Houses in Multiple Occupation in the private rented sector

On 5th May 2006 the responsibilities of the Office of the Deputy Prime Minister (ODPM) transferred to the Department for Communities and Local Government.

Department for Communities and Local Government
Eland House
Bressenden Place
London SW1E 5DU
Telephone: 020 7944 4400
Website: www.communities.gov.uk

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HOUSES IN MULTIPLE OCCUPATION

Figure 1

This report provides a range of information on the premises and households in Houses in Multiple Occupation (HMO) in England. The information provided is largely based on the English House Condition Survey (EHCS) 1996. Where appropriate, information from other sources like the Survey of English Housing (SEH) has been used. Throughout this report, the term HMO is used to mean the DETR classification of HMOs. Full details of this and alternative definitions are contained in Annex A.

It is important to note that this report does not cover hostels, guesthouses or bed and breakfast establishments. These premises are excluded from the EHCS as they are commercial rated and therefore not classed as domestic dwellings.

PRIVATE RENTED SECTOR

Figure 2

Generally, the report focuses on HMOs that are part of the private rented sector. Such premises are the main focus of attention both in policy and enforcement. Details of private rented, purpose-built HMOs are excluded from the main body of the report, as the EHCS96 sample size is too small to produce reliable conclusions. Therefore, the private rented HMO sector considered here consists of:

- private rented and owner-occupied traditional HMOs/bedsits;
- private rented shared houses;
- all households with lodgers; and
- private rented, self-contained, converted flats.

The report also seeks to compare private rented HMOs with the private rented sector as a whole. However, numerically, converted flats dominate the private rented HMO sector. This prevents the similarity and differences between other types of HMOs and the private rented sector being identified. Therefore, converted flats are excluded from the private rented HMO category and instead included as a separate category to allow comparisons with the private rented sector.

The HMOs included in the survey are only a small sub-set of the total EHCS sample and therefore the results should be interpreted as indicative of a general pattern rather than as an

attempt to provide precise estimates.

NUMBER OF HMO PREMISES AND HOUSEHOLDS

In 1996, there were almost 800,000 private rented HMO dwellings in total. Approximately half of these are converted flats. This compares to just under two million private rented dwellings in total. There is no evidence of any significant change in the number of buildings or accommodation units per building since 1991.

In 1996, there were approximately 860 thousand households in private rented HMOs, and over 1.5 million people. Approximately 35% of all HMO households are in converted flats, whilst less than 20% are in traditional HMOs. When considering the number of residents, shared houses contain the greatest number of residents at about 0.5 million. This is over double the number of lodgers or residents in traditional HMOs. There is little evidence of any significant changes in the number of private rented HMO households since 1991.

Table 1 **Private rented HMO premises and households in England 1996** thousand/%

	Traditional HMO	Shared flat	Household with lodger[2]	PRS, flats[1]	All PRS HMOs	PRS[3]
Number of buildings	56 (10.3)	189 (34.8)	202 (37.2)	96 (17.7)	543 (100)	*
Number of units	219 (23.1)	189 (20.0)	202 (21.3)	337 (35.6)	947 (100)	1,998
Number of dwellings	56 (7.1)	189 (24.1)	202 (25.8)	337 (43.0)	784 (100)	1,998
Number of households	165 (19.2)	188 (21.9)	202 (23.6)	302 (35.2)	857 (100)	1,817
Number of people	267 (17.3)	547 (35.5)	253 (16.4)	472 (30.7)	1,539 (100)	4,161

1Shared converted flats, households with lodgers in converted flats and bedsits in converted flats are included in the respective columns not in the converted flat total.

2The number of people refers to the number of lodgers and excludes the members of the landlord's household.

3This relates to the whole private rented sector including HMOs.

*It is not possible to estimate the number of buildings in the private rented sector.

HMO PREMISES

Private rented HMOs (excluding converted flats): In terms of physical characteristics, private rented HMO premises tend to include proportionally more pre-1919, terraced buildings than the private rented sector[1]. Flats and post-1944 buildings are under-represented among HMOs. The overall number of storeys and number of rooms in HMO buildings are similar to the average for the private rented sector. Such buildings are more often found in urban areas, particularly London and southern England. The level and modernisation of facilities in HMOs compares

well with the private rented sector. After allowing for the size of the premises, location, and tenure, the standardised cost to remedy disrepair in the private rented HMOs is slightly lower than the private rented sector (£21 per m2 for urgent repairs compared to £27 per m2). Overall, the rate of unfitness for single occupancy use (section 604[2]) is lower in HMOs than the private rented sector. However, HMOs are much more likely to be unfit due to structural stability and heating. HMO premises tend to have a higher market value than other private rented premises, probably due to their size and location.

However, this overall picture does not indicate the substantial differences between types of HMOs.

Traditional HMOs: These premises are typically pre-1919 houses. They are much more likely to be three or more storeys with five or more habitable rooms. This type of HMO is more common in city centres than other private rented HMOs and less common in suburban areas. Only about a quarter of traditional HMOs have food preparation facilities for the exclusive use of each individual. Even less have exclusive use of washing facilities. After allowing for the size of the premises, location, and tenure, the standardised cost to remedy disrepair in traditional HMOs is almost twice as much as for HMOs generally, at £37 per m2 for urgent repairs. Despite the high level of investment needed to bring these properties into satisfactory repair, traditional HMOs tend to have the highest market value of HMO properties.

Traditional HMOs have a slightly higher rate of unfitness than most private rented HMOs at over 20%. They are also more commonly unfit for more than one reason, usually disrepair plus another reason. Traditional HMOs can also be assessed for fitness for multiple occupation (section 352)2. Approximately 40% of bedsits buildings are unfit under section 352 only, mainly due to fire precautions and means of escape. This is reflected in high fire fatality rates in traditional HMOs. Overall, almost two-thirds of traditional HMOs are unfit under section 352 or section 604. However, there is some evidence that the level of section 604 unfitness in traditional HMOs has decreased since 1991.

There is a relatively low level of complete vacancy of traditional HMO buildings, but a high level of partial vacancy. On average, for the traditional HMOs stock as a whole, there is approximately one accommodation unit per building vacant.

Shared houses: These premises are typically two-storey terraced houses with five or more rooms. Otherwise, shared houses broadly reflect the characteristics of private rented HMOs as a whole.

Lodgers: Lodgers are more likely to live in flats than other HMO residents, however the majority still live in houses. Otherwise, premises containing lodgers broadly reflect the characteristics of private rented HMOs as a whole.

Private rented, converted flats: Converted flats are almost exclusively pre-1919 buildings and much more likely to be three or more storeys compared to the private rented sector. Most flats have less than five rooms. They tend to have a market value lower than the private rented sector, probably because of their small size. The standardised cost to remedy disrepair tends to be higher than in private rented premises and at a similar level to traditional HMO investment needs. Converted flats have a slightly higher rate of unfitness than most private rented HMOs. There is a similar level of vacancy in converted flats as in the private rented

sector as a whole.

Turnover: Even though the overall figures for the number of premises in the HMO sector have remained fairly stable since 1991, there is in fact considerable turnover of premises. This is highest among households providing lodgings, with only a third of 1991 households with lodgers still having lodgers in 1996. The shared house sector has a similar level of turnover. This is despite the total number of premises in each category remaining stable since 1991. In contrast, two-thirds of bedsit buildings in 1991 are still bedsits in 1996. Numerically, however, the most significant change has been the net gain of approximately 60,000 converted flats since 1991.

Conclusion: For many factors relating to HMO premises, there does not appear to be huge differences between private rented sector premises and private rented HMO premises. However, this initial impression is often hiding considerable differences between the different types of HMOs themselves and the private rented sector. In particular, traditional HMOs appear to form a stable sector of large, high market value buildings in poor condition.

HMO RESIDENTS

Private rented HMOs (excluding converted flats): HMOs are generally the preserve of younger people, with over half the residents under 30 years old. This age profile is reflected in the type of households present in HMOs. It is rare to find households with children, or single people over 60. Instead private rented HMOs are dominated by large adult households (shared houses, households with lodgers), and single people (traditional HMOs, converted flats). In turn, this age and household profile is reflected in the employment status of residents, with those in full-time education over-represented in HMOs. The HMO sector has a higher level of transience than the private rented sector. There are shorter lengths of residence and a greater expectation of moving within a five-year period. As a whole, there are more residents with low incomes in the HMO sector.

Traditional HMOs: Traditional HMO residents tend to be working men on relatively low incomes. They pay a median rent of about £40 for a bedsitting room. About half of these tenants receive housing benefit. On the whole, those living in traditional HMOs are less inclined to be satisfied with their home, state of repair and neighbourhood than residents living in other types of HMOs.

Shared houses: Shared houses are dominated by students in full time education with low incomes and limited access to housing benefit. The households tend to be predominately households of either men or women, but rarely mixed. The median rent for a shared house is over £100, and tenancy arrangements are generally for one year only.

Households with lodgers: Most households have only one lodger who tends to be a working male. Again lodging appears to be a short-term option.

Private rented, converted flats: Those in converted flats tend to move less often. The residents reflect a more diverse range of household types, ages and incomes compared to the other private rented HMOs. This results in patterns closer to the characteristics of private tenants as a whole.

1991-1996: There is some evidence that the number of unemployed individuals in traditional HMOs has reduced slightly since 1991 with a corresponding increase in those in some form of employment or on a Government Training Scheme. Alongside this, is some evidence of a slight increase in the number of residents earning higher incomes than in 1991. The percentage of full-time students in shared housing also appears to have increased from 1991 to 1996. This is probably due to the overall increase in full-time student population. There appears to be a tendency for HMO residents to be more satisfied with their home, state of repair and neighbourhood in 1996 than 1991. This is reflected more widely with all private tenants being more satisfied in 1996 than in 1991.

Conclusion: Most of the residents of HMOs are single, young people, and only living in the premises for a short time. They tend to be on low incomes, mainly because they are economically inactive, full-time students or working in low-paid jobs.

1All comparisons are with the private rented sector including HMOs.
2See Annex B for details of criteria for unfitness for Section 604 and Section 352.

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Introduction

This report provides a range of information on the premises and households in Houses in Multiple Occupation (HMO) in England. The information is largely based on the English House Condition Survey (EHCS) 1996. Where appropriate, information from other sources, like the Survey of English Housing (SEH), has been used. The report has four main sections - Introduction, Number of premises and households in HMOs, HMO premises, and HMO occupants.

Generally the report focuses on HMOs that are part of the private rented sector. Therefore each section contains comparisons of the different types of HMO premises and occupants with the private rented sector (PRS) as a whole. Comparisons are also drawn between the different types of HMOs.

DEFINING HMOS

When people think about HMOs, the first question that springs to mind is 'what do you mean by HMO?'. The DETR has a research classification of different types of HMO, as does the Chartered Institute of Environmental Health (CIEH). There is also the legal definition of an HMO. These three definitions/classifications are discussed and compared in detail in Annex A. However, it should be recognised that given the complexity of some housing circumstances, the lines between the categories are not always clear cut.

