CITY OF HOBART

MINUTES ATTACHMENTS

CITY PLANNING COMMITTEE MEETING

OPEN PORTION OF THE MEETING

MONDAY, 25 NOVEMBER 2019
AT 5:00 PM
VENUE: LADY OSBORNE ROOM, TOWN HALL

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Private care and public waiting

Stephen J Duckett

Abstract

Waiting time for public hospital care is a regular matter for political debate One political response has been to suggest that expanding private sector activity will reduce public waiting times. This paper tests the hypothesis that increased private activity in the health system is associated with reduced waiting times using secondary analysis of hospital activity data for 2001–02.

Median waiting time is shown to be inversely related to the proportion of public patients.

Policymakers should therefore be cautious about assuming that additional support for the private sector will take pressure off the public sector and reduce waiting times for public patients.

Aust Health Rev 2005: 29(1): 87–93

What is known about the topic?

Waiting times for elective admissions to public hospitals are an entrenched problem. Recent changes in public policy to support private health insurance have been justified in part on the grounds of their capacity to address this problem.

What does this study add?

Longer waiting times for public patients in Australia are associated with higher proportions of hospital care being provided in the private sector. This finding is consistent with international studies.

What are the implications?

Increasing private sector throughput may reduce the capacity of the public sector to provide for public patients, rather than reduce waiting times.

ALTHOUGH MEDICARE HAS ELIMINATED financial barriers to access to hospital care, the existence of hospital waiting lists indicates that there are other barriers to access. Fifty per cent of patients requiring elective surgery in public hospitals in Australia in 2001–02 waited more than 27 days, and in the ACT the median wait was 40 days. Ten per cent of patients waited more than 203 days, with 10% of patients in Tasmania waiting almost one year.[1] Waiting time for access to public hospital care is a significant political issue and a matter of concern to voters in Australia and, indeed, in most OECD countries.[2]

Strategies to reduce excessive waiting times need to be carefully designed to avoid creating perverse incentives to reward hospitals with long lists or waiting times.[3] Contemporary supply-side strategies, which assume that current surgery rates are too low, include increasing funding; increasing productivity (through changing incentives, payment arrangements, or day-surgery rates); improving management of waiting lists; creating specialist elective surgery centres; use of private sector facilities; or transferring patients to facilities with lower demand or shorter waiting times. Demand-side strategies include use of explicit guidelines; and reducing pressure on public services by encouraging use of private services.[2] Waiting list reduction strategies such as these have been shown to work and it should not be assumed that waiting lists are intractable or that demand is infinite.[4]

The most prominent demand-side strategy in Australia has been the introduction of a 30% health insurance rebate which, it was argued, would take the "burden off the public hospital system".[5] Other policies to promote private health insurance have included the introduction of life time community rating, which led to an increase in private health insurance prevalence of around 50% to a current level of 43%.[6] The rebate costs around $2.5 billion per annum, money which might be better spent on assisting public hospitals directly.[7]

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One of the justifications for the 30% health insurance rebate is that the rebate encourages people to take out health insurance, thus facilitating access to private hospital care, which in turn reduces demand on the public sector and, presumably, eventually leads to reduced waiting times. When the rebate was introduced, a government advertising campaign encouraged people to take out private insurance with visual images of the beds of the privately insured racing past those waiting for public hospital treatment.

However, household survey data from the United Kingdom confirms that longer public waiting lists in the local health authority are associated with higher take-up of private health insurance.[8] A comprehensive systems dynamic simulation confirmed the link between increasing waiting lists and private activity growth.[9] Time series analysis of United Kingdom national data found that a 1% increase in a waiting time variable (measured as cost of waiting) was associated with a 0.6% increase in demand for private care.[10]

There are clearly significant interactions between the public and private markets, not least that the surgeons who operate on public patients are often the same surgeons who operate on private patients, and so an interaction between private practice and public activity should be expected.[11-14]

The payment per hour for fee-for-service activity in the private sector is generally greater than for sessional payments for the same operations in the public sector. This gives surgeons a perverse incentive to maintain high waiting times in the public sector to encourage prospective patients to seek private care. A Canadian study found that ophthalmologists' practice patterns affected the waiting times for their patients: for surgeons who only operated in the public sector, the median waiting time for a cataract operation was 7 to 8 weeks (depending on the year for which data were analysed); for surgeons who operated in both the public and private sectors, the public waiting time was 15 to 20 weeks.[15]

Expanding private care as a solution to public waiting lists may weaken social solidarity as well as support for ensuring that public care is available when required. Depending on a society's concern for equity, expanding private activity could reduce overall welfare.[16]

Analysis of regional patterns of provision in England has shown that regions with higher levels of private health insurance have longer waiting lists, controlling for demographic characteristics (age, population size and household income).[17] A cross-national study also suggested a "positive association between the level of health insurance coverage ... and size and length of public sector waiting lists".[18]

In contrast to these international studies, two Australian studies have suggested that the private health insurance rebate may have been associated with a reduction in waiting times or lists.[19,20] The two studies used similar methods, essentially comparing the extent of waiting before and after the effects of increased private health insurance prevalence. Both suffer from short time periods for analysis (a point recognised in both papers). The more detailed study, based on Victorian data, shows that the most significant reduction in additions to the waiting list (from 41 077 in the September 1998 quarter to 35 777 in the December 1999 quarter) took place before there was any impact of policy changes on health insurance prevalence.[19] Subsequent reductions (to 31 567 in March 2002 using the data in the published paper) are consistent with a hypothesis of continuation of previous trends rather than an effect of increase in health insurance prevalence.[20]

This study is designed to examine the interaction between levels of private activity (measured by its inverse: proportion of public activity) and waiting times for public patient care, testing the hypothesis that an increased proportion of care being provided in the private sector is associated with reduced public sector waiting times. It is the first Australian study to test whether the rhetorical basis of support for private insurance is confirmed by data, and whether the findings of the international literature can be replicated in Australia.

Methods

Data were obtained from the Australian Institute of Health and Welfare's authoritative publication on Australian hospital statistics.[21] This publica-

tion provides data for 2001–02 on waiting times for 15 indicator procedures such as cataract extraction, cholecystectomy, coronary artery bypass graft and hip and knee replacements. (Box 1 shows the full list of indicator procedures and descriptive data on the procedures.) Three measures of waiting times are published, all derived from the experiences of public patients admitted in 2001–2002: the median waiting time, days waited at the 90th percentile, and the proportion of patients who waited more than 12 months before admission.

The AIHW also publishes data on separations (discharge, deaths, and transfers) from all hospitals by Diagnosis Related Group (DRG). This data source was used to calculate two measures of public patient separations: public patients separated from public hospitals as a proportion of total separations in a DRG (or group of DRGs) and a second measure based on all public patient separations, including public patients separated from private hospitals. This latter measure includes public patients separated from private hospitals which are contracted to the public sector (eg, Port Macquarie Hospital in New South Wales, Mildura Hospital in Victoria) and also a small number of public patients treated under contract in private hospitals.

The indicator procedures used by AIHW are reported at the procedure level whereas separation statistics are provided by DRG. The two data sources were linked by identifying the minimum groupings of DRGs which together account for more than 85% of the separations for that procedure. In some cases, the assignment of DRGs to a procedure is self-evident and the procedure and the DRG are almost identical. Box 1 shows the DRGs that were used to identify the relevant separation data to be assigned to each procedure.

1 Indicator procedures in AIHW data set and associated Diagnosis Related Groups

			2000–01 Australian data		
Procedure	Key DRGs	Separations for this procedure in these DRGs (%)	Admissions	Median waiting time (days)	All public separations as proportion of total separations
Cataract extraction	C08Z	87%	35574	88	0.26
Cholecystectomy	H04A, H04B	96%	15466	41	0.50
Coronary artery bypass graft	F05A, F05B, F06A, F06B	94%	5985	16	0.49
Cystoscopy	L41Z, M40Z, Z40Z	88%	26892	28	0.34
Haemorrhoidectomy	G11A, G11B	97%	2896	40	0.42
Hysterectomy	N04Z	99%	10404	36	0.40
Inguinal herniorrhaphy	G09Z, G10Z	94%	13386	36	0.40
Myringoplasty	D09Z	98%	1392	98	0.39
Myringotomy	D13Z	86%	6486	32	0.39
Prostatectomy	M02A, M02B	91%	5272	29	0.37
Septoplasty	D06Z, D10Z	88%	3851	105	0.27
Tonsillectomy	D11Z	91%	11697	63	0.40
Total hip replacement	I03A, I03B, I03C	99%	5927	96	0.40
Total knee replacement	I04A, I04B	99%	7164	131	0.33
Varicose veins stripping & ligation	F20Z	99%	4126	73	0.34

The data set included data on 15 procedures for the six states. However, for privacy reasons, data on private hospital activity in the Northern Territory were suppressed in the AIHW publication and data for only six procedures performed in ACT hospitals were published.

Observations were not weighted for size of state in the principal analyses reported. The measures of waiting times and of public patient activity are independent of size of the state. Unlike waiting *list* measures that are related to the total number of separations, waiting *time* measures are not influenced by the number of separations. Separate analyses were performed on the two largest states and the three most frequently performed procedures, together accounting for 50% of procedures in the dataset, to verify that the results were not skewed by smaller states or procedures with aberrant observations. The data were analysed using SPSS version 11.5.

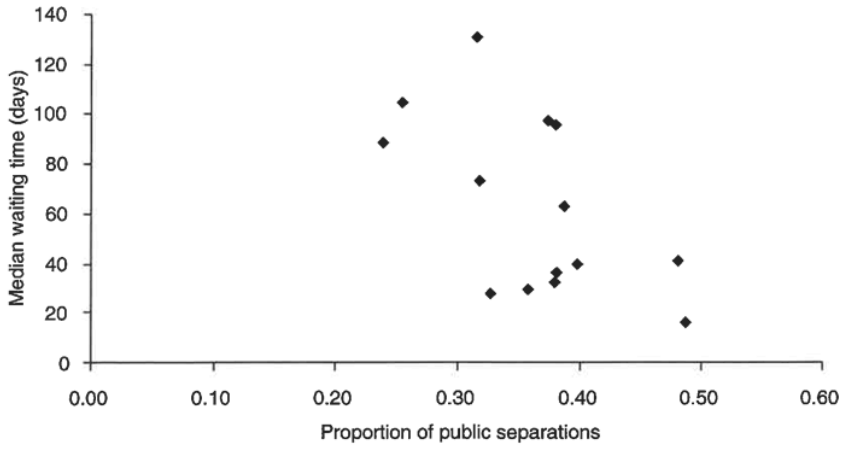
Results

Data from six states and the ACT for 15 procedures (6 in the ACT) give a potential 96 observations of the interaction between waiting time for a procedure and the extent of public activity. Box 2 shows descriptive statistics for the relevant variables. An outlier reporting a four year wait at the 90th percentile (myringoplasty in Tasmania) was removed from the relevant analyses.

2 Descriptive statistics for waiting time and public patient proportion

	Minimum	Maximum	Mean	SD
Median waiting time (days)	10	404	78.28	67.8
Waiting time at 90th percentile	45	1610	339.99	235.32
Proportion of patients waiting more than 12 months	0	0.57	0.1032	0.109
Public patients (all sources) as proportion of total patients	0.11	0.90	0.4013	0.117
Public patients in public hospitals as proportion of total patients	0.04	0.90	0.3652	0.124

3 Relationship between level of public activity and median waiting times by procedure, 2000–01



Box 3 shows the relationship between median waiting time and public patients separated from public hospitals as a proportion of total separations. It can be seen that larger proportions of patients being separated from public hospitals is associated with shorter waiting times, the reverse trend from the hypothesis that increased private sector activity is associated with reduced waiting times for public care.

The graphical representation is supported by bivariate regression analysis. Box 4 shows regression results for the three measures of waiting time and the two measures of public patient activity. It can be seen that using the data set of all 96 observations (state by

4 Correlation between proportion of activity in selected procedures in public hospitals and public patient waiting times, 2000–01

	Median waiting time		Days waited at 90th percentile		Proportion of patients waiting more than 12 months		
	r	2-tailed significance	*r*	2-tailed significance	*r*	2-tailed significance	*n*
State level selected procedures data							
Public separations from public hospitals as a proportion of total separations	–0.35	0.00	–0.42	0.00	–0.44	0.00	96
All public separations as a proportion of total separations	–0.19	0.07	–0.33	0.00	–0.32	0.00	96
Australian total data							
Public separations from public hospitals as a proportion of total separations	–0.59	0.02	–0.62	0.01	–0.65	0.00	15
All public separations as a proportion of total separations	–0.58	0.02	–0.62	0.01	–0.65	0.01	15

5 Relationship between waiting time and public patient activity (public patients separated from public hospitals as proportion of total separations), 2001–02

	Dependent variable		
	Median waiting time (days)	Waiting time at 90th percentile	Percent waiting more than 12 months
Public patient proportion	–172 (–3.7)	–626 (–4.4)	–0.32 (–4.1)
Tasmania	60 (3.8)	–	0.08 (3.2)
Queensland	–36 (–2.4)	–	–
Knee replacement	111 (5.4)	205 (3.1)	0.12 (3.3)
Hip replacement	–	205 (2.8)	–
Constant	126 (6.4)	519 (9.3)	0.19 (6.2)
Adjusted r^2	0.44	0.31	0.32

Table shows unstandardised B coefficient and *t* value in brackets. All *t* significant at < 0.05; F for each of the regressions significant at < 0.05

procedure), for each measure of waiting time and for both measures of public patient activity, there is a low to moderate negative correlation which in four cases is highly significant ($P<0.01$) with a further interaction significant at the 0.05 level.

Box 4 also shows results from analysis of the national position (Australian total data) for the 15 specialties. Again the table shows a moderate inverse relationship between waiting times and public patient separations for each of the different measures of waiting times and both measures of public patient proportion. The large state results showed a similar pattern (eg, median waiting time correlated with public patient proportion at –0.41; $P=0.024$) as did the analysis of the three most common procedures (using the same example $r=-0.47$; $P=0.023$).

Multivariate analysis confirms the bivariate findings. Stepwise multivariate regression analyses were undertaken, testing the association between each of the three waiting time measures and explanatory variables: the proportion of public patients and, as indicator variables, state/territory and two long waiting procedures (knee and hip replacement). The results are shown in Box 5.

The measure 'Public patients as a proportion of total patients' was entered into each of the multivariate models. Between 31% and 44% of the variation between states and procedures in waiting time was explained by the models. These quite simple models (including public patient proportion, states with high and low patterns of waiting, and one distinguishing type of procedure) are all significant on F-tests. Again, the models indicate that waiting times decline with increasing proportion of public activity: for example a 1% increase in the public patient proportion is associated with a 46-day reduction in median waiting time (constant of 126 days plus coefficient of public patient proportion of –172 days).

Conclusion

This study has confirmed the findings of previous overseas studies that suggest that increased private sector activity is associated with increased public sector waiting times, the reverse of the rhetoric supporting policies to increase support for the private sector in order to "take the burden off the public sector".

There are two limitations of this study derived from the nature of the available data. First, the waiting time data are reported on the basis of indicator procedures, and activity data on the basis of DRGs. The mapping process may have introduced some errors. Secondly, the analysis is of aggregate data at the state and territory level by procedure, and this exposes the study to the 'ecological fallacy', that the aggregations disguise considerable within-group variation. Unfortunately, finer aggregation of the data, such as intra-state regional data and more and more detailed procedural groupings, are not available.

Despite these limitations this study suggests that policymakers should be cautious about pursuing policies based on expanding private access as a strategy for achieving reductions in public sector waiting times. A stronger conclusion is not warranted, given the low degree of correlation shown in the bivariate results, and because, as this is a cross-sectional study, what is measured here is an association, not causation. Even if directionality and causation were proved, because this is a study of proportions of activity, the results could be driven by either public or private sector actions (eg, the public sector not providing sufficient services, causing a private market response versus private sector activity crowding out public activity). Despite these caveats, the indicative results suggest scepticism about conventional nostrums. It is also interesting to note that the correlations in the table show a stronger relationship between median waiting times and the tighter measure of public activity: public separations from public hospitals. Contracted activity thus appears to act more like private activity than public hospital activity, suggesting that private contracting for public patients may not be an efficient strategy for improving public sector waiting times.

Despite the rhetoric about the benefits of private health insurance in reducing public waiting times, these results should not be surprising. Similar results have been found internationally and, indeed, the Canadian Health Services Research Foundation has gone so far as to characterise the hypothesis that expansion of the private sector would reduce wait-

ing time as a myth.[22] Occam's razor* would also suggest that a simple proposition, that more public activity would reduce public waiting times, should be preferred over the complex, 'trickle down' hypothesis that more private activity will somehow flow through to benefits to those reliant on the public sector.

* the principle that, given many possible explanations, the simplest one is usually correct

Competing interests

None identified.

