The Housing Health and Safety Rating System is a means of assessing the health and safety risks in dwellings and is designed as a replacement for the current fitness standard (section 604 of the Housing Act 1985 as amended). This report addresses the concerns expressed about the system's applicability to houses in multiple occupation and how it might fit in with risk assessment, priority planning and enforcement.

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The Application of the Housing Health and Safety Rating System in Houses of Multiple Occupation

May 2003

Robert Flynn, Simon Nicol, Mike Roys, Lorna Hamilton and Kathryn Rathouse, BRE Ltd

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Executive Summary

The research project used case studies of 6 local authorities and interviews with a variety of local authorities and interested parties to identify perceived and actual problems in the application of the Housing Health and Safety Rating System to Houses in Multiple Occupation (HMOs).

Very few people have actually applied the HHSRS to HMOs in practice. They have had problems in applying it to single family houses, and have found that these problems are multiplied when it is applied to HMOs. In particular there has been confusion over what the HHSRS is being applied to – the whole building or each individual HMO unit within it.

The vast majority of problems reported were the result of misunderstandings and lack of information.

Two key areas of concern were over how vulnerable groups and the occupancy of HMOs by more than one household could be incorporated into the hazard scoring process. The issue of vulnerable groups has particular relevance to HMOs because of the specialist client groups often occupying hostel accommodation. A key output of this report is a proposal for an amendment to the guidance which demonstrates how these two issues can be taken account of.

Interviewees were also concerned that the system was too subjective and this would lead to variability. We recommend that this issue be dealt with by the provision of additional guidance in the form of worked examples which have emerged as one of the successes in explaining the system.

A series of objections were made about the practicality of the system mostly relating to difficulties encountered when using the Palm computer and survey program. The most serious of these relates to the lack of a survey procedure for recording information in HMOs. We recommend that HMOs are best surveyed using paper based methods while retaining the Palm for hazard scoring purposes. Recommendations for changes to the survey program for authorities wishing to use the survey program for HMOs are also included. We further recommend that a sketch facility be included in the program as this is essential to gather information on the layout of an HMO. This is within the capabilities of programs using the Palm operating although programs running on Microsoft's PocketPC appear to be further advanced in this area.

There was widespread concern that the system would lead to a reduction in standards. We believe this to be a misconception and recommend that the best way to resolve this is to provide additional guidance in the form of worked examples.

There was also concern that the statistics on which the system was based were not helpful in determining hazard scores.. One of the objectives of this report was to produce advice on adjusting likelihoods of hazards in HMOs. The research has shown that there is very little hard information on the risks associated with the different HMO types and hence the statistical evidence was found to be insufficient to provide accurate adjustment factors. Despite this a table has been produced which provides practitioners with an indication of the type of change they should consider making. For the majority of hazards the adjustments suggested are based on the professional expertise and judgements of the compilers.

Further work on HHSRS statistics is being undertaken by the Legal Research Institute at Warwick University and users of the HHSRS should have regard to this work. In addition, as part of the statistics work, recommendations are made to improve future statistics. It is therefore hoped that in future it will be possible to provide improved guidance on the adjustments to be made.

We further recommend that additional research is undertaken particularly in the area of fire safety. While the statistics on fire safety are among the best available for HMOs there is concern that the research on which these statistics are based used a very small number of cases in reaching its conclusions.

Some interviewees also felt that it was difficult to separate issues which the HHSRS should cover and items best covered by a separate review of the approach to management of HMOs. We recommend that additional guidance be issued which bases the distinction on items which are to do with the physical structure, which being the responsibility of the owner are clearly within the remit of the HHSRS. Items which are the responsibility of the tenant such as cleanliness and decoration are not covered by the HHSRS and should not be included in the guidance. When 'tenant' items are in the common parts these will be the responsibility of management and therefore still outside the HHSRS and not included in the guidance.

In addition to items directly relating to HMOs interviewees reported a number of issues which were relevant to the HHSRS generally. Most of these have already been covered in the separate report by DTZ Pieda.

CONTENTS

CHAPTER 1

Introduction 1

CHAPTER 2

Description of the project 3

CHAPTER 3

Actual and perceived difficulties in the application of the HHSRS to HMOs 5

CHAPTER 4

Hazards where health and safety risks or matters to be taken into consideration in HMOs are likely to be differ from single family dwellings 17

CHAPTER 5

Feasibility of using the HHSRS to specify minimum physical requirements under HMO licensing 25

CHAPTER 6

Recommendations for changes to HHSRS system (guidance and survey program) and additional guidance to improve the use of the system in HMOs 26

CHAPTER 7

Recommendations on form, structure and content of HMO guidance 33

APPENDIX A

General HHSRS issues arising from case studies and interviews 35

CHAPTER 1
Introduction

1.1 Background

The Housing Health and Safety Rating System (HHSRS) is a system for assessing the health and safety risks in dwellings, and is designed as a replacement for the current fitness standard (section 604, Housing Act 1985 as amended). The system is a risk assessment process and is comprehensive in its coverage of key health and safety risks in dwellings. The full details of the system and its development were published in July 2000.

In very broad terms, the Rating System works by assessing the risk associated with 24 major home hazards and a number of sub-hazards. The basic method of calculating risk associated with each hazard is:-

Risk = probability of an occurrence causing major harm X severity of likely harms caused.

Following an inspection of a dwelling, the users of the system are asked to provide these two pieces of information (likelihood and harm outcome) in a standard format through a hand held computer. The computer then uses a formula to calculate the risk of an accident or illness to the occupant because of the presence of a hazard in the home – the hazard score.

There are a number of components to the HHSRS.

- A computer program based on the Palm Operating System that contains a computerised survey form and automatically calculates the hazard score. Published July 2000.

- Detailed written guidance on the 24 hazards and the issues that users should consider when carrying out an assessment. Published July 2000.

- A series of worked examples to illustrate the decision making process under the HHSRS. Published April 2001.

- An enforcement consultation paper detailing the enforcement regime proposed. Published April 2001.

In addition to the current fitness standard under Section 604, there also exists an additional standard (Section 352) which relates to fitness of a dwelling for multiple occupancy use. The HMO fitness standard relates to health and safety issues that are considered to be more serious in multiple occupancy in comparison to single occupancy dwellings. Specifically it covers fire precautions and the number and location of a range of amenities such as washing and cooking facilities. All the items within the HMO fitness

standard are covered by the HHSRS. The HHSRS should therefore provide a single standard applicable to all housing, whether in multiple occupancy or not.

Since its introduction, there have been concerns expressed about its applicability to HMO situations and how it might fit in with risk assessment, priority planning and enforcement generally. Particular concerns have been expressed about possible lower standards and the practicality of applying HHSRS to HMOs. It is against this background that this project was commissioned to provide guidance to support the application of the HHSRS to HMOs.

CHAPTER 2
Description of the project

2.1 Introduction

BRE was commissioned to undertake this research, which is part of a programme of linked projects aimed at developing and improving the HHSRS, in September 2001. The research has the following aims:

- To identify actual and perceived difficulties in the application of the HHSRS to HMOs, with an emphasis on understanding the reasons for these views.

- To identify hazards where health and safety risks or matters to be taken into consideration are likely to be different in HMOs in comparison to single family dwellings.

- To evaluate the feasibility of using the HHSRS to specify minimum requirements under HMO licensing.

- To make recommendations for changes to the HHSRS system (guidance and survey program) to improve the use of the system in HMOs.

- To make recommendations as to the need for additional guidance to assist local authorities in the application of the HHSRS to HMOs, including assessing the need for separate HMO statistics to support the HHSRS, and guidance relating to differential risk. To make recommendations as to the form structure and content of such HMO guidance.

The reports follows the order described in the specification but also includes, in Appendix A, a summary of problems reported by interviewees which relate to the HHSRS generally rather than with HMO issues.

2.2 Methodology

The work has progressed through: a combination of desk top and database research; consultation with a variety of key players in the field of HMOs and the HHSRS and through six case study visits with a variety of local authorities with significant HMO problems and differing experience of the use of the HHSRS.

The six case study authorities were:

- Camden

- Hackney
- Leicester
- Sheffield
- Southampton
- Stockport.

The case studies involved a structured interview followed by field visits to HMOs known to the authorities in which palm computer based HHSRS surveys were attempted and discussed. It is intended to use the material from these field visits to produce worked examples of the application of the HHSRS to HMOs to put into future guidance.

CHAPTER 3
Actual and perceived difficulties in the application of the HHSRS to HMOs

3.1 Introduction

The actual and perceived difficulties in the application of the HHSRS to HMOs which have been reported by interviewees have been broken down under 7 headings: -

1. Problems with the HHSRS generally
2. Problems with the application of the HHSRS to HMOs
3. Problems with the guidance on applying HHSRS to HMOs
4. Problems with the Palm Program
5. Problems associated with the survey
6. Problems associated with the statistics
7. Problems with using HHSRS as part of an enforcement strategy

3.2 Problems with the HHSRS generally

These fell into 5 main subject areas; physical standards, subjectivity and variability, the definition of vulnerable groups, scoring hazards which are based on multiple faults and the spread of the likelihood and outcome scale. These items are covered in more detail in the report by Pieda on The Evaluation of Version 1 of the HHSRS, (hereafter referred to as the Evaluation Report). For this reason the issues are given only limited summary coverage in the main part of this report but Appendix A includes them in detail.

A commonly expressed view was that basic provisions are not always clearly actionable and would be better dealt with by physical standards or explicit requirements in the guidance. There is a concern that the HHSRS will be seen as a retrograde step as users were unwilling to enter likelihoods and outcomes that would result in high scores for items such as external WCs. Many interviewees felt a lot of time is wasted on trying to justify basic requirements which could be either incorporated in a physical standard or made explicit in

the guidance. This issue is not covered in the Pieda report as it questions the basic principles of the HHSRS which are outside the remit of both pieces of research.

The perception of many interviewees is they were given the impression that the system would be more objective than the current fitness standard. They feel that what has emerged is far more subjective than they had expected and results in too much variability. In trying to get to grips with the system many felt they wanted a comprehensive document detailing the research which underpins the system. They felt that if they understood the strengths and weaknesses of the underlying statistics this would help them apply their professional judgement.

Almost all interviewees were concerned that basing the definition of vulnerable groups on age ranges ignores more significant groupings based on health or other criteria. They are not aware that they can use their professional judgement to increase hazard scores when there are more vulnerable groups based on non-age criteria are present (excepting the disabled).

Another frequently expressed concern was over the difficulty in quantifying risks which are derived from a number of different hazards in different locations (e.g. falls on the level).

Lastly the likelihood scale (and to a lesser extent the outcome scale) is felt by many to be too wide, particularly when the average risk is low (e.g. falls between levels).

The responses from the Legal Research Institute (LRI) at Warwick University (who were responsible for much of the development of the system) and the ODPM on four of the problem areas are very helpful. They make it clear that for three of them i.e. subjectivity, vulnerable group definition and scoring multiple faults, the problems result from the incorrect way in which the system is perceived. This implies that improved guidance in these areas is necessary. With regard to the width of the likelihood scale, we acknowledge that the issue of adopting a simpler scale has already been considered and rejected. It would be worthwhile explaining the reasons for this in any revised guidance. The continuing requests for the retention of physical standards may as LRI suggest be the result of insufficient training. Practitioners may well find that after further training they are scoring items that concern them in the 1000+ range and the need for physical standards disappears.