The six DETR HMO classifications are listed below.

i. Traditional HMOs (bedsits).
ii. Shared houses.
iii. Households with lodgers.
iv. Purpose-built HMO with shared facilities.
v. Hostels, guesthouses, boarding houses, and 'bed and breakfast' establishments.
vi. Self contained converted flats.

It should be borne in mind, that the DETR classifications were developed pragmatically to support policy priorities and take into account data availability and reliability. Throughout this report, the term HMO is used to mean the DETR classification of HMOs. The EHCS96 collects information on five of these groups. Group (v) premises - hostels, guesthouses etc - are excluded from the EHCS as they are commercial rated and therefore not classed as domestic dwellings.

TENURE OF HMOS

The private rented sector is the dominant tenure for HMOs as a whole. However, different

tenures are closely associated with different types of HMO.

Traditional HMOs: Traditional HMOs/bedsits are mainly in the private rented sector. However, there is significant minority in the owner-occupied sector. In this case, owner-occupied means that one of the bedsits is occupied by the owner of the building, whilst the remaining bedsits are rented out. Therefore, 'owner-occupied' traditional HMOs can still be considered part of the private rented sector.

Shared houses: Shared houses are by definition rented, and are almost exclusively part of the private rented sector. (See Annex A for definition).

Table 1.1 **HMO dwellings by tenure** thousand/%

	Traditional HMO	Shared house/ flat	Household with lodger[1]	Purpose-built HMOs[1]	Converted flats	All HMOs (excluding hostels)
Owner-occupied	17 (3.4) (26.2)	0 (0.0) (0.0)	138 (28.2) (68.2)	0 (0.0) (0.0)	334 (68.3) (41.2)	489 (100) (36.8)
Private rented	40 (6.4) (62.5)	189 (30.1) (94.2)	53 (8.5) (26.2)	8 (1.3) (15.5)	337 (53.7) (41.5)	627 (100) (47.2)
Social rented	7 (3.3) (11.3)	12 (5.6) (5.8)	12 (5.6) (5.9)	41 (19.2) (84.5)	141 (66.2) (17.3)	213 (100) (16.0)
All tenures	64 (4.8) (100)	201 (15.1) (100)	203 (15.3) (100)	49 (3.7) (100)	812 (61.1) (100)	1,329 (100) (100)

1Based on tenure of lodger's landlord.

Households with lodgers: The situation with households with lodgers is more complex. Table 1.1 shows the tenure of the lodger's landlord. However the lodger, by definition, is privately renting regardless of the tenure of the lodger's landlord. Therefore, all lodgers or premises containing households with lodgers can be considered within the private rented sector.

Purpose-built HMOs: In contrast, purpose-built HMOs are generally part of the social rented sector.

Private rented, converted flats: The tenure of converted flats is distributed more evenly, with just over 40% in the private rented sector.

ANALYSIS PARAMETERS

Private rented sector

HMOs can include premises in the private rented sector, social rented sector and those in owner-occupation. However, policy and enforcement concerns about HMOs tend to focus on private rented premises. HMOs in the social rented sector are generally excluded because

mechanisms already exist to regulate social housing providers.

As part of the debate on national mandatory licensing systems (prior to the Housing Act 1996), there was widespread discussion on the inclusion of owner-occupied (leasehold), converted flats in proposed HMO policy initiatives. The outcome was a continuation of the existing exclusion of such premises from HMO legislation, and the inclusion of private rented, converted flats.

Therefore, this report focuses on private rented HMOs taking into account the above discussion on tenure. Specially, the following types of HMO are considered:

- private rented and owner-occupied traditional HMOs;
- private rented shared houses;
- all households with lodgers;
- private rented, self-contained, converted flats.

The small number of private rented, purpose-built HMOs does not allow a comparative analysis to be carried out.

The report also seeks to compare private rented HMOs with the private rented sector as a whole (including HMOs within the private rented sector figures). However, numerically, converted flats dominate the private rented HMO sector. This prevents the similarities and differences between other types of HMOs and the private rented sector being identified. Therefore, converted flats are excluded from the private rented HMO category and instead included as a separate category to allow comparisons with the private rented sector.

Figure 1.2 **Proportions of different types of private rented HMO dwellings**

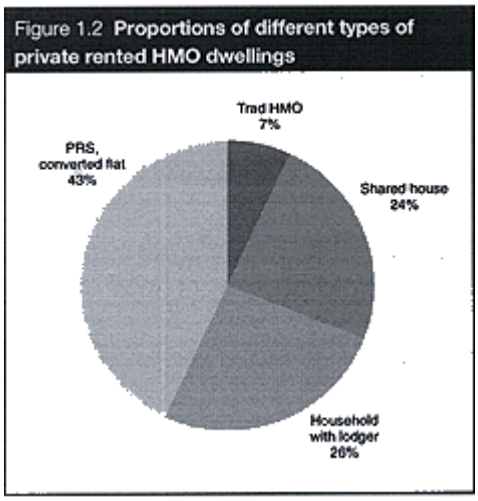
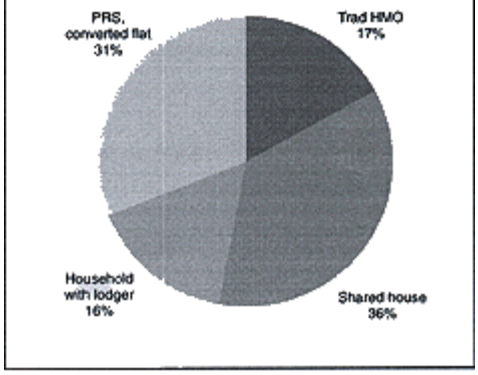


Figure 1.3 **Proportions of residents in different types of private rented HMOs**



Limitations of data

It is important to emphases that the detailed analysis in this report has been undertaken on a relatively small sample of HMOs. All the findings for traditional HMOs, and to a lesser extent, shared houses and households with lodgers, should therefore be interpreted as indicative of a general pattern rather than as an attempt to provide precise estimates.

In the 1996 EHCS, for each HMO building, only one person from one household was interviewed. This household was randomly selected. Conclusions are therefore based on the assumption that, across all HMOs, a reasonably representative set of individuals and households were interviewed. Again, because of the limited sample size, the emphasis is on the pattern rather than the precision of the estimates.

SUMMARY

Throughout this report, the term HMO is used to mean the DETR classification of HMOs. The EHCS96 collects information on five types of HMOs: traditional HMOs (bedsits), shared houses, households with lodgers, purpose-built HMOs and converted flats. The definitions of these types of HMOs are contained in Annex A.

This report focuses on the private rented sector as this is the main focus of attention both in policy and enforcement. Details of private rented, purpose-built HMOs are excluded from the main body of the report as the sample size is too small to produce reliable conclusions. Therefore, the private rented HMOs consists of:

- private rented and owner-occupied traditional HMOs/bedsits;
- private rented shared houses;
- all households with lodgers;
- private rented, self-contained, converted flats.

Sections 3and 4 of this report compare private rented HMOs with the private rented sector. However, numerically, converted flats dominate the private rented HMO sector. This prevents the similarities and differences between other types of HMOs and the private rented sector

being identified. Therefore, converted flats are excluded from the private rented HMO category and instead included as a separate category to allow comparisons with the private rented sector.

The HMOs included in the sample are only a small sub-set of the total EHCS sample and therefore the results should be interpreted as indicative of a general pattern rather than as an attempt to provide precise estimates.

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Section 2 - Number of premises and households in HMOs

There are difficulties in obtaining precise estimates of the number of HMO premises and the number of households living in HMOs. The number of HMOs can be counted as the number of buildings, accommodation units or dwellings. The number of households depends on the precise living arrangements of the occupants.

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Section 3 - HMO premises

This section looks at private rented HMOs premises in the wider context of the private rented sector. Consideration is given to a range of issues including physical characteristics, facilities, disrepair, fitness and vacancy. Where evidence is available, any changes since 1991 are indicated.

PHYSICAL CHARACTERISTICS

Type and age of premises

Figures 3.1 and 3.2

Private rented HMOs (excluding converted flats): In comparison with the private rented sector as a whole, private rented HMOs tend to include more pre-1919 (60%), terraced houses (48%). They also have a higher tendency to be semi/detached houses. Flats (30% of HMOs) and post-1944 dwellings (18% of HMOs) are under-represented in the HMO sector compared to the private rented sector.

Traditional HMOs: These premises are particularly likely to be pre-1919, houses (terraced and semi-detached) rather than flats. Just over 10% of traditional HMOs are in buildings that have been partially converted to contain a fully self-contained converted flat, and a number of bedsitting rooms.

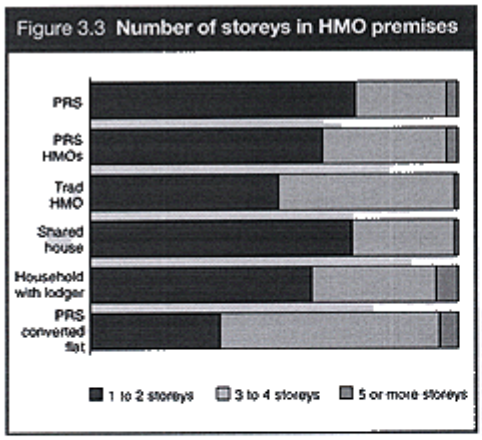
Shared houses: Shared houses are typically terraced (60%). Compared to the other HMOs, there are a large number of 1919-1944 premises.

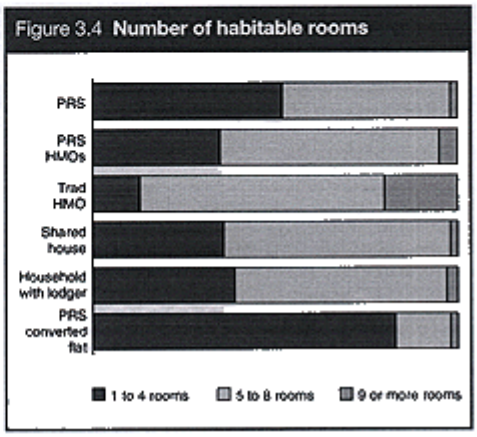
Lodgers: Lodgers are more likely to live in flats (40%) compared to the other HMO premises, particularly purpose built flats. However, these premises are still more likely to be pre-1919 buildings.

Private rented, converted flats: About 15% of private rented HMOs (i.e. traditional HMOs, shared houses and households with lodgers) are converted flats. This is in addition to the 337,000 converted flats excluded from the private rented HMO category. Converted flats are almost exclusively in pre-1919 buildings.

1991-1996: There does not appear to be any major changes between 1991 and 1996, except for a slight reduction in the proportion of post-1944 HMO buildings.

