing, the next most common intervention, is also widespread, with 6 of the local authorities having implemented additional licensing schemes (not all of which remain in place). Generally, these schemes require all HMOs within a specific geography to be licensed, thereby capturing smaller HMOs that do not fall under national mandatory licensing. In some cases, Section 257 Properties are also explicitly included. Additional licensing schemes apply for 5 years, at which point local authorities determine whether they should be renewed.

6.2.4 Selective licensing is seemingly less common. This tends to require all private rented dwellings within a given area to be licensed. Bristol City Council and Thanet District

Council have or had selective licensing schemes, and this is under consideration by Portsmouth City Council.

6.2.5 Many local authorities also have Local Plan policies in place in relation to HMOs. These are frequently presented as ways to achieve established planning objectives such as maintaining mixed and balanced communities and providing for a range of housing needs, or to mitigate negative impacts such as pressures on local infrastructure, pricing and competition in the housing market and poor standards for tenants. They commonly set out:

- Thresholds for the number, concentration and pattern of HMOs within a geographic area. For example:
  - No more than a set percentage of dwellings within a certain radius of the application should already be HMOs. (Note that this is typically 50-100m or by road. Concentration by Ward is too modest in Eastbourne to serve as a suitable indicator)
  - The proposal should not result in a row of consecutive HMOs or a non-HMO being sandwiched between two existing HMOs
- Specific requirements needed to gain planning permission for new HMOs. For example:
  - Suitable car parking, cycle storage and waste collection arrangements should exist or be put in place
  - Unacceptable impacts should not be exerted on local amenities, the living conditions of neighbouring residents or the character of the area
- Space standards for rooms and other features, notably communal areas. (Note that licensing approaches can also include space standards. A consistent dual approach across planning and licensing could ensure these continue to be met beyond the point of conversion.)

6.2.6 The least frequent type of intervention, although not one that would necessarily be documented or publicised in the same way, includes other measures adopted within the council, such as expanded enforcement powers, HMO forums to encourage idea sharing and trouble shooting, and joint working arrangements with landlords and referring organisations.

6.2.7 In terms of the evidence presented to justify these interventions, local authorities typically carry out consultation work prior to their introduction. This is usually mandatory for Article 4 Directions and some forms of licensing. Prior to this, some local authorities undertake research studies that consider the growth and spatial distribution of HMOs, the condition of properties, qualitative evidence and other specific considerations (such as the trajectory of the student housing market). The evidence cited sometimes includes information gathered through routine HMO inspections and the assessment of complaints to the Council. In some cases, local authorities establish and maintain databases of HMO properties and other forms of tracking.

6.2.8 There are few assessments of the relative effectiveness of the interventions in the public domain, although some local authorities make reference to management improvements, declining anti-social behaviour and other benefits, and have renewed and expanded schemes over time. It is worth noting that in some cases, including the Selective Licensing Area in Margate in Thanet, licensing of HMOs was part of a package of relatively intensive intervention measures involving multiple agencies, including the compulsory purchase of some problem properties (former hotels serving as HMOs) and converting them to affordable rented family sized accommodation. The improvements in Margate's Selective Licensing Area can be attributed to a range of interventions therefore and it is likely that licensing works best where it is accompanied by supporting measures.

6.2.9 It is also worth noting, however, that some difficulties were experienced, including legal challenges and appeals as well as broader non-compliance. Not all of the measures remain in force, particularly around licensing, though the reasons for this are not always clear.

6.2.10 In summary, all of the available courses of action are frequently taken by local authorities with identified HMO issues, and often in combination. The standard of evidence cited to justify these interventions varies significantly. From the examples reviewed, AECOM does not observe any particular minimum standard of evidence in terms of strength or type, although the details of legal challenges are not fully clear. The few local authorities that stated the number of HMOs exceeded Eastbourne's current estimated total, but justification was more frequently about concentration and impacts than overall numbers.

6.2.11 The specific types of impacts in Eastbourne that may provide justification for action, and the implications of the options available, are considered in the following sub-sections.