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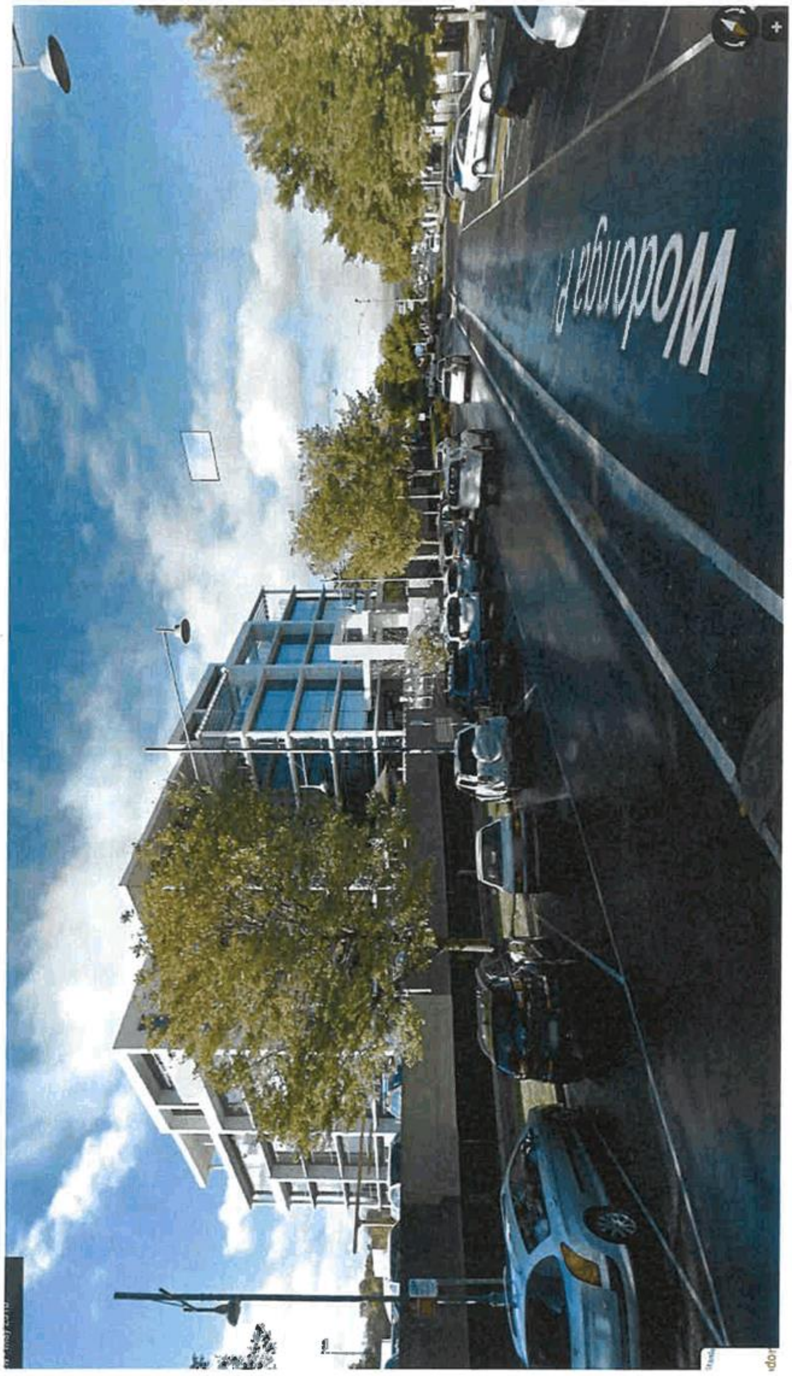
(Received 19 Aug 2004, accepted 6 Dec 2004) □



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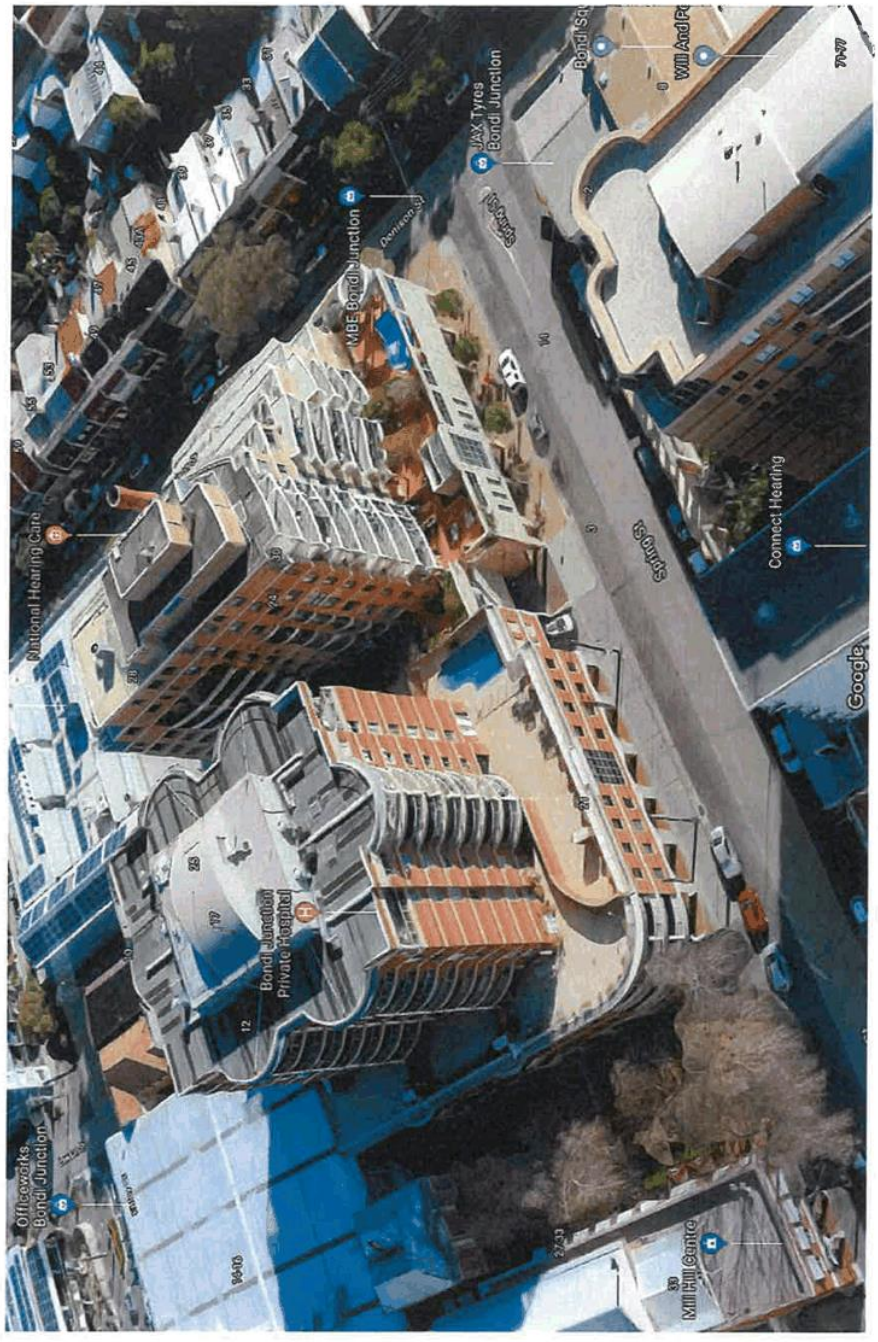

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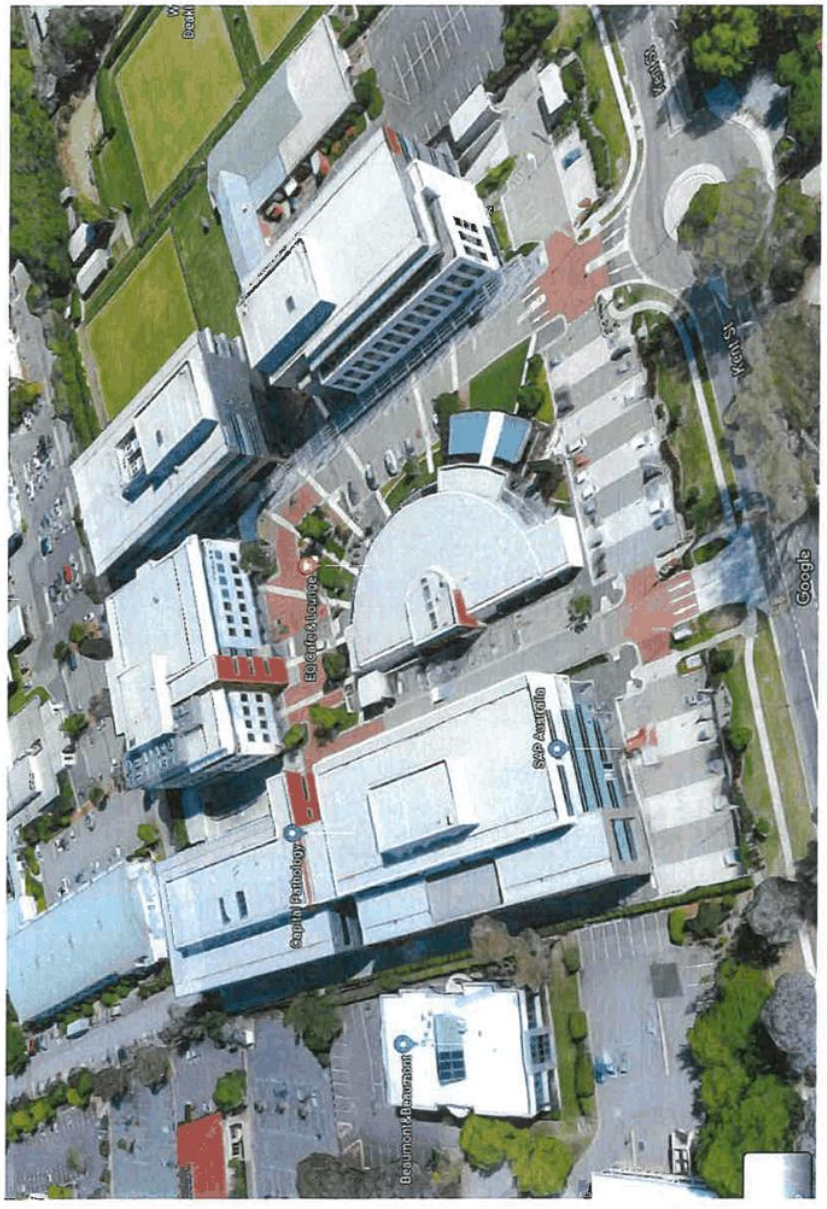

Building 2. L3 70 Kent Street, Deakin ACT Canberra Private Hospital


David St
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92 David St., Dandenong
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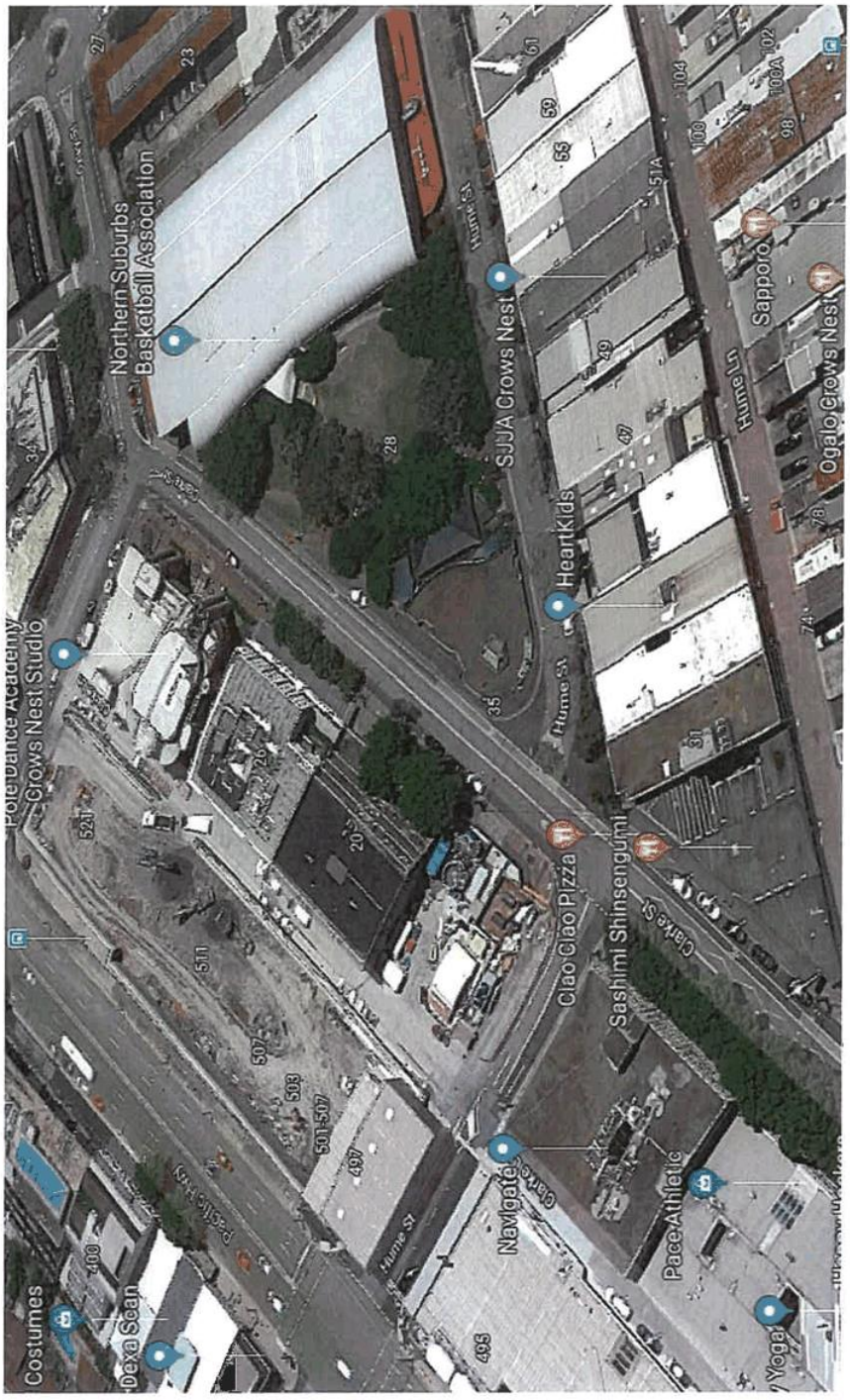
COLYMBIA. DAY HOSPITAL.

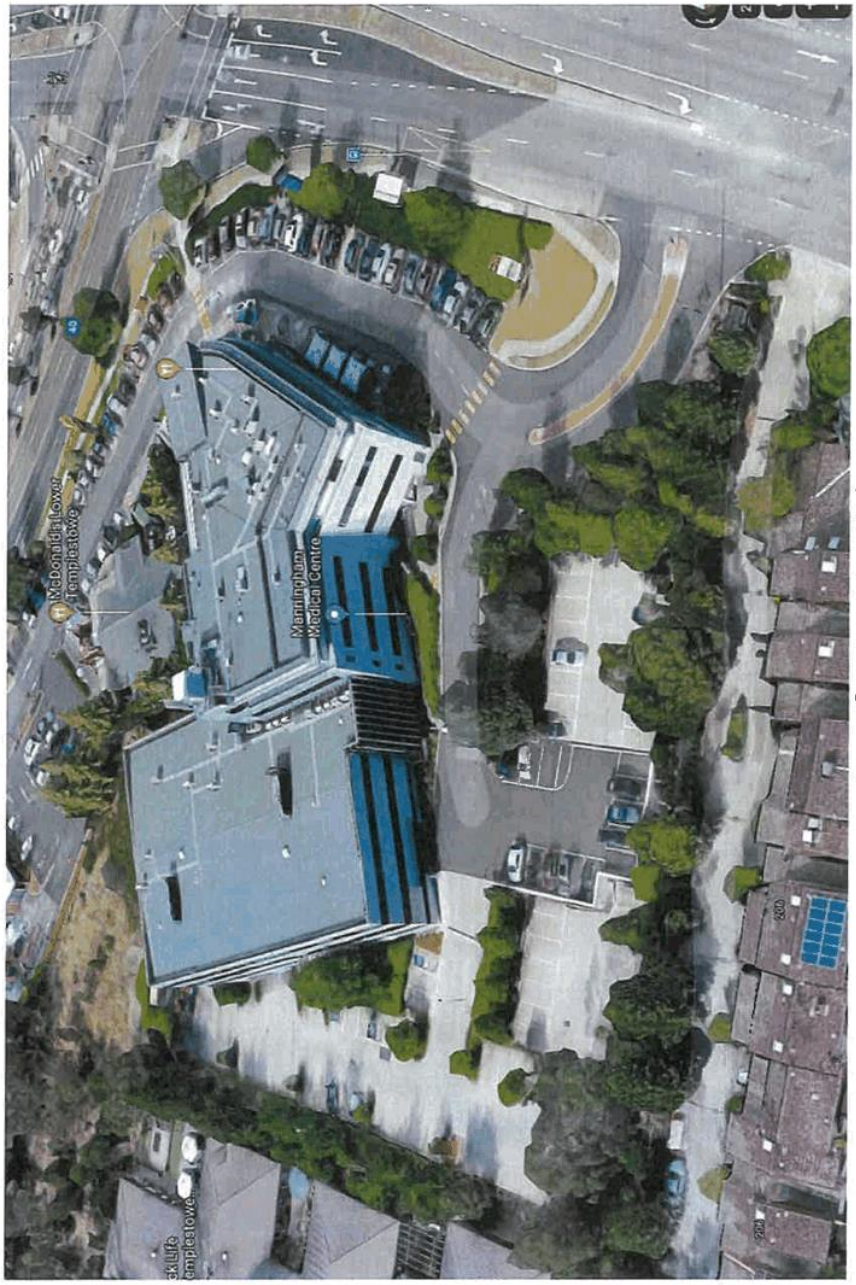
250 Pacific Hwy., Charleston NSW

Charlestown Private Hospital

10 Warnneford St., Sth Hobart Hobart Day Surgery


Warneford St
297


Northern Suburbs Basketball Association
SJJA Crows Nest
HeartKids
Ogalo Crows Nest
Sapporo
Hume Ln
Hume St
Clarke St
Pole Dance Academy - Crows Nest Studio
Clao Ciao Pizza
Sashimi Shinsengumi
Navigate
Pace Athletic
Costumes
Dexa Scan
Yoga
1/22 Clark St., Crows Nest
Crows Nest Day Hospital



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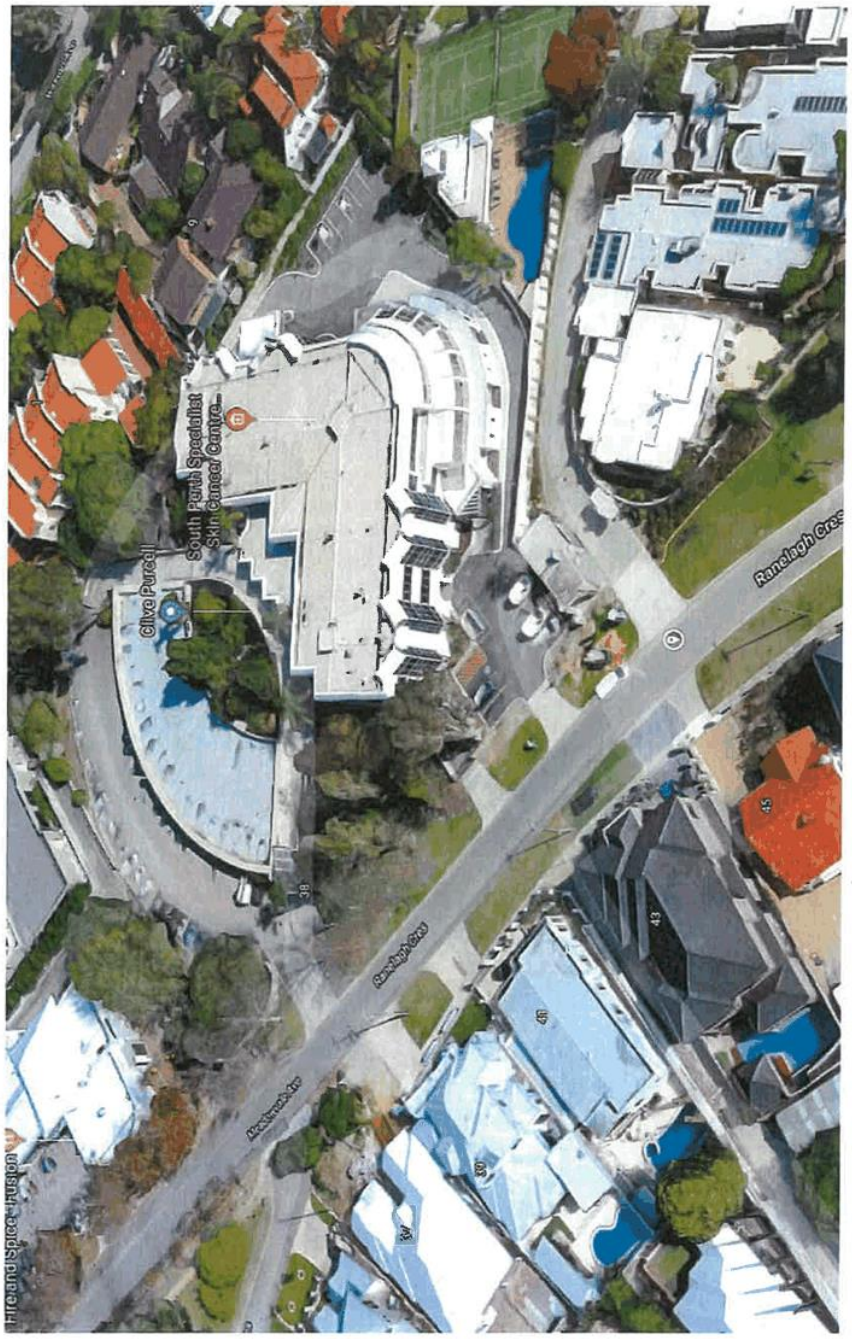
1/1 Derby Street, Kogarah