Number of Storeys





Private rented HMOs (excluding converted flats): Around 40% of private rented HMOs are three or more storeys, which is more than the private rented sector. This combined figure hides considerable differences between the different types of HMOs.

Traditional HMOs: Approximately 50% of traditional HMOs are above three storeys, but they are rarely five or more storeys.

Shared houses: Shared houses are typically two storeys, which reflects the dominance of houses.

Lodgers: There is a large minority of lodgers living in buildings of three or more storeys which reflects the high number of lodgers living in flats.

Private rented, converted flats: The majority of private rented, converted flats are above three storeys.

Number of habitable rooms

Private rented HMOs (excluding converted flats): Overall, there is a tendency for private rented HMOs to contain more habitable rooms than other private rented premises. Five or more rooms is typical. It is highly likely that larger houses lend themselves more to multiple occupation rather than occupancy by a single family both in economic and physical terms.

Traditional HMOs: Traditional HMOs are not only high buildings, they also have many rooms. Around 80% have five or more rooms.

Shared houses: Typically, shared houses have five or more rooms.

Lodgers: Typically, premises have five or more rooms.

Private rented, converted flats: The majority of converted flats are small with a maximum of four habitable rooms.

1991-1996: There is no evidence of a major change in the size and height of HMO premises since 1991.

Location

Figures 3.5 & 3.6

City centre refers to the area immediately around the centre of large cities. Urban is the area around the core of towns and small cities, and also older urban areas swallowed up by a metropolis. Suburban residential is the outer area of towns or cities, characterised by large, planned housing estates. Rural covers suburban areas of villages, villages as well as traditional rural areas.

Private rented HMOs (excluding converted flats): Private rented HMOs of all types are less likely to be found in rural areas. Almost 90% of HMOs are in urban and suburban areas. The north of England has fewer private rented HMOs than the private rented sector (18% compared to 25%). There is a corresponding increase in HMOs in London and southern England. This regional distribution reflects the nature of HMOs as a source of affordable housing in areas of high population densities and limited housing supply in the private sector.

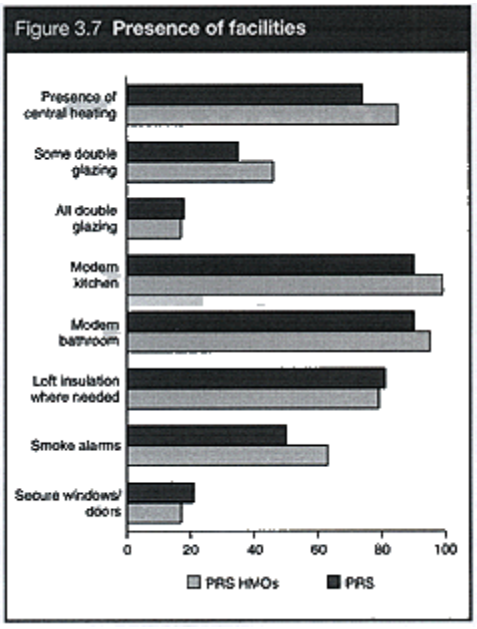
Shared houses: Shared houses are extremely rare in rural areas, and not common in city centres. They are commonly found in suburban areas (50%).

Lodgers: Households with lodgers have a similar distribution to the private rented sector, but with slightly more suburban premises and less rural premises.

Private rented, converted flats: Like traditional HMOs, these premises are more common in city centres than shared houses or households with lodgers. Most converted flats are concentrated in urban areas, and less common in rural areas.

1991-1996: There is no significant evidence of changes in geographical distribution of HMOs since 1991.

FACILITIES



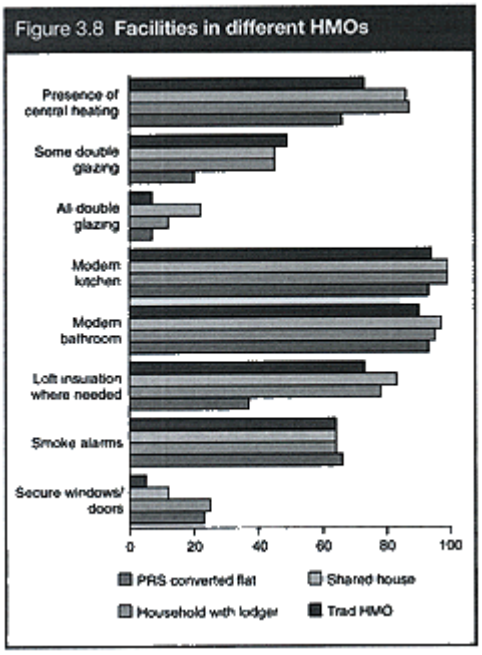
Private rented HMOs (excluding converted flats): As a group, private rented HMOs compare well with the private rented sector for most facilities. However, there is considerable variation in provision among different HMOs.

Traditional HMOs: In general, traditional HMOs have a slightly lower level of facilities than other HMOs.

Shared houses: Shared houses tend to have a full range of modern facilities.

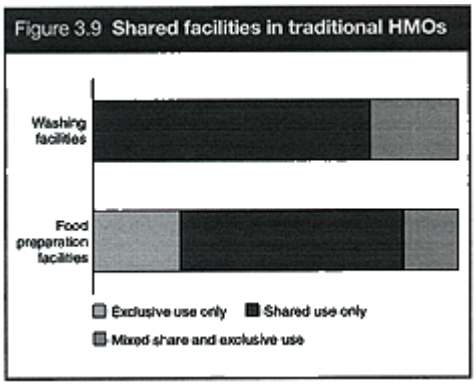
Lodgers: These premises tend to have a full range of modern facilities.

Private rented, converted flats: In general, private rented, converted flats have a lower level of facilities compared to other private rented HMOs.



Shared Facilities

Traditional HMOs can contain facilities that are for the exclusive use of an individual occupant, or shared facilities. The shared facilities are usually washing facilities (baths, showers and wash hand basins) or food preparation facilities. For example, there may be a wash hand basin in each bedsitting room and a shared shower/bathroom.



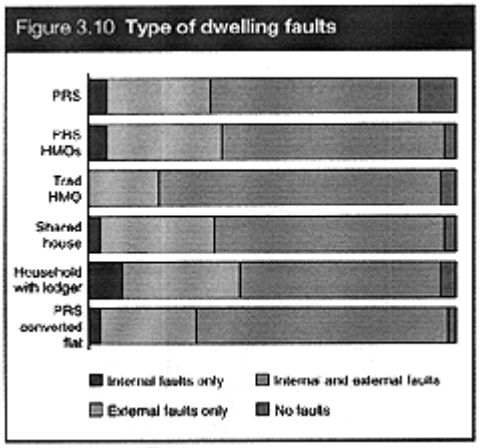
Traditional HMOs: About a quarter of traditional HMOs have food preparation facilities exclusively for the use of each individual living there. Typically, these are likely to be the small electric ring (or similar) within the bedsitting room. However, the majority of traditional HMOs contain only shared food preparation facilities. A small number have a combination of exclusive and shared facilities. There is a tendency for those with only shared washing facilities to also have only shared food preparation facilities and vice versa.

DISREPAIR

Dwelling faults

There are a number of measures that can be used to assess the extent of disrepair in

premises. The 'type of faults' measure indicates the location and extent of faults in the fabric of the premises. A fault is any problem that is not of a purely cosmetic nature and which either represents a health or safety hazard, or threatens further deterioration to the specific element or any other part of the building.



Private rented HMOs (excluding converted flats): There are fewer private rented HMO dwellings with 'no faults' recorded than private rented dwellings (less than 5%). However, there is a similar pattern in the type of faults recorded, with 60% of premises having internal and external faults.

Traditional HMOs: Traditional HMOs appear to have more extensive faults. They are much more likely to have both internal and external faults than the other types of HMOs (75%). This could partly be a reflection of the large size of these premises.

Shared houses: Shared houses have a pattern similar to the private rented HMOs as a whole.

Lodgers: Premises with lodgers are more likely to have internal faults only.Private rented, converted flats: These premises are more likely to have faults both internally and externally (70%).

Repair costs

Urgent and comprehensive repairs: 'Urgent repairs' are works specified to deal with a fault where the treatment was specified as urgent, plus all recorded work to internal elements of the dwelling. 'Comprehensive repairs' include all urgent repairs, all repairs/replacements to external elements where the surveyor indicated a fault (but the work was not urgent) and any replacement falling due over the next 10 years.

Standardised costs to remedy disrepair: The location and number of faults does not necessarily indicate the extent and seriousness of disrepair. Instead, the cost of repairing faults can be used as a measure of the seriousness of disrepair. The actual cost to remedy disrepair is partly dependent on the dwelling size, tenure, location and other issues. This report uses a standardised cost to remedy disrepair. This is a better measure of condition because it allows for location, tenure and contract size differences that affect the actual cost of the works and allows a direct comparison of the cost of repairs across all types of private rented HMOs and

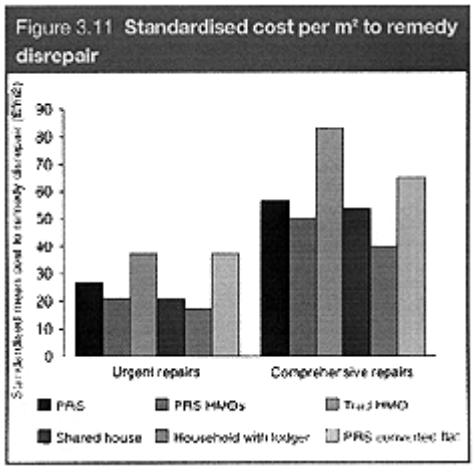
private rented premises. The standardised cost does not reflect the actual expenditure required to remedy disrepair.

Private rented HMOs (excluding converted flats): In general, the standardised cost of repair in private rented HMOs is slightly lower than private rented sector (£21 per m2 compared to £27 per m2 for urgent repairs).

Traditional HMOs: Traditional HMOs have a standardised repair cost almost double that of the private rented HMOs as a whole (£37 per m2 for urgent repairs). This implies that there is a higher level of disrepair regardless of the dwelling size. This is probably a reflection of a number of factors including dwelling age, previous low levels of investment, intensive use, poor design and poor quality of work that is carried out.

Shared houses: The standardised costs are very similar to the private rented sector.

Lodgers: The standardised costs to repair these premises are generally low.