The Pieda Report covers the issue of subjectivity and variability in some detail. There is evidence that there is considerable variability in assessments. Much of this, however, is associated with relatively mundane issues such as misinterpretation and misclassification rather than disagreements over professional judgement (Pieda Report section 4.5)

The Pieda Report suggests that they in common with ourselves and most of our interviewees have misunderstood the meaning of the term “Vulnerable group” . Initially They state “the Guidance is clear on how houses are to be assessed in relation to vulnerable groups”. In the remaining part of this section, however, and later in the report they seem to believe (as we did) that the system does not allow consideration of vulnerable groups other than those based on age ranges.

The Pieda Report also considers the issue of scoring multiple faults and concludes that it is not adequately covered in either the Guidance or the worked examples.

3.3 Problems with the application of the HHSRS to HMOs

3.3.1 THE AGE BASED DEFINITION OF VULNERABLE GROUPS DOES NOT CATER FOR CERTAIN HOSTELS SPECIALISING IN CLIENT GROUPS WITH SPECIAL NEEDS E.G. HOSTELS FOR ALCOHOLICS

Reason: Interviewees are concerned that high hazard scores would not be generated where the occupiers have particular needs based on aberrant behaviour. It was observed that the age based vulnerable group would not give a true impression of the risks associated with their behaviour. The specific examples included in the case study authorities were alcoholics and bail hostels.

Perceived problem. In general interviewees do not seem to be aware that they can use their professional judgement to increase the likelihood and outcomes for such groups over and above the likelihoods based on the vulnerable age group criteria.

3.3.2 IT IS NOT CLEAR IF THE VULNERABLE GROUP DEFINITION CAN BE INTERPRETED IN HMOS TO INCLUDE CHILDREN AND MORE PARTICULARLY WHETHER IT IS UP TO THE LOCAL AUTHORITY TO DECIDE ACCORDING TO LOCAL HOUSING MARKET CONDITIONS.

Reason: The definition of a vulnerable group includes the phrase "and who might typically be expected to occupy the dwelling". In HMOs in Camden, children as part of homeless families are likely to occupy any HMO unit. In Leicester, it is highly unlikely that any children will be found in an HMO. It is not clear whether the definition allows authorities to take account of the impact of the demand in the area. A practical implication is that in Camden a bath which is expensive and space consuming (and landlords do not want to install) is required by the authority in all HMOs to cater for families with young children who are likely occupants. In Leicester a (cheap and space effective) shower is all that is needed and therefore required by the current standards. Authorities in high demand areas are concerned that "the typical occupants" part of the definition would allow landlords to argue against provision of amenities suited to young children.

Perceived problem. Issue arises out of interpretation. Could easily be resolved by additional guidance.

3.3.3 OCCUPANCY CAN VARY ON A DAILY BASIS, BUT CLEARLY AFFECTS THE RISK ASSOCIATED WITH THE PRESSURE ON SHARING AMENITIES ETC. MEASURES TO DEAL WITH THIS WILL BE RESOURCE INTENSIVE AND RESULT IN DISCRIMINATION AGAINST VULNERABLE GROUPS.

Reason: Interviewees wanted to be able to deal comprehensively with an HMO and then leave it and move on to the next one. In general, they wanted the HHSRS to justify action which would minimise a hazard for the largest practical number of occupants rather than

prohibit the use of a part of an HMO thereby making it acceptable for a smaller number. Prohibition was further disliked as it required more monitoring than most authorities felt they could resource. There were further concerns that the use of Prohibition Notices and Suspended Improvement Notices in combination to replace Directions and notices requiring provision of amenities would result in discrimination against vulnerable groups.

Real problem: The main difference between the proposed enforcement regime and the existing use of directions and notices requiring amenity provision is that the process now has to take account of vulnerable groups. It needs to be clarified that the new procedures can be used such that discrimination against these groups will not occur. While the resource issues are real, the individual local authority can decide on the extent to which they use prohibition and suspended notices (although the alternative of improvement notices would also impact on resources).

3.3.4 THE HHSRS IS NOT MANAGEABLE WHEN APPLIED TO HMOS, E.G. IF THERE ARE 18 UNITS IN AN HMO THEN THE SYSTEM NEEDS TO BE APPLIED 18 TIMES.

Reason: Not one of the interviewees had been able to complete a survey using the Palm computer. Most were unclear on whether they should be entering a separate record for each unit. If they were to do so, nearly all felt this would be far too time consuming using the existing program. During the first case study at Hackney the latter view was confirmed as it immediately became clear that the process was too time consuming to be practical even in a typical 3-storey bedsit HMO. Some short-cuts are obvious such as recording all the shared amenities under the record for a single unit and then creating a new record for each bedsit and just recording the information for the bedsit room. However, there is no way, other than using notes, of associating a specific bedsit with specific shared amenities such as bathrooms. Furthermore, there is no facility for a sketch plan to bring the information together. The emphasis on using the Palm was felt to be unrealistic by most interviewees and there was a general feeling that a paper based survey was more appropriate for HMOs and the Palm should be used solely for hazard scoring.

Real problem. The use of the Palm program in HMOs is clearly an issue. If the emphasis on using the Palm is reduced and guidance is provided on using paper based approach this problem could be resolved. Guidance may be needed on extent to which the Palm program or elements of it are required for a HHSRS inspection and assessment.

3.3.5 THE VULNERABLE GROUP MAY VARY BETWEEN UNITS.

Reason: Some interviewees were concerned that having more than one vulnerable group present would lead to problems. It was however difficult to pin down what their concerns were.

Perceived problem. This issue seems to be due to a misunderstanding of the system. As units are assessed independently so would any subsequent enforcement action. If more than one vulnerable group is present within a unit one would expect the action to be based on the vulnerable group specified as most vulnerable to the hazard.

3.3.6 UNCLEAR IF THE NUMBER OF PEOPLE IN THE HMO IMPACTS ON THE RISK TO INDIVIDUAL UNITS.

Reason: Interviewees were unclear on how the occupancy of an HMO affected likelihoods and outcomes. The only worked example that deals with occupancy relates to a house (the Crowding and Space example) rather than an HMO but interviewees infer from this that occupancy will also affect individual units of an HMO but are unclear on how they should go about altering likelihoods and outcomes.

Perceived problem. This is similar to the issue of how sharing with a number of households impacts on hazards scores (see 3.4.2 below). It may be possible to resolve by provision of additional guidance.

3.3.7 HAZARDS ASSOCIATED WITH HIGH RATIOS OF HOUSEHOLDS TO AMENITIES E.G. THE HAZARD ASSOCIATED WITH INADEQUATE FACILITIES FOR PERSONAL HYGIENE, WILL BE THE MAIN DRIVER BEHIND AMENITY PROVISION AND THIS WILL LEAD TO A DRASTIC DROP IN THE LEVEL OF PROVISION THAT CAN BE REQUIRED

Reason: Most interviewees feel there is a need for physical standards for some areas such as bathroom ratios which are more to do with issues of comfort and privacy than hazards to health. The hazard score resulting from the associated hazard e.g. the hazard associated with inadequate facilities for personal hygiene, is unlikely to result in a duty to take action. Some form of action is felt to be required on social grounds, even if the impact on physical health of the associated hazard is minimal. Many feel that this could best be dealt with by incorporating simple standards into the guidance or by reference to a standard e.g. CIEH standard for amenities. The feeling is particularly strong with regard to bathroom ratios but there is also concern over other amenity ratios. Some interviewees felt that very high likelihoods, which could trigger mandatory action, might be justified by taking into account stress related illnesses and which they felt could generate high scores under the space and crowding hazard. These illnesses they argue might result from sharing amenities at excessive ratios. However, most felt that they would prefer not to have to argue this case. There is a strong feeling that these issues would be better covered by standards that were grounded in an acceptance that a dwelling should provide a basic level of comfort. These, they argue should not have to be underpinned by health issues but should have equal status to those that are. Some expressed the hope that worked examples might resolve the problem. If experts in the application of the crowding and space hazard demonstrate that HHSRS scores could justify amenity provision at a level similar to current this objection would largely disappear.

Real problem. More guidance and worked examples may provide a solution acceptable to most users. As the HHSRS currently stands, it does not cover comfort issues, and as such is unlikely to be able to support certain physical standards promoted for comfort. Mandatory action could only be justified under the health argument which local authorities would prefer not to use.

3.3.8 THERE IS CONFUSION OVER HOW THE HAZARD FROM FIRE SHOULD BE ASSESSED IN HMOS AND WHETHER PHYSICAL MEASURES SUCH AS FIRE DOORS HAVE AN IMPACT ON LIKELIHOOD, OUTCOMES OR BOTH

Reason: This is seen by practitioners as the most serious hazard and has led to much discussion. The LRI at Warwick use the Fire Risk in Houses in Multiple Occupation: Research Report as a source to justify up to a 10 x increase in likelihood for 3 storey and above bedsit HMOs. This is generally accepted and welcomed. What is less clear is whether the presence of fire doors and AFD should reduce the likelihood or merely make outcomes more favourable. Some practitioners argue that nearly all fires in HMOs result in a major harm. They argue the minimum outcome is a fire gutted room (the only room in which the person lives and which contains all of his or her possessions). This, it is argued, causes severe stress (a major harm) to the occupier. From this it follows that only outcomes should therefore be altered as the various fire prevention measures will not prevent the fire but will merely limit its spread and the fire gutted room will result in a major harm (due to the stress to the occupier). Others do not agree and believe that fire doors and AFD reduce the likelihood of a major harm as stress might not be sufficiently severe to justify this level of harm and are unlikely to have been included in the base statistics.

When challenged on his argument the protagonist observed that had his argument been put forward by a member of the LRI team he is sure it would have been given very serious consideration. He further submitted that had the stress event not been recorded as an outcome this is a fault of the statistics and not of his argument.

In the absence of clear guidance and worked examples, the above is a typical example of the sort of inferences the interviewees have been resorting to in trying to apply the system.

Perceived problem. This issue is fundamentally one of interpretation where experts need to produce a worked example or guidance to give a clear lead to practitioners.

3.4 Problems with the guidance on applying HHSRS to HMOs

3.4.1 THE HHSRS COVERS EACH UNIT INDIVIDUALLY. GUIDANCE IS REQUIRED ON HOW THIS INFORMATION SHOULD BE BROUGHT TOGETHER FOR THE WHOLE HMO BUILDING.

Reason: Most interviewees were concerned that the HHSRS had to be applied at the level of the unit. They felt this was a big departure from the whole house assessments they are used to. Some of the respondents conceded that their thought processes currently began at the level of the unit of accommodation and then worked up to the whole house. Most expressed the concern that there was no step by step guidance on how to move from the assessments of the individual units to the whole house. Concern was also expressed at the term 'whole dwelling hazards', which interviewees seemed to want to take to be the whole HMO rather than apply to the individual unit (which would be the dwelling). Attempts at explaining there could be 8 whole dwelling assessments in an 8 bedsit HMO were met with some incredulity.