6.3 Evidence for Intervention

6.3.1 This report has considered a range of evidence for the potential impacts of HMOs in Eastbourne. Before summarising the strength of the findings it is worth classifying the various kinds of sources used. These include:

- Tangible, physical impacts on occupants and on the surrounding streetscape that can be attributed to HMOs with reasonable confidence. Evidence on such issues was gathered through inspections of a sample of Eastbourne HMOs and supplementary EPC data, which are summarised in Section 3.
- Direct effects on the housing market, such as the introduction of rental options at particular price points and the loss of properties for other uses. Data on this topic and a discussion of the broader dynamics and trade-offs are presented in Section 5.
- Intangible impacts on residents and communities for which hard data potentially exists. This includes the effects of HMOs on the experience of people living in or near them that are in some way recorded, such as noise complaints, police call

outs and the findings of internal inspections. Data on these points are not currently available for Eastbourne but could be collated in future.

- Intangible impacts on residents and communities that are more subjective and would not otherwise be recorded. This includes the community's sense of cohesion, safety, and views about the neighbourhood. Data on these and other topics has been gathered though a series of doorstep interviews in Eastbourne, the results of which are summarised in Section 4.
- The knock-on impacts of HMOs on broader systems, notably the local tourist economy and the health and social care sector. The evidence for this is drawn from conversations with key local stakeholders as well as secondary data on the local hotel market that has wider relevance. The tourist sector is discussed at the end of Section 4, while the dynamics touching on social care are explored in Section 5.

6.3.2 The table below distils the various impacts of HMOs identified through the forms of evidence-gathering outlined above into overarching categories. For each of these categories the key evidence that might warrant intervention in Eastbourne is summarised, any countervailing points, weaknesses or gaps in the evidence are noted, and an overall view is provided on whether and what action might be justified. Note that the table is not exhaustive, and detailed evidence, statistics and sources can be found in the main sections of this report.

6.3.3 To summarise, while there is not compelling evidence that HMOs are in worse condition than other properties, or indeed cause many of the problems that residents are concerned about, there are cumulative issues that could warrant some form of intervention in Eastbourne. The following points summarise the key evidence:

- The number of HMOs appears to be increasing over time. However, the relevant indicators also express the increasing visibility of HMOs due to regulatory changes and enforcement efforts, meaning that the rate of growth may not be as high as perceived.
- The conversion of family-sized accommodation to HMOs theoretically depletes a segment of Eastbourne's housing stock that is acutely needed, although the scale of this effect is proportionally small.
- On the other hand, HMOs provide the most affordable accommodation in the town and satisfy (if imperfectly) a range of housing needs that may otherwise be unmet, such as that of single people reliant on housing benefits and those placed in temporary accommodation. It is important to remember the useful role of HMOs in the housing market, and the risk that restricting them may limit affordable accommodation options on which many individuals rely, including essential workers such as carers.
- HMOs are concentrated in a relatively small area in Eastbourne, notably Devonshire Ward and the town centre. With some notable exceptions, it is not individual properties but this concentration that creates or compounds many of the impacts identified.
- The concentration of HMOs in the town centre increases the number of vulnerable people there, adds to parking and other infrastructure pressures, and

contributes to high levels of population churn. Associated impacts (even if small or associated with problem properties or individuals with complex needs) are also seen to have a detrimental effect on key parts of the local economy, notably tourism.

- That said, the town centre is potentially the most sustainable location for HMO uses, given its existing densities, deprivation levels, and the ease of access to employment and services relied upon by occupants. Displacing these people may exacerbate their disadvantages and related social problems. The concentration of HMOs at the scale of specific streets may be the more relevant issue.
- Though the evidence gathered in this study does not reveal significant problems with the external condition of HMOs, the views of EBC officers and local people suggest that issues with waste accumulation in particular are acute and widespread. Internal inspections have not been conducted as part of this research, so the nature and extent of related impacts on occupants is unknown.
- Survey evidence suggests that people living in areas with high proportions of HMOs experience slightly lower rates of safety, trust and overall satisfaction with their neighbourhoods. Behavioural issues appear to be the key concern of local people, although they are difficult to evidence objectively or to attribute directly to HMOs. The overall survey results do not point to drastic differences in quality of life caused by the presence of HMOs.
- In fact, people living in HMOs themselves are seemingly impacted the most by any issues of condition, lack of community cohesion and safety. This is more likely to be effectively addressed through efforts around management, enforcement and the provision of affordable housing than by limiting HMO numbers.
- Central government decisions exert an impact that is difficult to address locally, notably that housing benefits are insufficient to cover rents, exacerbating the deprivation of the vulnerable people who rely on HMOs, and the placement of refugees by the Home Office in hotel/hostel accommodation.