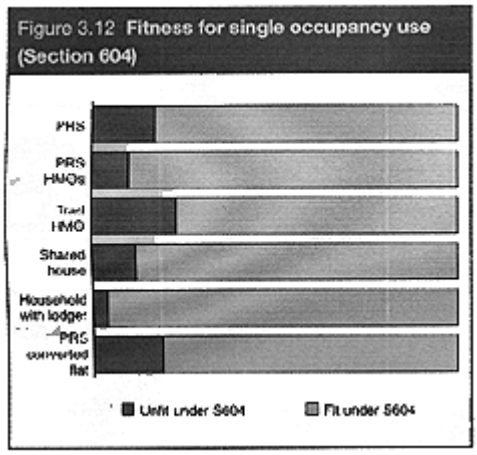
Private rented, converted flats: Converted flats have a similar level of urgent disrepair costs as traditional HMOs. Again, this is probably a reflection of a number of factors including dwelling age, previous low levels of investment, poor design and poor quality of work that is carried out. However, the intensity of use is probably lower than for traditional HMOs.

1991-1996: Although the standardised cost of repair in 1991 was different from 1996, repair costs for traditional bedsits in 1991 were higher than other categories of HMOs. There is no evidence of any significant change.

UNFITNESS

Section 604 unfitness

All dwellings can be considered in terms of their fitness for human habitation under Section 604 of the Housing Act 1985. There are nine criteria for determining fitness under section 604. See Annex B for more details.



Private rented HMOs (excluding converted flats): Private rented HMOs are less likely to be unfit under section 604, than the private rented sector as a whole (10% compared to 17%). The highest level of unfitness is in the largest HMO buildings, rising from 10% unfit in buildings with less than five habitable rooms, to 16% in buildings with nine or more rooms. There is insufficient data to assess whether this pattern holds true for individual categories of HMO.

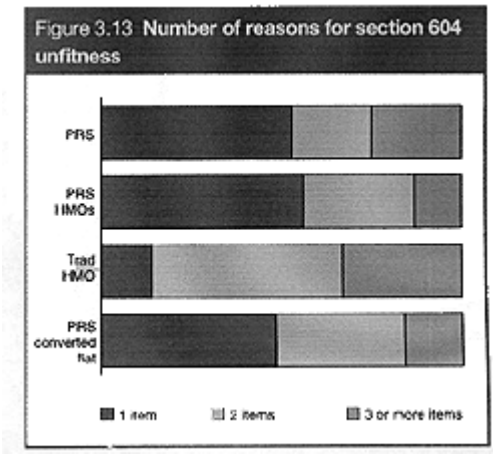
Traditional HMOs: Over 20% of traditional HMOs are unfit.

Shared houses: The level of unfitness is half that of traditional HMOs.

Lodgers: These premises have a lower level of unfitness (5%) than other types of HMO, probably because of the number of owner-occupied premises.

Private rented, converted flats: Converted flats have a similar level of unfitness as the private rented sector at around 20%.

Reasons for section 604 unfitness



Private rented HMOs (excluding converted flats): The majority (55%) of unfit private rented premises and HMOs are unfit on a single item. However, a significant minority of HMOs are

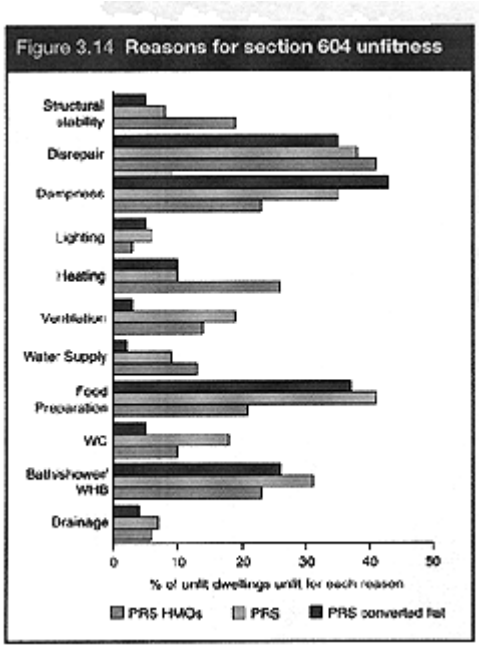
unfit on two items.

Traditional HMOs: These premises are rarely unfit on one item alone. They are much more likely to be unfit on two or more items (70%), one of which is normally disrepair.

Shared houses: Insufficient unfit properties to analysis.

Lodgers: Insufficient unfit properties to analysis.

Private rented, converted flats: These premises are commonly unfit for one reason (50%). Unfitness for three or more reasons is not common.

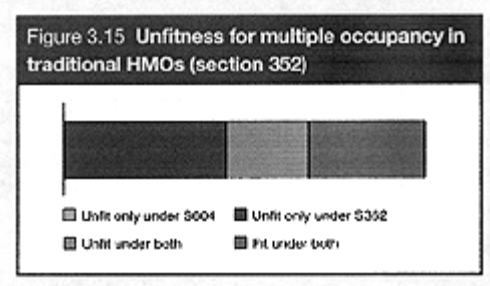


Private rented HMOs (excluding converted flats): There is a slightly different pattern of reasons for unfitness between private rented sector and HMOs. Unfitness due to structural stability and heating is much more likely in private rented HMOs. Unfitness due to dampness, food preparation and WCs is less common. The number of second WCs and kitchens is high in private rented HMOs and therefore it is more likely that at least some food preparation facilities and WCs are fit. Both the private rented sector and private rented HMOs are commonly unfit due to disrepair.

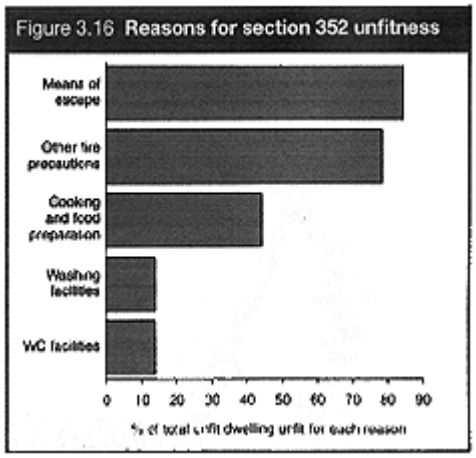
Private rented, converted flats: These premises are rarely unfit due to ventilation, water supply and WC. This probably reflects the adequate design of these facilities during the conversion process. For most other criterion, the converted flats reflect a similar pattern to the private rented sector.

Section 352 unfitness

Traditional HMOs are also subject to additional legal requirements for fitness for multiple occupation under section 352. See Annex B for more details.



Traditional HMOs: In the sample of traditional HMOs surveyed, there were no occasions where the property was unfit for single occupancy but fit for multiple occupancy. Under section 352, an additional 40% plus of traditional HMOs become unfit. Overall, almost two-thirds of traditional HMOs are unfit for their use as multiple occupancy dwellings.



Traditional HMOs: The most common reason for unfitness for multiple occupancy relates to fire precautions. Self-closing fire doors, fire fighting equipment and fire protection of walls, floors and ceilings are often unsatisfactory. These are all issues relating to the physical design of the dwellings and are often more expensive and difficult to remedy. Issues relating to management and the general state of repair of precautions are often satisfactory.

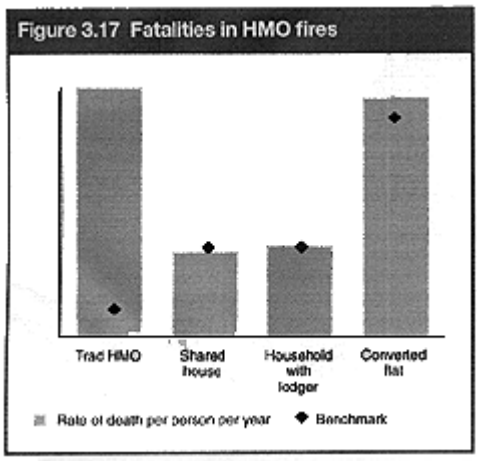
Almost half of unfit traditional HMOs fail on cooking and food preparation. Section 352 takes into account the number of food preparation facilities available and the distance from the accommodation unit to the kitchen. Therefore, it is possible to have a high quality kitchen (fit under S604) that is more than three or four floors from the bedsitting room and so unfit under S352.

1991-1996: In comparison with 1991, the level of section 604 unfitness in traditional HMOs appears to have decreased. However, the level of unfitness due to disrepair appears to have increased, indicating a continuing degree of under-investment in maintenance. There is no evidence of any other major changes.

FIRE RISK[3]

Figure 3.17 is based on all HMOs and not simply those in the private rented sector. The columns represent the actual risk of death in a fire per person in various HMOs. The black diamond indicates the benchmark rate of fatalities based on similar types of occupants living in

a non-HMO dwelling.



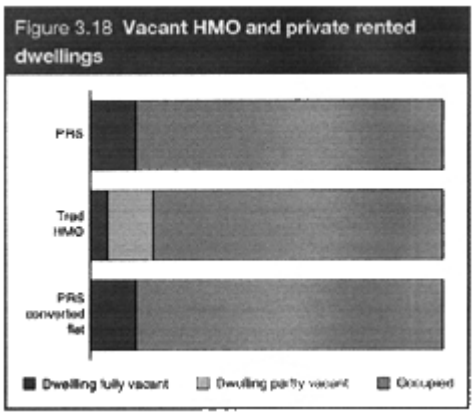
Traditional HMOs: The rate of death per person per year in traditional HMOs is approximately three times more than the benchmark. This higher risk is reflected in the high level of unfitness due to poor fire precautions.

Shared houses: The risk of death from fire is no higher in a shared house than in a comparable non-HMO dwelling.

Households with lodgers: The risk of death from fire is no higher in a household with lodger than in a comparable non-HMO dwelling.

Converted flats: There is a slightly higher risk of death in a fire in a converted flat compared to the benchmark rate of fatality in a purpose built flat. However, the risk of death in fire in any type of flat is approximately twice as high as in houses.

VACANCY OF PREMISES



Traditional HMOs: Traditional HMOs appear less likely to have the whole building vacant. Approximately 15% of traditional HMO premises have about half of the accommodation units (bedsitting rooms) vacant. This is probably due to the nature of renting individual units rather than the whole building. Over the whole traditional HMO stock, this vacancy averages to about

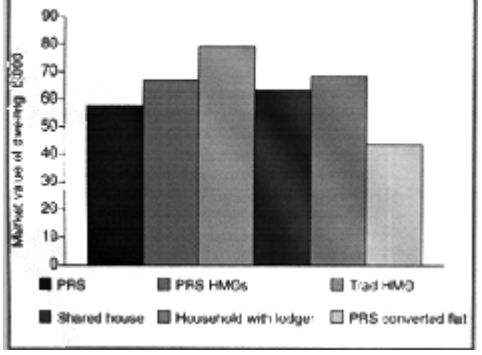
one accommodation unit per building vacant. Traditional HMOs that are fully vacant tend to be unfit under S352. However, 65% of those unfit under this section are occupied. There appears to be little relationship between S604 unfitness and vacancy levels.

Private rented, converted flats: There is a similar level of vacancy in the private rented sector as in private rented, converted flats (15%).