Perceived problem. This issue can be resolved by providing guidance on survey procedure including worked examples.

3.4.2 THE GUIDANCE DOES NOT MAKE EXPLICIT HOW PRACTITIONERS SHOULD APPROACH ISSUES ARISING FROM THE PRESENCE OF MULTIPLE HOUSEHOLDS OVER WHOM THE OCCUPIER OF THE DWELLING INSPECTED HAS NO CONTROL

Reason: Most interviewees feel the lack of control over the actions of other households will increase the likelihood of hazards such as fire, personal hygiene, food safety, sanitation, domestic hygiene etc. They observe that the issue is covered in some parts of the guidance e.g. at para. 18.16 which deals with shared WCs, but is not touched upon in others such as hazards from inadequate facilities for personal hygiene. In general the interviewees did not feel it was sufficiently or consistently addressed. They felt it was not clear to what extent associated legislation on management would deal with these issues. If this was to be dealt with solely as a management issue it was inappropriate to cover it in the guidance. A few interviewees took the worked example for space and overcrowding as a precedent and felt there should be a 2-stage approach. The first would score the dwelling as if there was no sharing and a second would take account of the actual level of sharing of amenities and increase the hazard score accordingly. Guidance on the extent to which likelihoods and spreads should be increased was still felt to be needed.

Perceived problem. This issue could be resolved by guidance and worked examples. These would need to make clearer the distinction between where HHSRS stopped and management began.

3.4.3 NEED FOR MORE DETAILED GUIDANCE ON HOW HAZARDS IN HMOS SHOULD BE ASSESSED.

Reason: Interviewees were generally very positive about the value of worked examples. Their principal complaint was that none dealt with the more difficult hazards to assess in HMOs, specifically critical hazards such as Crowding and Space, Food Safety, Personal Hygiene. Several interviewees commented that the two-stage approach to Crowding and Space (included in the worked examples) has no mention in the Guidance which is confusing. Several interviewees felt a worked example for a complete HMO would be helpful as would guidance on hazards which were related to the different categories of HMO should be assessed.

Real problem. The case studies have shown how different interpretations of the HMO hazards can be. Additional guidance and worked examples needed.

3.4.4 THE APPROACH TO RECORDING INFORMATION ON HMOS IS NOT MADE EXPLICIT

Reason: Interviewees generally felt that there was no guide to procedure for surveying an HMO (while there is for a single dwelling). In particular it was not clear where information on shared amenities should be recorded.

During the case studies it was asked whether every room in a 450-room hostel needs to be surveyed? If not it was felt there needed to be guidance for the appropriate procedure. Interviewees felt it was not clear whether units could be taken to be representative of groups of units and if this was the case it needed to be made explicit.

Real problem. Procedure for survey of an HMO needs to provided. It is difficult to see how this could be achieved using the Palm program.

3.5 Problems with the Palm program

Most interviewees thought the system to be laborious to use as it seems to require too much unnecessary information to be gathered and many thought it ought to be more defect based. They anticipated there would be greater problems in HMOs due to their generally greater size and complexity. The majority of problems encountered are general problems and have no particular relevance to HMOs. They are included in Appendix A.

3.5.1 THE PALM SYSTEM IS DIFFICULT TO USE GENERALLY, AND THE PROBLEMS ARE MULTIPLIED WHEN APPLIED TO HMOS

Reason: Some interviewees found the system difficult to use in single dwellings. They found it fails to accurately record what is present e.g. there is no drop down list entry for a UPVC window in a wooden frame (very common) or for more than one window type in a room. Some also find it difficult to navigate and report having to scroll through many screens to return to an item. Notes are generally regarded as too time consuming but unfortunately are essential to record all the information which is required. Notes pages are not always available when they are needed.

Interviewees generally report that in HMOs these problems are magnified. The most obvious are the lack of options to record the fire safety status of doors to rooms and the lack of options appropriate to recording defects in bedsit kitchen areas. The result is the need to take extensive time-consuming notes. No interviewee had managed to complete an HMO inspection using the system. Most had not dared to survey an HMO as they found it challenging enough getting to grips with the Palm in a single dwelling. Those who had attempted it had quickly abandoned the attempt and cited time and confusion over where and how to record information as the main reasons for giving up.

Real problem. Similar to above. It is hard to see how can resolve without resorting to paper system. LRI suggest making greater use of “Shortcuts” which can be set from the “Preferences’ menu. This could greatly reduce the need for extensive note taking but there are some areas such as fire safety features that would be better to include their own specialist menus.

3.5.2 THE SYSTEM DOES NOT READILY ALLOW GATHERING OF INFORMATION ON ALL ASPECTS OF HOUSING INCLUDING MANAGEMENT IN HMOS AND ISSUES AFFECTING PERSONAL COMFORT WHICH ARE OUTSIDE OF HHSRS

Reason: Officers do not want to do two inspections using paper for one and the Palm for the other and want to see information gathering for all housing issues brought into a single system. The notes facility was felt to be too slow and common management defects such as obstructions on staircases should be included in the standard approach.

Real problem. There is potential for improving the Palm for both HMOs and single dwellings by ensuring options are available to pick up issues which do not necessarily produce hazards covered by HHSRS. However, even if this were undertaken most interviewees indicated they would opt for paper based systems in HMOs.

3.5.3 THERE IS NO SKETCH PLAN FACILITY

Reason: Nearly all interviews regarded an annotated sketch plan as a key element in HMO inspections. The lack of such facility in the program meant they would have to use both Palm and paper based methods. Most felt it would therefore be easier to do the whole inspection using paper.

Real problem. Many felt this was the best reason for using the paper-based survey. There are various methods of incorporating sketch plans into Palm programs and there is no obvious reason why the facility could not be incorporated into the survey program

3.6 Problems associated with the survey

3.6.1 THE SURVEY TAKES TOO LONG, PARTICULARLY WHEN THERE ARE A LARGE NUMBER OF UNITS IN AN HMO

Reason: While none of the interviewees had managed to complete an HMO survey, all were convinced it would be too time consuming to be practical. This was mainly because of the need to take too many time consuming notes. Other issues including the collection of redundant information and the lack of a clear survey procedure were also cited. There are no recommended short cut methods for dealing with large HMOs e.g. 450 bedroom nurses home in Camden included in Case Studies.

Real problem. Already covered in various sections above. Could probably be resolved by moving to paper based system for HMOs, with a computerised scoring system.

3.7 Problems associated with the scoring sheet

3.7.1 IT WOULD BE USEFUL TO HAVE SCORING SCALES WITH AVERAGES THAT REFLECTED THE RISK IN HMOS RATHER THAN THE STOCK AS A WHOLE.

Reason: Nearly all interviewees felt this was desirable as they felt that specific hazards were far more serious in HMOs but many acknowledged that it was likely to be very difficult.

Real problem. Research on statistics likely to allow some such adjustments to be made.

3.8 Problems associated with the statistics

3.8.1 THE NUMBER (SAMPLE SIZES) OF DIFFERENT HMO TYPES ARE TOO SMALL TO PROVIDE RELIABLE STATISTICS

Reason: A few interviewees referred to previous research on Fire Safety as being based on a census of fire deaths in HMOs over 2 years. This was felt to be too few cases to provide meaningful results.

Real problem. Additional research covering more years would improve the statistics. It does however need to be recognised that the small number of cases limits how robust the statistics can be.

3.8.2 THE STATISTICS RELATING TO DIFFERENT HMO TYPES ARE NOT HELPFUL, WHEN THE KEY DETERMINANT OF RISK IS THE TYPE OF HOUSEHOLD

Reason: Many interviewees expressed a concern that the age based HHSRS would prevent them from requiring special measures to deal with vulnerable groups e.g. alcoholics hostel, bail hostel. The age-based approach would not take account of the aberrant behaviour of these groups. The Inner London authorities were particularly concerned with this issue.

Perceived problem. While the numbers of these hostels are small, they nearly always come to the attention of authorities. It is highly unlikely that statistics could be made available to cover such specific types of HMO. Comments from LRI suggest that practitioners will need to use their professional judgement to increase likelihoods above those suggested for the relevant age group to take account of the vulnerable groups likely to be present.

3.8.3 SOME OF THE STATISTICS WERE BASED ON GROUPS OF DWELLINGS THAT DID NOT SEEM TO RELATE TO THE DWELLING BEING ADDRESSED

Reason: The only example interviewees were able to quote relates to asbestos in HMOs. The risk from asbestos refers to the population base of post-war non-traditional stock. In

HMOs the risk tends to arise from asbestos panels which were once used to fire proof doors and partitions and mainly arises in pre-1919 stock. Very few interviewees noted the issue but those that did felt it would be difficult to argue the validity of the statistics when they are drawn from such a different group.

Real problem. Provide guidance on how to deal with the specific example quoted above.

3.9 Problems with using HHSRS as part of enforcement strategy

3.9.1 STANDARDS BASED ON THE HHSRS MIGHT BE TOO LOW (LOWER THAN BASED ON CURRENT FITNESS STANDARD)

Reason: Interviewees were concerned that the system will not allow them to comprehensively improve HMOs and that hazard advice will in some instances replace what was previously compulsory. They feel this would leave the job of upgrading HMOs incomplete.

Perceived problem. This is related to the often-stated desire of interviewees to deal with all problems in an HMO and then move on. HHSRS may well require them to change their modus operandi and they regard this as a retrograde step. LRI however are of the opinion that other legislative provisions will remain which are likely to allow comprehensive action to be taken.

3.9.2 THERE IS A LACK OF CLARITY OVER HOW THINGS FIT TOGETHER – HOW THE HHSRS WOULD BE USED IN HMO LICENSING, HOW IT WOULD RELATE TO OTHER LEGISLATION AND HOW IT WOULD BE INCORPORATED INTO THE LA HMO STRATEGY

Reason: Particular concern has been expressed that there had been no parallel consultation on how management and comfort standards will relate to the new standard. The CIEH report they have been involved with a meeting on the issue with the ODPM but most interviewees were concerned that the Management Regulations would be swept away or modified without consultation. Some interviewees noted that the enforcement consultation paper asked for views on how a power to deal with defects affecting personal comfort might be retained.

Perceived and real problem. There is a need to make clear that Management issues are under review and to consult with interested parties on how these issues should be addressed.

3.9.3 LICENSING RELATES TO THE MANAGEMENT OF THE HMO FACILITY IN RELATION TO THE CURRENT/INTENDED OCCUPANTS, WHILE THE HHSRS RELATES TO THE PHYSICAL DESIGN OF THE BUILDING FOR THE MOST VULNERABLE OCCUPANT

Reason: Some interviewees did not appreciate that HHSRS is expected to deal with intended occupancy. Some of those that did felt that as long as license conditions could specify certain types of occupant then licensing and the HHSRS were compatible. This could work well in student hostels or nurses homes. There was however, a concern that specifying a type of occupant would allow potential for discrimination and it should therefore be an exception and only appropriate for purpose designed accommodation.

