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TRANSCRIPT OF PROCEEDINGS

TRANSCRIPT IN CONFIDENCE

O/N H-1289508

INDEPENDENT PLANNING COMMISSION

MEETING WITH APPLICANT

RE: REDEVELOPMENT OF GREENWICH HOSPITAL

PROJECT #: SSD 8699

PANEL:	**PETER DUNCAN (CHAIR)** **ADRIAN PILTON**
OFFICE OF THE IPC:	**LINDSEY BLECHER**
APPLICANT:	**RON THOMPSON** **MICHAEL COONEY** **KATIE FORMSTON** **ANGELA RAGUZ** **MICHAEL ROWE** **CHRIS FORRESTER**
LOCATION:	**VIA VIDEO CONFERENCE**
DATE:	**11.02 AM, THURSDAY, 8 OCTOBER 2020**

THIS PROCEEDING WAS CONDUCTED BY VIDEO CONFERENCE

MR P. DUNCAN: Well, good morning and welcome, everybody. Before we begin, I would like to acknowledge the traditional owners of the land on which we meet and I would also like to pay my respects to Elders, past, present and emerging. Welcome to the meeting today to discuss the concept application for the Greenwich Hospital redevelopment, which includes new healthcare, allied health facilities, residential aged care and seniors' housing. My name is Peter Duncan, and with me is my fellow Commissioner, Adrian Pilton. We form the panel appointed for this application. Joining me from the office of the Commission is Lindsey Blecher. At this point, Michael, I will let you do some introductions from your side, if that's okay.

MR M. COONEY: Sure. Yes. Peter and Adrian, thanks, and thanks for the opportunity to formally discuss our submission with the IPC today. In today's meeting – and I might just, as we're talking on this, Chris Forrester is actually going just to put up our presentation. Thanks, Chris.

MR DUNCAN: Just before you launch into it, I've got a bit more to say, Michael. So if you just do - - -

MR COONEY: Sure.

MR DUNCAN: - - - the introduction first, then I will get on, and I've just got a couple of more - - -

MR COONEY: Sure.

MR DUNCAN: - - - things to say before we start the presentation. Okay?

MR COONEY: All right. Okay. So we've got representatives from HammondCare, as well as the – I guess, the broader project team. So that page that's up there now indicates those in attendance on this Zoom meeting. So some will be presenting slides and others are on standby if needed. So happy to kind of go around, Peter, or are you happy just with that slide as the – I guess, as the attendance?

MR DUNCAN: I'm happy with that slide, and what we will do – and I will say a little bit about this in a moment, but when you – when each of you speak, if you just, the first time, say who you are and what your role is, but then, each time you speak, if you could just remember to say who you are because we're recording this.

MR COONEY: Great.

MR DUNCAN: Just makes it a bit easier. So in the interests of openness and transparency and to ensure the full capture of information, today's meeting is being

recorded and a complete transcript will be produced and made available on the Commission's website. This meeting is one part of the Commission's decision-making process. It is taking place at a preliminary stage of this process and will form one of several sources of information upon which the Commission will base its decision. As you are aware, we had a site inspection recently. We've also met recently with the department and local council. It is important for the Commissioners to ask questions of attendees and to clarify issues whenever we consider it appropriate. If you are asked a question and not in a position to answer, please feel free to take the question on notice and provide any additional information in writing which we will then also put on our website.

To ensure the accuracy of the transcript, as I mentioned, I request that all members today introduce themselves before speaking every time they wish to speak, if possible, and for all members to ensure that they do not speak over the top of each other because it just makes it a bit harder for transcript process. But with that, I now begin and pass back to you, Michael. Thank you.

MR COONEY: Thanks, Peter. So, Peter, we've structured today's presentation to focus in on the three themes that the Commission suggested as discussion points, that being the statutory context, the strategic context and the built form. So in attendance today are HammondCare's two operational general managers: Ron Thompson, who oversees our health and home care services, as well as Angela Raguz, who oversees our aged care services. Now, both Ron and Angela have more than 50 years' experience between them in the sector and they will be responsible for delivering the proposed services on the Greenwich site. So they will address the first two themes. Discussions on the third theme will be led by your town planner, Michael Rowe from Ethos Urban. Michael will be supported by HammondCare's head of design, Katie Formston, who you met as well out on site, and a number of our other consultants, including our architects from Bickerton Masters. Chris, do you want to just slide over to, I guess, the next screen there. Thank you. Yes.

So, I guess, before we get into the first theme, I just wanted to kind of spend a moment just telling you a bit about HammondCare. HammondCare is an independent Christian charity founded back during the Great Depression of the 1930s by Archdeacon Bob Hammond who, at the time, identified a need to provide accommodation to support families who were living in the inner city and who were being evicted. And at that time and, I guess, throughout the last 85 years of HammondCare operations, we've continued to focus on helping those that need our support. That support has kind of moved from housing initially. to aged care, to supporting people living with dementia and, in 2008, HammondCare strengthened its expertise and capacity in the subacute disciplines and in palliative care, rehabilitation and older persons' mental health when we acquired Hope Health Care, which was a network of hospitals and related health services. One of those hospitals actually included the Greenwich Hospital site. Now, that acquisition was made with a commitment for longer term capital investment to ensure the viability of services to support the local community.