Kogarah Private Hospital



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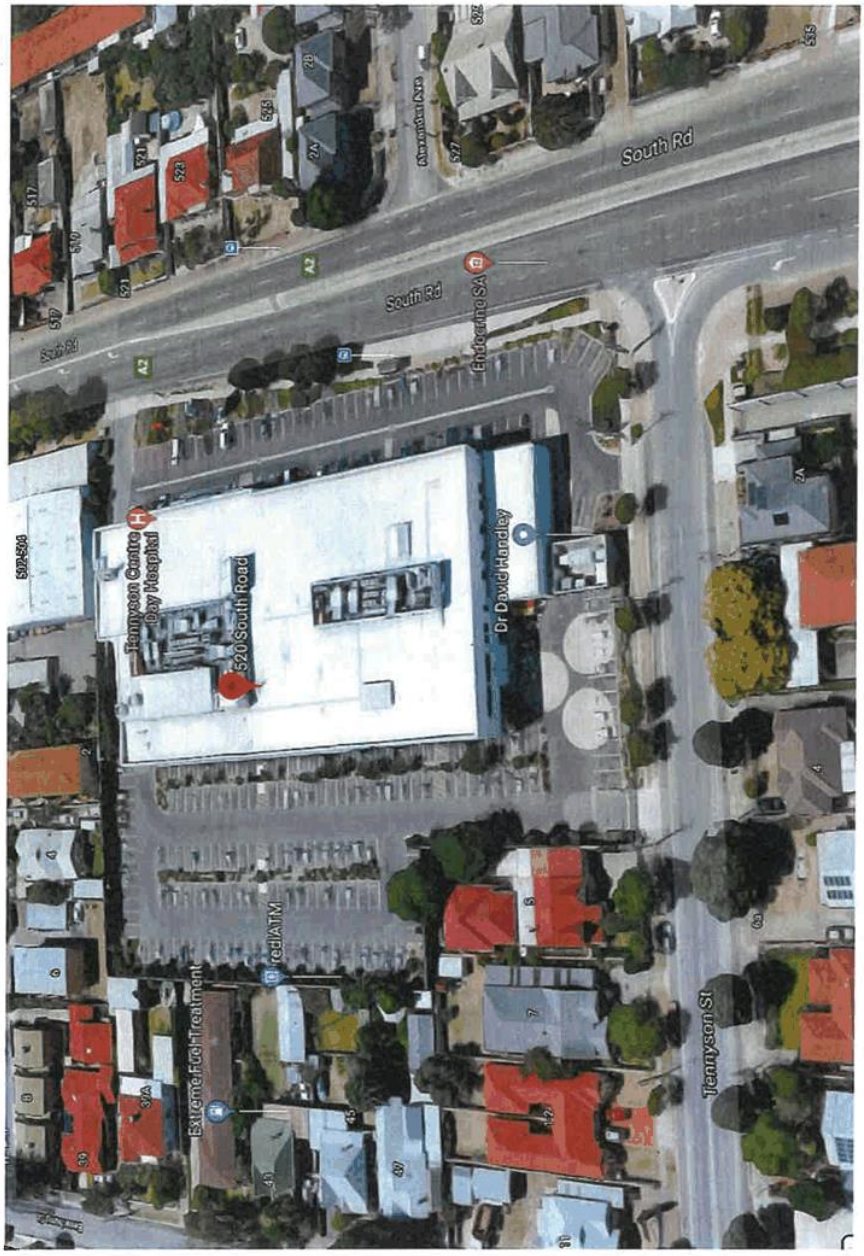

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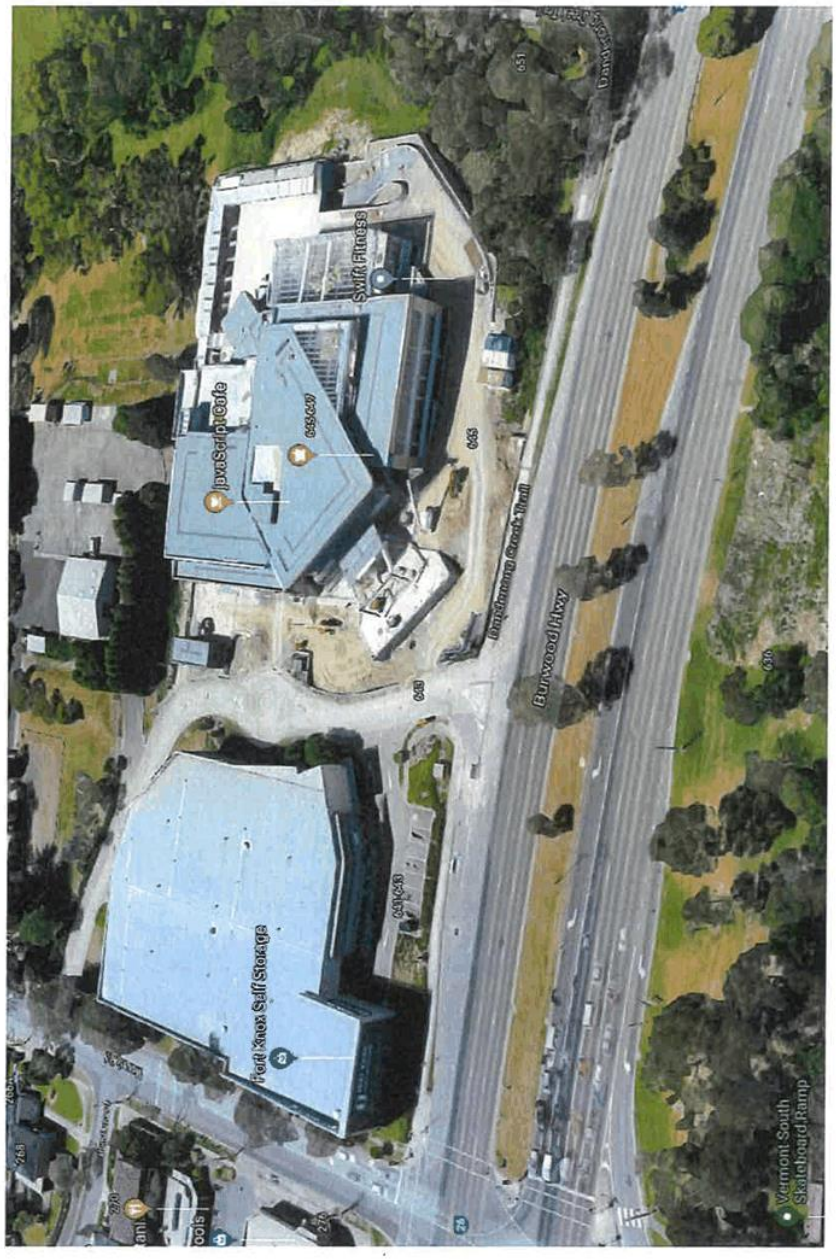

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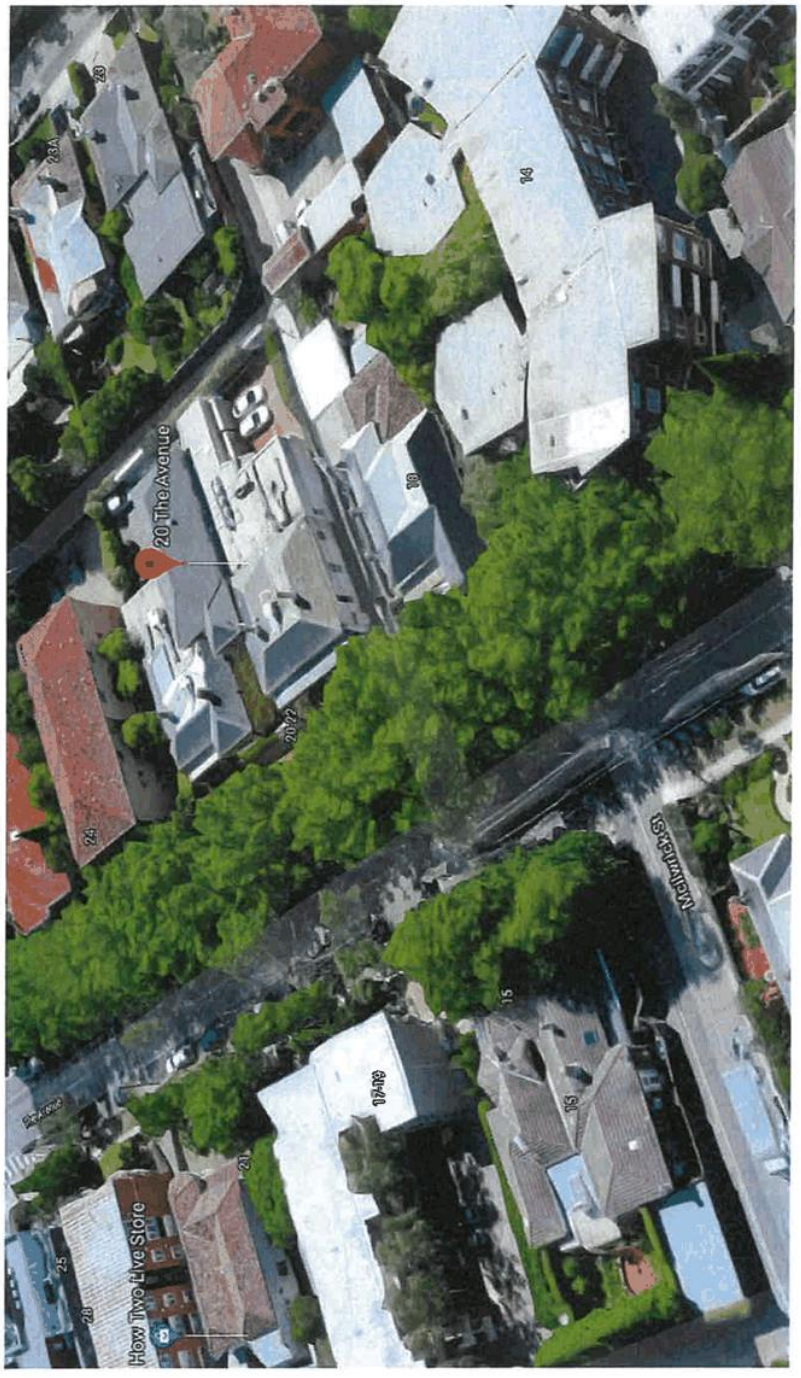


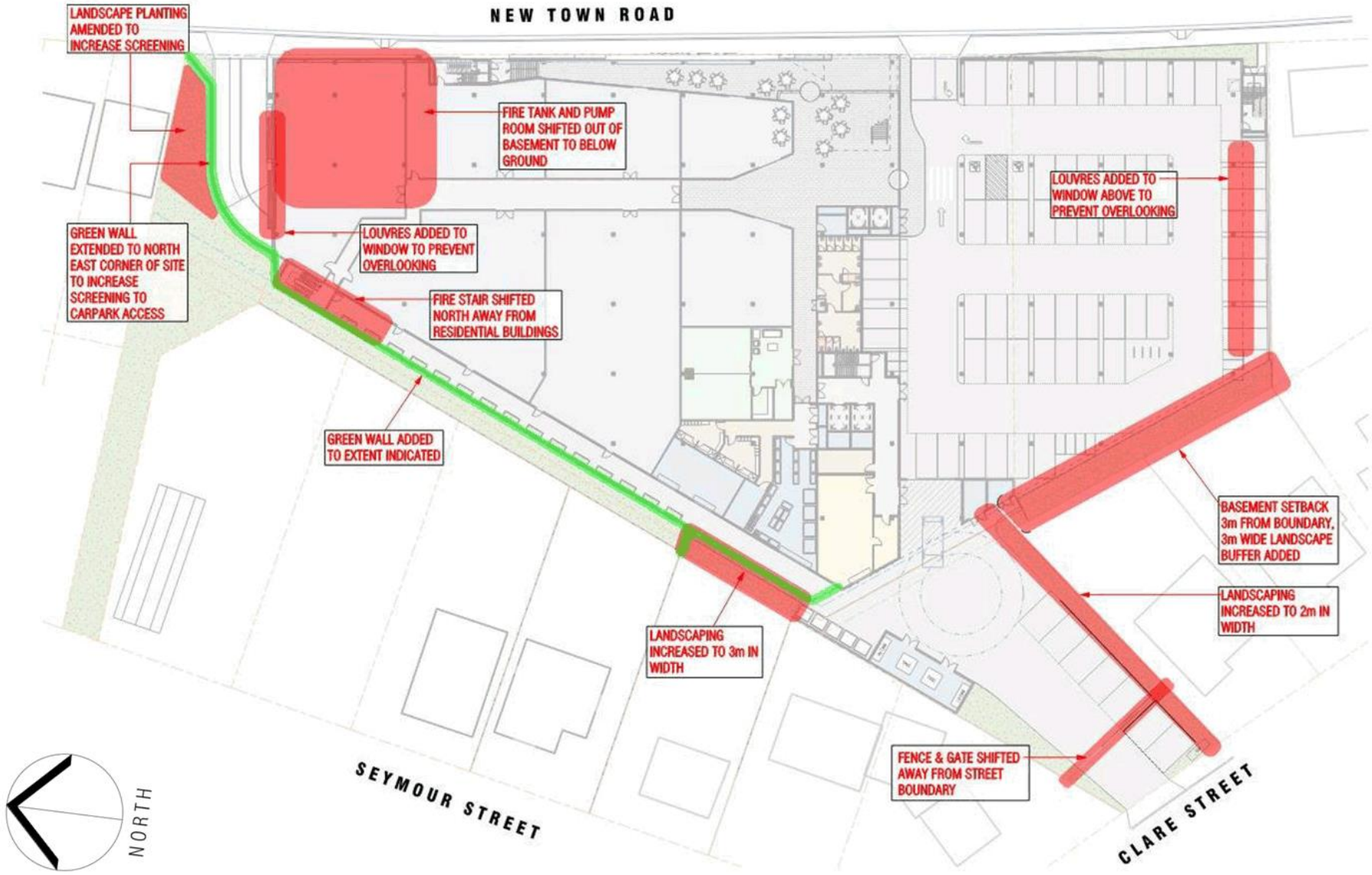
20 The Avenue, Windsor

NEW TOWN MEDICAL CENTRE

INCORPORATING TASMAN PRIVATE HOSPITAL

Swanbury Penglase

Design Changes



Planners Recommendation to Refuse

1. Proposed hours of operation (24 Hour)
2. Commercial vehicle movements
3. Building height – scale and transition
4. Building height – compatibility
5. Setback to residential zone
6. Extent of landscaping

