

**GLAXOSMITHKLINE**

***Investor event***

***Wednesday, 26 July 2017 @ 14.00***

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**Emma Walmsley (CEO):** Welcome and good afternoon to everybody here and good morning to those of you who are either watching or listening in from the US. Today, we have announced our Q2 results and I am also setting out the priorities that we shall drive to improve our performance and our returns for the long term with the first phase focus on the next three years.

**Cautionary statement**

Of course, for the whole presentation we start off with our cautionary statement as usual.

**Agenda**

As far as the agenda this afternoon, Simon and I are going to share our priorities and financial implications for the next hour and a half, then we shall have a short break followed by an extended one and a half hour Q&A with a broader group. Today, we have a fantastic team from GSK here: Patrick who leads R&D; David Redfern, Chair of our HIV business and Chief Strategy Officer and Leader of the Strategic Pharma work; Brian and Luke are here, the relatively new Heads of our Consumer and Vaccines businesses. I also have with me Jack Bailey, President of our US Pharma and Vaccines businesses; Eric Dube who leads our Global Respiratory business; Deb Waterhouse, the new leader in our HIV business and her head of R&D John Pottage. They have both landed here today directly from attending the IAS meeting in Paris.

To stay with our R&D theme and to answer more specific questions you may have, either in the later session or afterwards in the reception this evening, we also have another eight key R&D leaders here in the room.

**Do more, feel better, live longer**

I shall spend most of this presentation talking about our pathway to better returns but I want to start, standing in front of you for the first time as the new CEO, by sharing with you my view on the purpose of GSK. This company does important work. Our purpose matters: to help millions of people every day do more, feel better and live longer. We prevent and cure disease in more than 150 countries around the world. We keep hundreds of millions of people well from the new-born babies through to the elderly. This is the reason that most people join GSK - it is certainly true for me - and it is what drives the discretionary effort of

our employees and partners all over the world. So this purpose will remain our ultimate priority under my leadership.

We have a long history, traceable back perhaps 300 years, in a variety of company configurations: a history of helping to change the burden and impact of disease through innovation. As we strengthen and modernise this company, this business, to set a platform for its future success, we must make sure that we drive performance, first and foremost, through applying great science to impact human health.

The demand for healthcare and innovation is more intense than ever as life expectancy, of course, continues to improve but we are no doubt in a challenging and fast-changing industry and environment.

### **Fast changing environment and competing industry trends**

The good news, of course, is that this is a market full of opportunity, first and foremost with fundamental advances in science, perhaps most notably in genomics but also exciting new frontiers such as our own bioelectronics. In fact, with this acceleration of science and technology, we should all expect some material shifts in the way our industry operates, in who our competitors and partners are as we use digital, data and analytics fundamentally to transform the way we discover and develop medicines; the way we interact with patients and consumers and healthcare professionals.

As life expectancy expands, of course demographics drive demand but, equally, they put pressure on budgets and pricing pressure is not new in this industry. It has long been a concern in Europe but it is now a major factor in the US as both public and privately funded bodies look at ways to tackle the affordability of medicines. For us, this pressure is most obvious now, and as we look into next year, in the inhaled respiratory market.

Finally, it is hard to believe that the industry is not poised for more change. Potential tax reforms in the US, pressures on performance and R&D output could all be drivers of sector consolidation over the next few years, and this could have in turn significant implications. So, it is important that we are agile and have flexibility if these changes should materialise.

### **Balanced business to deliver sustainable growth and returns to shareholders**

In this kind of healthcare world, GSK offers the opportunity to capture value and withstand the pressures across our three businesses. We participate in a broad spectrum of the healthcare market: if you think about it chronologically, from prevention with Vaccines, self-medication and wellness in Consumer Health, to high end therapeutic treatment with strong life-cycle management in Pharma. We are not reliant or over-dominated by one therapy area or product. Portfolios in each of these businesses have innovative and

established products with leading positions in major therapy areas and categories, whether it is meningitis in Vaccines, Respiratory, pain relief and oral health in Consumer or, again, of course, Respiratory and HIV in Pharma.

Our recent transaction in 2015 created new scale in Vaccines and Consumer. All three businesses now benefit from a global footprint, capable of accessing growth in established and emerging markets. This includes significant scientific, technical and regulatory expertise for the manufacture of high quality products.