Now, importantly, over the last 8t years, HammondCare has not always waited for others to kind of address the care issues that others often aren't willing to do and, you know, we've found innovative ways to deliver care and to support those people in need. So, I guess, while this application you have in front of you has been developed over the past few years, it has taken HammondCare more than 12 years to develop a sustainable operational model that will firm up the future for Greenwich Hospital. So I just wanted to touch on that history first-up because I think it represents HammondCare's approach to this project and, as Ron and Angela will talk about shortly, you know, these are services that will meet a growing need in the area and will form a part of how health care is delivered in the future. So I might actually now just hand over to our general manager for HammondCare Health, Ron Thompson, just to kind of talk through the next few slides.

MR R. THOMPSON: Thanks, Michael. Just in terms of what HammondCare does across the whole organization. We deliver subacute care, residential care or nursing home care and home care or community care services. We're in New South Wales, Queensland, ACT and Victoria and we also provide a Dementia Support Australia service nationwide in every state and territory. HammondCare Health is an affiliated health organisation under the Health Services Act and that – a principal reason for recognising an affiliated health organisation is to enable certain non-profit, religious and charitable and other non-government organisations to be treated as part of the public health system, where they operate hospitals, health institutions and significantly contribute to the public health services in the state. So just to stress that HammondCare Health, for all intents and purposes, is a public health service, not a private health service.

In 2019, we had a social dividend of $26 million to the community and, as part of our mission, HammondCare is committed to supporting people of low no financial means and, within that, we've got 45 per cent of our people in nursing homes are low income or disadvantaged, 50 per cent of the people in hospitals we look after are public patients and, within Seniors Living, we provide subsidized housing to 15 per cent of our people across all our services.

This is the first of three themes that I think we've been requested to address: what is the nature of the care provision for the proposed seniors' housing compliance with the SEPP 2004? The SEPP has a broad definition of Seniors Living. We are at the high end in terms of service to Seniors Living. We provide services beyond what is delivered in home care, for example, a 24/7 onsite nursing service will be available to people who live onsite given that we have an integrated campus. It's not just another retirement village. It's more. It's a serviced Seniors Living connected to the hospital, connected to people with long-term care needs.

Just moving on in terms of our vision: to transform Greenwich Hospital. As much as I love Greenwich Hospital, it is dated. It goes back to the 1960s and it shows it in many ways. Our vision is to see it as an integrated contemporary healthcare campus providing specialised healthcare services and looking after people over a continuum of care over a longer period of time. Currently, we provide palliative care, older

persons' mental health and rehab services onsite and we're looking at adding to this in our new service by having residential aged care, serviced Seniors Living, GP clinics and general outpatient clinics, including rehab and community palliative care, and to have 24/7 onsite care available. No comparable integrated campus is within the LHD or within Northern Sydney. It's not just another retirement village. It's integral – certainly the serviced Seniors Living is integral to our healthcare plan for this site, notwithstanding that it's also absolutely necessary to raise capital funds for this development as we receive no capital funding from New South Wales Health for our hospital services. Just move on to the next one. Thanks.

We serve the local community, are a significant provider of public health services. I think we've got there 3000 inpatient admissions, over 30,000 outpatient occasions of care and, in the Northern Sydney Local Health District, we're the only major provider of aged care mental health services, of specialist palliative inpatient care, of community palliative care and, of course, we have an internationally recognised and Australia-wide dementia centre and Dementia Support Australia services. A very significant part of the role we play in the LHD, particularly in the recent times in terms of COVID, we work closely with the Northern Sydney LHD and Royal North Shore Hospital and Ryde Hospital and Hornsby Hospital in terms of having a pandemic plan and having surge capacity, and we've also made one of our wards available – and thankfully we haven't needed to access it, but one of our wards available for COVID patients, if required.

As I said earlier, we've got a 1960s hospital. Health, the world and the way we live has changed over the last many decades. People are living longer and there's a need for complex aged care health services. Demand, chronic care – chronic healthcare needs in the elderly has increased significantly. The provision of healthcare is changing. People, I think we all agreed, don't want to stay in hospital. They would like to be looked after in their homes, if that's possible.

More treatment is available in the home, and that includes palliative care as well as mental health services, and also rehab in the home is growing. There's increased opportunities for people to age in place or age in site, or to live in communities with access to specialised healthcare services, and that's one of the key things with our serviced Seniors Living, that there is ready access, if required, to rehabilitation, ready access to people with a life-limiting illness to specialists onsite and ready access for people with continuing mental health issues, be it schizophrenia or other complex cases, to have people onsite so that if something does happen or if there is an acute episode, the ability for those people to be looked after within their home and therefore avoid a hospital trip.

With changes in the way patients are now managed and the improvements of a new campus, we could see a tripling or a quadrupling of patient care given that over time, and that's possible because of increasingly shorter lengths of stay. So the admissions will increase but bed days will probably remain relatively static in terms of the way length of stay is going. Healthcare trends, as I've said, we've got high prevalence of chronic disease, longer durations of illness. People are living palliatively for far

longer than they were a decade ago, and that has also led to complex comorbidities. So you have a number of illnesses overlaying each other. More than half of the people aged over 76 have five or more chronic health conditions. Now, I think I hand over to Angela.

MS A. RAGUZ: Hi. It's Angela Raguz and, as Michael stated, I'm the general manager of HammondCare's residential aged care services. Just thinking about some of the things that we've seen coming out of the Aged Care Royal Commission over the last 18 months since that has been in place, firstly, the interim report and then, secondly, just last week there was the release of the COVID special report into aged care services. One of the things that is absolutely being highlighted as a gap in the system is that connectivity between older people more broadly in the community and those health services that people require as they age, and the view from many – and it's alluded to within the Royal Commission's, both its first interim report titled Neglect and in its COVID report – that there is an element of ageism and, as a society, we must choose the way that we provide care and services to older people.