Swanbury Penglase

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6. Extent of landscaping

Swanbury Penglase

Photomontages

Swanbury Penglase


Proposed Building


Compliant Building Envelope


Overlay


Proposed Building
½P
8 AM ~ 6 PM
MON ~ FRI


Compliant Building Envelope
½P
8 AM – 6 PM
MON – FRI


Overlay
½P
8 AM ~ 6 PM
MON ~ FRI


Proposed Building
TASMAN
D 49 MU


Compliant Building Envelope


Overlay
TASMAN


Proposed Building


Compliant Building Envelope


Overlay


Proposed Building


Compliant Building Envelope


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Proposed Building


Compliant Building Envelope


Overlay

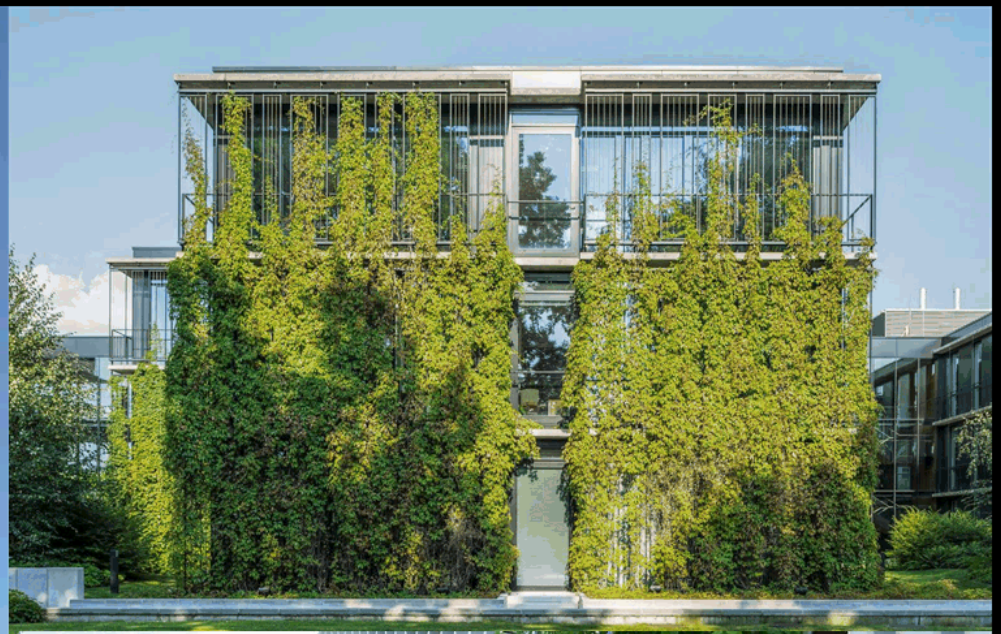
Greenwall Concept

Swanbury Penglase

Green Wall Concept - Extent

Swanbury Penglase

Green Wall Concept – Precedent Images

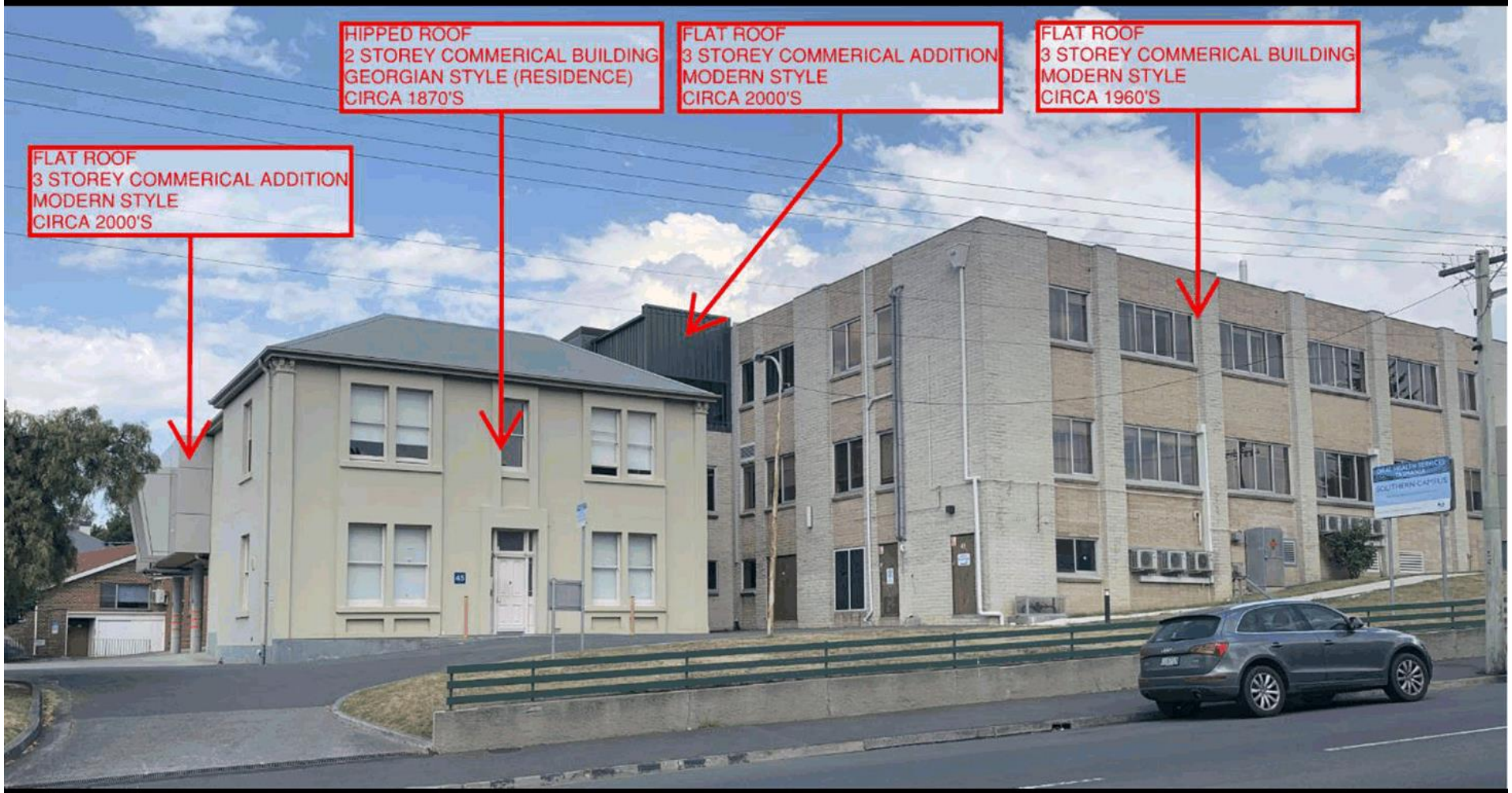


Compatibility

Swanbury Penglase

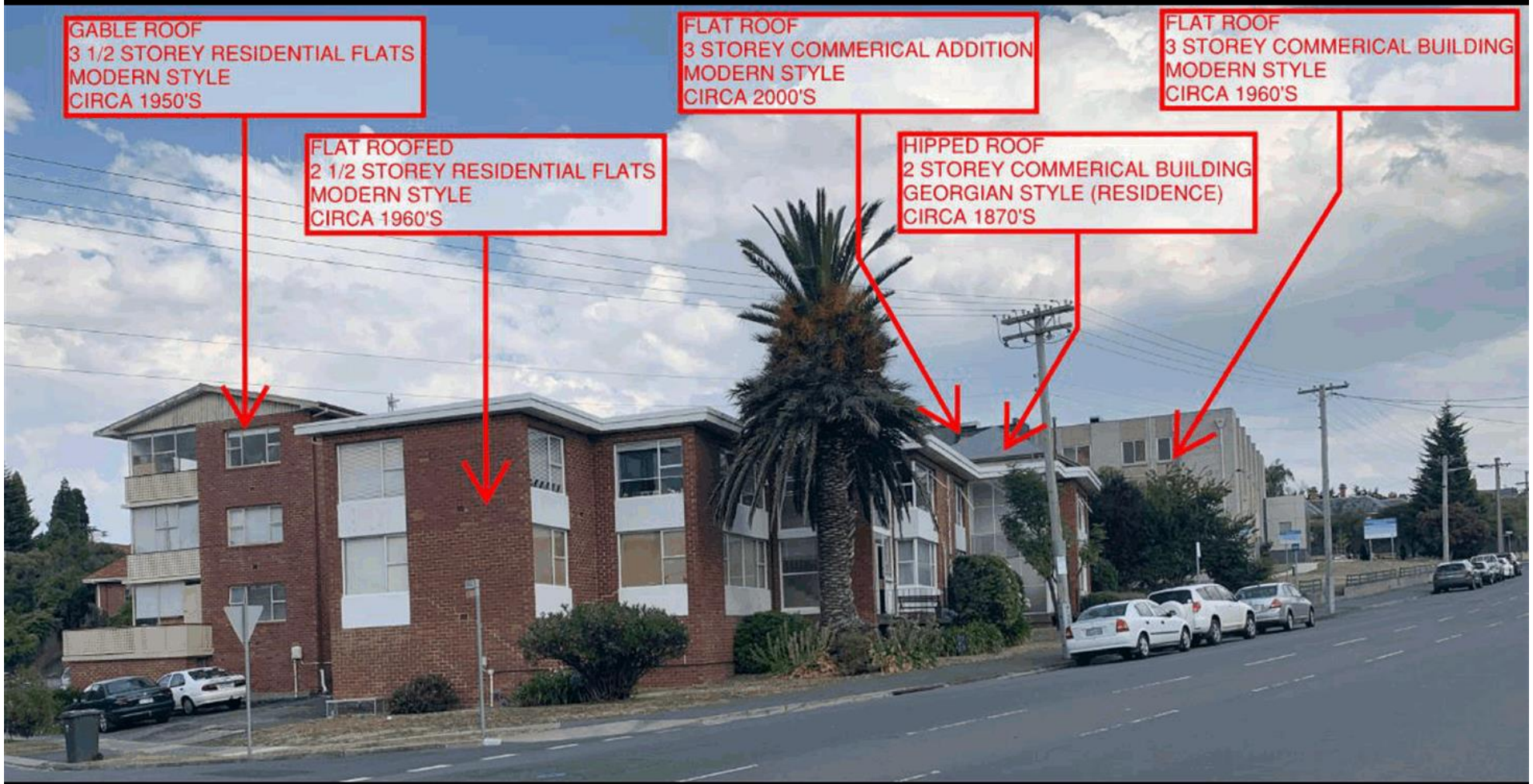
Surrounding Context

Surrounding Context



Swanbury Penglase

Surrounding Context



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NEW TOWN MEDICAL CENTRE

INCORPORATING TASMAN PRIVATE HOSPITAL

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Planners Recommendation to Refuse

1. Proposed hours of operation (24 Hour)
2. Commercial vehicle movements
3. Building height – scale and transition
4. Building height – compatibility
5. Setback to residential zone
6. Extent of landscaping

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Planners Recommendation to Refuse

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Planners Recommendation to Refuse