6.3.4 The table below suggests that impacts with the strongest supporting evidence in Eastbourne are the loss of alternative family accommodation from rising conversions and local people's experience of anti-social behaviour in areas where they are concentrated. Secondary arguments with less conclusive evidence include the condition of properties and standards for occupants, the impact on parking and waste collection amenities, and knock-on impacts on the wider economy.

6.3.5 On the other hand, there is also evidence of the positive role that HMOs play in the housing market and it is not clear that their numbers are accelerating. Some of the impacts investigated did not reveal conclusive evidence, and the potential knock-on effects for occupants and communities if HMOs accommodation is restricted or displaced deserve consideration.

6.3.6 Though the cumulative evidence in Eastbourne appears to be sufficiently robust to justify intervention in general, it is important for EBC to think about the costs, benefits and wider implications of the available interventions. These are considered in the following sub-section.

Table 6-1: Intervention Summary Table

Potential Impact	Evidence for intervention	Evidence against intervention	Action justified
Internal condition of property	Limited evidence on internal condition can be inferred from inspections of external condition (e.g. doors, wiring). Survey evidence indicated that HMO residents have a poorer sense of personal safety and satisfaction with their environment, which may be influenced by the standard of their immediate surroundings.	The evidence gathered is indirect and cannot confirm whether this is a particular issue. Limited secondary data (EPC metrics) show little difference between the HMO and non-HMO stock. No internal inspections were possible within the scope of this project, making action difficult to justify without additional evidence.	The evidence available in this research provides limited justification for action to address internal issues, but does not prove that such issues do not exist. Further evidence from EBC inspections and enforcement actions would be a robust additional source. Enhanced data collection and monitoring is therefore a potentially useful soft action, potentially justifying higher investment in inspections and enforcement.
External condition (e.g. public-facing areas, gardens, fences, walls)	Anecdotal evidence suggests HMOs are less well-kept than other properties, and that they therefore degenerate the housing stock. Inspections highlighted some issues with building and boundary walls, though these were generally not severe. Key issues, e.g. safety, are an issue primarily for occupants rather than the surrounding area.	Issues identified through external inspections were relatively uncommon or required repair or tidying rather than replacement. Inspections were limited to HMOs so it is not possible to establish whether non-HMOs were in better condition. Local agents attest that new conversions from old terraces provide an opportunity to renovate and renew the housing stock, and further checks are possible at the point of letting (although there is potential inequality in how different occupant groups are treated).	Some justification for action, but more in terms of targeted interventions to the few problem properties (i.e. enforcement) rather than blanket restrictions.

Potential Impact	Evidence for intervention	Evidence against intervention	Action justified
Condition of streetscape / appearance of neighbourhood	External inspections identified a few specific problems (e.g. fly tipping in gardens). Though these were not widespread in the sample of inspections, anecdotal evidence from Council officers suggests this snapshot may not be representative. Survey indicated only slightly stronger perceptions of issues like litter in HMO areas. Anecdotal evidence from the business community suggests additional waste and litter can also attract pests.	Both main forms of evidence point in the direction of issues existing, but not to a strong degree.	Potential for intervention, particularly targeting streets or areas where issues are most common. This aspect could warrant restrictions on new HMOs, but is more relevant to how they are managed and overseen.
Additional stress on infrastructure (e.g. waste)	External inspections identified a moderate number of HMOs that did not appear to have adequate waste storage.	Additional evidence from complaints and spot inspections could add robustness to this limited finding.	Evidence would justify policy provisions to ensure waste storage amenities are protected or expanded as a condition for future HMO conversions (most effective when accompanied by an Article 4 Direction to require a planning application). Issuing of additional bins to relevant properties may also be helpful.
Car parking (due to increased population density)	Parking was by far the most common issue highlighted by residents surveyed, often (anecdotally) connected to HMOs. There is a clear causal link between additional adult residents in a property and higher car use (although potentially not for lower income and vulnerable groups).	Parking highlighted by survey respondents as a significant issue in all areas – not only where HMOs are concentrated. This suggests HMOs could be exacerbating an existing issue rather than creating it, although the statistics do not point to higher car ownership among HMO occupants. This is because the higher levels of car ownership among 'other' households with multiple unrelated individuals	Clear evidence of a problem that impacts local residents, though this does not necessarily justify actions relating to the single lens of HMO supply. Adequate parking could be made a requirement of planning permissions for conversion. This issue may be more appropriately considered in the context of wider measures around parking