Most older people do not want to have their care provided within institutional settings. The vision that we've had at Greenwich Hospital and on the site was to provide an integrated service where the location of an older person with chronic conditions, with care needs, with dementia, someone palliating, in requiring rehab or mental health services, was that those services could be provided by experts on an integrated site rather than it being specific to the accommodation type, and that's the big thing that is different for the seniors who would be living on that site. The idea that the future is building more nursing homes, I think, is a false concept of the future and, in acquiring Hope Health Care in 2008, this was very much a component of HammondCare's strategic approach to an integrated service for older people that we could acquire some of those specialist services that were very difficult, and continue to be difficult, for older people to access and to access continuously and seamlessly.

An integrated model really does encapsulate that concept of restorative care, avoiding hospitals, as Ron has already mentioned, and focusing on enabling people to remain within their own home and receive the care and services. We have heard recent presentations from industry experts in unravelling what is the future of aged care services and what is the future of health and aged care. Increasingly, we are hearing that the in-home care services will grow, residential aged care services far more specialised, and the missing link is exactly what we're aiming to achieve on this Greenwich Hospital site.

The second theme that the Commission has asked us to speak to is the strategic context: so what's the impact of the proposed seniors' housing upon the financial viability of the proposed redevelopment? Well, this cuts to the core of why the proposed conditions requiring a reduction in the Seniors Living shouldn't be imposed by the IPC given that, as Ron has already mentioned, there is no capital to build new hospitals. That's just not something that is provided through the current health infrastructure. Aged care does have a system which enables capital to be raised, including through seniors' housing and through the component of RADs for

residential aged care. The concept of the health service delivery, though, building a hospital, that does have the ability to provide some of the specialist end of care but has the human, and capability and capacity resources to extend that into the housing of people's choice regardless of whether or not – of what those needs are.

So the Seniors Living, if we just move to the next slide, the title remains with HammondCare. The residents will be 75-plus, chronic health needs and often we will have people who perhaps come together and one partner requires extended care and the other may require a lower level of care but being on an integrated campus enables people to be in the same place and continue to maintain those relationships.

Serviced Seniors Living is an integral part of the development and it's a contemporary approach. It's the future of connectivity between aged and health that currently is under critical review by Royal Commissions, by – if we look at the 20-odd reports that have been written about aged care over the past two decades, it is very much the idea that we must find a better way for people to receive the healthcare that they need whilst maintaining a home that provides independence and opportunity to continue a lifestyle but have services that are actually meeting the care needs of the individuals.

The Seniors Living will be offered on a licence basis. So this is not – ownership will always be retained by HammondCare. This is not real estate. It's not housing. It's a continuum of care that can be delivered regardless of a person's physical location but with the resourced being onsite and being able to be deployed efficiently, effectively and with expertise. It addresses the need for episodic care regarding people need – in order to prevent long-term care, being that that's what people do not want, the episodic care and the way that that is provided can either decondition and provide people with a pathway to long-term care that is not what they would choose or it can be provided in a way where reconditioning and ensuring that the person's independence is maintained throughout that episode of care on an integrated campus. There is absolutely the – it's a unique opportunity to be able to provide that and avoid those hospital admissions and deteriorative deconditioning that often leads to long-term care needs.

The diagram that you're looking at attempts to differentiate the offering and how this fits with other things that may be seen as sort of Seniors Living, or retirement living or this idea that people buy into sort of a cruise ship down the road. When not coupled with health services, then that's entirely reasonable to say that's a completely separate product. But looking at people 75-plus, five or more chronic health conditions, absolutely the biggest users of the public health system currently and well into the future, a recognised gap in the way that older people are being treated through the health service and that connectivity between the aged services and health services, this aims to bring an innovative model to the table that is potentially something that is replicable throughout the broader health/aged care sector.

The site will offer 24/7 access to specialised care. Currently, aged care runs on a primary care model. The future is that that model is not going to be sustainable either for the – in terms of what the expectations of people are, what the expectations of the aged care sector are, and the public health system will not be able to cope with the growing number of older people unless that bridge between the two services is built, and this attempts to build a bridge that connects those two services. So I think, Michael, at this point, I will hand that back to you in terms of why the requirement on the site.

MR COONEY: So I might – I think I've got two kind of slides to kind of wrap up, I guess, the HammondCare piece before handing over to Katie and Michael Rowe. So just to summarise in terms of the need, the why. You know, as Ron and Angela have noted, there is an escalating need for specialised care within the region. There is no public capital funding for the project. There is a need for an expansion of services to remain sustainable. There is a critical mass required for the site to cross-subsidise hospital infrastructure upgrades. And, as Angela has touched on, co-location of these services is critical for operational integration. And finally, the amended proposal already includes a number of concessions that have responded to community feedback.

And finally and – I don't know if that's flicked over. I think it's flicked over. Thank you. So finally, the importance of the Seniors Living. Spoke about there is no public capital funding for the project. So the integration of Seniors Living is required in order to cross-subsidise, as I said, the upgrades. I guess the big point is the removal or further reduction of the Seniors Living on the campus will impact the financial feasibility of the project and, without Seniors Living, the project cannot be funded. We don't have other forms of capital funding for this.

You know, we know that the community, the local interest groups and council, all value the services of Greenwich Hospital and they actually want to see these services continue to be delivered. So, for us, the inclusion of Seniors Living will allow Greenwich Hospital to continue to operate, to grow and to address this emerging care need of the local community for many years to come. Katie, I will pass over to you now, and I think then that kind of leads into community consultation into, I guess, the work with Michael Rowe.