Shared houses/households with lodgers: The classification of lodgers and shared houses depends on the relationships between occupants. If there are no occupants, it is not possible to classify the dwelling as a shared house or household with lodgers. Using the status of the former occupants would be misleading as there is no guarantee, and in fact it may be unlikely, that the subsequent occupiers will have the same tenancy arrangements. This problem also applies to all vacant private rented dwellings, but it is considered more likely that the new occupants of a former rented dwelling would also be private tenants.

MARKET VALUES

Figure 3.19 **Mean market value of premises (£,000)**



Private rented HMOs (excluding converted flats): HMOs as a group have a higher market value than private rented premises. This is partly due to their size and also their predominance in areas of the country where residential property values are higher (London and southern England) due to high housing demand and limited land supply.

Traditional HMOs: Traditional HMOs are the most valuable properties (£80,000) despite the high level of work required to put them into satisfactory repair. This is probably a reflection of the large size of the dwellings and the possible economic advantage should the dwelling be converted into self-contained flats.

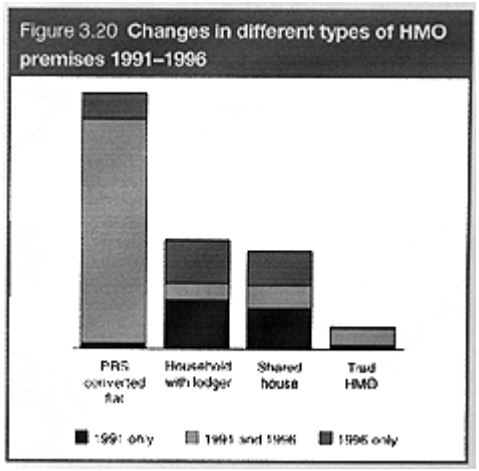
Shared houses: These premises have a slightly higher market value compared to the private rented sector, again probably a reflection of size.

Lodgers: These premises have a similar market value to the shared houses at £68,500.

Private rented, converted flats: Converted flats are considerably less valuable premises than other HMOs at only £43,500. This is largely due to their small size in comparison to other dwellings.

TURNOVER BETWEEN 1991 AND 1996

Figure 3.20 is based on HMOs in all tenures in order to obtain sufficient cases for analysis. It shows the actual numerical change in order to emphasis the relative size of the different categories of HMO.



Traditional HMOs: Over two-thirds of traditional HMOs identified in 1996 were also traditional HMOs in 1991. The remaining premises have come into use as bedsits over the intervening period. There appears to have been an overall reduction in the number of bedsit buildings since 1991 of about 10,000. The EHCS sample of bedsit buildings moving into and out of this sector is small. However, approximately half the buildings (that ceased to be traditional HMOs between 1991 and 1996) were converted into fully self-contained flats by 1996. These premises tended to be partly converted in 1991, containing a combination of bedsits and self-contained flats in a single building. Almost 15% of all traditional HMOs in 1996 contained at least one self-contained converted flat. This is possibly the top floor or basement that can readily be converted to be 'self-contained' with its own front door on the stairs. The remaining buildings have reverted into single occupancy use.

Shared houses: These premises often move into and out of the HMO sector. Although the overall number of shared houses remained fairly stable between 1991 and 1996, only 40% of the premises were shared houses in both 1991 and 1996. Former shared houses tend to revert back to single household dwellings.

Lodgers: The number of households with lodgers in 1996 is similar to that in 1991. However, only about a third of households with lodgers in 1991 still had lodgers in 1996. Former households with lodgers tend to revert back to single occupancy dwellings.

Converted flats: In comparison to new building, conversions are only a small percentage of gains in the housing stock. However, between 1991 and 1996, it is estimated an additional 83,000 dwellings have been added to the stock through converting buildings into self-contained flats. It is also possible for converted flats to be lost to the housing stock. An estimated 6,000 converted flats have been demolished since 1991. Alternatively two or more flats can be combined to a single dwelling. This 'new' dwelling may still be a converted flat, but the conversion can result in the restoration of a single house. It is estimated that 15,000 converted flats have been lost to the housing stock through this process. Between 1991 and 1996, the

net result is an estimated 60,000 converted flats added to the housing stock. This is numerically the most significant change to the HMO stock as a whole.

SUMMARY

Private rented HMOs (excluding converted flats): In terms of physical characteristics, private rented HMO premises tend to include proportionally more pre-1919, terraced buildings than the private rented sector. Flats and post-1944 buildings are under-represented. The number of storeys and number of rooms in HMO buildings are similar to the average of the private rented sector. Such buildings are more often found in urban areas, particularly London and southern England. The level and modernisation of facilities in HMOs compares well with the private rented sector. Allowing for size of the dwelling, tenure and location, the standardised cost to remedy disrepair in the private rented HMO sector is slightly lower than the private rented sector (£21 per m2 for urgent compared to £27 per m2). Overall, the rate of unfitness for single occupancy (section 604) is lower in HMOs than the private rented sector. However, they are much more likely to be unfit due to structural stability and heating. HMO premises tend to have a greater market value than private rented premises.

Traditional HMOs: These premises are typically pre-1919 houses. They are much more likely to be three or more storeys with five or more habitable rooms. This type of HMO is more common in city centres than other private rented HMOs and less common in suburban areas. About a quarter of traditional HMOs have food preparation facilities for the exclusive use of each individual. Even less have exclusive use of washing facilities. The standardised cost to remedy disrepair in traditional HMOs is almost twice as much as for the HMOs generally at £37 per m2. However these properties have the highest market value despite the high level of work needed to bring them into satisfactory repair.

Traditional HMOs have a slightly higher rate of unfitness than most private rented HMOs at over 20%. They are also more commonly unfit for more than one reason, usually disrepair plus another reason. Traditional HMOs can also be assessed for fitness for multiple occupation (section 352). Approximately 40% of bedsits buildings are unfit under section 352 only, mainly due to fire precautions and means of escape. This is reflected in high fire fatality rates in traditional HMOs. Overall, almost two-thirds of traditional HMOs are unfit under section 352 or section 604. However, there is some evidence that the level of section 604 unfitness in traditional HMOs has decreased since 1991.

There is a lower level of complete vacancy of traditional HMO buildings, but a high level of partial vacancy. On average for the traditional HMOs stock as a whole, there is approximately one accommodation unit per building vacant.

Shared houses: These premises are typically two storey terraced houses with five or more rooms. Otherwise, shared houses broadly reflect the characteristics of the private rented HMOs as a whole.

Lodgers: Lodgers are more likely to live in flats than other HMO residents however the majority still live in houses. Otherwise, premises containing lodger broadly reflect the characteristics of the private rented HMOs as a whole.

Private rented, converted flats: Converted flats are almost exclusively pre-1919 buildings

and much more likely to be three or more storeys compared to the private rented sector. Most have less than five rooms. Converted flats tend to have a market value less than the private rented sector, probably because of their small size. The cost to remedy disrepair tends to be higher than the private rented sector premises and at a similar level to traditional HMO investment needs. Converted flats have a slightly higher rate of unfitness than most private rented HMOs. There is a similar level of vacancy in converted flats as in the private rented sector as a whole.

Turnover: Even though the overall figures for the number of premises in the HMO sector have remained fairly stable since 1991, there is in fact considerable turnover of premises. This is highest in the households with lodger sector, with only a third of 1991 households with lodgers still having lodgers in 1996. The shared house sector has a similar level of turnover. This is despite the total number of premises in each category remaining stable since 1991. In contrast, two-thirds of bedsit buildings in 1991 remained bedsits in 1996. Numerically, however, the most significant change has been the net gain of about 60,000 converted flats since 1991.

Conclusion: For many factors relating to HMO premises, there does not appear to be huge differences between private rented sector and private rented HMO premises. However, this initial impression is often hiding considerable differences between the different types of HMOs themselves and the private rented sector. In particular, traditional HMOs appear to form a stable sector of large, high market value buildings in poor condition.

3Information from DETR (1998) Fire Risk in Houses in Multiple Occupation: Research Report, Stationery Office: London.

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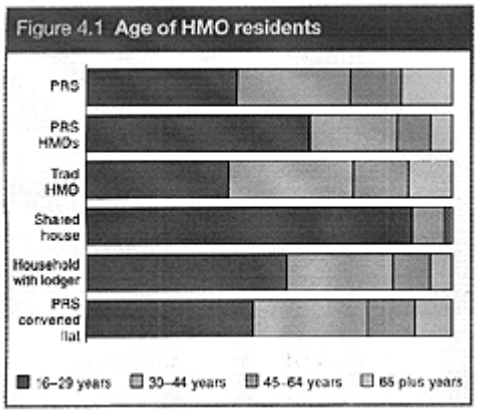
Although this report was commissioned by the Office, the findings and recommendations are those of the authors and do not necessarily represent the views of the Office of the Deputy Prime Minister.

Section 4 - HMO households

This section of the report focuses on the people and households that live in private rented HMOs. Although a range of information was collected about all HMOs, the extent of information about lodgers is limited. The EHCS interview survey focused on the main household (lodger's landlord) and not the lodger. Where available, information about lodgers has been included. Approximately a third of the private rented HMO sector are lodgers, therefore when information is not available about the lodger, no overall figure for the private rented HMO sector is provided. This section considers household characteristics, income and benefits, tenancy, satisfaction and the length of residence.

HOUSEHOLD CHARACTERISTICS

Age of residents



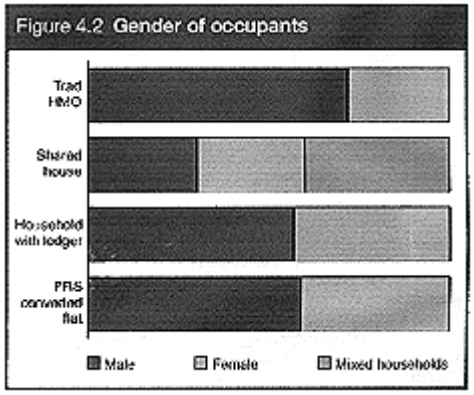
Private rented HMOs (excluding converted flats): Compared to the private rented sector, private rented HMOs are generally the preserve of younger people. Over half the residents are under 30 years old. There are also significantly fewer residents over 65 years old than in the private rented sector.

Traditional HMOs: Traditional HMOs have a smaller number of younger occupants (40%), and the pattern of age distribution is similar to the private rented sector as a whole.

Shared houses: Almost 90% of occupants are under 30 years old.Lodgers: Almost 50% of lodgers are under 30 years.

Private rented, converted flats: These households have a similar distribution to the private rented sector, with slightly lower levels of young occupants compared to other private rented HMOs.