Potential Impact	Evidence for intervention	Evidence against intervention	Action justified
		is counterbalanced by low levels of car ownership among renters and those with lower incomes. EBC wishes to densify sustainable locations in the town centre. Increased densities theoretically enable improvements to public transport.	facilities, permitting, car share schemes, public transport and promoting active travel (e.g. through secure cycle storage).
Loss of alternative forms of accommodation (e.g. family housing)	There is a clear need to protect existing family housing. Demand pressure is higher on larger homes, so HMOs exacerbate Eastbourne's existing imbalances. The number of HMOs is plainly increasing over time, though the rate of increase is driven as much by regulatory changes increasing the visibility of HMOs as raw growth, and it is not necessarily accelerating. There are high concentrations of HMOs in certain wards where those imbalances are strongest – e.g. Devonshire.	This impact is important in the context of limited housing supply and suitable land, but is relatively small in scale at present. Even if properties are retained as family housing, it is not necessarily possible to control occupancy. Restricting HMOs for this reason could exclude single person households who cannot afford a self-contained flat and therefore rely on HMOs to live in Eastbourne. There are potential knock-on effects to this – e.g. on care sector workers.	This clearly established impact, combined with the broader evidence of gradually rising HMO numbers, would underpin actions to limit or better assess future conversions. To mitigate negative impacts on low income people, some geographical limitation may be appropriate to target the concentration and distribution rather than overall numbers of HMOs. A more proactive intervention of acquiring and converting HMOs back into family housing or affordable rented housing could be beneficial (though resource intensive).
Provision of low-cost housing	It is theoretically more suitable for low income and vulnerable people to be accommodated in affordable rented housing in terms of access to further support and security of tenancy.	This is predominantly a benefit of HMO provision. Affordability analysis suggests HMOs serve a significant group of people with few other options. Demand is closely linked to LHA room rate (particularly for single under 35s, who have no alternatives).	This reason does not justify restricting HMOs, although management measures would help to mitigate the impacts on residents. Boosting the supply of affordable rented housing would provide a preferable alternative, although supply may be limited and other groups remain in equally urgent need.

Potential Impact	Evidence for intervention	Evidence against intervention	Action justified
			EBC could lobby for national changes regarding affordable rented housing and LHA levels.
Impacts on vulnerable groups (e.g. those linked to concentration, social exclusion)	HMO residents surveyed seemed less satisfied and comfortable in their neighbourhoods. Low feelings of safety and trust are possibly influenced by their experiences in their homes. Housing officers note that issues with mental health and substance use can be amplified when people with complex needs are placed in high concentrations, potentially leading to physical harm and mortality. HMOs offer no or limited support from landlords, unlike the alternatives of affordable housing, supported housing or other arrangements. There is potential for other local authorities to discharge their duties in Eastbourne, which is perceived to have significant impacts at times.	The direct evidence from occupants is limited although the broader anecdotal picture suggests these impacts exist. There is minimal evidence that these impacts are amplified by the concentration of HMOs in a neighbourhood (as opposed to the concentration of occupants in a building). The concentration of vulnerable individuals makes the provision of support and services to them more efficient. This is the way placements are deliberately made.	It is clear that HMOs are not the optimal way of accommodating vulnerable people, and that this can exacerbate the potential for harm. However, the supply of HMOs is not driven by this demand stream: they provide a flexible option where alternatives are undersupplied. Rather than restricting HMOs, place-based interventions to enhance support and the provision of suitable alternatives would have a greater mitigating effect on these issues. Cooperative efforts with placing agencies, service providers and other Councils could be beneficial. Tracking of placements from outside the Borough could help to manage and mitigate sudden influxes from elsewhere.
Anti-social behaviour of occupants (e.g. noise, crime)	There are clear correlations between HMO concentration and deprivation indicators (particularly crime). The resident surveys established clear differences in the perception of anti-social behaviour problems and safety between HMO areas and the control sample.	Though correlations are present for these issues, causation is less easy to demonstrate. The evidence is largely based on the perceptions of local people rather than evidence of complaints and call-outs.	The evidence appears to justify some form of intervention to limit the further concentration of HMOs and incentivise better management. Multi-agency interventions could provide greater support (e.g. addiction services, mental health, probation, housing support).