MS K. FORMSTON: Thanks, Michael. So Katie Formston, Head of Design at HammondCare. I just wanted to touch on the community consultation side of the project. So, obviously, our main priority is always to liaise with our community one-on-one and we've made a commitment to that. But in addition to personalized one-on-one communication, there has also been, you know, drop-in events at Pallister House. We've had several meeting with Lane Cove Council. Our newsletters went to over 1800 local residents. There was five newsletters. And, in addition with the media releases, we've also been running and maintaining the Ask Greenwich webpage, which is specific for the project.

I think, and just moving on to the next slide, what was clear in the community feedback, the four primary concerns were bulk and scale, trees, traffic and the Seniors Living, and I think evidenced by our response to the submission is we did listen and we amended the proposal significantly. So there was the reduction in bulk and scale. We committed to increasing the tree canopy. We re-looked at the landscaping and the reinstatement of the heritage landscape for Pallister House curtilage. We also increased the amount of landscape open space and really looked at improving the pedestrian access and linkages through the site. And finally, the other change we made in the amended proposal was the prioritization of the health services in the construction phasing. The design is informed by the need to keep the hospital running throughout the redevelopment and ensuring that we can continue to deliver care while we upgrade the infrastructure.

The changes have, you know, delivered 60 per cent open landscaped area which looking – as you would have seen from the site visit, at the moment really is a car park. So, you know, turning that back into a landscape that's actually beneficial for residents, patients and their visitors is important, and with 40 per cent of that being, you know, deep soil, I think that's a significant improvement. There's over 212 trees being retained and we've committed, in the amended proposal, to planting more than 60 trees.

So the key modifications were revising the building footprint to decrease the tree loss within the building footprint. So there was an additional 46 trees retained as a result of the modification. We deleted the Seniors Living villas along St Vincent's and included a respite care facility. We also looked at reconfiguring the buildings and opened up the view from River Road through to Pallister House. Around Pallister, too, we've deleted basement so that there is, you know, no – there's a lessened potential impact on the heritage fabric, and the purple there indicates the reduction in the bulk and scale to the interface with Pallister of the Seniors Living as well as the interface with our western neighbours and further afield at Northwood. The other key modification in the response was a commitment to retain the driveway in from the signalised intersection. So previously we were planning to replace that, and that did result in significant tree loss and potential impacts on our three most closest western neighbours.

The next slide, I think, demonstrates better the reduction in the envelope that we made in response to the community feedback and discussions with council. So that yellow area is representative of what has been removed from the envelopes and, like I said, it was to improve the relationship with Pallister, which we discussed in detail with the Heritage Office and they very much supported, and also to bring the western end of the Seniors Living down to be more analogous with what's currently on site and provide more modulation to that western façade to mitigate any potential visual impact.

On traffic, whilst it has been a recurring concern for the community, I think generally with the agencies and council, people have accepted and supported the traffic position. So neither Traffic – Transport for New South Wales nor council have

raised issues with the traffic impacts of the proposed concept. So I might just move on from that one.

The tree canopy. As I mentioned, the modified scheme significantly changed the retention numbers as well as increasing what we're planting on the site. We've also committed and support the draft condition to retain the significant tree number 167. So we're supportive of that. I think, you know, through the detailed site planning what we've worked very hard to do is – and you can see the dotted yellow line there which is the podium of the campus, is to ensure it's where the buildings are now and we can then retain the green fringe to the site and the setbacks to all existing neighbours have been maintained, and that really has improved the tree position. Like I mentioned, 60 new trees we've committed to planting. The strong landscape setting to River Road, so we've augmented that further, and we will talk a little – Michael Rowe will talk a little bit more to that setback a bit later.

The new landscape concept, which we prepared further plans in more detail in our response to submissions, I think it more clearly demonstrates that the concept does prioritise pedestrians on this site and it really does return the landscape back to residents, patients and their visitors, as well as improving the heritage character around Pallister House, and moving all those cars – you know, 329 cars into the basement has a real positive impact on the landscape setting of the hospital. That's just a graphic demonstrating, you know, there is a significant tree canopy on the site and that it will be augmented as part of this proposal. And I might hand across now to Michael Rowe for the built form discussion.

MR M. ROWE: Thanks very much, Katie. So Michael Rowe from Ethos Urban, the planner on the project, and I want to talk about the built form issues today. It's obviously one of the key assessment issues and one of the major talking points for the community, and so Chris, if you want to go to the next slide. The big question is, you know, is the built form compatible? And the best way for us to understand that is to look through the statutory framework that applies to the site. The department, in its assessment, helpfully separated out the hospital building from the seniors living, and so I'm going to follow with a similar pattern there for the purpose of this discussion. And I will talk briefly about the hospital building, but focus on the seniors buildings.

And so hospital building – the site is zoned for hospital uses. It doesn't have a height limit or an FSR, and that's obviously deliberately in recognition of a hospital building and that type of use and the need to be able to accommodate health services. As HammondCare has already talked to earlier, there's a clear demand for hospital beds and specialised care. If you look at the strategic planning framework, it all points to the fact that we need expanded health facilities to support our aging and growing population. And the nature of the infrastructure typology or the building typology of hospitals is that it necessitates the need for vertical expansion rather than horizontal. So there might be some view of people that you could have a much bigger floor plate, get rid of the seniors and make a larger hospital, but the actual operational purposes of the hospital, as you see in hospitals everywhere, they work

off a vertical model rather than a horizontal one. That also then has the benefits of allowing for greater landscape setting for Pallister and improved landscaping for patients and people and users of the site as well as those neighbours.