Perceived problem. Dealt with in more detail in section 5.

3.9.4 THE APPLICATION OF THE HHSRS TO INDIVIDUAL UNITS DOES NOT FIT WELL WITH A STRATEGY FOR THE OVERALL MANAGEMENT OF THE LANDLORD'S PROPERTY. COULD END UP WITH A SITUATION WHERE INDIVIDUAL UNITS ARE CLOSED RATHER THAN THE OVERALL STANDARDS IMPROVED

Reason: This concern was expressed by a number of interviewees but does not seem to take account of the consultation paper's proposals on Prohibition notices that sets out specific measures designed to avoid this occurring.

Perceived problem. Suspended Improvement Notices should prevent landlords from keeping dwellings vacant for long periods.

CHAPTER 4
Hazards where health and safety risks or matters to be taken into consideration in HMOs are likely to be differ from single family dwellings

4.1 Introduction

To enable sensible judgements to be made regarding the risk presented by the different hazards identified in HMOs, HHSRS assessments must be backed up with good statistics. BRE has examined a number of sources to try to provide statistics relating to all of the hazards, broken down into the ODPM classification of HMOs, Which is:

- Traditional HMOs (bed-sits)
- Shared houses
- Households with lodgers
- Purpose built HMOs with shared facilities
- Hostels, guest houses, bed and breakfast establishments
- Self-contained converted flats

4.2 Hazard likelihood adjustments for HMOs

The research has shown that there is very little hard information on the risks associated with the different HMO types.

One of the objectives of this report was to produce advice on adjusting likelihoods of hazards in HMOs. The research has shown that there is very little hard information on the risks associated with the different HMO types and hence the statistical evidence was found to be insufficient to provide accurate adjustment factors. Table 4.1 therefore provides practitioners with an indication of the type of change they should consider making. For the majority of hazards the adjustments suggested are based on the professional expertise and

judgements of the compilers. Evidence relating to the Hazard from Fire is given in section 4.3.

Further work on HHSRS statistics is being undertaken by the Legal Research Institute at Warwick University and users of the HHSRS should have regard to this work. In addition, as part of the statistics work, recommendations are made to improve future statistics. It is therefore hoped that in future it will be possible to provide improved guidance on the adjustments to be made. To assist practitioners in using their professional judgement, some of the factors to be taken into account are highlighted below.

4.3 Matters to be taken into account when adjusting Hazard statistics in HMOs

For the purposes of this section it has been assumed that hazards, where they are made more likely due to failures of management, would not be considered under the HHSRS but separate remedies would be provided under either existing or new legislation. Only where management failures impact on the physical structure of the building would they be included in the HHSRS. An example of an item which can currently be dealt with under the Management Regulations is a fire door which has been damaged such that it cannot prevent the spread of smoke. It is assumed such an item could be dealt with under the HHSRS as it is a fault to the physical structure of the building which increases the likelihood of a fire hazard. An accumulation of old soft furnishings dumped in a fire escape route also increases the likelihood of a harm occurring by providing combustible material and blocking the route to the exit. It does not, however, affect the physical structure and is therefore not included in the HHSRS scoring but would be dealt with under separate management legislation.

Many hazards in HMOs are made more likely by the effect of poor management but most of these do not impact on the physical structure and do not therefore result in a higher HHSRS score. They could however still be dealt with by other legislation.

It should be emphasised that this approach is a working assumption of this report and alternative approaches to dealing with management are still under consideration by ODPM,

Hazards from excessive cold

Once the energy efficiency of the building has been taken into account, there are several factors related to availability and control of heating which may have a particular impact in HMOs. If heating costs are included with rent, or shared among tenants, then the risk may be smaller as the individual occupants may be less concerned about the cost of maintaining an adequate temperature. This assumes that sufficient heating power is available, and might apply only to tenants, not to any owner who is in residence. If the heating times and amount of heat output are controlled by a landlord, then tenants might not have heating available to the extent that they would wish. Consideration should also be given to the extent that common parts are heated, particularly bathrooms and the routes to and from them. These are mainly management issues and are therefore outside the remit of the HHSRS and would not be included in a hazard score but would need to be addressed under separate management legislation.

Hazards from excessive high temperatures

There are no data on any issues that are particular to HMOs.

Hazards from falls on stairs, steps or ramps

Common stairs in purpose built HMOs, hostels and other larger establishments usually have larger goings and smaller rises, but users may have more steps to negotiate to reach shared facilities and the exit. The decrease in risk associated with the going and rise dimension is likely to be outweighed by the increased risk associated with the number of steps. The risk associated with falls on stairs may increase where an attic or basement has been converted to provide an extra unit of accommodation.

Hazards from falls on the level

Most falls on the level accidents are related to slippery floor conditions in wet areas such as kitchens and bathrooms. Where access to the kitchen is restricted, as in some guesthouses and 'bed and breakfast' establishments, the risk may decrease. The risk may also be decreased in traditional bedsits, where the kitchen floor area may be small, and the likelihood of contaminants on floors is reduced since less movement of water and oils is likely to occur. In shared houses, and other HMOs with shared facilities, more people are likely to be using the bathroom and kitchen than would normally be expected in other types of dwellings. There may therefore be a greater risk of people being unexpectedly exposed to contaminated floors.

Hazards from falls between levels

The risk will increase with the number of storeys, the number of easily openable and accessible windows and the likelihood of unsupervised children being exposed to these windows. This will be the case whether the building is an HMO or not, although in some HMOs the number of unsupervised children may be higher than expected.

Hazards from falls associated with baths etc

There is no data on any issues that are particular to HMOs.

Hazards from fire

The following data is taken from the 'Fire Risk in Houses of Multiple Occupation: Research Report'. It indicates an increased likelihood of risk in specific HMOs compared to 'single occupancy self-contained houses'. Comparisons are made on rates of death per person, and the purpose built HMOs value is for those built for the elderly only:

HMO type	Increase in likelihood of occurrence over singly occupied dwellings
Traditional HMOs (bedsits)	x3
Shared houses	–
Households with lodgers	–
Purpose built HMOs with shared facilities (data for those occupied by the elderly only)	x7.5
Hostels, guesthouses, boarding houses, 'bed and breakfast' establishments	x2
Self contained converted flats	x3

Other important factors which should be taken into account are the number of storeys, number of occupants, occupant characteristics and the quality of management (as far as it impacts on the physical characteristic of the building).

Hazards associated with hot surfaces and materials

Where access to the kitchen is restricted, as in some guesthouses and 'bed and breakfast' establishments the risk may decrease. In some HMOs the number of unsupervised children, less than five years of age, may be higher than expected. Where this is the case the risk may increase. In bedsits where living, sleeping and food preparation all may have to take place in one room there may be a greater likelihood of coming into contact with hot surfaces and materials.

Hazards associated with damp and mould growth etc

The English House Condition Survey 1996 (EHCS) records that HMOs in general are more likely to suffer from mould. This may be related partly to the characteristics of the building itself (which would be taken into account before considering it as an HMO) and partly to the way in which the dwelling is used. HMO occupants may feel less motivation to remove or control mould, especially if their tenancy is expected to be short. Any requirement to rely on portable gas/oil heaters could make mould and damp worse. On the positive side, if the tenancy conditions promote good heating and ventilation (see *Hazards from excessive cold)*, then mould and damp may be reduced.

Hazards from carbon monoxide

The introduction of The Gas Safety (Installation and Use) Regulations 1974 which require annual boiler services should decrease the risk overall. However, where HMOs are poorly maintained or the boiler is located in the sleeping area then the risk may increase. The risk may also increase if the main sleeping area contains a gas cooker, as in some bedsits. Any requirement to rely on portable gas/oil heaters could increase this risk. On the positive side, if the tenancy conditions promote good heating and ventilation (see *Hazards from excessive cold)*, then the risk may be reduced. The management issues, are outside the remit of the HHSRS and would not be included in a hazard score but would need to be addressed under separate management legislation. Failure to provide evidence of an annual boiler inspection would be an issue for management legislation while evidence of an actual fault such as smoke staining would be covered by the HHSRS.

Hazards from oxides of nitrogen

The risk may increase if the main sleeping area contains a gas cooker, as in some bedsits. Any requirement to rely on portable gas/oil heaters could increase the risk. On the positive side, if the tenancy conditions promote good heating and ventilation (see *Hazards from excessive cold)*, then the risk may be reduced. Once again this is a management and as such is outside the remit of the HHSRS and would not be included in a hazard score but would need to be addressed under separate management legislation. See comments under *Hazards from carbon monoxide*

Hazards from sulphur dioxide

The risk may increase if the main sleeping area contains a traditional open fire, as in some bedsits. On the positive side, if the tenancy conditions promote good heating and ventilation (see *Hazards from excessive cold)*, then the risk may be reduced. The same comments on management apply here as for *Hazards from carbon monoxide.*

Hazards from volatile organic compounds
There are no data on any issues that are particular to HMOs.

Hazards from biocides
There is a small risk that a biocide (e.g. rat poison) placed by one tenant may have an adverse effect on another, who is not aware of its presence. It may be possible to quantify this risk from analysis of data on poisoning incidents but at present no data is available.

Hazards from radiation
The risk of radiation from radon sources will depend mainly on the location of the building. The risk may however decrease when the dwelling unit is on higher storeys.

Electrical hazards
The risk may increase when a large number of users are required to use the same appliances with no individual user responsible for the maintenance of these appliances (as in shared kitchens). The risk may also increase in shared housing if all individuals have a large number of electrical items connected to the same ring main, overloading the circuit.

Hazards from noise
Risk of noise from neighbours is likely to be generally greater because of greater occupant density and partitions that offer, on average, poorer resistance to the passage of sound. This is particularly so in bedsits and many converted flats where noise attenuation has not until relatively recently been a major design consideration.

Hazards from lead
There are no data on any issues that are particular to HMOs.

Hazards from asbestos and other fibrous materials
The main risk is likely to be from asbestos materials used in fire proofing walls, ceilings and doors. There is no issue if these are not disturbed. There is a risk that information on the presence of asbestos will not be passed on and that, subsequently, a tenant may disturb asbestos-containing material. This again is a management issue and as such is outside the remit of the HHSRS and would not be included in a hazard score but would need to be addressed under separate management legislation.

Hazards associated with entry from intruders
This risk increases with poor control over access to the dwellings, or where the levels of security are low. Where the HMO is more vulnerable to entry from intruders the fear of crime may increase and hence the risk increases.

Hazards associated with crowding and space
With the exception of self contained flats the majority of HMOs will consist of one room and as such will fall far short of the ideal as described in the Guidance and in general the risk will be higher. Particular account should also be taken of the level of privacy afforded to the unit and to any shared bathrooms and WCs. The psychological impact of sharing both bathrooms and kitchens should be considered under this heading.

Hazards from explosions
The risk will be dependent only on the quality of the maintenance of unvented water heaters and gas appliances.

Hazards associated with pests and design

The risk factors are similar to non-HMOs but many of these factors are found in the type of buildings used as HMOs.