Potential Impact	Evidence for intervention	Evidence against intervention	Action justified
		It is not clear whether these impacts are associated with one or more particular occupant groups (e.g. vulnerable people, students) rather than HMOs in general.	Enforcement could target landlords and problem properties. Space standards requiring common living areas could prevent issues from arising in the street (because occupants have no internal space to congregate). Localised campaigns to increase the feeling of safety would be a soft measure to address this perception.
Population transience	Agents note that HMOs tend to have shorter minimum tenancies and thus greater churn. The resident surveys confirmed that there is a moderately weaker sense of community and trust in areas of high HMO concentration.	Town centres (and the wider PRS) are generally more transient, and this is not inherently a problem. None of the other impacts considered are directly caused by transience.	Limited justification for action at present but if the number of HMOs continues to grow this is likely to become a greater issue based on the experience of other authority areas.
Sense of community cohesion	Overall sense of community is slightly lower in HMO areas than the control areas, but the difference was slight. More significant contrasts were found in sub-issues like trust. The conversion of family housing to HMOs theoretically replaces rooted families with more transient populations. Agents and elected members note that HMO occupants tend to be less involved in community meetings etc.	This is not a clear area of contrast in the survey findings.	Limited justification for action. This point could serve as supporting evidence for action on the basis of preserving family housing and balance in the wider dwelling stock. Space standards and shared space would again help to foster a sense of community within HMOs.

Potential Impact	Evidence for intervention	Evidence against intervention	Action justified
Knock-on impacts on economy (e.g. hotel sector)	HMOs potentially represent a financially attractive alternative for struggling hotels at a time of volatility. Conversions tend to be irreversible and impact the tourism industry and wider hospitality economy. HMO conversions (with the attendant impacts summarised above) are perceived to deter guests of nearby hotels and create a domino effect of further conversions.	Data on the hotel stock and occupancy patterns only lightly corroborates the anecdotal sense of increased HMO conversions and domino effects. COVID-19 and energy costs are potentially bigger drivers. Hotels are more concentrated on the Seafront while HMOs are set back – a less precise overlap than widely perceived. Some lower cost hotels not converted to HMOs are still housing people temporarily (e.g. refugees). Associated impacts cannot be addressed through HMO controls. Both these trends toward eventual use changes and the perceived impacts on local communities are skewed by the use of hotels/hostels as refugee and asylum seeker accommodation.	The existing mechanism to protect tourist accommodation appears proportionate and could be expanded, with the secondary effect of reducing future HMO supply.

6.4 Options for Intervention

6.4.1 In comparison with the precedents reviewed at the start of this section, the cumulative impacts identified in Eastbourne appear comparable to the standard of evidence met by other local authorities that have intervened to control HMOs through a combination of planning policies, additional licensing and Article 4 Directions. The table below highlights the potential advantages and disadvantages of each intervention, as well as the specific form they might take in Eastbourne's particular context.

6.4.2 Generally speaking, measures to grant EBC more control over the conversion of the existing housing stock to HMOs would seem sensible given the general trajectory of conversions, the Borough's bias toward smaller homes and the consequent demand pressure on larger properties. Policy criteria established elsewhere could usefully place a greater burden on applicants to demonstrate the mitigation of impacts in addition to potentially limiting the number of conversions. Putting in place such measures also enables EBC to respond more quickly if supply trends or impacts change in future. It is relevant to note that the clear concentration of HMOs and associated impacts in Devonshire Ward and the wider town centre would seem to support geographically targeted interventions, although there is a risk that HMOs will begin to spread to other parts of the Borough, with potentially negative consequences for occupants.

6.4.3 These requirements at the point of conversion could be complemented by additional licensing to influence the internal amenities available to a larger pool of occupants (beyond those in currently licensable HMOs) and enable EBC to demand improvements for non-compliant properties at reapplication or inspection stages. Space standards that include requirements for shared internal living space (i.e. a living room) stand out as a measure that could cut across a number of potential issues for occupants and neighbours, in addition to reducing occupancy numbers. Additional licensing has the further benefit of bringing the unknown number of smaller HMOs within the Council's oversight and providing more precise data on their number, distribution and trends over time. However, expanded licensing needs to be complemented by a robust enforcement process. The decision about whether to proceed with such measures is as much a question of their resourcing implications as whether they are sufficiently justified by the evidence.

6.4.4 This analysis also makes a fairly strong case for supplementary interventions beyond these core courses of action. Many of the impacts highlighted could be optimally addressed through more targeted approaches, also listed in the table below, although these also bring potentially significant resourcing implications for the Council unless innovative funding measures can be identified (such as additional licensing fees).