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Thank You

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Existing


Existing
½P
8 AM – 6 PM
MON – FRI


Existing
D 49 MU


Existing


Existing


Existing


Existing


Proposed Building


Compliant Building Envelope


Overlay


Existing


Proposed Building


Compliant Building Envelope


Overlay


Existing

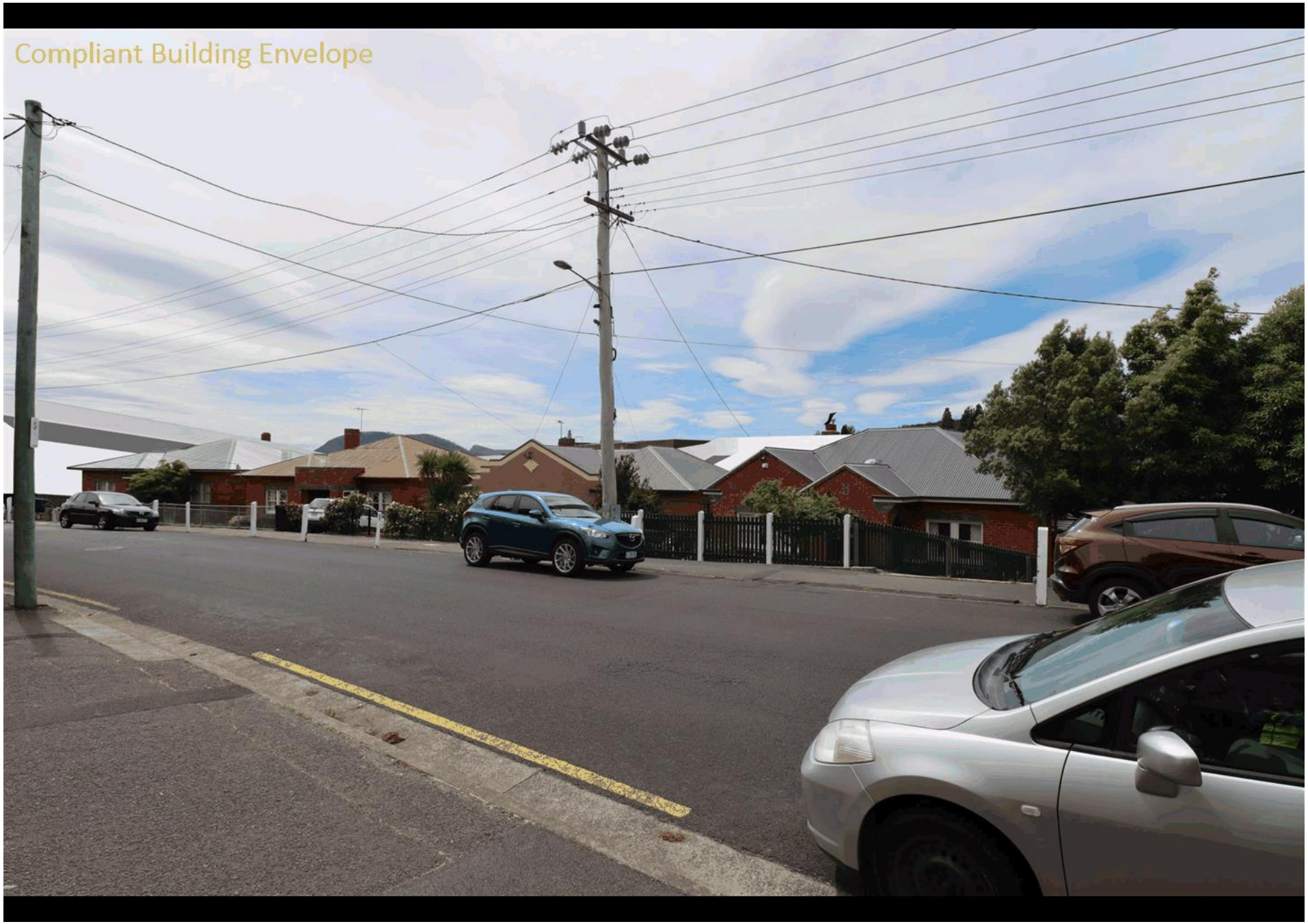

Proposed Building


Compliant Building Envelope


Overlay

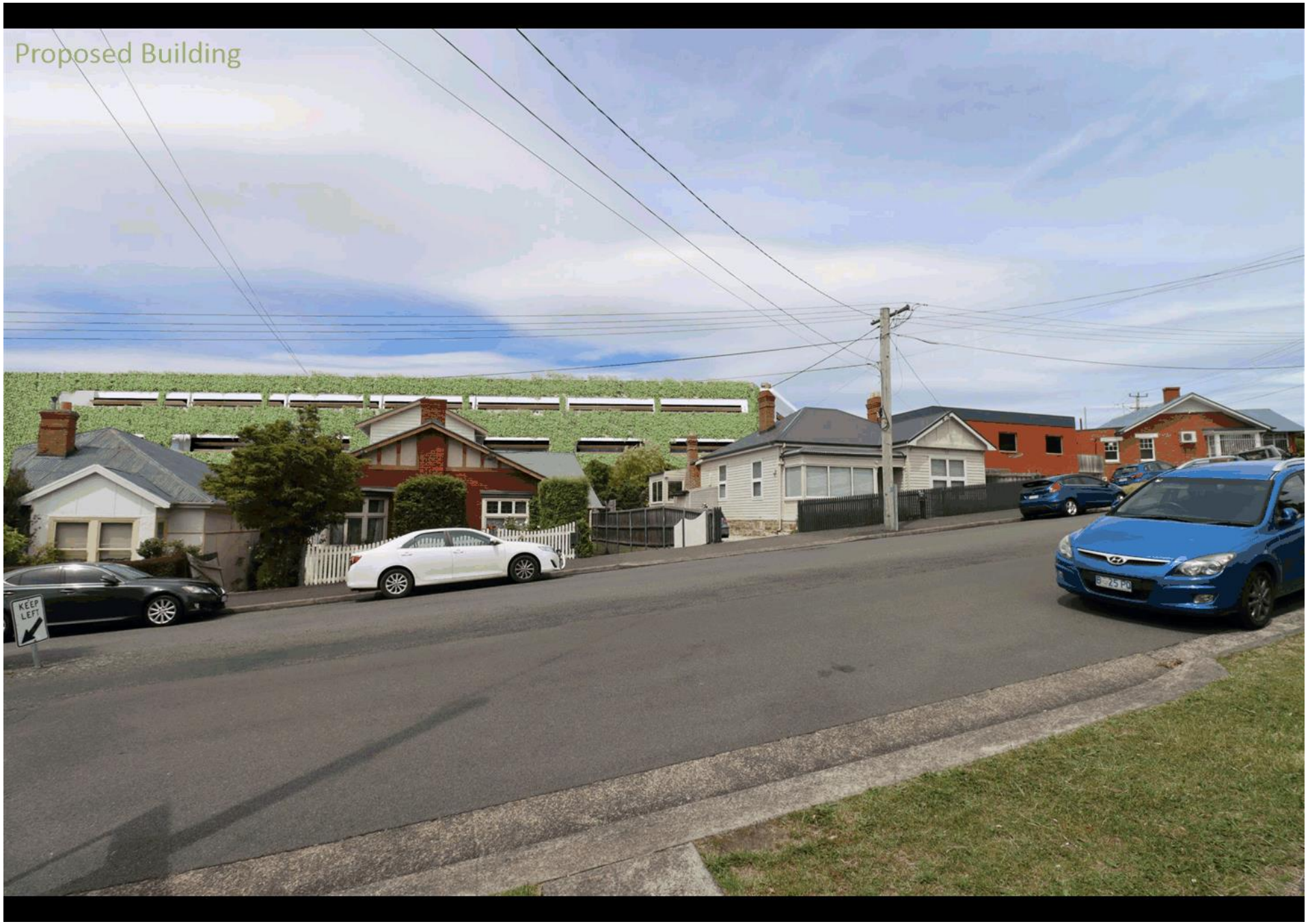

Existing


Proposed Building


Compliant Building Envelope


Overlay


Existing
KEEP LEFT


Proposed Building
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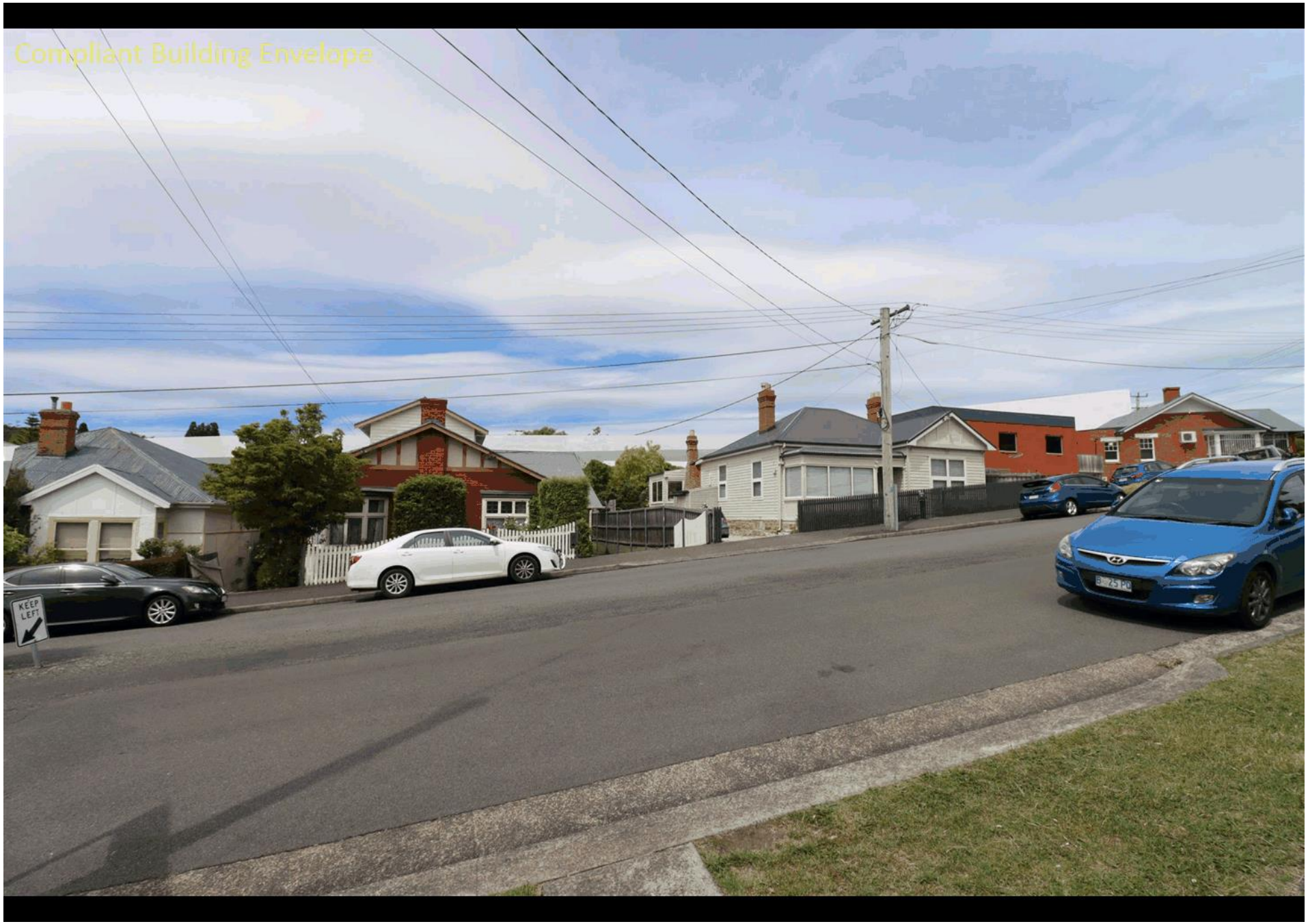
Compliant Building Envelope
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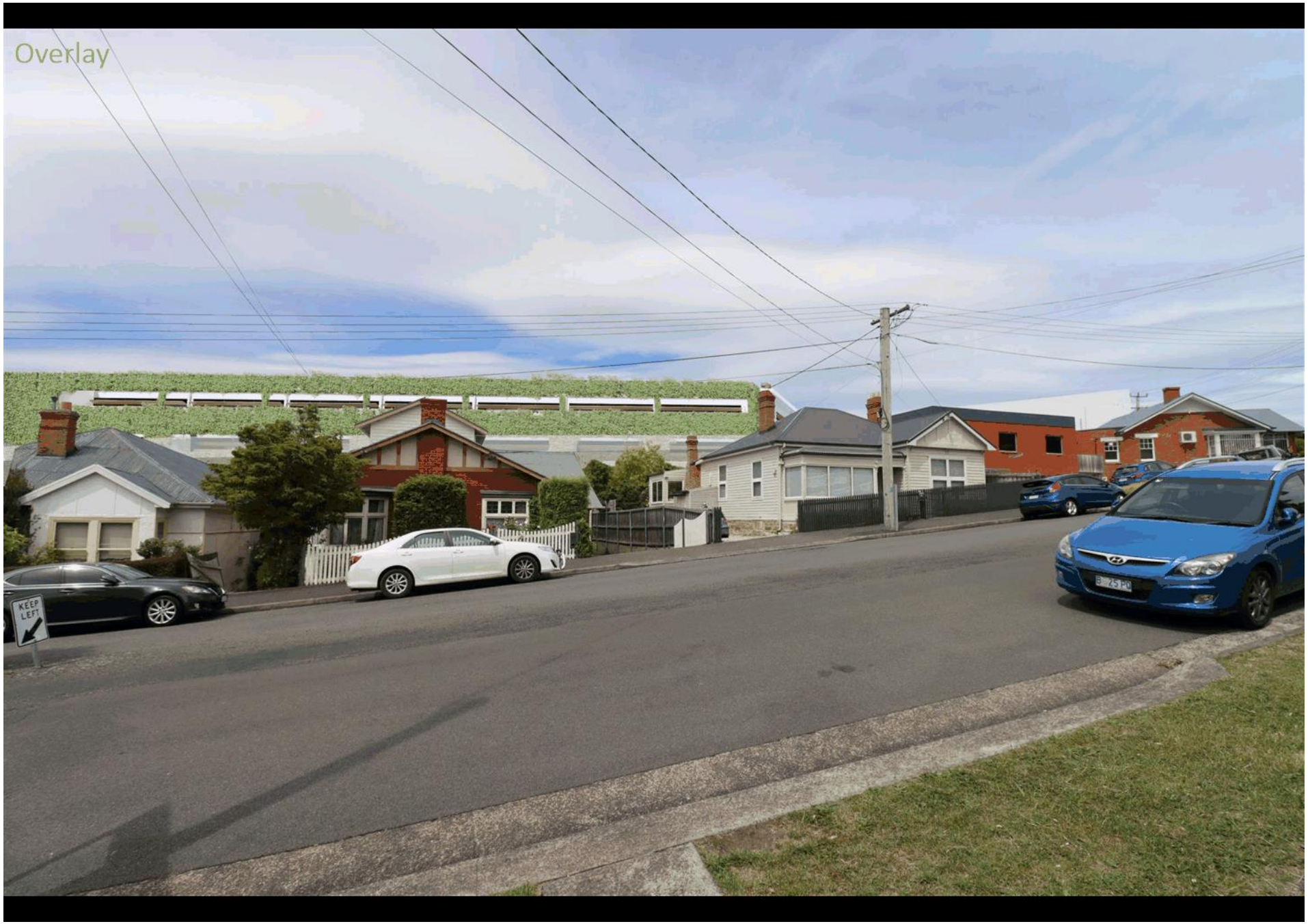
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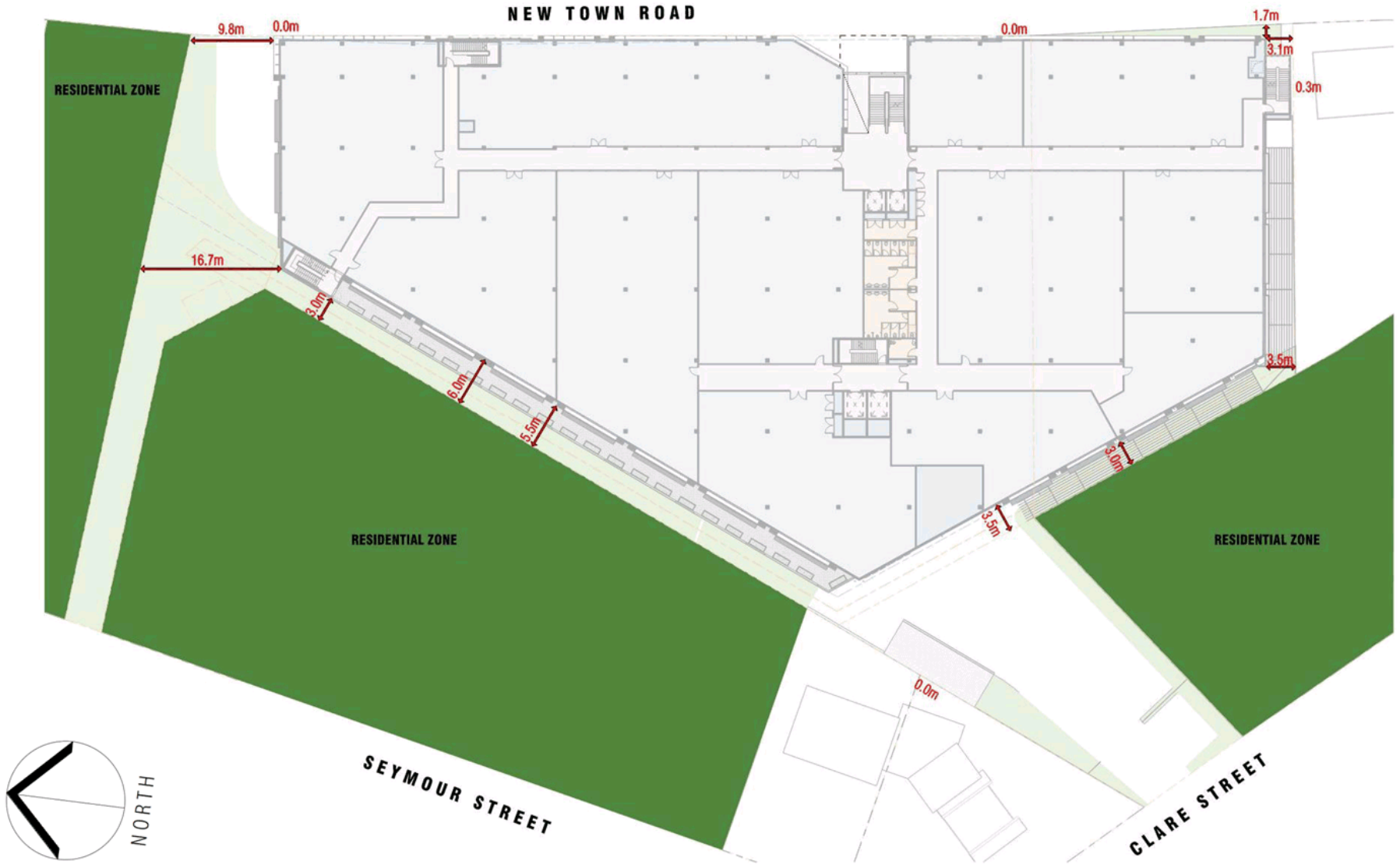
Existing


Proposed Building


Compliant Building Envelope


Overlay

Building Setbacks



Building Setback – North

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Building Setback – North West

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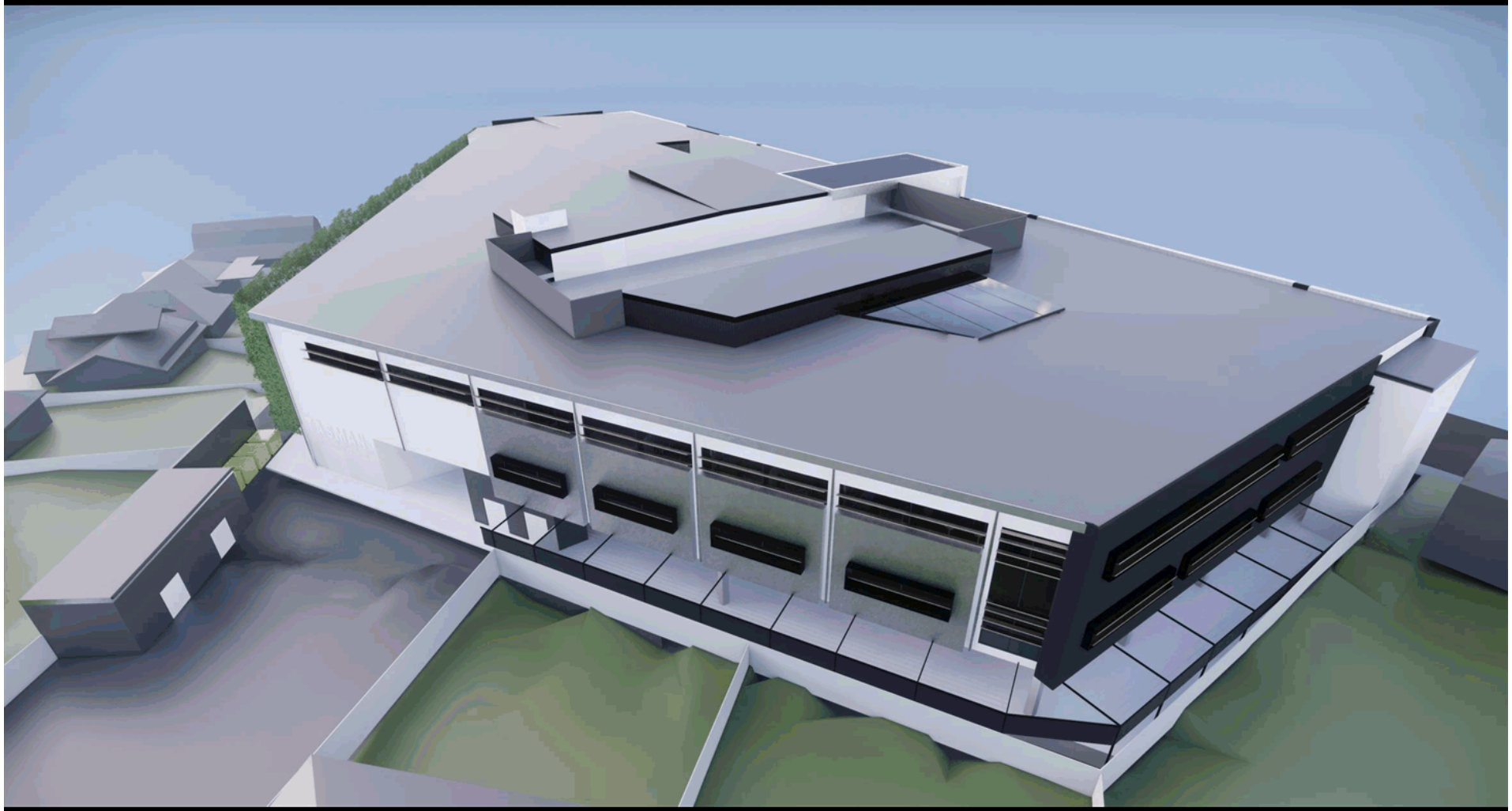
Building Setback – South West & South



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Building Setback – South & East

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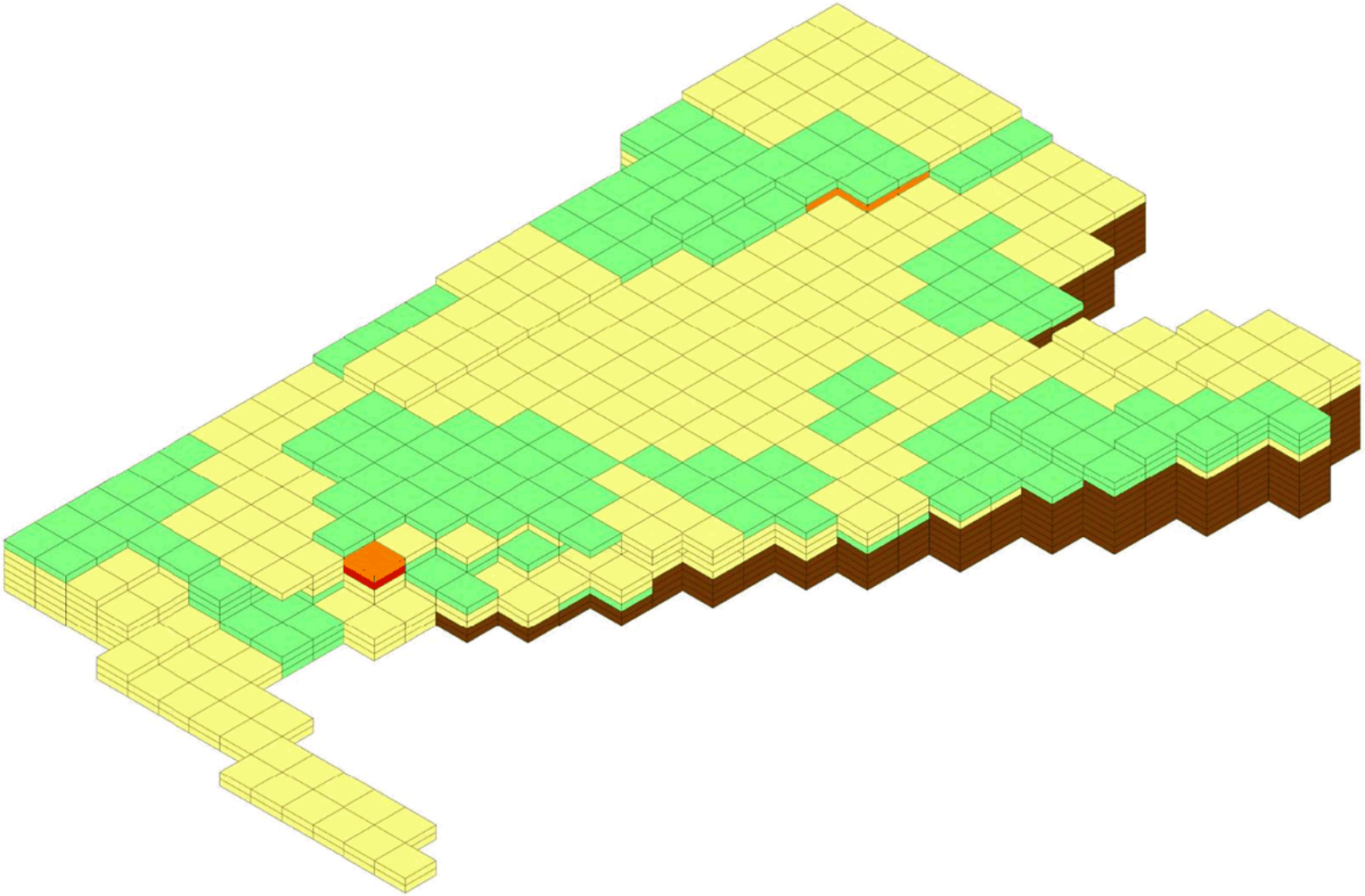
Contamination Modelling



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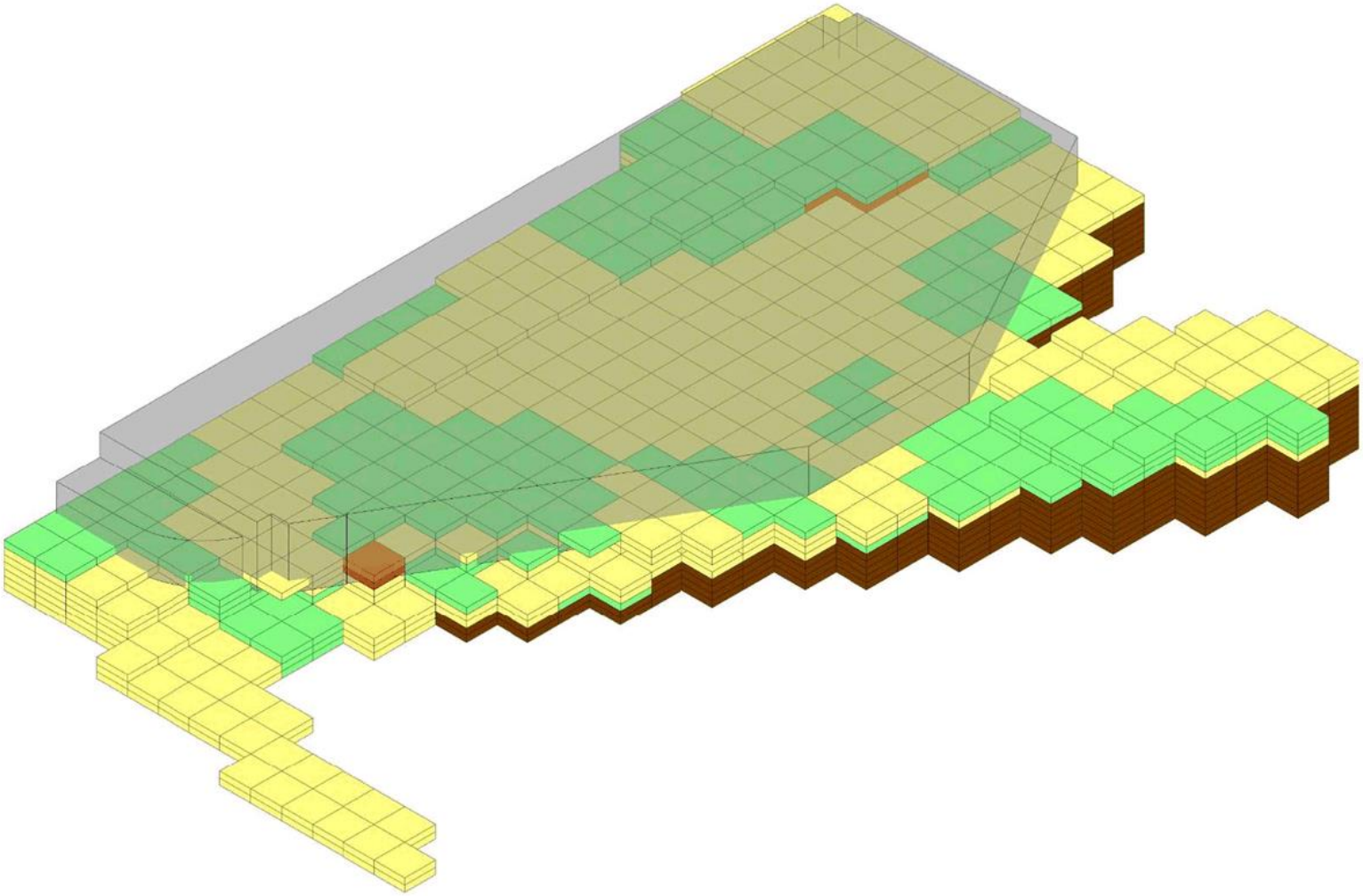
Contamination Modelling