Hazards associated with household waste

The risk factors are similar to non-HMOs but where management is inadequate and wastes accumulate in inappropriate areas, then the risk can increase. In general such management failures should not be dealt with under the HHSRS unless they lead to actual physical changes in the building structure which increase the hazard e.g. failure to provide a bin store or provision of too small a bin store.

Hazards from inadequate provision for food safety

Where responsibility for domestic hygiene is shared, it is inherently more likely that hygiene standards will slip, especially if the tenants are not known to each other before moving in. The presence of a responsible landlord or premises manager should effectively remove this excess risk hence this is again an item which should be dealt with by management legislation rather than the HHSRS. If all food for tenants is supplied from a professionally run kitchen, then the risk may be reduced. If there is no kitchen at all, and tenants have to use makeshift facilities in their habitable rooms, than the risk may be increased. When considering acceptable ratios of shared kitchens to households, the social impact of this should also be considered under *Hazards associated with crowding and space*.

Hazards associated with inadequate provision for personal hygiene

There are no data on this issue of particular relevance to HMOs. When considering acceptable ratios of bathrooms to households, the social impact of this should also be considered under *Hazards associated with crowding and space*

Hazards associated with inadequate sanitation or drainage

Where responsibility for domestic hygiene is shared, it is inherently more likely that hygiene standards will slip, especially if the tenants are not known to each other before moving in. The presence of a responsible landlord or premises manager should effectively remove this excess risk hence this is again an item which should be dealt with by management legislation rather than the HHSRS.

Hazards from contaminated domestic water

The main issues are likely to relate to stored water. Cold water storage cisterns generally receive little maintenance from occupants and this could be either better or worse for HMOs, depending on the tenancy arrangements and whether there is a responsible landlord or premises manager. Hot water needs to be stored at a sufficiently high temperature to avoid microbial contamination (e.g. by Legionella). It is not known whether this may be compromised by a desire to cut energy costs and/or avoid scalding in HMOs.

Hazards from structural failure

There are no data on any issues that are particular to HMOs.

Hazards from inadequate lighting

There are no data on any issues that are particular to HMOs.

Hazards from uncombusted fuel gas

There are no data on any issues that are particular to HMOs.

Entrapment and collision hazards

Many bedsits and self contained flats seek to maximise potential occupancy often at the expense of design resulting in low ceiling heights mainly to basements and attics and accessways to them.

Hazards from poor ergonomics

For reasons similar to those immediately above bathrooms and kitchens are often poorly designed and more likely to result in injuries induced by these design deficiencies,

Table 4.1 **Hazard likelihood adjustment table**

Hazards	Traditional HMOs (bedsits)	Shared houses	Households with lodgers	Purpose built HMO with shared facilities	Hostels, guesthouses, boarding houses, 'bed and breakfast' establishments	Self contained converted flats	All Groups (Based on source 3 - BRE Expertise)	Number of storeys	Number of occupants	Occupants characteristics	Source	Reasoning
Hazards from excessive cold	-	-	<[B]	-	<[A,B]	-	-	-	-*	-	3	Assuming SAP rating accounted for before HMO status considered
Hazards from excessive high temperatures	-	-	-	-	-	-	-	-	-	-	3	Effects are dependent on weather conditions
Hazards from falls on stairs, steps or ramps	>[C]	-	-	-	>[C]	>[C]	-	>>	-	>>	1,3	Common stairs should have safer dimensions
Hazards from falls on the level	<[D]	>[E]	-	>[E]	<,>[E]	-	<	-	-	-	2,3	Most accidents occur in the bathroom/kitchen
Hazards from falls between levels	-	-	-	-	-	-	-	>>	-	>>	1,3	
Hazards from falls associated with baths etc	-	-	-	-	-	-	-	-	-	-	3,4	There are no data available
Hazards from fire	x3	-	-	x7.5	x2	x3	x2	>>	5+	>>	3,4	
Hazards associated with hot surfaces and materials	-	-	-	>	<[F]	>	>	-	>>	>>	2,3	Higher proportion of under 5's likely to be present
Hazards associated with damp and mould growth etc	-	-	-	-	-	-	>>	-	-	-	1,3	
Hazards from carbon monoxide	>[G,H]	>[G]	-	<	<	<	<	-	-	-	1,3	Possible improvements due to gas regulations
Hazards from oxides of nitrogen	>[H]	-	-	-	-	-	-	-	-	-	3	No data available
Hazards from sulphur dioxide	-	-	-	-	-	-	-	-	-	-	3	No data available
Hazards from volatile organic compounds	-	-	-	-	-	-	-	-	-	-	3	No data available
Hazards from biocides	-	-	-	-	-	-	-	-	-	-	3	No data available
Hazards from radiation	<	<	<	<	<	<	<	<	-	<	3	
Electrical hazards	>[1]	>[J]	-	>[1]	-	-	>	-	-	-	3	Possible circuit overloading
Hazards from noise	>	>	-	>	-	>	>	-	>	>	3	Noise more likely to be an issue in flats
Hazards from lead	-	-	-	-	-	-	>	-	-	-	3	No data available
Hazards from asbestos and other fibrous materials	-	-	-	-	-	-	-	-	-	-	3	No issue if not disturbed
Hazards associated with entry from intruders	>>[K]	>[K]	-	>>[K]	>[K]	>[K]	>>	-	-	>	3	
Hazards associated with crowding and space	>	>	-	-	>	-	>	-	>	>	2,3	
Hazards from explosions			-			-	>	-	-	-	3	Dependent upon the quality of maintenance
Hazards associated with pests and design	>[L]	>[L]	-	-	-	-	>	-	>	>	3	
Hazards associated with household waste	>[L]	>[L]	-	-	-	-	>	-	>	>	3	
Hazards from inadequate provision for food safety	>	>	-	>	<[M],>>	-	>	-	>	>	1,3	
Hazards associated with inadequate provision for personal hygiene	-	-	-	-	-	-	-	-	-	-	3	
Hazards associated with inadequate sanitation or drainage	>	>	-	-	-	-	>	-	>	-	1,2,3	
Hazards from contaminated domestic water	-	-	-	-	-	-	-	-	-	-	3	No data available
Hazards from structural failure		-		-	-		-	-	-	-	3	
Hazards from inadequate lighting		-	-	-	-		-	-	-	-	3	
Hazards from uncombusted fuel gas		-	-	-	-		-	-	-	-	3	No data available
Entrapment and collision hazards	>	-	-	-	-	>	>	-	-	-	3	No data available
Hazards from poor ergonomics	>	-	-	-	-	>	-	-	-	-	3	Resultant of poor conversions and limited spaces

NOTE:- The source of data for the differences in risk for each hazard is listed in the source column. In the majority of cases there was insufficient data on HMOs to to draw meaningful conclusions, hence where possible proxis were used.

- Although not represented in the above table the age of a building will also be a contributing factor in the determination of risk for many of the hazards listed, as in the main HHSRS guidance.

- The arrows indicate a difference in risk for HMOs from the specified hazards compared to that incurred in dwellings of the same age within the national housing stock. Double arrows signify a greater change in risk there is with single arrows, whilst a dash indicates no change.

Source Key

1. 1996 EHCS
2. LRI & LSHTM (Warwick data)
3. BRE Expertise
4. Fire risk in Houses in Multiple Occupation Research Report

A Assuming there is provision to heat the room which is occupied
B If the occupants are paying a fixed amount for heating i.e. it is inclusive in the rent, then the risk may be reduced
C Increasing likelihood of risk where HMO unit is converted basement or attic.
D Smaller floor areas if kitchen constitutes part of the bedsit rather than being a shared facility.
E More people using kitchen/bathroom.
F If no access to kitchen facilities.
G Boilers are often in the sleeping area.
H If the HMO contains a gas cooker within the room the levels of exposure is greatly increased.
I Number of potential users of shared facilities.
J Overloading in ring mains.
K Dependent on types of people housed e.g. students are high risk group and the level of security.
L Dependent on food preparation, cleanliness and management.
M Dependent upon the source of food e.g. a well maintained professional kitchen, individual preparing of food in the room, etc.
***** If the occupants are particularly poor and cannot afford sufficient heating then the risk may be increased.

{ Note: A & B apply to the lodgers only and not the whole household

CHAPTER 5
Feasibility of using the HHSRS to specify minimum physical requirements under HMO licensing

5.1 Background

The focus of all the interviewees was on the issues described in Section 3 and no substantive contributions were made on licensing. The general feeling was that applying the HHSRS to HMOs was quite challenging enough without having to consider how it would relate to licensing.

However, from our experience of looking at the potential for licensing HMOs in Scotland it would seem sensible for the HHSRS to be part of an overall HMO licensing strategy. Such a strategy might involve the following stages:

1. ***Information gathering***, including from the existing HMO database, from surveys, and from license applications.

2. The ***priority planning*** system, which is based on the information gathered above, and which determines if and when and HMO is to be inspected.

3. The ***HHSRS assessment***, which is undertaken when a dwelling is inspected.

4. The ***action*** required to remove or minimise hazards identified by the assessment.

5. The issuing or withholding of a ***license***.

Nothing in the work done in Scotland suggested that the HHSRS would be an inappropriate tool to use in a licensing framework.[1]

1 BRE were commissioned to describe the advantages and disadvantages of risk assessment in HMOs and to produce an HMO risk assessment methodology. This culminated in the provision of draft guidance for a priority planning system to determine the frequency of inspection and period of license.

5.2 Recommendation

Guidance would be needed on the overall strategy, but the work done for the Scottish Executive provides a clear framework on which this could be based. There does however need to be clarity about what aspects of the dwelling are covered by HHSRS and what would be covered by management standards.

CHAPTER 6
Recommendations for changes to HHSRS system (guidance and survey program) and additional guidance to improve the use of the system in HMOs

6.1 Changes to the HHSRS System

The specification does not require a review of the underlying principles i.e. focus on risk assessment, general use of hand held computers with the Palm Operating System, the likelihood, harm outcome and hazard score banding and the number and coverage of the hazards.

A requirement of the specification was that changes should be confirmed as possible within the limitations of Palm operating system. Where changes were required sufficient information should be provided to allow third party implementation of changes.

Section 3 "Actual and perceived difficulties in the application of the HHSRS to HMOs" identified problems and grouped them by seven categories. These categories tended to overlap as the issues emerging from the consultations were often touched on all aspects of the system. It is therefore easier to recommend changes to the system under the following headings than the original eight categories: The headings are:-

- Impact of occupancy
- Definition of vulnerable groups

Although many other issues came up during the case studies and interviews, most of these related to general HHSRS issues and these are dealt with in Appendix A.

6.1.1 IMPACT OF OCCUPANCY AND THE DEFINITION OF VULNERABLE GROUPS.

These issues came up in almost every interview. Interviewees felt that when calculating hazard scores there was little or no guidance on how to take account of occupancy and that the age based definition of vulnerable groups did not take account of the problems of specific client groups.