The other key aspect of what was thought about with the hospital was putting it in the centre of the site, where it had the minimum impact on the adjoining properties, the integration with the podium, which helped mitigate the scale, and the work that was really done with Heritage New South Wales in order to make an appropriate relationship with Pallister. And at the end, as you would have read and spoken to the department, that that bulk and scale was supported by them. So even though it's the biggest building on the site, we think that that's strongly supportable. Then we get to the seniors housing, and this is obviously the more contentious side and where we have some disagreement with the department.

And so we're going to look at and focus in on some of the detail around this, and again, looking at it from the lens of the statutory framework that allows us to consider it, noting that, you know, seniors housing is permissible on the site and is allowed where hospitals are allowed under the Seniors Living SEPP, and the SEPP then sets out a number of clauses that need to be considered, and I won't go into the specific detail of this, but when you really refine them down of what is quite a confusing bit of legislation, the question that the IPC needs to consider is is seniors living compatible, having regard to its built form impact?

And so – Chris, if we can go to the next slide – how can you actually assess if the built form is compatible? The best case that we have for this, or framework to think through those questions, was a recent judgment from last year, which was Catholic Healthcare v Randwick City Council, which the department has also referred to, and that looked at the specific professions of the Seniors Living SEPP in a similar but different context. And Robson J, when he handed down that judgment, gave us some really helpful considerations of how you go about assessing if the built form is compatible, and it really established some really important principles, which I've highlighted here, and that is compatibility is different from sameness. So buildings can exist in harmony without having the same density and scale of appearance.

And so that then flows through to this idea that even though you can be in a low density area, you're not expected to replicate the surrounding development in order to achieve compatibility. And so that's really important that we've got this idea that we do see it as a bit of an island amongst the low density residential area, but the principles that this case established was that there isn't an expectation, if you're applying the Seniors Living SEPP, that you're just going to replicate what's around you, and you can still achieve compatibility without doing that. And it comes back to – and the case highlights the thinking around the design measures that you might integrate and the way that you masterplan a site. So stepping the built form and locating the massing where they have less impacts is how you go about achieving compatibility, not replicating what's around you.

Chris, if you want to go to the next one. And so the design that we have for approval in front of the IPC has really been informed by a very detailed master planning analysis, and that's overlaying all of the important considerations through the assessment process, thinking about visual impact, heritage impact on Pallister, restoring the landscape setting and the arbour cultural analysis that's gone into which trees can be retained, the built form and streetscape analysis, the overshadowing, the solar, SEPP 65 and ADG, bushfire diversity, and when you layer all of those things on, we firmly believe that the envelopes that we're asking the IPC to approve are strongly founded in the framework of that analysis and that they ultimately show that through that, we've achieved compatibility because of the way that we've thought carefully about the master planning of this site.

Chris, moving on to the next one. So where we do agree with the department, there's that recognition that the Seniors Living SEPP is specifically drafted to allow for seniors on SP2 land such as this site, that the seniors as a use is compatible with low density residential and with the hospital, obviously, and that the site has no height controls, and the department does not consider that the height controls from the adjoining land should be transposed to this site. As you can see from the photo – and you've been on the site visit – the existing built form on the site significantly exceeds the surrounding height control. It's significantly larger than all the surrounding development, and so – but the site is large and it allows us to actually mitigate the impacts of the development within our site. So all of those things we agree with the department on.

But where we disagree comes – and I've just extracted out of the assessment here of the key points from the department in where they've drilled down to where they kind of see the difference, and that's ultimately led to their decision to impose the conditions that reduce the height. And what they've said is that they don't think that seven storeys fits at the local neighbourhood scale, and they've applied the 400 metre radius and determined what they think is appropriate based on that 400 metre radius. And ultimately, they've concluded that the impacts of the development aren't necessarily what would be reasonably expected for the development when it's surrounded by R2, and therefore they've imposed the height limit that they have.

So I think that, you know, for us has raised some questions. Like, let's drill down to some of those statements that the department have raised here and understand them in greater detail to see if they actually hold true. Chris, if you want to go to the next slide. So what are the actual impacts? Because we've talked about, you know, what impacts would be reasonably expected, and the two things that the department has drawn out are around neighbourhood character and visual impact. And I think it's important to note at this point we're not talking about overshadowing, we're not talking about view loss, we're not talking about privacy. Heritage was obviously supported by the Heritage office. We're not talking about wind. So we're really just focused on neighbourhood character and visual impact.

And in terms of determining the neighbourhood character, the department referred to the Catholic Healthcare judgment, and in that case, they looked at the 400 metre

radius as that kind of appropriate basis to consider the local character. Now, that might have been appropriate in that particular case, where the site – this is an extract from that design report from that court case, which we worked on. and in that event, that was a bowling club in the suburban part of Maroubra, and it was an appropriate way to think about it contextually, because it sat within that local area of Maroubra. Where I think we differ and why the 400 metre radius isn't appropriate is that Greenwich Hospital is different to this particular site that was int hat court case. Greenwich Hospital really sits as what I think is identified as part of a river road corridor. And so people's experience of Greenwich Hospital and its context form much more as part of its situation as part of this road corridor that slices through the centre of the Greenwich, rather than the arbitrary radius of the 400 metres that the department's using.