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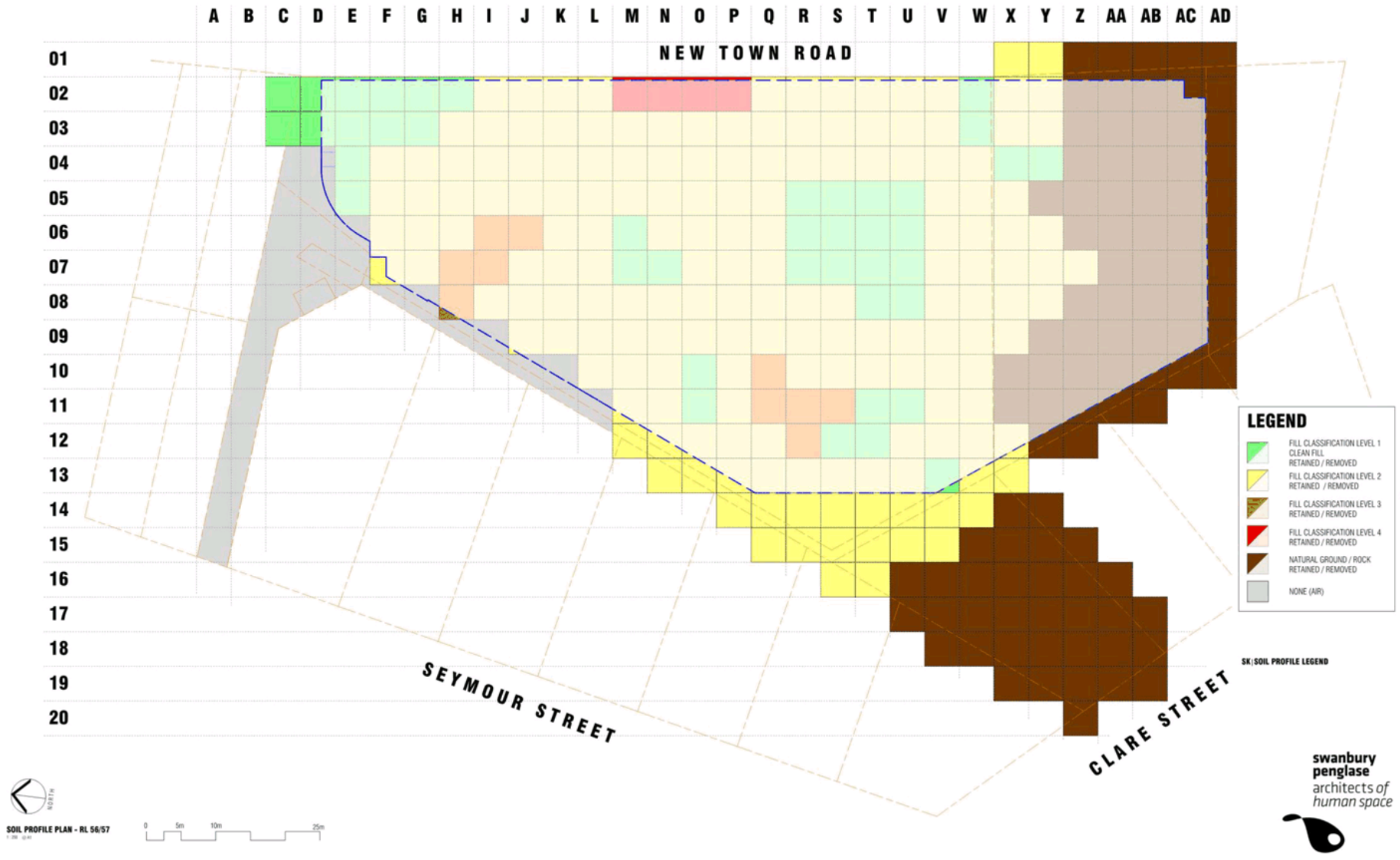
Contamination Modelling



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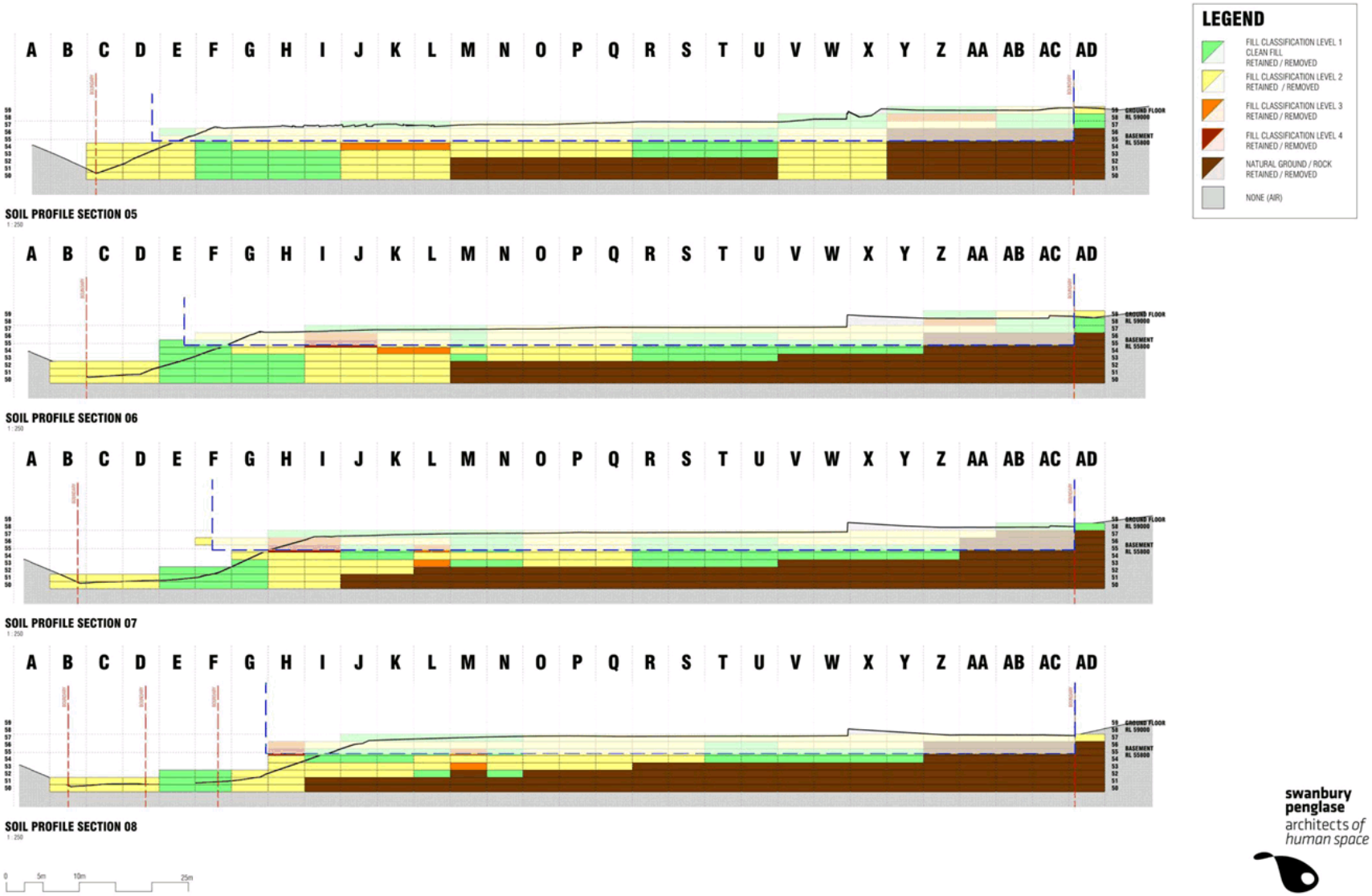

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architects of human space

Council Resolution (28 October)

That the item be deferred to a subsequent City Planning Committee meeting to allow time for a meeting to be convened between the Applicant and Representors to see if a satisfactory solution can be reached in relation to the concerns raised by the Representors.

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Meeting with Representors

1. Held on site Thursday 7 November

2. Applicant Attendees:
   - Geoff Schaedel
   - Stephen Penglase
   - Bill Fromberg
   - Wade Fromberg
   - John barker

   Representor Attendees:
   - David Reilly
   - Chris Clinton
   - Allison Turnock
   - Glenn Woodfall

3. Applicant presented drawings, concepts and precedent images for proposed changes

4. No formal feedback provided by the Representors

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Amended Design Documentation

1. Amended architectural drawings (plans, elevations and sections)
2. Amended landscape plan
3. Amended acoustic report
4. Updated and additional photomontages

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Compliant Building Envelope

15.4.1 Building height
A1 Building Height must be no more than 10m
A2 Building height within 10m of a residential zone must be no more than 8.5m

15.4.2 Setback
A1 Building setback from frontage must be parallel to the frontage and must be no more than 1m from the median street setback of all existing buildings on the same side of the street within 100m of the development site.
A2 Building Setback from a residential zone must be no less than:

a. 3m;
b. half the height of the wall;

which is ever the greater

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Operating Hours

Hospital Hours of Operation (Surgical Theatres/Discharge)

- Mon to Friday: 6.30am to 6.00pm
- Saturdays: 7.30am to 3.30pm (occurs approximately once per month)
- Sundays and Public Holidays: 3-4 hours for emergency for mainly retinal procedures (rare event).

After Hours Operations - Ward Area

- Monday night to Thursday night only (unoccupied Friday night to Sunday night)
- 24 bed capacity, expected to operate at 75% maximum occupancy.
- Visiting hours: 3.00pm to 4.00pm and 7.00pm to 8.00pm
- Shift change: Occurs at 10pm, 3 nurses coming on to replace 3 nurses going off.

Tenancy Operating Hours (expected normal business hours)

- Mon to Friday: 8.30am to 5.00pm
- Saturdays: 8.00am to 2.00pm
- Sundays and Public Holidays: None

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Commercial Vehicle Movements

Commercial Vehicle Movements (Controlled by TPH)
- Mon to Friday: 7.00am to 5.00pm
- Saturdays: rarely and unlikely, between 8.00am and 5pm
- Sundays and public holidays: None

Southern At Grade Carpark
- Secure carpark at all times operating 24 hours
- Staff parking only

Northern Basement Carpark
- Open during normal hospital hours from 6.30am to 8pm
- Secured after hours with no access
- Public parking and minor staff parking

Rear Loading Area off Clare Street
- Open during normal hospital hours from 6.30am to 8pm
- Secured after hours with no access
- Loading, deliveries and short term parking for commercial vehicles
- Ambulance access.

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Clare Street - Sacred Heart College

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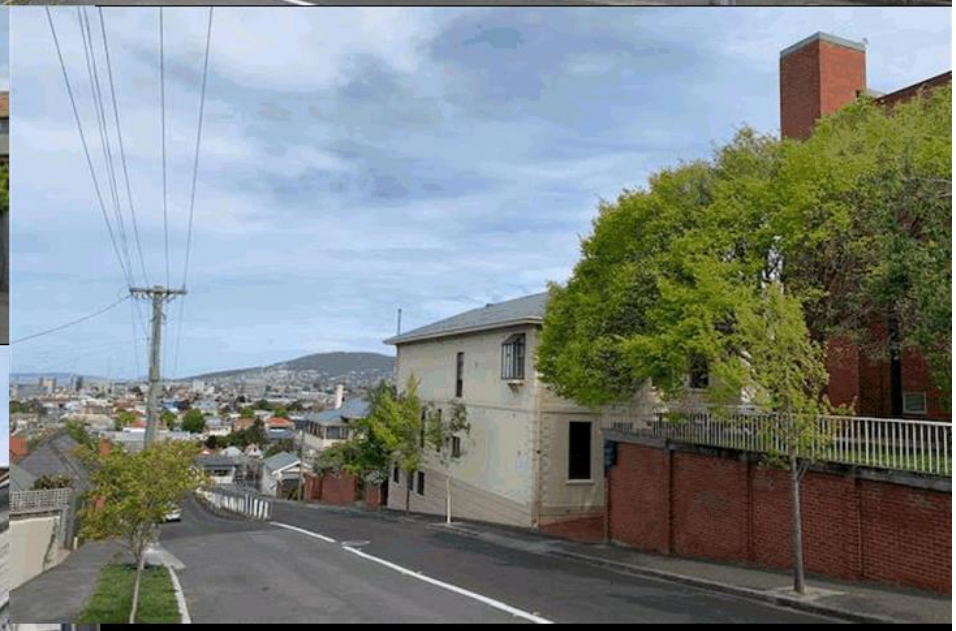
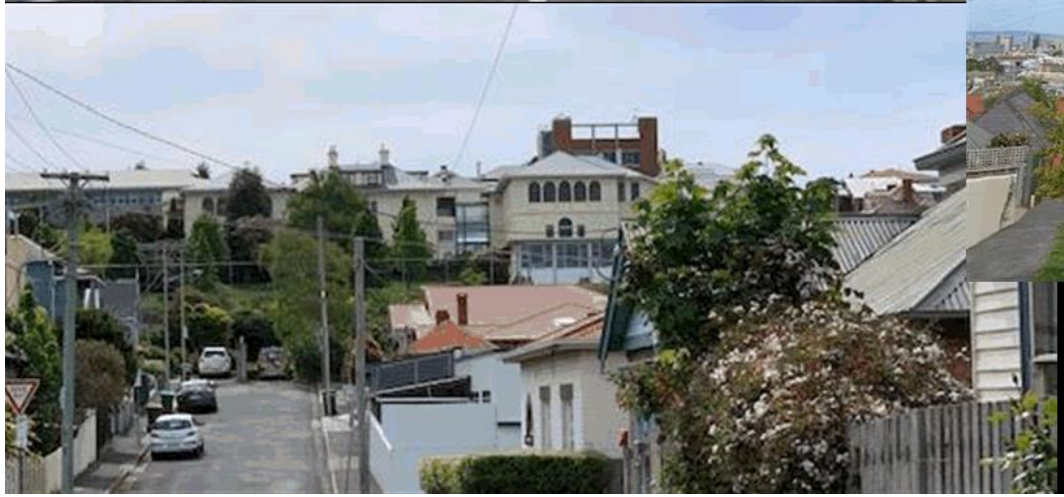
Carr Street - The Friends' School





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Façade greening: A case study from melbourne, Australia

Article in Acta horticulturae · November 2010
DOI: 10.17660/ActaHortic.2010.881.116

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Kirsten Raynor
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6 PUBLICATIONS 214 CITATIONS
SEE PROFILE


Nicholas S G Williams
University of Melbourne
105 PUBLICATIONS 3,567 CITATIONS
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Façade Greening: a Case Study from Melbourne, Australia

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Australia

Keywords: green walls, green roofs, plant evaluation

Abstract

Despite increasing interest in façade greening, there is little published research in the area. This paper describes the results of a study of the façade greening at Council House 2 (CH2) in central Melbourne, Australia. Located on nine levels of the northern side of the building, the installation consists of 90 modular planters placed on balconies external to the building and supported by a 150 mm gauge stainless steel X-tend™ mesh trellis. 164 plants from five different species were planted in August 2006: *Clematis aristata, Kennedia rubicunda, Kennedia nigricans, Pandorea pandorana, Trachelospermum jasminoides*. Evaluation in March 2008 showed a 61% 'failure' (death, poor cover) of all plantings. This 'failure' was caused by multiple factors including irrigation system failure, poor plant selection, plant quality, container substrate issues and problems in installation and establishment. The paper explores and discusses each of these factors in detail, particularly comparing species performance, site issues and substrate properties. It concludes by identifying some key research questions important to developing façade greening in the future.

INTRODUCTION

Façade greening is a term used to describe vegetation used on or adjoining a building surface (Dunnett and Kingsbury, 2008). Traditionally self-clinging climbing plants grown directly on a building have been the main type of planting treatment, but newer methods utilize plants grown away from the face of a building, often using high-tensile steel cables, wire and/or modular trellis systems. Twining and tendril climbing plants are generally used in these systems although others, including trained shrubs and trees, can be manipulated to produce similar results in some settings (Dunnet and Kingsbury, 2008). Plants can be grown in ground or in specialized plant containers at any level of the building. Façade greening is distinct from 'living walls' – which are engineered modular or hydroponic systems, supporting ferns, grasses and herbaceous perennials to form a vertical carpet of foliage and flowers (Johnston and Newton, 2004; Blanc, 2008; Dunnett and Kingsbury, 2008).

The benefits of façade greening are similar to those provided through green roofs, including reductions in building energy and resource use, reduced urban heat island effect, additional biodiversity habitat, noise and air pollution attenuation, localized food production and improved amenity and aesthetic values (Osmundson, 1999; Oberndorfer, et al., 2007; Currie and Bass, 2008; Dunnett and Kingsbury, 2008). The effects on building microclimates can be substantial. One study reported a 28 % reduction in peak radiation from a west-facing wall covered with Ivy (*Hedera helix*) during summer (Di and Wang, 1999). Urban greening strategies such as these are also becoming critical climate change adaptation and mitigation responses, particularly as studies of the life-cycle cost-benefit analysis quantify the economic benefits they can provide (Wong et al., 2003; Carter and Keeler, in press). Unlike green roofs and roof gardens, there are comparatively few studies of façade greening in urban environments, despite the increased potential benefits due to the larger percentage of vertical building surfaces in cities. Dunnett and Kingsbury (2008) identify climate and aspect, building size, growth characteristics (growth rate and profile, climbing mechanism), visual qualities and ecological considera-

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Eds.: G. Prosdocimi Gianquinto and F. Orsini
Acta Hort. 881, ISHS 2010

tions as key factors influencing plant selection for façade greening. The only existing technical guide for façade greening (Wassman, 2002) places significant emphasis on calculating the load distributions of the façade as a basis for plant selection. Other factors of importance can include the nature and type of support systems, the soil or substrate properties, maintenance requirements and the available budget.

This paper reports on a study undertaken at Council House 2 in central Melbourne to evaluate plant performance in a façade greening project from 2006 to 2008.

CH2 FAÇADE GREENING

Council House 2 (CH2) is the municipal offices of the City of Melbourne. This nine storey office building opened in October 2006 and was the first six-star rated green building in Australia. The building supports an amenity roof garden, a semi-extensive green roof and façade greening. The façade greening consists of 90 molded black plastic containerized planters placed on small balconies on the northern face of the building. The dimensions of each planter include 0.3 m x 0.97 m at the surface, 0.89 m in depth, with a volume of 260 L. Each balcony supports two containers (10 per level), housed in a galvanized iron frame and offset 90° to the building face. A steel cable X-tend™ mesh trellis, 1 m in width (150 mm aperture size) was built behind and above the planters, forming a vertical screen the full height of the building. The planting substrate consists of 55% white washed sand, 40% Hydrocell™ flakes and 5% organic compost. Slow release fertilizer (NPK 16:4.4:10, 6 months) was added at the rate of 3 kg/m^3. The container design includes a sub-irrigation system encompassing a small cistern at the base (100 mm depth), controlled by a foot valve (Aqua-minder™) connected to the water supply. Each cistern houses vertical, inverted cone-like 'columns' rising upwards in the substrate and filled with Hydrocell™ flakes to form a capillary irrigation 'wick' into the container proper.