Recommendation:

i) The Version 1 HHSRS guidance should be amended to make the following process explicit. This may be best achieved by amending Chart 5 P31 and sections 7.09-7.17 (To Score a Hazard and Spread of Outcomes and inserting an additional flowchart to describe the scoring process). An alternative would be to leave the existing Guidance unchanged but provide supplementary guidance on HMOs. This would mean that the issue of non-age based vulnerable groups would not be dealt with in single household dwellings (where it could also be an issue)[2]. A third alternative is therefore to amend sections 7.09-7.17 to deal with vulnerable groups but leave the issue of occupancy to supplementary guidance on HMOs.

The following approach lays out a procedure which could be used for all dwellings (including HMO units and details how vulnerability and occupancy could be considered.

Stage 1 begins with an assessment of the HMO based upon the most vulnerable group. At this stage, bad management practices and over-occupancy, and sharing of facilities need to be taken into account. There are therefore multiple sub-stages within stage 1.

Stage 1a – selecting most vulnerable group

1. Consider the 'standard' vulnerable person for the hazard – i.e. those based on age.

Stage 1 b – take account of impact of sharing with other households and adequacy of management practices

1. Decide the statistics associated with this group if they were not sharing the building with other households.

2. Revise the statistics to reflect any changed risk associated with sharing the building with other households and the level of sharing.

3. Revise the statistics to reflect any changed risk associated with poor management practice which alter the physical condition of the HMO thereby impacting on the hazard (Management practices which don't impact on physical condition would not be considered).

Stage 2 is about *what action should be taken* and considers the actual occupiers (who may or may not be the most vulnerable).

1. Decide whether there is any other group that would typically occupy (or are actually occupying) the HMO which would be more vulnerable than the standard age group vulnerability (hereafter referred to as the non-age based vulnerable group).

2 There are some dwellings (usually institutionally run) where members of non-age based vulnerable groups live together as one large household. This has tended to cause friction between local authorities and the landlords. The local authorities often prefer to classify these dwellings as HMOs and require amenity provision and fire safety measures. The landlords who say they are trying to provide a less institutional home environment may resist this by arguing these building are not HMOs. Amending the guidance itself would make it clear that non-age based vulnerable groups could also be taken account of in single households and the issue as to whether or not the building is an HMO becomes irrelevant.

2. Confirm that the non-age based vulnerable group are not specifically excluded by the guidance (e.g. registered disabled).

3. Assess the hazard to give a hazard score

When deciding what action to take, the local authority should consider both the hazard score based on the vulnerable group and that based on the actual occupants, but it is the worst of the two scores which should have greater impact on the decision of what action is to be taken.

The guidance should list the hazards which are most likely to require scores to be calculated using all stages of this process:

- Fire
- Hot surfaces
- Crowding and space
- Personal Hygiene
- Sanitation

6.2 Additional guidance to assist local authorities in the application of HHSRS

6.2.1 IMPACT OF OCCUPANCY

As stated above this issue came up in almost every interview. Interviewees felt there was little or no guidance on how to take account of occupancy but in HMOs, there is the added dimension of multiple households.

Recommendation:
Worked examples should be produced to support the process described in the previous section for HMOs.

6.2.2 SUBJECTIVITY AND VARIABILITY

There was particular concern from some interviewees on how they should assess likelihoods and spreads for fire safety in HMOs.

Recommendation:
Worked examples should make as explicit as possible how likelihoods and spreads are built up from consideration of the faults present.

6.2.3 PRACTICALITY

This was the single biggest objection to the use of the system in HMOs but most of the objections are against the use of the Palm computer and program rather than the system itself. Interviewees felt:

i) The issues which affect all dwellings are magnified because of the larger scale of HMOs. In addition, the following were identified as problems to be resolved.

ii) There is no guide to HMO survey procedure and it is unclear how users should enter information on an HMO.

iii) Users were not clear on whether to enter one record per accommodation unit. Those that adopted this procedure became confused about where to enter information relating to shared facilities.

iv) Some common management defects were not covered by the survey program.

v) While a sketch plan is desirable for a single dwelling survey, it is essential for an HMO.

vi) HMOs are difficult to survey using paper methods and the Palm is an added complication.

One of the most basic issues to address with regard to survey procedure is how to enter information on rooms/circulation space which are shared. Rooms used by the bedsit are currently entered with the bedsit. This leads to potential for duplication and confusion as information is scattered over several records. It would be more logical to name each unit, enter occupancy details, and then keep all this information in a single record. This would however require amendments within each room page to allow units using the room to be recorded. It would also require the score sheet to be amended to allow hazards to be assigned to one unit, a selection of units or all units.

Such a system could work for houses divided into bedsits, shared houses, houses let in lodgings. For large purpose built HMOs with shared facilities and hostels it might be more manageable to group units which share common facilities into single records.

In self contained converted flats it seems logical to score each flat as a record. It would then be necessary to use one of the records to store information on the shared parts and the external survey.

If the department is serious about very large HMOs being inspected using the Palm some form of cloning information is likely to be necessary.

Recommendation:
The complexities of HMOs are such that they are best surveyed using paper methods. A survey procedure using a paper form should be devised. The form should be fairly simple (relying on freehand notes to deal with the complexities) but should include a hazard list as an aide memoire to prompt surveyors to record faults relating to all hazards. The form should not attempt to emulate the Palm program and should not include a scoring sheet.

Scoring would be done using the Palm or on a PC using a spreadsheet or the Palm emulator. The form could be developed from a local authority's current practice.

For authorities preferring to use the Palm program, we would recommend the following amendments.

i) In bedsits, shared houses and houses let in lodgings, information should be entered on a single record. An additional page or pages should be added for occupancy information to be entered against each dwelling. A page should also be added for each room to allow lettings using each room to be recorded. The score sheet should be amended to allow hazards to be recorded against one unit, a selection of units or all units.

ii) Guidance should be written on survey procedure advising that hostels and purpose built HMOs with shared amenities are best dealt with by grouping units into clusters around shared amenities. While this results in several records per HMO it is a practical method of making large HMOs more manageable to survey.

iii) We would also recommend that a facility to clone records be included in the system. By adopting the above procedure of clustering units it should also be possible to clone groups of records. This could be used to speed up surveys of large HMOs where there are repeating layouts as is (sometimes found in hostels).

iv) A sketch plan facility should be incorporated into the program

6.2.4 REDUCTION IN STANDARDS

This was a major concern with regard to HMOs. Interviewees were concerned that amenity provision in HMOs would be more difficult to justify as only likelihoods of 1 in 1 resulted in Band A-C hazards for those hazards dealing with basic amenities. This is an issue that is potentially easily settled by provision of worked examples which justify such likelihoods. It may be that these would have to depend on issues of stress and mental health rather than physical harms as it is very unlikely that major physical harms would arise from inadequate ratios of bathrooms etc.

Recommendation

Worked examples should be provided to cover hazards exacerbated by sharing by multiple households and these should include:

- Fire
- Hot surfaces
- Crowding and space
- Personal Hygiene
- Sanitation

6.2.5 STATISTICS

The main issue raised was the need for separate HMO statistics which have been provided. Some interviewees were critical of the small sample that was used in the research which is the basis of the fire safety statistics. A further criticism was that some of the statistics were not applicable to HMOs as they were drawn from other dwelling types although the only case quoted was the hazard for asbestos.

Recommendation
Further research be considered with regard to fire safety in HMOs.

A worked example should be provided to cover the use of asbestos insulation boarding in HMOs. It should consider the greater risk of disturbance brought about by heavy wear and tear associated with HMOs as well as potential for damage arising from aberrant behaviour.

6.2.6 MANAGEMENT

Many interviewees were concerned that there was no parallel consultation on management of HMOs as they felt that hazards in HMOs were either created or exacerbated by poor management. They were not clear on how they were expected to separate the management issues from those arising from the physical inadequacy of the dwelling.

Section 4 of the guidance specifies responsibilities of landlords. This provides a basis for deciding which items are the responsibility of the owner (manager) and which fall to the occupier. Items which fall to the owner, mainly the physical structure, are clearly aspects which should be dealt with by the HHSRS and those which fall to the tenant are aspects which may have to be dealt with by management e.g. decoration and cleanliness fall to the tenant within their dwellings but to the management in the common parts. Currently the Management Regulations also allow authorities to deal with many items of disrepair using these regulations. Concern was expressed that the HHSRS might not be the best legislative tool to deal with what is usually an accumulation of minor issues which do not necessarily present a hazard but may do so if left to further deteriorate. Such items also have an impact on the internal and external appearance of HMOs and it is an accumulation of items usually dealt with by the Management Regulations which contribute towards the general impression of squalor often associated with HMOs.

Recommendation
Additional guidance should clarify those aspects which are covered by the HHSRS and this should be based on the distinction between landlord and tenant responsibilities. In general, items that are tenants' responsibilities should potentially fall to management e.g. cleanliness. However, we would recommend that a consultation exercise on Management consider the retention of powers to deal with minor disrepair items which while covered by the HHSRS are currently very effectively dealt with as management issues.

CHAPTER 7
Recommendations on form, structure and content of HMO guidance

7.1 Amendments to existing guidance

The guidance should be amended to make explicit the process by which non-age based vulnerable groups and occupancy by more than one household can be considered. This may be best achieved by amending Chart 5 P31 and sections 7.09-7.17 (To Score a Hazard and Spread of Outcomes and inserting an additional flowchart to describe the scoring process. An alternative would be to leave the existing Guidance unchanged but provide supplementary guidance on HMOs. This would mean that the issue of non-age based vulnerable groups would not be dealt with. A third alternative is therefore to amend sections 7.09-7.17 to deal with vulnerable groups but leave the issue of occupancy to supplementary guidance.

Worked examples should be produced to illustrate this process and should be based on dwellings occupied by non-age based groups in multiple occupation e.g. hostel for alcoholics.

7.2 Additional guidance

A separate guidance note should be produced covering the application of HHSRS to HMOs. This will draw on the original guidance, plus the amendments, clarifications and additions identified during this research. The guidance should be illustrated with examples, and the most up–to-date statistics. The guidance should suggest how the HHSRS might be used to inform an authority's HMO strategy.

We recommend that the guidance includes a HMO survey procedure using a paper form, although scoring should continue to be undertaken using electronic methods (using Palm, Palm emulator or spreadsheet).

If ODPM wishes to allow for authorities to use the full Palm system for HMOs, we would recommend a number of amendments to the program to allow information on more than one unit to be recorded within a single record (see Section 7). Additional guidance would be required on how this information should be recorded.

Following on from this, whether or not a sketch plan facility is incorporated into the program we would see one as essential for applying the system to HMOs. Guidance on and when to use the facility would be required.

Additional guidance on management issues in HMOs should clarify those aspects which are covered by the HHSRS and this should be based on the distinction between landlord and tenant responsibilities (see Section 7).

The additional worked examples should be produced to illustrate:

- how hazards can be scored when they arise from multiple faults scattered throughout the HMOs;
- how hazards which are particularly associated with HMOs should be scored in a variety of different types and sizes of HMO;
- how hazards which are exacerbated by buildings being shared by multiple households should be scored.

Separate guidance should also be issued on the place of the HHSRS in the licensing process, from information gathering through priority planning to the assessment of the dwelling and the issue of the license itself.

As well as guidance, it is recommended that separate training on the application of the HHSRS to HMOs is promoted by the Department.