And as you will see and you would have experienced from driving along River Road, there isn't an established character. There's three to four storey buildings. There's five storey buildings. There's eight storeys buildings that are planned in St Leonards South. There's obviously the existing hospital on the road corridor. And so there's no – you know, there's different buildings. There's no real transition in scale. It jumps up and down. But that doesn't define Greenwich's local character. The suburbs of Greenwich, as we know them today, aren't defined by what happens on the Pacific Highway in the same way. It's a different corridor. It's zoned differently. It's treated in that way. And I don't think that the character of Greenwich is determined by the character of the River Road corridor. And so the department's, you know, ultimate condition to then restrict the seniors living building based on its fit in the local area – I don't think if the building is five or six storeys or seven storeys, it's not actually going to alter whether the development fits for the local character.

It is already an anomaly, and it's viewed within that context of the River Road corridor. It doesn't actually define what happens and the people's experience of Greenwich as a suburb around it. And – but as we've highlighted before, the reduction that the department is proposing will detrimentally impact on the provision of public health services and meeting the demand. And so we really think that you've got to weigh this up as we're going through this assessment. Chris, if you want to go to the next one. So when we then start thinking – if it's not about local character, then what about the visual impact? And there are three key users or people – affected groups that are impacted by the visual impact of the seniors buildings, noting that all of the eastern catchment is going to see the hospital before they see the seniors building. And so we've got road users, we've got the Northwood residents, and we've got the residents in that pocket to the west of the site, which I've termed the River Road West residents.

And so – Chris, if you want to go to the next one. The visual impact from Northwood – any proposal with a scale of the existing buildings is always going to have a visual impact. You'll see the extract here from the visual impact assessment that shows the new development, which is obviously a concept design, and the existing building. So the views are largely consistent with the existing view that you

get from Northwood, which is large buildings set within mature vegetation. And obviously, there's a landscape strategy that works to further enhance that vegetation, and the design measures that are met in the amended proposal that step the buildings will further help with reducing those perceived impacts.

But the reality is that no design modification to the maxing will materially remove the impact, but they will have a big impact on our ability to deliver the campus. Chris, if you want to go o the next one. These are some views which we've further taken from the discussion about the rotation of the building with the department that I believe you saw before, but these ones model no rotation, but the reduction in height that the department has proposed. So you can see the amended proposal is our proposal that we would like to see approved, and then you've got the conditioned, height-reduced version of the proposal. Now, these drone shots were taken because we weren't given access by any of the residents in Northwood, despite trying to seek access to get in there, but they do give us a really good illustration. But actually, obviously, because it's higher, you see more of the buildings than you would when you drop down to the height of those houses.

What they really highlight here is that the draft condition has negligible to no material benefit on the visual impact of the hospital and the campus and the seniors buildings when viewed from Northwood. Yes, you're going to see it. You see there's an existing building. But the reduction in height doesn't actually improve the visual impact from Northwood. If you want to go to the next view, Chris. That highlights it again from a different angle up at another location at Upper Cliff Road, which comes further round, where, again, you can reduce the height of the seniors buildings, but you don't actually have any material benefit to the visual impact.

Chris, if you want to go to the next one. So then we start thinking about, well, what's the visual impact benefit of reducing the height from the River Road West residents, which are the other impacted group from this location, and these sections which we've prepared also really help understand the fact that this won't actually deliver a benefit. And so what you see here are the views from the most affected dwellings, and so we've got from the upper level of 117 River Road and 117A, which sits lower in the valley, and what you see here is obviously, the building is actually even set back further than the existing building, but the parapet of the stepped form, so the lower part of our envelope, is already sitting in front of the sightline of the reduced height of the building. So the red line on that diagram is the department's height limit that they're seeking to lower our building down to, and what you see is the building is stepped and sits above it. So the sightline of someone in the most affected dwelling adjacent to our property is actually not going to receive a benefit from the department's reduced height limit.

So if you want to go to the next one, Chris. So where does that leave us? Circling back round to that original question that the IPC has to consider here: is seniors living compatible having regard to the built form impact? We believe the answer firmly is yes. Reasons for that is that we think it demonstrates compatibility in the framework that Catholic Healthcare judgment set out, helpfully, for us with these

provisions. The character of River Road is different to the rest of the character of Greenwich. So we can't be thinking about the hospital as part of, necessarily, suburban Greenwich. We've done a lot to mitigate our impacts on that, but really, it doesn't determine or define the character of Greenwich as a suburb, in our view.

And then the fact that if you reduce the height by one or two storeys, it doesn't actually materially change whether this development fits in that local character as a result, and when you drill down to the actual visual impacts of the reduction in height, it doesn't actually have any material benefit for the affected users both – at all, residents both in Northwood and the River Road West dwellings. And so on that basis – and coming back round to this overarching impact in terms of the ability to deliver public health infrastructure and the in-demand care that this ..... seeking to deliver, we think that the IPC should delete the department's condition A4(a) and (b).

Moving to the River Road setback. So this was the department's setback to align with 117 River Road, noting that that building is currently 9.1 metres setback from River Road, although it does have a garage that's almost at the zero lot line. But the existing River Glen building, which is the existing hospital, is setback 6.3, and we were proposing 6.5. But the department's condition, in effect, is about a 2.6 metre setback, where they envisage the whole envelope being shifted, as they've annotated on that drawing that we've extracted from their report there. And the reasons that they've given for that are that the setback should be the same as the dwelling, given that it's the scale of the building, and that it would allow for additional planting and ensure that the future development will contribute to the quality and identity of the area.