Gender of residents

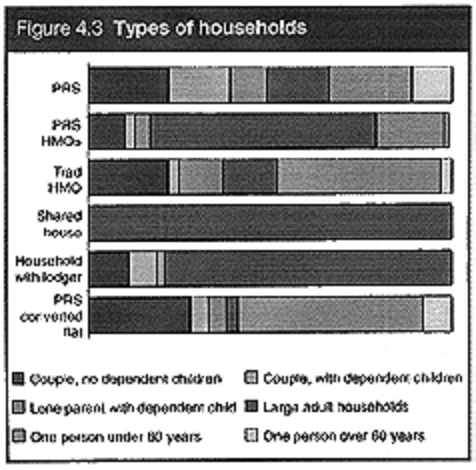


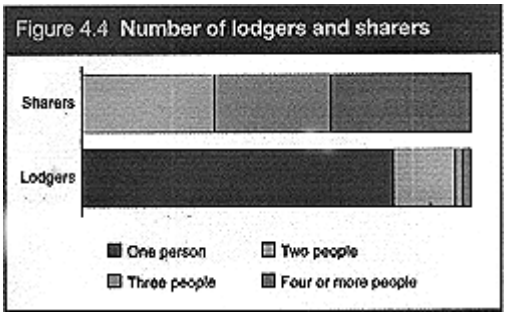
Traditional HMOs: Male residents are more common (75%), although there is a significant number of female residents.

Shared houses: The majority of shared houses contain single sex households of either men or women.

Lodgers: Although the lodgers and lodger's landlord tend to be men (approximately 60%), there is a sizeable population of female lodgers and landlords.

Type and size of households





Private rented HMOs (excluding converted flats): It is rare to find households with children

in HMOs, or single people over 60. Instead, large adult households dominate private rented HMOs (60%). This is in contrast to the private rented sector, where there is a more balanced distribution of different types of households.

Traditional HMOs: Residents of traditional HMOs are commonly single people (45%) but rarely the elderly. There is a relatively high number of couples. roportionally lone parents are over-represented in traditional HMOs in comparison to all HMOs.

Shared houses: By their nature, shared houses contain large adult households. The majority (65%) of shared houses contain three or less people, although a significant number contain more than five.

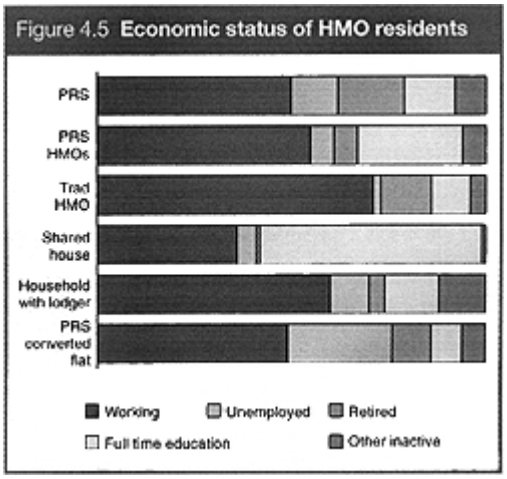
Lodgers: Households with lodgers also tend to be adult only households (80%). The majority of households contain only one lodger.

Private rented, converted flats: Households in converted flats tend to be single people or couples with no dependent children. 1991-1996: The 1996 pattern of occupant age, type of household and gender appears to be similar to that in 1991.

ECONOMIC STATUS, INCOME AND BENEFITS

Economic status

Figure 4.5 **Economic status of HMO residents**



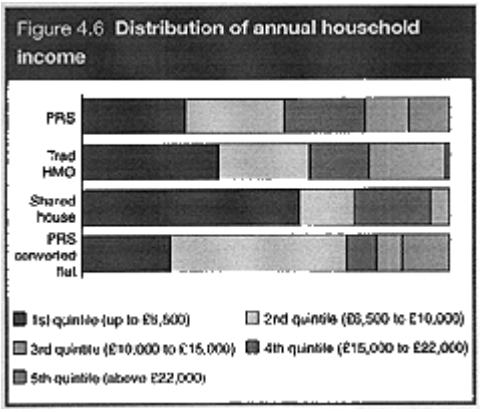
Private rented HMOs (excluding converted flats): In line with the household type and age classifications above, residents in full-time education are over-represented, and retired people are under-represented in comparison to the private rented sector. There is a high proportion (55%) of households involved in some form of paid employment (either part-time or full-time). This again reflects the working age of residents and the limited number of people with dependent children.

Traditional HMOs: The majority of residents in traditional HMOs are working (70%). About twice the number in work are in part-time employment compared to private rented HMOs as a whole (20% to 10%).

Shared houses: Those in full-time education dominate shared houses. Although there is a

view of shared housing as a typically student housing, over a third of residents, (mainly in London) are working. This may be a reflection of the higher costs of housing in London that can be lowered by sharing accommodation.

Annual household income



Lodgers: The majority of lodgers are working (60%). Private rented, converted flats: There is a high level of unemployed residents concentrated in converted flats.

Private rented HMOs (excluding converted flats): A greater number of HMO residents are concentrated in the lowest quintile of income level (incomes below £6,500 per annum) compared to the private rented sector.

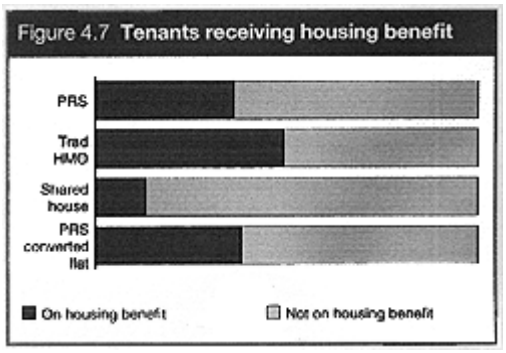
Traditional HMO: Traditional HMOs residents tend to have lower incomes than private tenants. This is partly because that those working tend to have low incomes. Almost 60% earn less than £10,000 per annum, partly due to the relatively high proportion of part-time workers. The unemployed and student residents are also concentrated in the lower income bands. The residents in the fourth quintile tend to be working (full-time) and a large percentage of the retired residents. The small number of residents in the highest income band (over £22,000 per annum) probably reflects their increased access to the non-HMO rented market and owner-occupation.

Shared houses: Low-income residents dominate shared houses with 60% in the lowest quintile. This is because 85% of the students in shared housing are in this income band. The majority of working residents (65%) living in shared houses are in the third and fourth quintile bands with incomes above £10,000 per annum.

Lodgers: No data available

Private rented, converted flats: The majority (50%) of residents in converted flats have income levels in the second quintile. Half of residents who are working, unemployed or economically inactive and living in converted flats have annual incomes between £6,500 and £10,000. It is likely that residents with incomes lower than this are unlikely to be able to afford a converted flat. Residents in the upper two quintiles tend to be working.

Housing benefit



Private rented HMOs (excluding converted flats): There are very different levels of housing benefit receipt in the different HMOs.

Traditional HMOs: There is a high level (50%) of tenants receiving benefit, in line with residents' relatively low incomes.

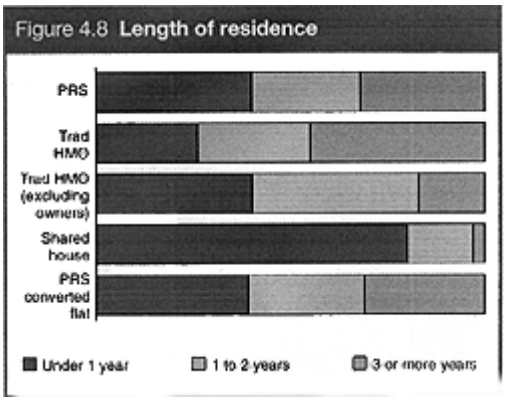
Shared houses: There is low level of tenants receiving housing benefit. Probably due to because special rules restricting full-time students from obtaining housing benefit.

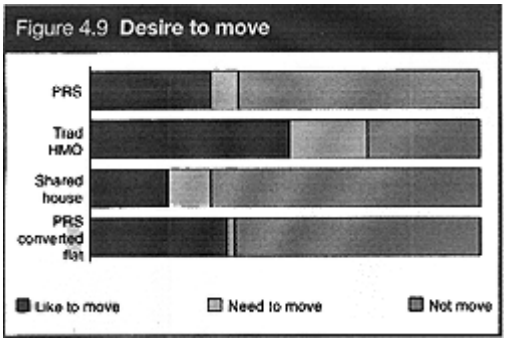
Lodgers: The SEH 1996/97 reports that for resident landlord and no security tenancies (such as lodgers) approximately 20% of tenants received housing benefit. There is no comparable date from the EHCS.

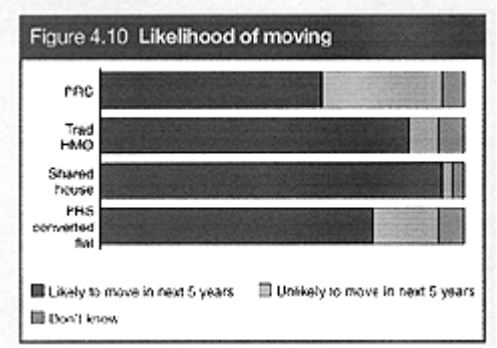
Private rented, converted flats: The level of tenants in converted flats receiving benefit is similar to the private rented sector as a whole, at a third of tenants.

1991-1996: There is some evidence that the number of unemployed individuals in traditional HMOs has reduced slightly since 1991 coupled with a slight increase in income levels. The percentage of full-time students in shared housing also appears to have increased from 1991 to 1996, reflecting increased numbers of students in higher education. The level of tenants receiving housing benefit in 1996 appears similar to that in 1991.

LENGTH OF RESIDENCE AND MOVING







Private rented HMOs (excluding converted flats): On the whole, tenancies in the private sector tend to be short, and most residents consider themselves likely to move within a five-year period. Individuals in poor HMOs or HMOs in substantial disrepair are more likely to want to move.

Traditional HMOs: As a whole, occupants in traditional HMOs tend to be resident for longer than those in the private rented sector. Almost half are resident for more than 3 years. However, those resident longest tend to be the owners living in traditional HMOs. This implies that owners living their own bedsits is not a temporary phenomenon due to short term housing market instability. These owners do not appear to move into self-contained accommodation and become non-resident landlords. If these owners are excluded, other bedsit residents still have a length of residence which is generally longer than residents in shared houses, but shorter than those in private rented sector generally. Traditional HMO residents also have a higher level of wanting and expecting to move, probably due to the high level of disrepair and dissatisfaction expressed about these premises.

Shared houses: The vast majority of sharers have been resident for under a year. They are not looking to move now, but are unlikely to be living in the shared house in five years time. This is a reflection of the full-time student status of most residents, with most student shared houses leased for a year at a time.

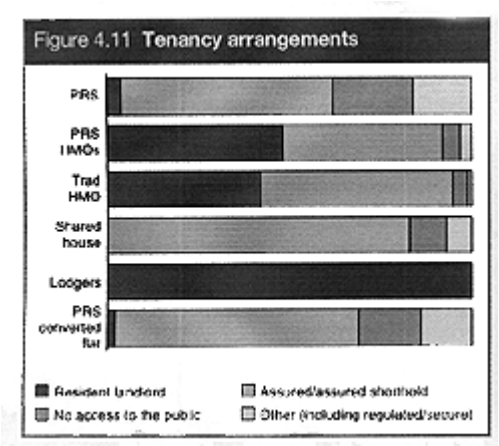
Lodgers: The SEH 1995/96 reported that 75% of lodgers had been resident for less than three years.