APPENDIX A
General HHSRS issues arising from case studies and interviews

During the case studies and interviews many general issues concerning the HHSRS were raised. These have been kept separate from the issues impacting more directly on HMOs and are detailed below. They will be taken on board by the Pieda research on the general evaluation of the HHSRS.

A.1 Problems with the HHSRS generally

The problem is identified followed by a brief explanation of reasons given by the interviewees and an assessment as to whether the problem is real or perceived.

A.1.1 THE SYSTEM IS TOO SUBJECTIVE AND THERE IS TOO MUCH VARIABILITY IN ITS APPLICATION.

Reason: Many interviewees feel they were given the impression that the system would be more objective than the current fitness standard. They feel that what has emerged is far more subjective than they had expected and results in too much variability.

Perceived problem. LRI point out that no claims of increased objectivity were made and the exercise of professional judgement was always integral to the system. It would, however, be more logical than what has gone before. The variability is a problem which can be improved by more worked examples. It needs to be made clear that not all situations can be anticipated and that practitioners, as they do now, will have to use what knowledge is available to inform their professional judgement. Making a comprehensive reference work available would help make clear the current state of knowledge.

A.1.2 SURVEYORS DO NOT FEEL CONFIDENT WITH THEIR ESTIMATES OF THE LIKELIHOOD OF AN OCCURRENCE OR THE POSSIBLE OUTCOMES.

Reason: Many interviewees did not feel confident with their estimates of the 'likelihood of an occurrence', or the possible 'outcomes'. They felt there is insufficient guidance for each hazard on the extent to which likelihood and spreads should be altered leading to inconsistency in judgements.

Perceived problem. This is essentially the fine detail of the previous problem.

A.1.3 IT IS DIFFICULT TO QUANTIFY RISKS WHICH ARE DERIVED FROM A NUMBER OF DIFFERENT HAZARDS IN DIFFERENT LOCATIONS (E.G. FALLS ON THE LEVEL).

Reason. The guidance does not state explicitly that more than one fault can contribute to a hazard. Interviewees quote the worked examples e.g. falls on the level, as clearly demonstrating that multiple faults contribute to a hazard. They are comfortable with making judgements based on faults occurring in various parts of a dwelling using the current fitness standard. However some practitioners are uncomfortable with the scoring mechanism and coupled with a little statistical knowledge i.e. that combining probabilities is a complex process, they have seized on what seems to them an omission in the guidance and ask for clarification on how they should be combining faults to arrive at a score.

Real problem. LRI point out that this issue is covered to some extent in Annex B to the Guidance but agree that more guidance should be provided. They are concerned that practitioners who have struggled with some of the concepts to date may find another apparently complex layer too much to grasp.

A.1.4 THE VARIABLE POSITION OF THE AVERAGE GIVES TOO MANY OPTIONS FOR ASSESSING THE LIKELIHOOD OF LOW RISK HAZARDS.

Reason: The scale is generally considered to be too wide, particularly when the average risk is low (e.g. falls between levels). Variability is less when it has been determined that a risk is greater than average as there are only a few points remaining on the scale to select. EHOs do not like the logarithmic scale (this was reported on in detail in the Pieda report).

Perceived problem. LRI point out that consideration of a more limited scale was included in the Development Report. The reasons for not using a simpler scale need to be explained as this was a frequent comment from interviewees.

A.1.5 BASING THE DEFINITION OF VULNERABLE GROUPS ON AGE RANGES IGNORES MORE SIGNIFICANT GROUPINGS BASED ON HEALTH CRITERIA, THE MOST OBVIOUS BEING ASTHMATICS.

Reason: It is argued that such significant groups should be the basis of the assessment for the hazards which affect them.

Perceived problem. This problem is resolved by the approach detailed in Section 6 where it is made clear that factors other than age can be used to define a non-age based vulnerable group for whom likelihoods may be higher.

A.1.6 BASIC PROVISIONS ARE NOT ALWAYS CLEARLY ACTIONABLE AND WOULD BE BETTER DEALT WITH BY PHYSICAL STANDARDS OR EXPLICIT REQUIREMENTS IN THE GUIDANCE

Reason: There is a concern that the HHSRS will be seen as a retrograde step as practitioners will be reluctant to enter likelihoods and outcomes which result in high scores

for items such as external WCs. Many interviewees felt a lot of time is wasted on trying to justify basic requirements which could be either incorporated in a physical standard or made explicit in the guidance.

Perceived problem. LRI believe this to be primarily a training issue and that well trained practitioners will return high scores for most areas of concern. Once again worked examples are the most likely method of dealing with this issue.

A.1.7 NEED MORE GUIDANCE ON WHAT IS AN 'AVERAGE' HAZARD.

Reason: Some interviewees felt they found it difficult to relate faults found in a dwelling to an average hazard and that more examples of average hazards were necessary to help them benchmark their judgements.

Perceived problem. Likely to be resolved by provision of more worked examples.

A.2 Problems with the Survey Program

A.2.1 INTERVIEWEES REPORT THAT IT IS IMPOSSIBLE TO TRANSFER THE KEY INFORMATION ON LIKELIHOODS, SPREADS, SCORES AND BANDS TO THE PC SOFTWARE.

Reason: Only a few authorities had reported any success in transferring the data to the PC. Those that have were not able to access the scores, likelihoods or spreads. This appears to be because this data is not stored in a permanent field.

Real problem. Could be relatively simply resolved by storing this information in permanent fields and writing a piece of software to display the data on a PC. The former has already been successfully undertaken by MSC (Managed Services and Consultancy). The programmer responsible has now left the company but he estimates it would take around 4 days of a programmers time to amend the HHSRS program). Interviewees report that their software providers are likely to provide a solution once the final version of the system is published.

A.2.2 THE FORMAT OF THE DATA WHEN TRANSFERRED TO THE PC IS NOT USER FRIENDLY AND HAS BEEN A DISINCENTIVE TO UNDERTAKE SURVEYS

Reason: Interviewees report the spreadsheet format as being difficult to interpret. There was a reluctance to spend more time gathering information if once gathered they could not view it in a convenient format.

Real problem. Also easily resolved by provision of PC software.

A.2.3 THERE ARE NO REPORTING FACILITIES ON THE PC SOFTWARE

Reason: Interviewees complain of a lack of summary information in the spreadsheet.

Real problem. Also easily resolved by provision of PC software.

A.2.4 THERE IS NO SPACE TO RECEIVE A UPRN, XY CO-ORDINATES, ADDRESSPOINT SEEDS FROM LA SYSTEM AND ADDRESS FIELD IS TOO SMALL

Reason: Interviewees say they would need to integrate HHSRS PC software with their own systems and a prerequisite would be downloading address information to the Palm.

Real problem. Could be easily resolved by small changes in program.

A.2.5 HAZARD SCORES, SPREADS AND LIKELIHOODS CANNOT BE RECALLED. ONLY BANDS APPEAR TO BE HELD IN MEMORY.

Reason: Interviewees report that they often wish to reconsider their judgements and alter them after discussion. The report that the Palm does not allow the user to recall the likelihoods and spreads which prevents a surveyor returning to reconsider his/her judgement.

Real problem. Could be easily resolved by small changes in program.

A.2.6 HAZARDS COULD NOT BE DELETED WHEN CORRECTIONS WERE MADE

Reason: Interviewees reported that when they wished to make a change in their decision they were unable to delete the first score and the result was two scores on the Palm.

Perceived problem. LRI have provided a step by step guide on how to achieve this. It was made difficult to avoid accidental deletion. Provision of program handbook would resolve this.

A.2.7 SEEING THE HAZARD BAND CHANGE AS LIKELIHOODS AND SPREADS ARE CHANGED INFLUENCES DECISIONS WITH PRACTITIONERS INCREASING LIKELIHOODS AND SPREADS TO ACHIEVE A DESIRED RESULT

Reason: A single interviewee felt this was a problem for the reason described above..

Real problem. The arguments in favour of leaving the display switched on are essentially that it makes it easier to see the effect of changes i.e. why agonise about changing a likelihood by a factor of 10 if there is no change in the band. We understand from LRI this has been the subject of considerable debate during development. It may be worthwhile

providing the option to switch off the hazard band display (easily achievable) to satisfy both sides of the argument.

A.3 Problems with the Palm Computer

These problems are associated with the device and are essentially outside of the control of the ODPM.

A.3.1 POOR VISIBILITY OF MOST MODELS WILL HAVE HEALTH AND SAFETY IMPLICATIONS

Reason: Many interviewees felt the Palm screen was difficult to read in poor light conditions and would cause unacceptable eye strain to users.

Perceived problem. Likely to be resolved by improvements in more recent models. Authorities could purchase more expensive models with better displays.

A.3.2 THE GRAFFITI HAND WRITING RECOGNITION SYSTEM IS TOO SLOW FOR EXTENSIVE NOTE TAKING

Reason: Interviewees cited one of the main reasons for the slowness of the system was the extent of notes required and the time taken to input these using the graffiti handwriting recognition system. The first case study in Hackney resulted in the need to take only limited notes but these were found to be too time consuming to complete the survey. Subsequent case studies confirmed the program to be impossible to use within a timescale acceptable to officers, tenants and landlords.

Real problem. It takes 4-5 times as long to enter text using graffiti as it does to write on paper. Graffiti is only one of the problems but is a significant contributor to the time taken. LRI point out that using the short cut facility can increase speed.

A.3.3 MOST AUTHORITIES WOULD PREFER THE SYSTEM TO BE AVAILABLE ON A MICROSOFT PLATFORM AS IT WOULD OFFER BETTER INTEGRATION WITH THEIR SYSTEMS

Reason: Many interviewees note the emergence of Windows CE/Pocket PC based handhelds notably the Compaq Ipaq as presenting a more sensible handheld choice for their departments. The main argument in favour of these devices is their cut down versions of the Microsoft Office suite of products.

Perceived problem. The software providers continue to improve integration with PC packages. Upgrading the system to the most recent versions of Satellite Forms would probably further improve database integration options. LRI point out there may be cost and licensing issues to consider.

A.4 Problems with the survey programme

A.4.1 CONTEMPORANEOUS NOTES WILL NO LONGER EXIST IN WRITTEN FORM

Reason: Most interviewees were concerned that the Palm would not be as useful as contemporaneous notes are in court, due to the unfriendly outputs from the PC system which would in any case, in their view, be inadmissible.

Perceived problem. When the HHSRS was developed by Warwick Law School, advice was taken on the admissibility of the records kept by the handheld computer and any print-out from those records. This advice was given by lawyers within the Law School, including respected experts on evidence and criminal procedures. All that the handheld computer is doing is recording facts and opinions entered by the user (rather like a printed form does). Only when it generates a score from the information entered is it doing more than a paper form, but the formula used is simple and clearly set down in the guidance. Records of data entered during a survey and printed from the computer, like all records, notices and reports printed off any PC, are acceptable as evidence in courts. Obviously, the person who entered the data will have to give evidence that the printout is an accurate record of their survey, just as they will have to for a paper form or note book.