Earnings and cash flows for the three businesses provide balance and a level of sustainability to the Group's performance and its ability to invest in future growth and in returns to shareholders.

### **Stronger recent performance across our three businesses**

Recent performance has demonstrated the benefits of our 2015 transaction and, in the last 18 months, new product growth in all three businesses has been stronger. Good delivery of our new inhaled *Ellipta* portfolio and *Nucala*, our new biologic asthma treatment, is driving an effective transition in our respiratory business. And the success of *Tivicay* and *Triumeq* has re-established GSK as a world leader in HIV. Both are showing strong and encouraging Q2 performance.

In Vaccines, new meningitis vaccines *Bexsero* and *Menveo* are both growing strongly and, whilst this business will continue to see volatility based on tender agreements, our supply position is stabilising, providing good further opportunities for growth.

In Consumer Healthcare, growth in our seven power brands is ahead of the market, driven particularly by well-loved brands like *Sensodyne* and *Voltaren*. We are seeing a marked slowdown in Consumer market growth and that is clear in our own Q2 numbers, but while growth has slowed we still very much believe that we have a portfolio capable of responding to this challenge and we definitely have the profitability levers in place to continue to deliver our target margin improvement of at least 20% by 2020. That is around double the proforma margin of 2014.

Sales growth and cost saving measures, together with exchange rate movements, have seen cash flow and margin improvements for all three businesses in the last 18 months. The adjusted operating margin has improved by 400 basis points since 2015.

However, while this recent delivery is encouraging, it has to be set against a longer-term context for GSK's performance.

## **Need to improve long term performance and build off recent momentum**

The reality is that longer-term performance has been weaker than we all would have liked. Although recent new product momentum has been better, sales growth on a longer-term basis has been limited due to some slow start or missed launches, the reducing contribution to profit and cash flows from our largest product, *Seretide/Advair*, and insufficient R&D output to compensate. Supply issues have also been a clear factor.

All of this is clearly reflected in our long term TSR performance, which has been uncompetitive when viewed against our peers.

## **Need to improve focus and output of pharma R&D**

Our R&D performance is an important part of what we need to change and improve upon. In fact, in output, we have had a significant number of launches, especially in the last three years. We have been amongst the industry leaders on volume metrics, and have had some undoubted successes.

However, Peak Year Sales per asset – the chart on the right here – have been among the lowest of our sector peer group, so we have not consistently translated the output into commercial success. Arguably, this is a combination of asset choices made, issues with the competitiveness of our labels, and the competitiveness of our commercial execution. In all cases, this requires a much more integrated partnership between Commercial and R&D.

## **Investment spread across too many projects**

What is also clear is that comparatively we have allocated capital in R&D to a much broader range of projects versus our peers and, as average spend per project was also low, we arguably did not back some key assets with sufficient resources for strong enough data packages.

## **Opportunity to improve development timelines**

And development cycle times for GSK also appear to be longer than the average for the industry, notably in Phase II clinical development, and we know that pace is critical in such a competitive environment. All of this points to the need for a significant overhaul and re-evaluation of how we develop our clinical assets and, most importantly, our Commercial and R&D interface.

## **Key objectives 2017-2020**

Alongside this challenge of addressing R&D development, there are several other key things we have to get right over the next three years. All three businesses need to perform, but our priority is clearly Pharma. It will start with some key changes to our operating model and portfolio.

- We must maximise value from recent and new product launches;
- We must address the pricing exposure in our portfolio - this is acute in the inhaled respiratory market. We have to ensure our pricing strategies and our cost base reflect the reality of the therapy areas and geographic markets we are operating in.
- We must make the right choices to invest and develop early clinical stage pharma pipeline for our next wave of innovation, which will come in the early 2020s. This pipeline appears promising but it is early, and much of it is still unproven. Over the next three years, we will start to see clinical data on many assets. How we get to the best decisions on investing behind them is of course of critical importance.

Beyond Pharma, we must realise the benefits of our newly scaled Consumer and Vaccines and, across all three businesses, put more discipline into our capital allocation processes.