6.4.5 These supplementary interventions include enhanced enforcement of the few 'problem' properties, actions to better support vulnerable people, wider measures to control parking issues, and centralised tracking of data on HMOs. However, it is apparent that many of the key impacts identified in this study should ideally be considered through a wider lens than HMO intervention. For example, to make a real difference to occupant wellbeing and antisocial behaviour, issues of deprivation experienced by vulnerable people and others housed in HMOs may need to be

tackled through a multi-agency approach encompassing addiction and mental health services, supported housing, employment and other support.

6.4.6 A final recommendation for whether and how EBC might intervene to manage the impacts of HMOs is not within the scope of this study but the menu of options presented here and the considerations highlighted will assist EBC in their decision-making process.

Table 6-2: Intervention Options

Intervention	Benefits	Costs	Justification and features
Planning policy	Clear and consistent precedents exist elsewhere Concentration thresholds are effective in managing spread Other requirements can target key specific issues, e.g. parking, waste, antisocial behaviour A new Local Plan is currently in the process of being drafted so could reflect evidence on HMOs Policy wording can clearly communicate EBC's position and concerns, demonstrating action taken	Limited to managing the characteristics and number of new HMOs Aspects may be difficult to enforce in practice (e.g. impact on local community from occupant behaviour) HMO-specific provisions would need to be integrated with existing development management policies for all housing	Overall, the standard of justification appears to be modest, and exceeded by the evidence in Eastbourne Concentration thresholds, space standards (aligned with licensing) and requirements to limit impacts on local amenities appear highly relevant Concentration thresholds would require a more precise knowledge of existing concentrations, particularly of smaller HMOs. Additional licensing would help in this regard
Article 4 Direction (removing PD right to COU from C3 to C4)	Makes policy provisions (above) more impactful, applying to a greater number of potential conversions Would capture largely unchecked and untracked conversions of smaller family homes	Only effective in combination with less strengthened Local Plan policy enabling the applications to be refused or amended Resourcing implications for the process to consult and apply the Direction, as	Precedents suggest this measure is appropriate to combat HMO proliferation and impacts on the scale seen in Eastbourne when combined with appropriate Local Plan policy provisions Geographical limitation to the three town centre wards appears

Intervention	Benefits	Costs	Justification and features
	Tighter space standards, including shared living space (aligned with planning policy standards) could address key impacts	well as on development management	sufficient, though risks HMOs emerging in new areas
Additional licensing and enforcement	Would bring additional HMO properties within EBC's purview, with the option to refuse or revoke licences for inappropriate and poorly managed HMOs This would also enable closer tracking of HMO numbers and concentrations Expanded enforcement could identify and target the small number of problem properties and create a reputational effect, making all landlords more compliant	Resource implications on consultation process, responding to potential legal challenge, and enforcement costs Risk that landlords pass on costs (e.g. licensing fee, renovations) to tenants, lowering affordability May disincentivise otherwise cooperative landlords, effectively 'lumping together' well and poorly managed HMOs Revocation of licences can have adverse consequences for occupants and Council resources	Evidence in Eastbourne is not weaker than the average standard among other authorities that have pursued this course. Limited cause (in the scope of this study) to expand beyond HMOs to wider PRS Would face limited scrutiny if targeted to a small area, i.e. town centre wards. Potential to expand over time Effectiveness may require tightened prescribed standards and enforcement efforts
Selective Licensing	Local housing authority can designate the whole or any part of its area as subject to selective licensing. This applies to all properties in the private rented sector which are let or occupied under a licence. HMOs already licensed would be exempt from this regime. This would enable closer monitoring of	Costs as above for Additional Licensing but likely to be on a larger scale because of the capture of all PRS properties in the SLA. Specific criteria set out in Government guidance. A SLA designation may be made if the area satisfies one or more of the following conditions. Whilst not mandatory guidance,	Limited cause (in the scope of this study) to expand beyond HMOs to wider PRS at present. Would face greater scrutiny as captures all PRS in an area. Other authorities (e.g. Thanet) experienced legal challenge (which were overcome) to their initial scheme.