A.5 Problems with the scoring sheet

A.5.1 THE POPULATIONS ON WHICH THE AVERAGES ARE BASED VARY AND ARE NOT MADE EXPLICIT

Reason: Interviewees use some form of benchmarking in every surveyor assessment and the starting point is usually the worked example. Interviewees made it clear that they make judgements on items such as dampness and burns and scalds, where the statistics are based on sub-groups of dwellings where defects exist, as if the starting point was actually the statistic for the whole population.

Real problem. Could be improved by normalising all the statistics for the whole population. This is being addressed by ODPM.

A.6 Problems with the statistics

A.6.1 A COMPREHENSIVE REFERENCE WORK ON THE STATISTICS IS REQUIRED

Reason: Some of the statistics were felt to be weak. There is a strong call for a comprehensive resource document that could be referred to when preparing court cases. Interviewees wanted to be aware of the strength of the evidence they would have to argue.

Real problem. Acceptance of the system is more likely if the state of knowledge on which it is based is made clear. Research is currently underway to provide this document. LRI

argue that in court practitioners will not have to defend the statistics provided in the system. They argue that a practitioner will start from the average and relate the dwelling conditions to the average. If questioned on the statistics underpinning the average, the practitioner would state that this is the current state of knowledge provided by official statistics and that questions on these would have to be referred to those who undertook the research.

A.7 Problems with using HHSRS as part of an enforcement strategy

A.7.1 CASES WOULD GET BOGGED DOWN BY APPEALS AS ALL ASPECTS OF HHSRS ARE TOO SUBJECTIVE AND AMOUNT TO A "LAWYERS CHARTER"

Reason: Most interviewees expressed some concerns in this respect. There was one notable opposing view from the Shelters Campaign for Bedsit Rights. They positively welcome the opportunity to take cases to court. They see it as an opportunity to make explicit the link between housing and health.

Some interviewees felt appeals would be more likely to come from HMOs where AFD and protected routes would require work to leaseholders dwellings.

Perceived problem. It is difficult to predict the extent of appeals and it is largely a matter of opinion.

A.7.2 AUTHORITIES WOULD USE OTHER LESS APPROPRIATE LEGISLATION SUCH AS THEY EPA TO AVOID USING THE MORE CUMBERSOME HHSRS

Reason: Several authorities said they would use the quickest, most effective method to deal with the tenant's complaint and would avoid using the HHSRS unless it evolves into a much streamlined form. While none of the authorities concerned wished to be quoted, there are a variety of methods being employed to coerce landlords into undertaking works. They acknowledged that these approaches are largely based on bluff and rely on the lack of knowledge of some landlords and their solicitors.

Perceived problem. System should be capable of being streamlined to make it the instrument of choice. LRI point out that the enforcement regime is likely to include other legislation and that local authorities should use that which is most appropriate.

A.7.3 THERE WILL BE A NEED FOR OTHER LEGISLATION TO DEAL WITH IMMEDIATE URGENT PROBLEMS

Reason: Many expressed the concern that the appeals procedure included in the enforcement consultation paper would make the HHSRS ineffective in dealing with urgent cases. There was concern that the EPA would be swept away and this would remove an authorities ability to deal with urgent items even if they were the subject of an appeal.

Others pointed out that the Everett Vs Bristol case made it impossible to deal with hazards which were likely to result in accidental physical injuries. CIEH point out other statutory provisions such as The Building Act 1984 may potentially deal with some of these issues. However, nearly all interviewees felt this was a rare opportunity to consolidate all the related legislation and they would be very sad to see it missed.

Perceived problem. LRI point out that by removing the requirement that a Start Date must be specified which cannot be less than 21/28 days , would allow local authorities to require immediate action. They also point out that there is no such emergency procedure under the current Housing Act regime for HMOs or for Fitness generally.

A.7.4 AS LOANS, GRANTS AND AREA IMPROVEMENT WILL STILL REMAIN THERE IS A NEED FOR A TARGET STANDARD FOR EACH OF THESE AS THE HHSRS COULD NOT DEAL WITH ISSUES OF CONDITION WHICH DO NOT GENERATE AN IMMEDIATE HAZARD

Reason: Some authorities more active in area renewal expressed concern that HHSRS could not provide a repair standard for local authorities to work to. There was an acknowledgement that the Decent Homes standard may help fill the gap.

Perceived problem. Some authorities do not appear to have taken on board the shift towards having to define their own standards rather than relying on national standards.

A.7.5 LANDLORDS WILL HAVE REAL DIFFICULTY GETTING TO GRIPS WITH WHAT IS A MAJOR CULTURAL CHANGE

Reason: Most interviewees felt their smaller landlords will be reluctant to employ experts and will expect local authorities to lead them through the new approach. They felt this will place an additional burden on the local authority unless the system is interpreted into simple standards that landlords can get to grips with.

The landlords organisations contacted were aware of the basic concepts of the system but did not feel they had anyone with sufficient knowledge or experience of the system to comment in detail on the issues dealt with by this consultation exercise. This tends to support the local authority view that they would have to take the lead in educating landlords.

Real problem. There is a substantial training requirement for landlords particularly the smaller landlords who were not a member of any of the landlords organisations.

A.7.6 THE HHSRS IS MUCH MORE TIME CONSUMING TO USE THAN THE CURRENT FITNESS STANDARD SO MAKING ASSESSMENTS WOULD PLACE A BURDEN ON RESOURCES

Reason: Most interviewees were concerned that the system took too long to use. Many were also concerned that they would be required to do a full assessment in all dwellings they visited. One authority which has a very small proportion of dwellings with radon

problems were concerned that all dwellings visited would now have to have a £40 radon test.

Perceived and real problem. Guidance should clarify whether a full HHSRS assessment would be required in all cases to determine the most appropriate course of action. Several authorities indicated that inadequate resources meant they would only undertake a full assessment where a serious hazard seemed likely to be present. The radon example cited above relates to the prediction of the national survey that a small number of dwellings in the Borough are likely to be affected but there are no indications as to where these will be located.

A.8 Recommendations

The following recommendations are based on the above observation on the HHSRS rather than HMO specific issues which are dealt with in the main body of the report. Some of the recommendations made in the main body of the report have implications for dwellings other than HMOs and section 6 of this report includes recommendations which cover items 9.1.2.1-5 above.

A.8.1 RECOMMENDATIONS FOR IMPROVING THE SURVEY PROGRAM

It should be emphasised that there was real support for the Palm providing it can be adapted to user's requirement. There was, however, a wide range of demands for alterations. Several interviewees indicated their software providers would be interested in examining such possibilities.

Recommendation

i) A comprehensive program manual should be provided covering installation and use

ii) The guidance be amended to make clearer that the core information that needs to be collected is for the user to decide and not all fields are compulsory.

iii) Specific amendments should be made to include frequently occurring items in the drop down menus

iv) Facilities for note taking should be made more widely available throughout the program

v) The use of 'shortcuts' be promoted

vi) A sketch plan facility should be provided

vii) Either faults should be linked to drop down lists of remedies (to form basis of specification of remedial work) or a similar facility should be provided in the PC Software. If recommendation (xii) is adopted this could be left to individual local authorities and their software suppliers.

viii) A user-friendly PC interface using an MS Access database or Excel spreadsheet should be provided. This should be capable of amendment by the user to suit their needs.

ix) Address and UPRN fields should be made larger and provision should be made to transfer these from PC software

x) The program should be amended (or guidance should be given) to allow deletion of hazard bands and recall of likelihoods and spreads.

xi) We would further recommend that the program be split into the hazard scoring module, which could not be altered, and the survey and administration module which should be freely available to amend according to the wishes of the user. We would suggest the Department encourage user groups probably based around those authorities with common software providers to further develop these modules. This may well be the most realistic way of adding a scheduling facility to the software (likely to be a major task).

We would further recommend that the source code for the program be made available to developers wishing to develop a program to be used on Microsoft Handheld platforms.

A.8.2 RECOMMENDATIONS TO DEAL WITH PROBLEMS OF SUBJECTIVITY AND VARIABILITY

This was one of the issues which caused greatest concern. It deals with the principles of the HHSRS a review of which is not the remit of this research. However, the concerns of interviewees are difficult to ignore. Some of the less confident users are concerned that they are being asked to exercise too much professional judgement and more guidance is needed to prevent them producing scores which do not properly reflect the conditions they find.

Interviewees were particularly unhappy about producing scores based on various locations in the house. There is currently no guidance on how these should be combined.

Recommendation 1
A series of worked examples be related to key points on the scale and these should include several examples for the average hazard and the first Band C hazard. Worked examples have been one of the successes in explaining the system. While some worked examples could be produced from the case study material these will be insufficient for the numbers envisaged. The production of the worked examples should be a separate commission.

Recommendation 2
Guidance should make clear how they should combine the effects of faults in various locations into likelihoods. It should be made clear whether they are looking at the combined likelihood or the worst case only.

A.8.3 RESOURCES

Most interviewees were concerned that the system would require more resources because of increased office time taken to undertake the inspections as well as the set-up and training costs. Most of these issues are outside the remit of this project.

Recommendation 3
This issue is best dealt with by separate guidance on enforcement.

A.8.4 REDUCTION IN STANDARDS

There was widespread concern that the system would lead to a reduction in standards. The main concern is with HMO standards but concern has also been expressed concerning singly occupied dwellings e.g. some argue that an external WC would not generate a high enough score to place an authority under a duty to take action.

Recommendation 4
In the absence of specified physical standards, worked examples should be provided to cover items of concern.

A.8.5 STATISTICS

There was an almost universal call for a comprehensive reference work on the statistics which underpin the system. Where hazard statistics were based on sub-groups of the population users were benchmarking from averages as if they were the whole population. To achieve consistency the statistics would ideally be normalised for the whole population.

Recommendation

i) A comprehensive reference work on the statistics underpinning the system should be produced.

ii) Statistics based on sub-groups should be normalised for the whole population.

A.8.6 ENFORCEMENT AND STRATEGY

Interviewees were asked how they thought HHSRS would fit into their enforcement strategy. Most were more concerned with problems relating to the actual enforcement mechanisms. The following were items of concern:

i) Contemporaneous notes – as these would no longer exist would the primary legislation allow printouts from PC software to be used in their stead (see A.4.1 above).

ii) Appeals – the "subjectivity" of the system which results in such specific scores was expected to lead to a large number of appeals.

iii) Several interviewees said they would attempt to achieve their goals using alternative legislation as they anticipated the HHSRS being too cumbersome.

iv) There was a need for a mechanism to deal with urgent defects which require immediate action including continuation with remedial works despite an appeal.

v) Interviewees involved with slum clearance or area improvement were concerned that there would be no target standards for unfitness and disrepair. LRI believe there is no reason why target scores for hazards should not be used.

vi) There was concern that issues of Discomfort would be overlooked in the move to the new enforcement regime.

vii) Licensing- there was general concern on how licensing would relate to HHSRS

viii) There was further concern about the reaction of landlords to HHSRS. Interviewees anticipated a major training/education load falling to the local authority. There was further concern that HHSRS would lead to closure of some accommodation and discrimination in others.

Recommendation

These issues are generally outside the remit of this research and should be referred to those charged with enforcement consultation.