Our distribution of returns to shareholders has also been ahead of cash flows in the past few years and so improving our cash generation for more flexibility to invest in future growth is also key.

As R&D data reads out, we have to make sure we can back our winners. At the same time, we need to be ready for inorganic solutions to strengthen our pipeline or take advantage of other opportunities to strengthen our company, such as the Consumer put option.

Today we are repeating and updating the 2020 outlooks for the Group which were set out to investors in 2015. To deliver this outlook we have a lot of work to do. All of these objectives need to be met and, as a reminder, our outlook is for sales to grow at a compound annual growth rate of low to mid-single digits over the five-year period to 2020 and,

- for adjusted EPS to grow mid-to-high single digits.
- These outlooks are all given using constant exchange rates, with 2015 as the base year, and they do anticipate the launch of at least one *Advair* generic adding to an already strong market pricing pressure in the near term.
- But another very important point I want to make today is that these outlooks are also, given the potential development options in our pipeline, subject to data-driven R&D investment opportunities.
- Of course, we have already made some assessment of the R&D investment that will be required going forwards and built this into our plans, but I want to be clear and transparent with all our investors that if additional investment is required to maximise

full value of a particular asset we will act with the long-term interests of the Group's performance in mind.

So, let me start to outline some of the changes we are and will be making to achieve these important goals.

### **3 long term priorities for all 3 businesses**

First, we are going to have fewer and more focused priorities for GSK.

The environmental trends I already outlined at the beginning of this presentation are going to lead to fundamental changes in our industry. Responses to them require agility and our own change at pace, but they also need to be set alongside the long-term nature of R&D and responsible use of our capital.

So, under my leadership, all three businesses will be tasked to be focused on three long-term priorities:

- Innovation;
- Performance; and
- Trust.

### **Improve innovation across GSK, top priority is Pharma**

Now, innovation is important to all three of our businesses, but, again, the top priority is Pharma. We are very focused on maximising commercial opportunities for our recent and near-term launches.

We have made mention of the three important launches to come.

- Closed Triple - we know around a quarter of COPD patients end up on triple therapy and this will provide a simple, single inhalation, a way of delivering it in a device that allows the move from single to dual to triple as needed.
- The first of our HIV two drug regimens, potentially reducing the burden of drug treatment with a well-tolerated and highly efficacious combination.
- Then, lastly, *Shingrix* - we believe a step-change in efficacy for the prevention of shingles, a debilitating disease that is going to impact one in three of us in this room, one in two of us once we reach the age of 85.

Beyond the near-term launches, the big priority is to strengthen the pipeline and, as I said earlier, our performance here has been hampered by allocation of resources and suboptimal Commercial/R&D interface. A combined Commercial and R&D Team have reviewed the full asset portfolio and investment priorities and, as a result, we have

developed a priority list of assets to invest behind and develop, but, of course, this list will continue to evolve as the data reads out.

We will continue to invest behind areas where we already have strong leadership positions, Respiratory and HIV, expanding potentially from HIV into broader infectious diseases with our ongoing work in antibiotics and Hep B, but these two are our core therapy areas.

We will also focus our near-term investment into very specific assets in two potential specialty therapy areas, depending on data of course, Oncology and Immuno-inflammation. And, we have a number of programmes in both these areas that, if clinically successful, could provide us with options to generate value ourselves or with others.

We are targeting 80% of our R&D capital to be allocated behind these four areas over time and we intend to pursue disciplined business development to strengthen the early-stage pipeline in these priority areas.

We will also continue investing in our core capability differentiators, our expertise in developing targets through genetics, modern medicinal chemistry approaches and advanced manufacturing. We believe, for example, our cell and gene therapy technology platform could be a key manufacturing asset for GSK and we intend to be focused on deploying it behind our Oncology portfolio.

We will be part funding this reinvestment in more focused priorities by stopping investment in areas and assets where we see less opportunity for GSK. We have already made the decision to terminate, partner or divest 13 clinical programmes and around 20 additional preclinical programmes.

We have completed a strategic review of our Rare Diseases business and for the assets currently in our pipeline intend to secure opportunities for further development and generation of financial returns outside of GSK, to give them the very best possible chance of successful clinical development.