Intervention	Benefits	Costs	Justification and features
	rented properties generally, including HMOs, though it is not specifically targeted at HMOs.	this sets a higher burden on establishing a SLA, though relatively straightforward to evidence in EBC's case: • low housing demand • a significant and persistent problem caused by anti-social behaviour • poor housing conditions • high levels of migration • high level of deprivation • high levels of crime Local housing authorities are required to apply to DLUHC should the scheme affect more than 20% of privately rented homes in the local authority area. If a local housing authority makes a designation that covers 20% or less of its geographical area or privately rented stock, the scheme will not need to be submitted to the Secretary of State. The housing authority must satisfy the statutory requirements and consult for at least 10 weeks on the proposed designation.	Effectiveness may require tightened prescribed standards and enforcement actions Guidance states that other courses of action to address problems should be pursued before a SLA is established so it is unlikely to be the first policy option

Intervention	Benefits	Costs	Justification and features
Other measures	Additional joined-up measures can enhance effectiveness of core interventions, and target specific impacts Potential to be cost-neutral through additional licensing fees	Significant potential resourcing implications depending on the interventions pursued	Potentially useful measures include: - Multi-agency place-based interventions for vulnerable people - Increasing provision of affordable rented housing to meet needs currently (and imperfectly) absorbed by HMOs - Acquisition of HMOs for family or affordable rented housing - Special Interim Management Orders (to tackle anti social behaviour in a small number of properties) - Commissioning of temporary accommodation alternatives - Collaboration with referring organisations - Incentives for landlords practicing good management (e.g. direct benefits payments, loans for property improvements) - Further data gathering and ongoing tracking of HMOs numbers, distribution and

Intervention	Benefits	Costs	Justification and features
			impacts (made simpler if additional licensing is introduced) - HMO forum to build relationships and profile best practice - Measures to mitigate wider parking issues - Information campaigns to address perceptions (e.g. around safety)

6.5 Data limitations and opportunities for monitoring

6.5.1 It is important to note the limitations of this research into the number, distribution and impacts of HMOs in Eastbourne. Caveats have been provided where appropriate in the various sections of this report, and are summarised here along with associated opportunities for further data gathering or ongoing monitoring potentially available to EBC.

Table 6-3: Data limitations

Section	Key Data Limitations	Opportunities for Monitoring
2: Eastbourne's HMO Stock	Reliance on register of licensed HMOs, which may itself not be a complete reflection of currently licensable properties. Data suggesting trends over time in the number of licensed HMOs is clouded by regulatory and enforcement changes that have increased the visibility of existing HMOs, meaning that growth in the sector is lower than initially apparent. Data suggesting trends over time drawn from planning applications is	Additional licensing would bring additional categories of HMO within the oversight of EBC and allow for a more accurate understanding of their numbers, distribution and trends over time. Beyond this action, it may be possible to more track unlicensed HMOs by periodically reviewing the indicators compiled by EBC as part of this research or amending the relevant automatic data collecting processes. In particular, the findings of inspections and

Section	Key Data Limitations	Opportunities for Monitoring
	limited to the types of conversion that do not fall under permitted development rights, which is likely to be a small proportion of the total. Smaller unlicensed HMOs, larger Section 257 and Schedule 14 properties cannot be identified with sufficient accuracy to produce a total estimate or understand their distribution across the town (and whether this differs from the distribution of licensed properties).	enforcement actions could be compiled on a centralised database. Engagement with Registered Providers could help to identify the stock of Schedule 14 HMOs.
3: Condition of HMOs	The results of external inspections indicating the condition of HMOs are a snapshot in time of a small sample of properties. Anecdotal evidence from officers suggests that the relatively positive picture is not representative.	A system of logging reports of issues with waste, safety and other matters would help to demonstrate this impact more robustly and identify problem properties and streets. This metric could also be included in the inspections process and recorded centrally.
4: Impacts	The residents' survey produced statistically significant results about differences in the experience of people living in areas of high and low HMO concentration, and among HMO occupants themselves. However, the contrasts were not particularly stark in terms of demonstrating significant impacts associated with HMOs. The impacts measured in the survey are by definition intangible and subjective. The conclusions drawn about the link between HMOs and trends in the tourism sector are circumstantial because of a range of other potential causal factors (e.g. Covid-19, energy prices, the cost of living). This data is also limited to market of larger hotel and does not reflect trends in guesthouse and B&B	The survey was carried out as the sole expression of some of the key intangible impacts frequently associated with HMOs. More concrete secondary data may exist in relation to the number and distribution of complaints about anti-social behaviour, fly tipping, noise nuisance and other factors. This information may be recorded by a number of different agencies and come with data privacy limitations. However, if broad statistics on the number and type of complaints in different geographies could be compiled, it may be possible to draw correlations with the presence of HMOs. Planning application data for conversions of guesthouse and hotel to HMO uses could be monitored going forward to track the extent of this potential impact