Private rented, converted flats: The pattern of length of residence in converted flats is similar to the private rented sector. There are slightly more residents wanting and expecting to move than in the private rented sector. This is probably due to the high level of disrepair in converted flats in comparison to the private rented sector as a whole.

1991-1996: There is no evidence of any significant change in the length of residence or moving patterns in the HMO sector.

TENANCY ARRANGEMENTS AND RENTAL LEVELS

Tenancy arrangements



Private rented HMOs (excluding converted flats): In comparison with the private rented sector, resident landlords dominate private rented HMOs (50%). All other forms of tenancy arrangements are under-represented.

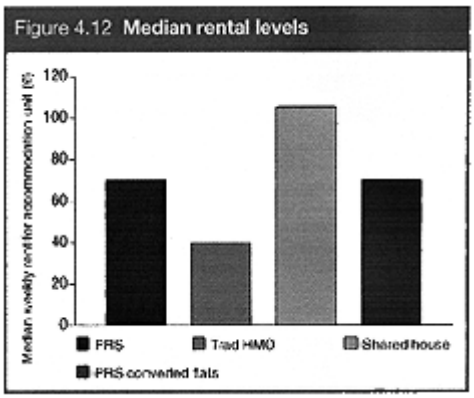
Traditional HMOs: Resident landlords are common in traditional HMOs as are assured/assured shorthold tenancies.

Shared houses: Shared houses are almost entirely assured/assured shorthold tenancies.

Lodgers: By definition, all households with lodgers have a resident landlord.

Private rented, converted flats: Assured shorthold tenancies dominate converted flats.

Rental levels



Private rented HMOs (excluding converted flats): Rent levels vary between the different

types of HMO.

Traditional HMOs: The rent for a traditional HMO relates to a single room and use of shared facilities, and is around £40. The SEH 1996/97 reported £51 as the average weekly rent for 'non-self contained accommodation', which would include bedsits.

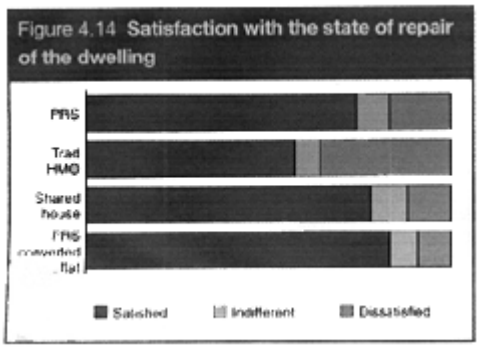
Shared houses: The median rent for a shared house is over £100, and probably relates to the cost of renting the whole house.

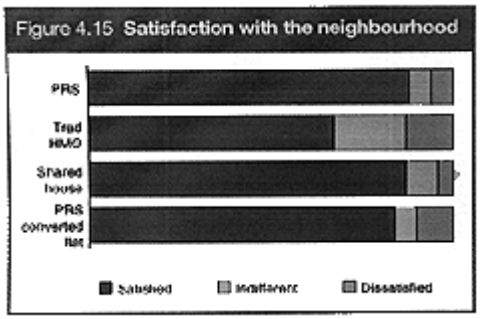
Lodgers: The SEH 1995/96 reports that lodgers have a median rent of £36 a week.

Private rented, converted flats: Private rented converted flats are rented for a median of about £70, for the complete flat. This is a similar level to the private rented sector as a whole. The SEH 1996/97 reported £79 as the average weekly rent for a self-contained flat.

HOUSEHOLD SATISFACTION

There are certain types of people who report higher or lower than average satisfaction levels towards a range of housing issues (as identified in the EHCS 1996 report). Owner-occupiers, elderly people, couples (with no children), long term residents (20 years or more) and retired people tend to report higher than average satisfaction levels. However, tenants, lone parents, young people, new residents (three years or less), unemployed or economically inactive people and full-time students all tend to report lower levels of satisfaction with housing. This is probably due to a variety of factors including socio-economic circumstances, current and future expectation of housing, life cycle stage and degree of choice of accommodation. This should be noted when considering the levels of satisfaction in HMOs.





Private rented HMOs (excluding converted flats): There is often more difference in levels of satisfaction between the difference HMOs, than between HMOs in general and the private rented sector. Residents in traditional HMOs are much less satisfied that residents in the other forms of HMO. Residents in converted flats and shared houses tend to be similar to the private rented sector as a whole. This is despite many of those living in these HMOs belonging to groups that have the highest level of dissatisfaction regardless of housing circumstances.

Traditional HMOs: Approximately two-thirds of residents of traditional HMOs are satisfied with their home, state of repair and neighbourhood. However, approximately a quarter are dissatisfied with their home or state of repair indicating more extreme reactions to traditional HMOs. This is a very high level of dissatisfaction in comparison to all other types of HMOs, and tenures. This may be a reaction to the presence of shared facilities where residents have no choice in who they share with and also problems with noise and anti-social behaviour. For traditional HMOs, satisfaction for home and state of repair tends to be lower amongst those in poor housing conditions. The high level of poor quality traditional HMOs is another partial explanation for the high level of dissatisfaction. Traditional HMO residents tend to be more indifferent to the neighbourhood than other private rented sector tenants. This high level of indifference may be partly due to the nature of these HMO tenants. However, it also may be because HMO tenants are resident in the neighbourhood for a shorter time and therefore the wider neighbourhood is not an important issue in their lives. Instead they focus on their own individual accommodation unit.

Shared houses: Residents in shared houses generally have a higher level of satisfaction than residents in the private rented sector. This is despite the presence of students who tend to be more dissatisfied generally. This may partly reflect the control most sharers have over their home and who they share with. The short-term nature of the residence may also be a factor.

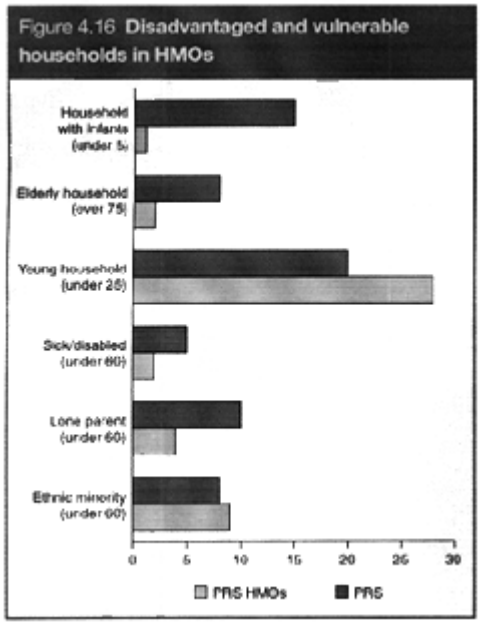
Lodgers: No data available.

Private rented, converted flats: Residents in private rented converted flats also have a slightly higher level of satisfaction than residents in the wider private rented sector. This high level of satisfaction may partly be related to occupants. The occupants of converted flats are least likely of all the HMOs to contain a large number of individuals who report lower satisfaction levels. Although the number of individuals in the HMOs generally who report higher than average satisfaction levels is not large, such individuals (elderly people, couples with children) are more common in converted flats than other HMOs.

1991-1996: There appears to be a tendency for HMO residents to be more satisfied with their home, state of repair and neighbourhood in 1996 than 1991. This may partly be a reflection of

the fact that private renting residents (as a group) report being more satisfied in 1996 than in 1991.

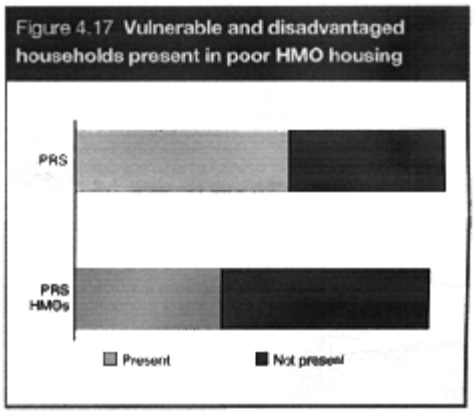
VULNERABLE AND DISADVANTAGED HOUSEHOLDS IN HMOS



Disadvantaged households: The 1996 EHCS report identified a number of (overlapping) groups who may be considered economically and/or socially disadvantaged: ethnic minority households, lone parent households, households headed a sick/disabled person, households headed by a person under 25 years.

Vulnerable households: In addition, the 1996 EHCS identifies two groups with a higher health and safety risk associated with living in poor housing (whether or not they live in such conditions). These vulnerable groups are elderly people (over 75 years) and infants (children under five). This does not imply that other individuals are not at risk from poor housing conditions.

Private rented HMOs (excluding converted flats): In comparison to the private rented sector, elderly people and infants are rarely found in private rented HMOs. This was identified in the households type classification discussed earlier. Two types of disadvantaged households are also rare in HMOs in comparison to the private rented sector: sick/ disabled households and lone parents. The number of ethnic minority households is similar to the private rented sector. Private rented HMOs are dominated by one particular disadvantaged group: those under 25 years old. It is important to recognise that about 40% of these young households are students are in full-time education, and they are unlikely to remain disadvantaged in the longer term.



Approximately 30% of the private rented stock and 20% of the private rented HMOs would be considered poor housing. Poor housing is considered to be that requiring modernisation of essential food preparation facilities, electric systems or heating facilities OR that which is unfit under S604 OR housing that is in substantial disrepair. Vulnerable and disadvantaged households in the private rented HMO sector are less likely to be in poor HMO housing that those in the private rented sector as a whole.

1991-1996: Comparable information is not available for 1991.

SUMMARY

Private rented HMOs (excluding converted flats): HMOs are generally the preserve of younger people, with over half the residents under 30 years old. This age profile is reflected in the type of households present in HMOs. It is rare to find households with children, or single people over 60. Instead private rented HMOs are dominated by large adult households (shared houses, households with lodgers), and single people (traditional HMOs, converted flats). In turn, this age and household profile is reflected in the employment status with those in full-time education over-represented in HMOs. As a whole, there are more residents with low incomes in the HMO sector.

The HMO sector has a higher level of transience than the private rented sector. There are shorter lengths of residence and a greater expectation of moving within a five-year period.

Elderly persons and infants are rarely found in the HMOs, but one particular group dominates the HMO sector - those between 16 and 25 years old. However 40% of this group are full-time students and therefore their disadvantage is likely to be temporary. The majority of the remaining residents are working employment with low incomes. The vulnerable and disadvantaged households that do live in HMO are less likely to be in poor housing in comparison to the private rented sector.