Chris, if you want to go to the next slide. So I think that – yes. Where the department has gone wrong here is that the decision to setback this building will actually have greater negative scale implications, where – in an unintended way that they perhaps didn't envisage. And so what you see is that when you shift the building back from River Road, what it does is it will actually make the building more visible by closing the gap between the two seniors living buildings for the residents that sit in that River Road West pocket. So if you're down in 117A, that gap between those two buildings that you see in that image there is actually going to get smaller, so they're going to see less view of the sky, and it's prioritising the view of what someone sees as they drive along River Road, which we don't think is something that should be prioritised or given value as part of – in the trade-off of this setback.

The other implication of it is that it will reduce the internal amenity between the residents of those buildings and the landscape courtyard that sits between them, which will obviously be an amenity, particularly, you know, for less mobile people to be able to go out of their dwellings and be able to be in that space. By reducing it down, you're obviously going to compromise some of the amenity of the people in that space, again, for what seems to be prioritising what someone might see as they drive along River Road. The render here shows our building and the envelope sitting.

When it comes to planting, as we've stood out onsite, you saw the established trees that sit in front and screen the building as you're coming up River Road. There's already significant landscaping both in the form of the retention of the existing trees that are going to be there from day 1, but also the landscape strategy that's already being delivered within the six metre setback. The additional 2.6 metres – and we've got Matthew Taylor here from Taylor Brammer, the landscape architect, if you did want to probe him more on this, but at the core of it, 2.6 metres doesn't allow you to put in any more established tree canopy type trees. We're obviously seeking to put established landscaping in that corridor, but 2.6 metres isn't enough to get another major tree in that zone, where the trees already have, obviously, much more significant crowns than what we're planting. So we don't think that it's actually going to deliver additional landscaping in the way that, perhaps, the department might have envisaged.

Chris, if you want to go to the next one. Again, so circling back round in summary, we don't – it's going to have a greater impact on the adjacent residential. It's going to impact on the internal amenity of the residents. It's not actually going to deliver the kind of additional landscaping that the department had hoped for, and there is already very established landscaping there, and for that reason, we also think that condition A4(c) should be deleted.

The final point from me today is in relation to the GFA reduction. And so this is the condition A5, which, arbitrarily, the department has worked out a reduction to our GFA based on the reduced height. Of course, if the IPC decides to delete those conditions, then this condition should just be deleted by course of that. But if the IPC did decide to make modifications to the envelope, we think it's really important that we have the full amount of GFA, to delete A5 or amend it to allow for the 13,000 that's proposed. And the reasons for that are, as we've set out really clearly before, the GFA from the seniors living is critical to funding the public hospital and meeting the demand for specialised care. And so deleting it is obviously – or capping it just purely on the envelope is actually impacting on our ability to do those key things that this project is setting out to do.

But the site also has no FSR control, so it doesn't really make sense to have an arbitrary cap on the GFA. The building envelopes, which are obviously the key focus of the assessment, ultimately define the acceptable maximum built form, so for us, it doesn't make sense to then restrict the ability to try and get back some of that GFA to provide these essential services and care if the envelope ultimately determines what's the acceptable form. And what comes through the assessment is there's no link between GFA and environmental impacts. This isn't about, you know, too much density on this site from an impact perspective or traffic generation. There's obviously considerations around built form, but the GFA is not the direct generator of those impacts. And so we think that it's appropriate that we're allowed to try and get our GFA within the envelope that the IPC ultimately decides. I'll now hand it back to HammondCare to round out with our conclusion.

MS FORMSTON: Thanks, Michael. So Katie Formston, HammondCare, again. Just to wrap up the key benefits of our proposed concept, obviously, as we've spoken, there is, you know, the public health benefit and upgrading, you know, a public hospital at no cost to New South Wales Government or taxpayers. Secondly, this site is essential to reducing the burden on the existing public hospital's acute system by providing integrated preventative and restorative care.

I guess the second key benefit is the additional specialised care and creating a sustainable continuum of care on the site via the integration of the health services, particularly for seniors. Sustainability. You know, as Michael opened up with, we've been working for a long time to make this campus sustainable, and we do need to bring it up to contemporary health standards. Meeting the growing demand. I don't think there's any dispute, and even the community has, sort of, evidenced this. There is a growing demand in the area and we need to grow. We need to get bigger to service that demand. The physical and operational integration is also a key benefit. It's what's been – Angela has mentioned has been called for through the Royal Commission and other areas, and, you know, integrated specialist healthcare, it's not provided anywhere else on the Lower North Shore.

The other big key benefit is, you know, the reinstatement of a quality landscape and heritage curtilage, restoring the views to Pallister, and turning that landscape area back for the benefit of patients, residents, and the community. And finally, employment. So there will be significant full-time employment jobs created as a result, as well as up to 4000 jobs during construction. So I'll hand across – back to you, Michael Cooney, to close.

MR COONEY: Thanks, Katie. Yeah, Michael Cooney talking again. So just to wrap up, you know, I'm hoping we've been able to kind of highlight the need for these integrated services which we believe will be somewhat a blueprint for others within the sector. It will meet local demand for health services and enable Greenwich Hospital to adapt to changes in the way most health services are delivered in the future. Importantly, HammondCare is in the business of care, so – and that has been our focus for 85 years and has been our focus in developing these plans for the redevelopment of Greenwich Hospital.