Planting Design Recommendations

A planting design project was completed by the first author in 2003 to provide species recommendations for the façade greening. This included extensive consultation with the designer to develop criteria against which plants would be selected. The criteria developed including vegetation screening, tolerance of high wind loadings (upper levels), tolerance of low light intensity (lower levels), suitable growth habit and form, low maintenance requirements, useful aesthetic properties and interpretation potential (Australian and/or indigenous plants preferred). While reduced water use was a key consideration, as all plantings would be under constant irrigation this could be assisted by lowering container plant density and by selecting plants with known 'drought tolerance'. A final list of ten taxa were recommended: *Akebia quinata, Aphanopetalum resinosum, Cissus antarctica, Clematis aristata, Distictus buccinatoria, Kennedia rubicunda, Macfadyena unguis-cati, Pandorea pandorana, Tecomaria capensis* and *Trachelospermum jasminoides.*

Installation and Planting

The original planting was proposed for winter 2005, with plants contract grown in 200 mm nursery pots. Building construction delayed the plantings until August 2006. Two plants were placed in each container, except in some of the upper level, smaller balconies where only one plant was used. A 50 mm layer of gravel mulch (20 mm washed river pebbles) was added following planting. One hundred and sixty-four plants from five taxa were planted: *Clematis aristata, Kennedia nigricans, Kennedia rubicunda, Pandorea pandorana* and *Trachelospermum jasminoides*. Table 1 shows the final planting design.

Plant Evaluation

Interviews with City of Melbourne staff were held in February and March 2008 to discuss plant establishment. All containers were evaluated in March 2008. Observations were made on plant survival (dead, alive), plant health status and cover values (good,

poor). Poor cover was determined to exist if plants were severely stunted and if there was less than 30% plant growth over the backing trellis area (two m^2). In April 2008 two containers were partially excavated in-situ to examine root growth and soil wetting patterns.

RESULTS AND DISCUSSION

Table 2 shows the survival and cover values of plants as at March 2008. A total of 60.9% of plants were classified as 'failed' due to death or poor cover values. Poor cover values were strongly related to plants that displayed low plant vigour and growth, pest infestation (Vine Moth, Two-spotted Mites) and abiotic stress symptoms (chlorosis, leaf burn). Pest infestation and stress symptoms were particularly prevalent in surviving *Kennedia* spp. Of the five plants used in the project, only *Pandorea pandorana* had low rates of failure (6.2%). Across all species the greatest rates of failure were located in the lower levels and eastern sides of the building (data not presented). Why did such a high percentage of plants fail on the building in such a short time?

Sub-Irrigation System

The most significant issue affecting plant performance was failure of the sub-irrigation system. The float valves in the container cisterns were designed to operate on low water pressure (100 pa), however the water pressure in the system was much higher than this, around 250 kpa. This led to the gradual failure of the float valves, stopping the flow of water into the cisterns. As the Hydrocell™ 'wick' in the cistern dried, they became impossible to re-wet, restricting capillary movement of water up into the containers. Partial excavation of containers in April 2008 showed inconsistent wetting patterns throughout the profile, particularly at depth. These problems led to the sub-irrigation system being gradually disconnected throughout 2007 and 2008, with hand watering used to maintain plants after this.

Plant Selection

Better plant selection would have assisted plant performance. Only four of the ten plant recommendations were used in the project. Some recommended plants (*Clematis aristata, Trachelospermum jasminoides*) had high rates of failure in conditions of reduced light intensity, despite both species being reportedly tolerant of shade (Jones and Gray, 1988; Kellow, 2000). Better plant acclimatization to low light in the nursery prior to planting could have assisted their performance on site.

Plant Quality

Delays in building led to delays in planting. Contract grown plants were held over a much longer time-frame than planned (almost one year) with the outcome that very mature, containerized plants were used. Typically, these have significantly higher water needs, particularly after planting (Gilman, 1997). If these water needs were not met by the failing sub-irrigation system, then these plants would have been under considerable drought stress. Visits made to the nursery in March 2006 by the first author also noted problems with basal shoot and lateral branching of the container plants. Formative pruning was recommended; it is unknown if these were addressed prior to planting.

Installation and Maintenance

A lack of maintenance specifications meant that reporting and monitoring, especially in respect to plant health, was inadequate. Further, changes in personnel at the City of Melbourne at key stages led to minimal supervision of contractors. One observation made across all 90 planters during February and March 2008 was the variation in 'catchment volume' at the top of each container – it ranged from 50 mm to 150 mm below the top of the container. Whilst this variation would not have had a huge influence on plant performance, it is indicative of a lack of consistency in installation methods.

Substrate Properties

No clear specifications were provided for the substrate, such as air-filled porosity, water-holding-capacity or hydraulic conductivity. These are important considerations for container substrates, particularly to ensure water availability and water movement (Craul, 1999; Handreck and Black, 2004). Another issue was the depth of the containers (890 mm), meaning the required capillary rise to the root zone is in the order of 600 to 800 mm. Under the best of conditions this can be very difficult to achieve and requires excellent substrate properties to ensure success.

CONCLUSIONS

One of the main conclusions drawn from studying the façade greening at CH2 is the need for adequate testing and performance assessment of systems and materials, particularly with regard to new technologies. Another key conclusion is the need for horticultural expertise early in the design of a project, as well as during installation and throughout establishment. Greater use of performance outcomes and adherence to specifications (i.e. for substrates) is essential, particularly where there is an absence of industry standards. At the very least testing and assessment of proposed substrates for key physical properties is needed to ensure greater reliability in outcomes. Plant products for specialized installations such as façade greening often require a different nursery product than what is currently available. Here plants with extensive lateral branching and basal shoots were required, rather than a pot specimen with few leading stems. As the industry develops further, hopefully this will lead to improved plant quality.

Fundamentally, more research into façade greening is needed. For virtually all climbing plants there is little or no empirical data available on growth rates and biomass, screening or cover values, strength of attachment and environmental tolerances. With so little technical literature, research into species' performance across climatic gradients and under specialized conditions is also urgently needed. This information would provide greater confidence to those selecting plants and aid plant performance in the future.

ACKNOWLEDGEMENTS

We would like to thank Mary Chapman from the City of Melbourne for providing great assistance in many areas, including endless questions and answers, site access and in reviewing this paper; Research Assistant Jenny Bear for her help with tables and revision and our colleague Dr. Peter May for interpretation and discussion of substrates and systems.

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Tables

Table 1. The numbers of species planted across each building level in the façade greening at Council House 2 in August 2006.

Species	Level									
	1	2	3	4	5	6	7	8	9	Total
Clematis aristata		4	4	2	2	2				14
Kennedia nigricans		4	6	9	9	9	6	6	2	41
Kennedia rubicunda				9	9	9	6	6	2	51
Pandorea pandorana							4	4	8	16
Trachelospermum jasminoides	20	12	10							42
Total	20	20	20	20	20	20	16	16	12	164

Table 2. Total plant failure of façade greening at Council House 2 at March 2008 based on death and poor plant cover.

Species		Plant Death		Poor Cover		Plant Failure	
	No. planted[1]	No.	%	No.	%	Total No.	Total %
Clematis aristata	14	10	71.4	1	7.1	11	78.6
Kennedia nigricans	41	22	53.6	12	29.3	34	82.9
Kennedia rubicunda	51	15	29.4	11	21.6	26	50.9
Pandorea pandorana	16	1	6.2	0	0	1	6.2
Trachelospermum jasminoides	42	22	52.4	6	14.3	28	66.6
Total	164	70	42.6	30	18.3	100	60.9

[1] At August, 2006

Hobart City Council
City Planning Committee

Joint Deputation
PLN 19-291

25 November 2019

Mr David Reilly
Mr Christopher Clinton
Mr Glenn Woodfall
Dr Allison Turnock


INCOMPATIBLE SCALE


24-HOUR OPERATION


TRAFFIC CONGESTION


NO TRANSITION


LIGHT POLLUTION


PARKING OVERSPILL


OVER-SHADOWING


NOISE POLLUTION


HEALTH CONCERNS


MINIMAL SETBACKS

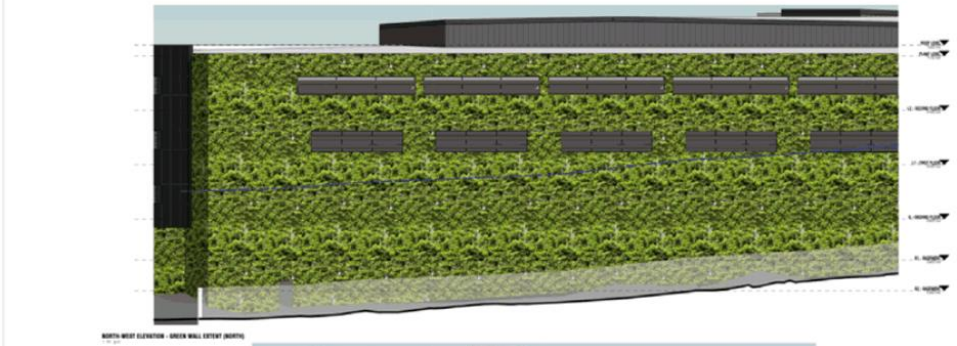

EMISSIONS


HERITAGE & CHARACTER


MINIMAL LANDSCAPING


LOSS OF PRIVACY


QUESTIONABLE INFORMATION



swanbury penglase
architects of human space

NEW TOWN MEDICAL CENTRE
48-52 NEW TOWN ROAD, HOBART

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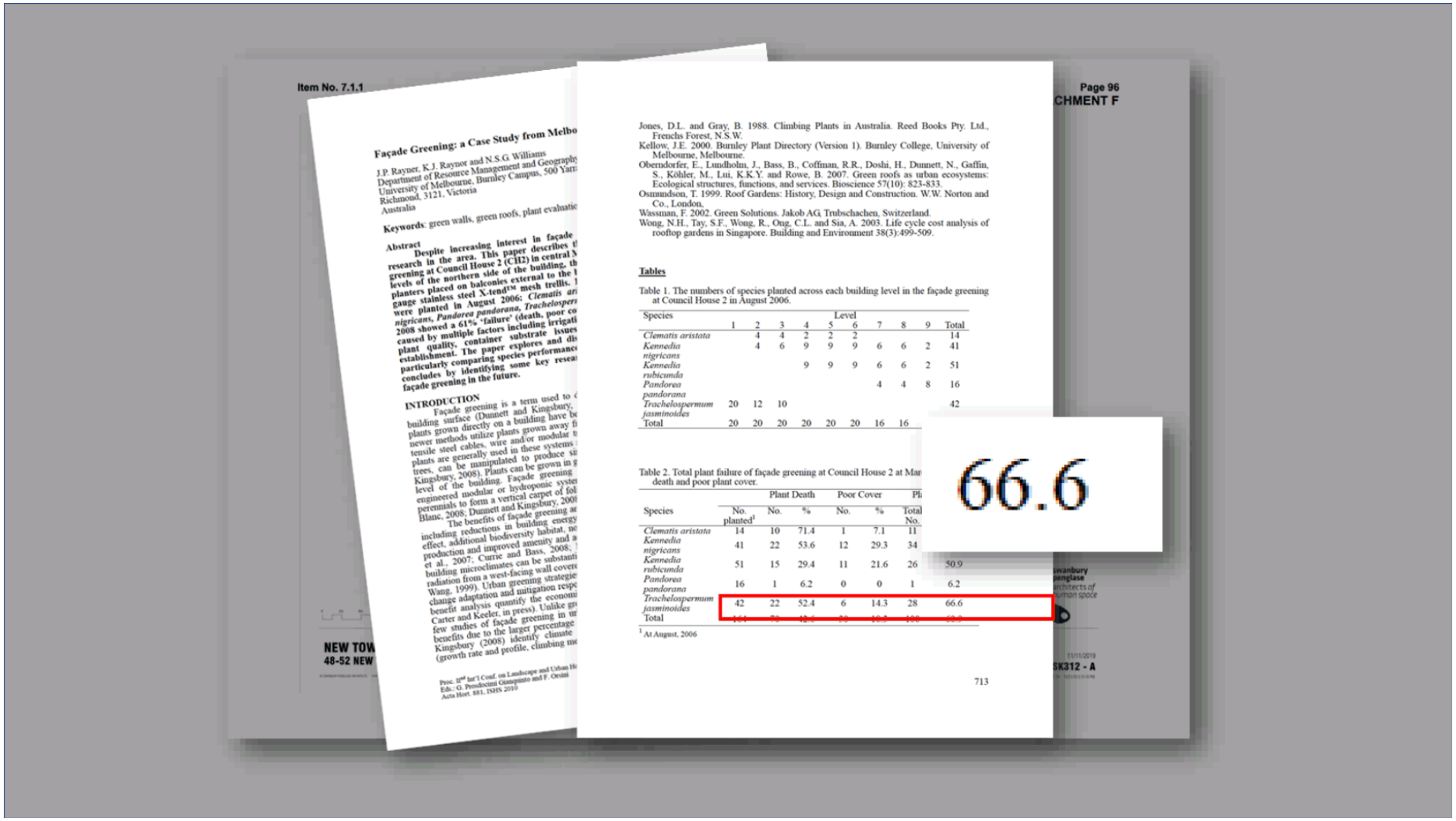
Item No. 7.1.1
Page 96
CHMENT F
Façade Greening: a Case Study from Melbo
J.P. Raynor, K.J. Raynor and N.S.G. Williams
Department of Resource Management and Geograph
University of Melbourne, Burnley Campus, 500 Yarr
Richmond, 3121, Victoria
Australia
Keywords: green walls, green roofs, plant evaluatio
Abstract
Despite increasing interest in façade
research in the area. This paper describes t
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levels of the northern side of the building, th
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INTRODUCTION
Façade greening is a term used to
building surface (Dunnett and Kingsbury,
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level of the building. Façade greening
engineered modular or hydroponic syste
perennials to form a vertical carpet of fol
Blanc, 2008; Dunnett and Kingsbury, 200
The benefits of façade greening a
including reductions in building energy
effect, additional biodiversity habitat, re
production and improved amenity and a
et al., 2007; Currie and Bass, 2008;
building microclimates can be substanti
radiation from a west-facing wall covere
Wang, 1999). Urban greening strategie
change adaptation and mitigation respe
benefit analysis quantify the economi
Carter and Keeler, in press). Unlike gr
few studies of façade greening in w
benefits due to the larger percentage
Kingsbury (2008) identify climate
(growth rate and profile, climbing m
Proc. IS on Int'l Conf. on Landscape and Urban H
Eds.: G. Prosdocimi Gianquinto and F. Orsini
Acta Hort. 881, ISHS 2010
Jones, D.L. and Gray, B. 1988. Climbing Plants in Australia. Reed Books Pty. Ltd., Frenchs Forest, N.S.W.
Kellow, J.E. 2000. Burnley Plant Directory (Version 1). Burnley College, University of Melbourne, Melbourne.
Oberndorfer, E., Lundholm, J., Bass, B., Coffman, R.R., Doshi, H., Dunnett, N., Gaffin, S., Köhler, M., Lui, K.K.Y. and Rowe, B. 2007. Green roofs as urban ecosystems: Ecological structures, functions, and services. Bioscience 57(10): 823-833.
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Tables
Table 1. The numbers of species planted across each building level in the façade greening at Council House 2 in August 2006.
Species | Level 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | Total
Clematis aristata | | 4 | 4 | 2 | 2 | 2 | | | | 14
Kennedia nigricans | | 4 | 6 | 9 | 9 | 9 | 6 | 6 | 2 | 41
Kennedia rubicunda | | | | 9 | 9 | 9 | 6 | 6 | 2 | 51
Pandorea pandorana | | | | | | | 4 | 4 | 8 | 16
Trachelospermum jasminoides | 20 | 12 | 10 | | | | | | | 42
Total | 20 | 20 | 20 | 20 | 20 | 20 | 16 | 16 | | 42
Table 2. Total plant failure of façade greening at Council House 2 at Mar
death and poor plant cover.
Species | No. planted[1] | Plant Death No. | % | Poor Cover No. | % | Pl Total No.
Clematis aristata | 14 | 10 | 71.4 | 1 | 7.1 | 11
Kennedia nigricans | 41 | 22 | 53.6 | 12 | 29.3 | 34
Kennedia rubicunda | 51 | 15 | 29.4 | 11 | 21.6 | 26 | 50.9
Pandorea pandorana | 16 | 1 | 6.2 | 0 | 0 | 1 | 6.2
Trachelospermum jasminoides | 42 | 22 | 52.4 | 6 | 14.3 | 28 | 66.6
Total
[1] At August, 2006
713
66.6
NEW TOW
48-52 NEW
SK312 - A