Traditional HMOs: Traditional HMO residents tend to be working men on relatively low incomes. They pay a median rent of about £40 for a bedsitting room. About half of these tenants receive housing benefit. On the whole, those living in traditional HMOs are less inclined to be satisfied with their home, state of repair and neighbourhood than residents living in other types of HMOs.

Shared houses: Shared houses are dominated by students in full time education with low incomes and limited access to housing benefit. The households tend to be predominately households of either men or women, but rarely mixed. The median rent for a shared house is over £100, and tenancy arrangements are generally for one year only.

Households with lodgers: Most households have only one lodger who tends to be a working male. Again lodging appears to be a short-term option.

Private rented, converted flats: Those in converted flats tend to move less often. The residents reflect a more diverse range of household types, ages and incomes compared to the other private rented HMOs. This results in patterns closer to the characteristics of private tenants as a whole.

1991-1996: There is some evidence that the number of unemployed individuals in traditional HMOs has reduced slightly since 1991 with a corresponding increase in those in some form of employment or on a Government Training Scheme. Alongside this, is some evidence of a slight increase in the number of residents earning higher incomes than in 1991. The percentage of full-time students in shared housing also appears to have increased from 1991 to 1996. This is probably due to the overall increase in full-time student population. There appears to be a tendency for HMO residents to be more satisfied with their home, state of repair and neighbourhood in 1996 than 1991. This is reflected more widely with all private tenants being more satisfied in 1996 than in 1991.

Conclusion: Most of the residents of HMOs are single, young people, and only living in the premises for a short time. They tend to be on low incomes, mainly because they are economically inactive, full-time students or working in low-paid jobs.

Although this report was commissioned by the Office, the findings and recommendations are those of the authors and do not necessarily represent the views of the Office of the Deputy Prime Minister.

Annex A - Definitions of HMOs

LEGAL DEFINITION[4]

The Housing Act 1985 provides the legal definition of HMO that was subsequently amended by the Local Government and Housing Act 1989. The legal definition of an HMO is 'a house which is occupied by persons who do not form a single household'. For the purposes of this Act, any part of a building originally constructed or subsequently adapted for occupation by a single household is a 'house'. There are three key parts to the definition, 'house', 'occupied' and 'not a single household'.

Over the years, a body of case law relating to the HMO definition has developed. Currently, in its broadest meaning, a house is 'a building which is constructed or adapted for use as or for the purpose of a dwelling (Ashbridge Investments Ltd v Ministry of Housing and Local Government 1965). It is also 'a place fitted and used and adapted for human habitation' (Reed v Hastings Corporation 1964). There are a variety of other premises included as houses under case law (e.g. lodging-houses, holiday homes for children, hostels and hotels occupied by homeless families). Houses converted into flats (whether self-contained flats or not) are still houses (Okereke v London Borough of Brent 1967). However, a single flat cannot be a house for the purposes of this part of the Housing Act. Although it has not been legally tested, it is generally assumed that a single tower block is not a house.

Occupied means 'lived in' (Silbers v Southwark LBC 1977). Therefore vacant houses cannot be HMOs under the legal definition.

The 'not of a single household' is the most complex part of the HMO definition. A 'single household' is not defined. Before 1969, membership of a family group or lettings in lodgings were considered a household, but this is no longer the case. The question of whether a group of people living in a house constitutes one or more household depends on the specific facts of the case in question. There is no single criteria to decide if a single household is present. However, in 1995, the Barnes v Sheffield City Council case provided nine 'helpful indicators'.

a. whether the persons living in the house came to it as a single group or whether they were independently recruited;
b. what facilities were shared;
c. whether the occupants were responsible for the whole house or just their particular rooms;
d. whether individual tenants were able to, or did, lock other occupiers out of their rooms;
e. whose responsibility it was to recruit new occupiers when individuals left;
f. who allocated rooms;
g. the size of the property;
h. how stable the group composition was; and
i. whether the mode of living was communal.

If residents are recruited individually by the landlord and allocated a room, do not share facilities, have little communal living, and live in a large property with a rapid turnover of residents, then they are likely to be considered separate households. However, each case is decided on its own merits. For example (Simmons v Pizzey 1979), 75 people were in occupation of a refuge for victims of domestic violence. The women organised the business of the house collectively, eating and undertaking the arrangements of the house together. No occupant had a special part of the house to herself. However, it was not intended that the women should live at the refugee indefinitely. Some would move to permanent accommodation of their own, and others return to their former homes. Despite, the communal arrangements, it was held that this could not amount to occupation as a single household.

The legal definition of HMO is very complex and often revolves around the definition of a household. Within the legal definition, there is no attempt to distinguish between different types of HMO.

CHARTERED INSTITUTE OF Environmental health DEFINITION[5]

The CIEH has six categories of HMOs - Categories A to F.

Category A covers houses occupied as individual rooms, where there is some exclusive occupation (usually bedroom or living room) and some shared amenities (bathroom/WC/kitchen). Each occupant lives independently of all others. Traditional HMO buildings would fall under this category.

Category B covers houses where the occupants 'share' the dwelling. Members of a defined social group, for example students or a group of young single adults would normally occupy these buildings. The occupiers each enjoy exclusive use of a bedroom but would share other facilities including a communal living space.

Category C covers houses with some degree of shared facilities, occupied by people whose occupation of the dwelling is ancillary to their employment or education. The housing is made available through employer or in connection with a recognised educational establishment. This would typically be student 'halls of residence', nurses' residences or soldiers' barracks.

Category D includes houses referred to as hostels, guesthouses, bed and breakfast hotels or the like. These provide accommodation for people with no other permanent dwelling as distinct from hotels that provide accommodation for temporary visitors to an area.

Category E covers premises requiring registration under the Registered Homes Act 1984. These provide board and personal care for persons in need by reason of old age, disability, past or present mental disorders, or drug or alcohol dependence.

Category F covers most houses or other buildings that by erection or conversion comprise dwellings that are self-contained, but the dwellings have access via a single 'front door' from a common area. Such dwellings would normally contain all the standard amenities but not necessarily. Nevertheless, there is no sharing of amenities with the occupiers of neighbouring dwellings.

DETR RESEARCH DEFINITIONS

Within the DETR, there are six categories of HMO recognised for research purposes. Not all of these categories are legally defined as HMOs, and not all are defined as residential dwellings.

Group (i): Traditional HMOs (bedsits). These are converted houses (and flats) that provide flatlets, bedsits and rooms, each occupied by a separate household. Within these houses, two or more households share one or more facilities (e.g. bathrooms, kitchen), or will have common circulation space between rooms that are for their exclusive use.

Group (ii): Shared houses. These are dwellings occupied on a shared basis, typically by students, or other groups of people who club together to rent a house or flat. Only dwellings occupied by two or more non-related adults, who are not partners, are included within this definition. Unrelated individuals buying a house together are excluded as it is often difficult to assess whether the individuals are a couple or not. In addition, they are outside the rented sector and as such not directly relevant to rented sector policy concerns.

Group (iii): Households with lodgers. These are households catering for lodgers on a small scale. Lodgers will share one or more facilities with the main household without having the facilities to prepare their own food independently. Meals are usually provided and/or the lodger shares a living room with the main host household.

Group (iv): Purpose-built HMO with shared facilities. This group is similar to group (i) but dwellings have been purpose-built to this specification. They are often sheltered accommodation with private rooms but shared kitchens/bathrooms.

Group (v): Hostels, guesthouses, boarding houses, 'bed and breakfast' establishments. These HMOs provide accommodation on a commercial basis. Most offer meals with the accommodation, but some provide kitchen facilities and are self-catering.

Group (vi): Self contained converted flats. These dwellings are fully self contained with all amenities behind their own front door. However, the flats were originally constructed as one house.It should be borne in mind, that the DETR classifications were developed for research purposes to support policy decisions. Therefore, the group classifications take into account the data availability and reliability as well as policy priorities. It should be recognised that given the complexity of some housing circumstances, the line between categories are not always clear cut.

COMPARISON OF DEFINITIONS

Under the legal definition, some shared houses and households with lodgers would not be considered HMOs because the occupants live as a single household. The other types of premises identified by CIEH and DETR are likely to be considered HMOs under the legal definition.

The CIEH and DETR classifications are similar. The main difference is the classification of purpose-built HMOs. The CIEH classification does not distinguish between purpose-built and non-purpose-built HMOs. Instead the use of the premises is the key to classification. The DETR classification separates out purpose-built HMOs. This is because such HMOs often

have very different conditions compared to non-purpose-built HMOs, regardless of use. Therefore, this group (iv) is split over CIEH categories C and E.

Table A **Comparing HMO definitions**

	DETR	**CIEH**	**Legal**
Bedsits	Group i	Category A	Yes
Shared houses	Group ii	Category B	Depends (probably)
Households with lodgers	Group iii	-	Depends (unlikely)
Student halls of residence, nurses residences etc	Mainly in group iv	Category C	Yes
Registered homes	Mainly in group iv, some in group v	Category E	Covered under Registered Homes Act 1984
Hostels, B&B etc	Group v	Category D	Yes
Converted flats	Group vi	Category F	Yes

4Obtained from the Encyclopaedia of Housing Law and Practice, A. Arden (ed), Sweet and Maxwell, London, updated August 1997.

5Obtained from 'Amenity standards for Houses in Multiple Occupation' (1994). Chartered Institute of Environmental Health, London

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Annex B - Fitness standard, 1989 Local Government and Housing Act

SECTION 604

Assessment: A dwelling house is fit for human habitation unless in the opinion of the local housing authority it fails to meet one or more of the requirements below and by reason of that failure is not reasonably suitable for occupation.

Requirements of the standard:

- It is free from disrepair.
- It is structurally stable.
- It is free from dampness prejudicial to the health of the occupants (if any).
- It has adequate provision of lighting, heating and ventilation.
- It has adequate piped supply of wholesome water.
- It has an effective system for the drainage of foul, waste and surface water.
- It has a suitably located WC for the exclusive use of occupants.
- It has for the exclusive use of the occupants (if any) a suitably located bath or shower and wash-hand basin, each of which is provided with a satisfactory supply of hot and cold water.
- There are satisfactory facilities in the dwelling home for the preparation and cooking of food, including a sink with a satisfactory supply of hot and cold water.

SECTION 352

In addition to the requirements for dwellings laid down in Section 604, the additional requirements for an HMO as laid down in Section 352 are:

- There are satisfactory facilities for the storage, preparation and cooking of food including an adequate number of sinks with a satisfactory supply of hot and cold water.
- It has an adequate number of suitability located water-closets for the exclusive use of the occupants.
- It has, for the exclusive use of the occupants, an adequate number of suitability located fixed baths or showers and wash hand basins each of which is provided with a satisfactory supply of hot and cold water.
- Subject to Section 635 (of the act), there are adequate means of escape.
- There are adequate other fire precautions.