There is an identified need, which I've spoken about, and we've got an innovative way of meeting that need that we hope supports the approval of this submission by the IPC. Peter and Adrian, can I just thank you both and the IPC for your time today. I know there's been a lot of slides we've got through. Happy to kind of open it up for questions, if there is anything for the team.

MR DUNCAN: Thanks, Michael. Thanks for the presentation. We probably do have a couple of questions. We're tight on time, but let's see how we go. Adrian, would you like to start off?

MR A. PILTON: Yes. Is there any special reason that you've got the respite centre in a separate building? The council are quite strong in saying that they prefer it to be back into the main building.

MR COONEY: Katie Formston, do you want to answer that one?

MS FORMSTON: Sure. Thanks, Michael. So Katie Formston. One of the key messages I think Angela touched on is people want to get treatment in the home, and respite is no different. For someone to have respite, having it in a familiar and domestic environment is really important, and that's driven the location and scale of that respite building to be quite analogous to the residential across the street and somewhat spatially segregated from the main podium building, but still close enough to receive specialised treatment.

MR PILTON: Okay. Thank you. I just notice that it seems to be sited where you're going to have to take out tree number 17, which is a quite significant tree. Is there any room to manoeuvre there that we might – I realise it's a concept scheme, but is it possible, do you think, to move it around to avoid as many tree removals as possible?

MS FORMSTON: Yes. Katie Formston again. Yes, I think, Adrian, you're right. There is plenty of room there now to look at the competing pressures there. So we have the heritage fabric and comments around the bridle path. We've got the trees, we've got relationships with house across the road. But to answer your question, Adrian, yes, I think there's flexibility there. And it is, as you say, at the moment a concept that, you know, would be further investigated in the detail phase.

MR PILTON: Okay. Thank you.

MR DUNCAN: That's all, Adrian?

MR PILTON: I've got one other just broad query. You talked earlier, Katie, about the 41 per cent, I think it was, of deep soil area. I'm not quite sure what you're referring – you just mean – do you mean unbuilt area?

MS FORMSTON: So - - -

MR PILTON: ..... you're not going to add a lot of soil into quite a lot of that area.

MS FORMSTON: Sure. No, when we say deep soil, I guess we mean it's available for planting. So it's either native ground or ground that doesn't have basement or built structures under it. So the other 20 per cent of landscaped area might be things such as the roof terraces or the gardens on top of the podium or between the buildings and above car parking. So that's the differentiating between the 60 per cent and the 40 per cent.

MR PILTON: Thanks, Katie.

MS FORMSTON: Does that answer your question?

MR PILTON: Yes. Thank you.

MR DUNCAN: Thanks, Adrian. I've got a couple of questions. One, in the presentation you mentioned there was no comparable campus in the LHD area of this style of development or, I guess, model. Is – and I think in the presentation you also mentioned, you know, a site in Victoria, Calvary Hospital. Is thee anything else in Sydney that's similar in model to this?

MR COONEY: Michael Cooney talking here. Not that we're aware of. I mean, there's certainly – you know, there are certainly sites that do retirement living, and they may have some residential aged care, but not with the extent of integrated services that we're referring to in this development.

MR DUNCAN: So the hospital itself is the bit that makes it different in this case?

MR COONEY: Yes. Absolutely, yes.

MR DUNCAN: Thank you. And I assume that that example in Victoria is similar, the one at Calvary Hospital?

MR COONEY: Michael Cooney talking again. Yes, and there is a – the stage of development there is – we probably need to get a status on that, but that was an approval 18 or so months ago that was – had a lot of similar themes and services to what Greenwich does. So I can't kind of give you an update on the status of that, Peter, but certainly it was a similar development.

MR DUNCAN: Okay. Okay. Then the other question I've got is it goes to the conditions, the five conditions, and you talked about A4 and A5. Do I – it wasn't quite clear from Michael. You're arguing the whole of A5 shouldn't be there, or simply the GFA for the hospital building?

MR ROWE: It was actually about not having – what happened in the A5 which – sorry. Let me start again, Peter. And Michael Rowe speaking.

MR DUNCAN: Yes. Thank you.

MR ROWE: A5 conditions GFA for the hospital and for the seniors, and what I was referring to was the fact that in the department drafting that condition, they have made their own assessment of what the GFA in the seniors living buildings should be, and then reduced the GFA that we were proposing as part of our proposal in that condition. So we – the envelopes that we proposed had a GFA of 13,000 square metres, and they've come up with a different number, we think just by working out the rough area of the floors and then deleting them. What we're saying is there shouldn't be a GFA restriction – my view is that if the envelopes determine the maximum built form and you're delivering something special like a hospital, what is

the purpose of capping the GFA if you're working within an approved envelope that's been deemed as acceptable?

MR DUNCAN: That clarifies it. Thanks, Michael. Appreciate that. Okay. Lindsay, is there anything from your point of view that you need to raise?

MR BLECHER: Sorry, Peter. I was on mute. Lindsey Blecher here. No, thanks. That answers everything for me. Thank you.

MR DUNCAN: All right. Nothing else from you, Michael – sorry, Adrian?

MR PILTON: No, nothing from me.

MR DUNCAN: Okay. Michael, I think – thanks very much for the detailed presentation. We're having a public meeting next week, the 15th, I think it is, and Lindsey will be in touch about arrangements for that.

MR COONEY: Great. Thank you, Peter, Adrian, Lindsey. Thank you. That's it. We'll wrap up and I'm sure we'll speak soon.

MR DUNCAN: Thanks very much to your team. Thank you. Thanks to everyone.

MATTER CLOSED at 12.05 pm