Section	Key Data Limitations	Opportunities for Monitoring
	accommodation – which may be more relevant targets for HMO conversion. The picture is also clouded by regulatory changes and enforcement action affecting where asylum seekers may be accommodated.	and investigate specific cases if appropriate.
5: Market Dynamics	Census data on the number of students in 2021 is an anomaly that skews historic trends and is unlikely to reflect actual numbers in that year. The implications of the imminent closure of the University of Brighton Eastbourne Campus are also unknown at this stage, depending on other demand streams for HMOs formerly occupied by students and the University's plans for its purpose-built accommodation.	Continuous tracking of data around housing need, notably the size mix of new homes required, changes in affordability, and updated figures on the need for affordable rented housing are all relevant to the role that HMO accommodation will play in the Eastbourne market. Policy provisions to address HMO impacts should have reference to the latest data on these and related points. There may be scope to more closely track the placement of vulnerable people into HMOs in Eastbourne from other local authorities and publish this data in a way that better informs public perceptions on this issue.

6.6 Summary

6.6.1 Clear and recent precedents exist for a range of interventions to mitigate the spread and impacts of HMOs. Combinations of planning policy requirements, Article 4 Directions and additional licensing regimes are common responses to similar issues and objectives to those present in Eastbourne. Key ingredients that could be impactful have been identified, including concentration thresholds, space standards and additional measures beyond planning and licensing.

6.6.2 The supporting evidence cited by other local authorities varies in scope and content, and does not suggest a particular minimum standard needs to be met. It is considered that the evidence gathered in this report provides sufficient justification for intervention in a form to be determined by EBC, subject to the resources the Council has available, any consultation requirements and further strategic considerations.

6.6.3 When each of the key potential impacts of HMOs are tested against the evidence present in Eastbourne, it is apparent that a small number of issues are directly caused by current concentrations of HMOs and are capable of being addressed through interventions to manage them and limit their number or concentration.

6.6.4 The primary arguments for intervention are to stem the loss of family housing and hotel accommodation in certain locations (though planning controls) and to reduce the impact on occupants and communities from behavioural issues (through licensing and enforcement). Furthermore, there are numerous additional impacts that are exacerbated (rather than generated) by HMOs, exerted indirectly or in combination, or are harder to conclusively evidence. These add up to a clear, cumulative picture of the issues associated with HMOs that could warrant intervention.

6.6.5 There is, however, also clear evidence of the valuable role that HMOs provide in the housing market by providing low-cost accommodation that people on lower incomes, key workers, and vulnerable groups rely on. Though alternative forms of housing could also meet their needs, in Eastbourne's present context there could be significant adverse consequences from overly restricting the current provision or future supply of HMOs. Interventions that mitigate impacts and improve standards for residents rather than aiming primarily to control HMO numbers may be more prudent.

6.6.6 The justification for intervention in Eastbourne appears to meet the standard of relevant precedents, so the decision whether to implement additional policy provisions, an Article 4 Direction and/or additional licensing is a matter for the Council to weigh in the context of their resourcing and other implications, with consideration to the value provided by HMOs.

6.6.7 In addition, a range of supplementary or alternative actions are proposed as ways to target specific issues that are not exclusive to HMOs, although the appropriate combination of actions again depends on their trade-offs and EBC's wider objectives. Producing and implementing strategies that address the reasons people rely on HMO accommodation in the first place, such as the delivery of affordable rented housing and support for vulnerable people, could bring benefits that apply beyond the mitigation of the specific impacts considered in this research.

Data limitations and monitoring opportunities

6.6.8 It should be noted that there are serious limitations with counting HMOs in Eastbourne's current landscape, and with the types of subjective primary research that form the core of parts of this analysis. The table in this section summarises some of the key limitations identified in the course of this research and identifies potential opportunities for further data gathering and/or closer monitoring going forward. These include making the most of the greater oversight brought by additional licensing if this option is pursued, potential ways to keep track of HMO numbers over time, and additional sources that could expand upon this study's findings in relation to the impacts of HMOs on local people and occupants themselves.

List of Abbreviations

Abbreviation	Meaning
EBC	Eastbourne Borough Council
EPC	Energy Performance Certificate
HMO	House in Multiple Occupation
IMD	Index of Multiple Deprivation
ONS	Office of National Statistics
PRS	Private Rented Sector

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