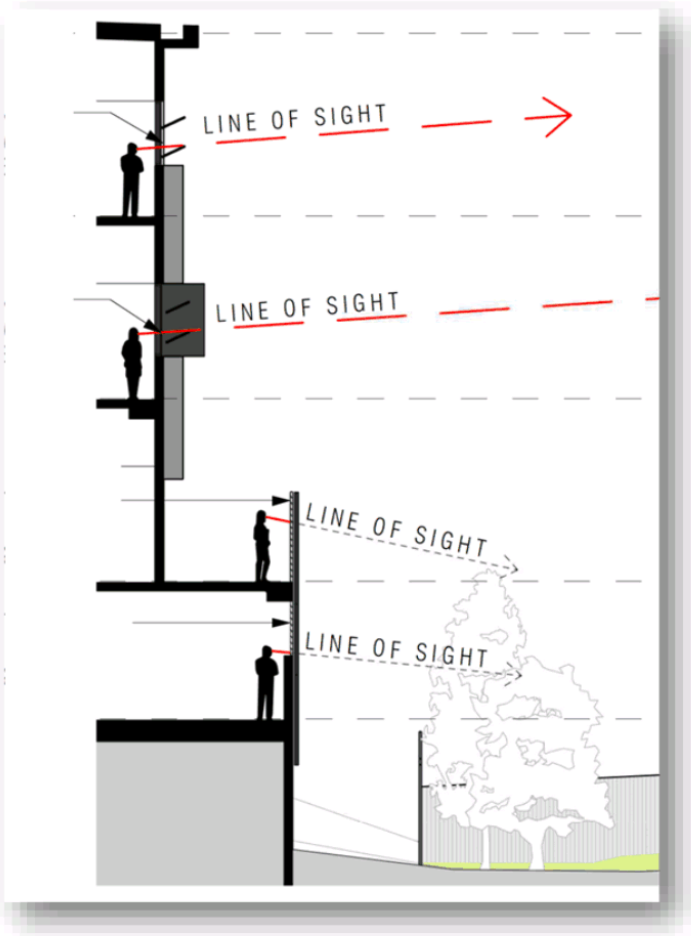
2017

Sky High Apartments (from *The Block*)
South Melbourne

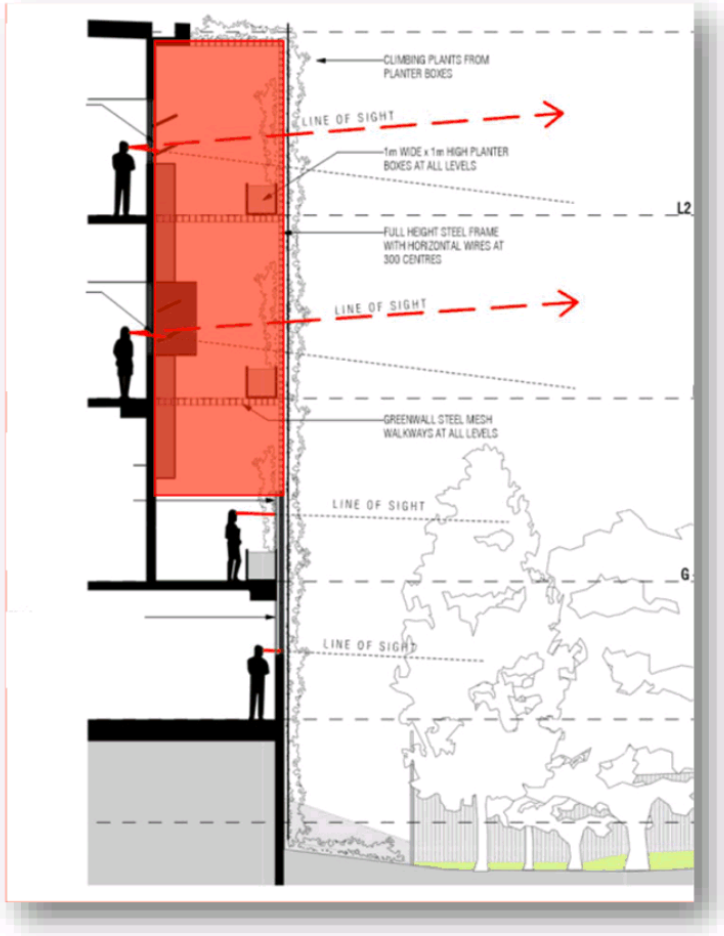
2018

Paradise Park Children's Centre
North London
2009

Alto Apartments
Vancouver
2013



Original plan



Revised plan with vertical garden

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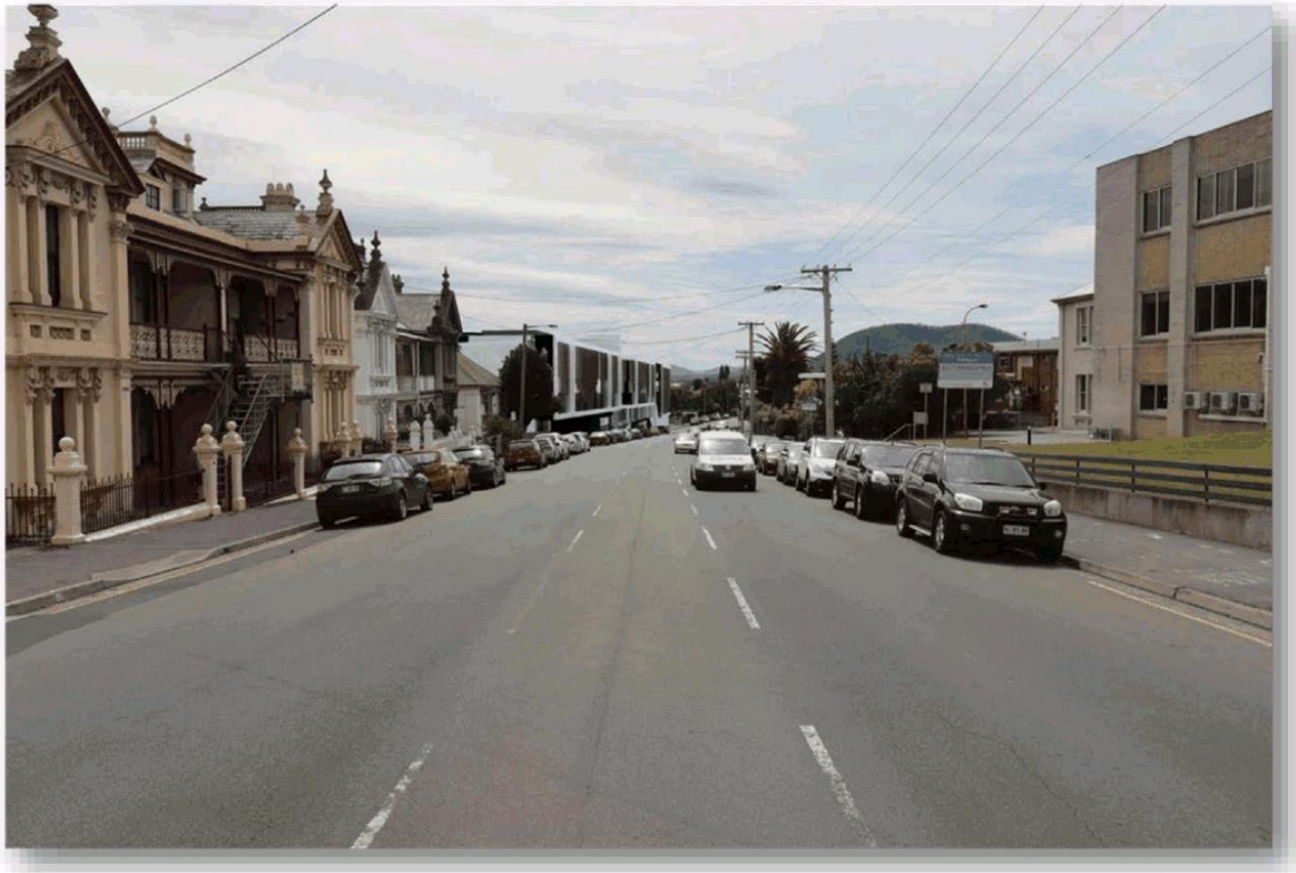
New Town Rd



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New Town Rd

Agenda, p. 147

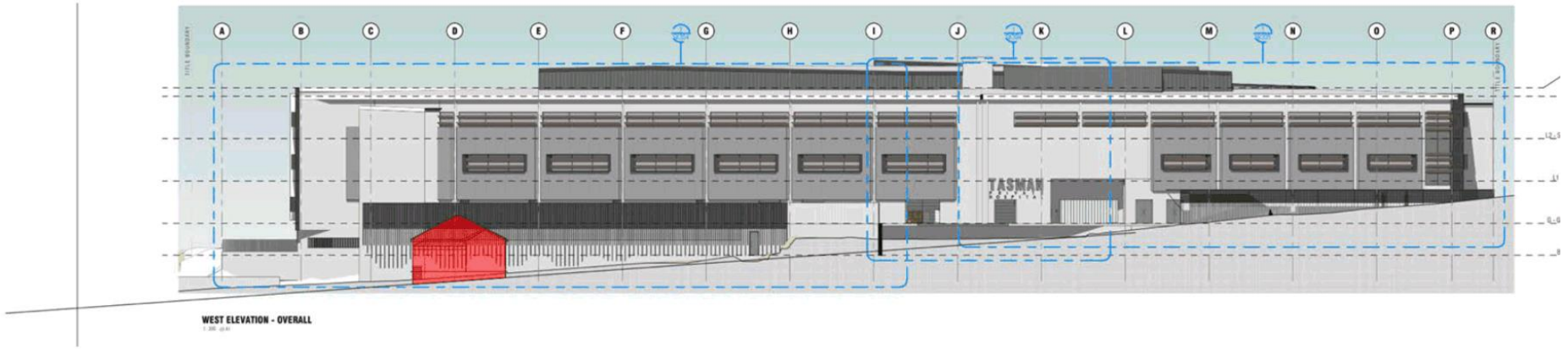
Seymour St

Agenda, p. 114

New Town Rd

Agenda, p. 154

Seymour St



Scale Comparison - 11 Seymour Street West Elevation


INCOMPATIBLE SCALE


24-HOUR OPERATION


TRAFFIC CONGESTION


NO TRANSITION


LIGHT POLLUTION


PARKING OVERSPILL


OVER-SHADOWING


NOISE POLLUTION


HEALTH CONCERNS


MINIMAL SETBACKS


EMISSIONS


HERITAGE & CHARACTER


MINIMAL LANDSCAPING


LOSS OF PRIVACY


QUESTIONABLE INFORMATION

Preston
—
Lane

21 GREGORY STREET EXTENSION

—

21 Gregory Street, Sandy Bay
Heritage Review Package
November 2019

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T 61 3 6231 2923
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Preston Lane

21 GREGORY STREET

Heritage Review Package 01

The project
A New Living space which is to integrate with the Kitchen, Dining spaces in a manner commensurate with todays living requirements. Additional light is desired to be drawn into the home and an addition sitting space to accommodate a growing family is also desired.

E13.7.1 - Demolition
P1 - Demolition must not result in the loss of significant fabric, form, items, outbuildings or landscape elements that contribute to the historic cultural significance of the place.

The proposed demolition work includes only that of a later extension located behind the original cottage and will not impact the shape or façade of the original building.

The slate tiles are also proposed to be removed (currently leaking). They are proposed to be replaced with a composite slate tile. CSR Monier are no longer the agent, however it is understood Barrington Roof tiles are now the supplier of this product.

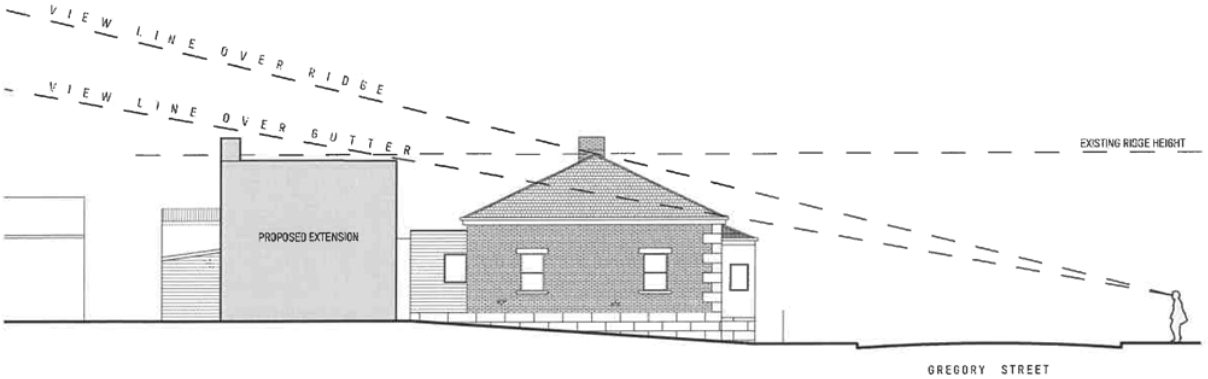
E13.7.2 - Building and works other than Demolition
P1 – Development must not result in any of the following;

a) Loss of historic cultural heritage significance to the place through incompatible design, including height, scale, bulk, form, fenestration, siting, materials colours and finishes.

The original brick building runs along the Northern (Gregory Street) and North Western boundaries, both of which will be retained in their original condition. The new works will be located behind the heritage building opening onto the existing kitchen space.

Whilst the form of the proposed extension differs from the original building; conceptually it is a simple pure form (6x6x6) which delineates the old from the new works, and acts as a backdrop to the existing. The proposal will incorporate refined detailing and be constructed with sold timbers and finished with a dark composite stain. The dark stain ensures the new works are recessive, enabling it to act as a shadow to the original building, whilst the lustre of the timber provides an inviting tactile quality.

Whilst the proposal is two levels in height (to accommodate the spatial requirements of the home and draw light into the heart of the home); its height is lower than the ridge line of the original cottage, and its proportion is commensurate with the existing.

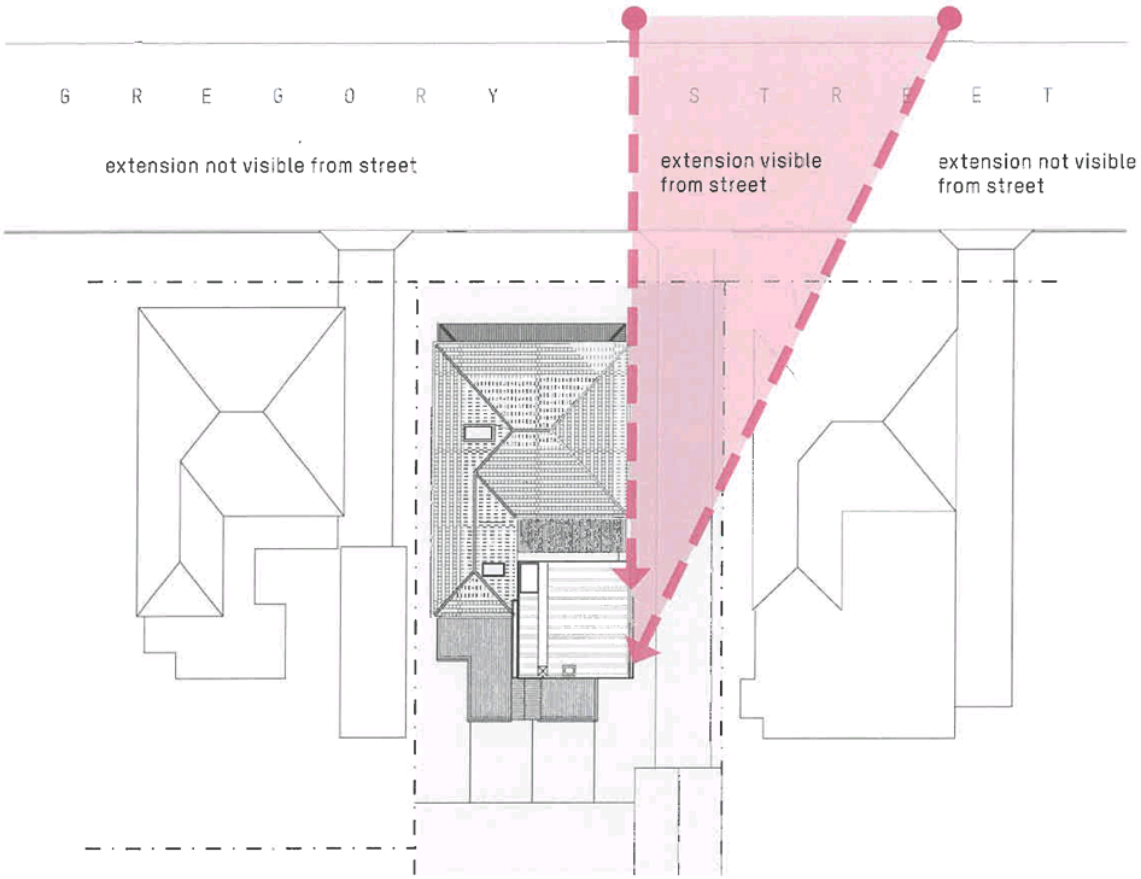


Proposed street section

Preston Lane

21 GREGORY STREET

Heritage Review Package 01



Proposed site plan with view lines

P2 – Development must be designed to be subservient and complementary to the place through characteristics including;

a) Scale and bulk, materials, built form and fenestration;

The extension is to be constructed in a refined and recessive manner, incorporating dark stained timber cladding. The extension is a simple pure form. Its scale is commensurate with the existing weight of the heritage home. Its refined nature celebrates the existing building, acting as a backdrop and enabling the existing through its material, and fenestration to retain its significance.

The proposal will be visually separated from the original building through rebated junctions, providing a clear delineation between old and new.

b) Setback and frontage;

Setbacks and frontage will be retained with all new works located to the centre of the site.

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21 GREGORY STREET

Heritage Review Package 01

c) Siting with respect to buildings, structures and listed elements;

The siting of the extension is located to provide living amenity for the way we live today; providing light and connection between the Living and Kitchen spaces. It sits behind the heritage part of the building, retaining the original brick façade, hipped roof, double-hung windows and sandstone quoins.

d) Using less dominant materials and colours.

Natural materials (timber) in a dark stain have been selected for the proposed extension, both on the advice of the Tasmanian Heritage Council and also as a design concept to provide a subservient building which compliments the existing brick and sandstone façade.

P3 – Materials, built form and fenestration must respond to the dominant heritage characteristics of the place but any new fabric should be readily identifiable as such.

The original cottage will remain the dominant element on the street, with the extended works sitting behind the cottage.

The scale of the new works respond to the existing through the proportion of its form.

Proportion – 'adjust or regulate so that it has a particular or suitable relationship to something else'

It is to be clad in natural timber with a dark composite stain. The tactile quality of such creating a dialogue with the brickwork.

P4 – Extension to existing buildings must not detract from the historic cultural heritage significance of place.

As indicated above, the extension is sited to the rear of the existing historic cultural heritage significance of the original building. It is only visible through a small view corridor as indicated within the diagrams.

E13.8.2 – Demolition

P1 – Design and siting of buildings and works must not result in detriment to the historic cultural heritage significance of the precinct, as listed in Table E13.2 (SB2).

P3 – Extensions to existing buildings must not detract from the historic cultural heritage significants of the precinct.

The extent of the proposed demolition does not include the original Victorian Georgian characteristics of the cottage. It will remain to be read as one of three cottages. Whilst it has been noted that there are no two storey extensions within the area; there are a number of two and three storey dwellings directly adjacent and nearby to this property. In addition, the scale of many of the single storey dwellings in the area are not too dissimilar to that of a two storey building.

Finally, the extended works sit behind the line of the original building, and ensure it is visible only via a small view line down the driveway. The recently constructed extension at 23 Gregory Street extends over the driveway (both sides), creating far greater impact than this proposal.

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Location Plan - Building Heights

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Lane

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3D Montage - view from Gregory Street 01

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21 GREGORY STREET

Heritage Review Package 01

3D Montage - view from Gregory Street 02

PAUL DAVIES PTY LTD
ARCHITECTS
HERITAGE CONSULTANTS

21 Gregory Street Sandy Bay - Additions

I have been requested by the owners to review the proposal and provide my opinion on the suitability or otherwise of the design in relation to heritage and streetscape values.

The proposal is to remove an early twentieth century timber addition to the rear of the main building, retain all of the original building form including the original roof forms and insert an approximately 6 metre squared two storey contemporary form into the location of the current addition. The design correctly adopts a contemporary finely detailed approach that fits with the quality of the existing house. I understand the proposal is to be recommended for refusal by council officers on the basis that the addition will be seen from the street and is not subservient enough.

I have inspected the property and reviewed the plans and in my judgement the proposal does not adversely affect heritage values, is quite modest in scope and will enhance the property and streetscape.

I make several observations about why I believe the proposal should be approved:

i While the proposal is for two levels, the overall scale of the form proposed is small, it is a 6 metre cube that is set behind the rear verandah alignment and is 14-15 metres from the front boundary. It is a recessive and subservient form. It will be seen in one oblique view along the driveway from Gregory Street but will form a background element retaining the pre-eminence of the group of three heritage houses.

ii The building footprint occupies roughly the existing building footprint and is set back 5 metres from the side boundary. As it aligns with the side of the house and is set behind the main house it sits very comfortably within the form of the house and is not a dominant element.

iii The changes inside the existing house are modest, allow spaces to be linked in a sensible way and improve the livability of the house while retaining the main rooms and central hallway.

iv A similar addition has been built recently immediately to the west of the property. While it is single storey, it has a similar materiality and form except the roof form projects across the driveway which increases its prominence when viewed from the street. Without wanting to draw too much comparison I would suggest that the proposed addition at no 21 has less visual impact from the public domain than the adjoining addition.

A key characteristic of areas such as Sandy Bay is the generally good quality of buildings that have been built since the area was developed. The proposed addition is high quality design that continues the tradition of high quality buildings, each phase of which responds to the design paradigms of the time.

The proposal is good and sound heritage and design response to the building, site and area.

Paul Davies

B Arch MBEnv Bldg Cons AIA
Chartered Architect