We have also recognised that we need to improve the governance of our pipeline decision making and this starts with changes in processes and people.

- Luke Miels, who is going to be starting with us in September as President of our Global Pharma business, and his experience at Roche and Sanofi and AstraZeneca will be invaluable in helping to build commercial rigor into the way in which we prioritise our pipeline programmes and define competitive target medicine profiles. We have also recently appointed Tony Wood who is joining us Pfizer and will be responsible for leading platform technology and science.



- We are undertaking a deep review of the efficiency and effectiveness of our Drug Development function and we have set up a new Development Advisory Board alongside, and as well as the new Board Scientific Committee to which I know our recently appointed Board member, Dr Laurie Glimcher, CEO of the Dana-Farber Cancer Institute will be a fantastic addition.

## **Developing the pipeline in Pharma**

### **Development capital focus on 2 core and 2 potential therapy areas**

So let me just give a few more details on the priority assets selected at this stage. Our clear aim here is to develop the next wave of innovation, a new Pharma portfolio for the early 2020s and beyond.

This slide lays out on the right-hand side the assets we are currently prioritising for development in the two core and two potential areas. Clearly again we are very data-dependent on progressing development on many of these earlier-stage assets here but in all cases, we believe they have the exciting potential to offer new, differentiated innovation to patients and payers and sizeable peak year sales contributions to the Group.

In some cases we already have encouraging early efficacy signals, be it with cabotegravir when given bi-monthly injection, maybe even eight weeks as you will have seen in our data presented at IAS or the exacerbation reductions in specific COPD populations for PI3K delta or danirixin, a good example of where we've just recently accelerated our trial times by more than a year with real-time data analytics.

In our two potential therapy areas we have also had some encouraging recent news, whether that's positive Phase IIb data on a new topical agent for psoriasis and atopic dermatitis, tapinarof or in the strong early efficacy readout in multiple myeloma for BCMA.

About 20% of our Discovery and Development spend will be allocated to areas outside these two core and two potential areas, so you can see here that there are still two late-stage development assets in other therapeutic areas which we believe with sufficient differentiation could still offer good commercial returns and of course we continue to invest in Discovery across a broad range of therapeutic areas. We believe retaining this broad reach at the earlier stages of R&D is important for our longer term success, and Patrick and John and the team can answer all of your specific questions on why these assets are our priorities for us later on.

Their successful commercialisation will of course be critical and with an improved R&D and Commercial interface, I expect us to be making better decisions going forwards and we will not be closed at all to exploring and achieving different routes to market for these assets, particularly with our potential new specialty medicines.

As we develop this next pipeline, there is a final critical point I would like to emphasise. This portfolio will have the advantage of being developed at a time when the Group's patent exposure is relatively low once we have digested *Advair* with nothing material until the mid-2020s, something we believe is attractive when considering GSK's risk profile.

### **Refocusing to reinvest**

#### **Decision made to terminate, partner or divest 13 clinical programs, others under review**

So I have said we are reinvesting behind priorities and partly funding that by terminating, partnering or divesting assets that are better progressed by someone else, where our new data perhaps shows they have a lower likelihood of success or we do not see them to be of sufficient scale for us. The 13 decisions that have already been made are listed here and there are more of course to come.

We have also made a decision to terminate, partner or divest around 20 preclinical programmes as I have said and this is going to free up immediately some R&D spend and up to, should it be appropriate, 500 people to put behind the priority programmes we have identified. And just as the priority list will continue to evolve as new data comes through, we should expect this list to evolve too with an ongoing reduction in the cost and time to stop.

#### **Data on key assets in next 3 years to inform investment in Pharma pipeline, organically or inorganically**

And lastly on the pipeline, this provides a timeline on data visibility, although clearly not visible in the room, but it is published and these data will inform our development choices and our investment strategies, both organically and in business development should it be appropriate.

As they become available, we will be updating investors and presenting them to the scientific community where appropriate and obviously the levels of capital we deploy in R&D will depend on these data.

## **Deliver competitive performance across all 3 businesses**

Our second priority is a new company-wide focus on performance and it must be sustainable, ethical and over time as near-term pressures are digested, more competitive. We need to drive growth with competitive products and competitive commercial execution and more clearly internally aligned objectives across our businesses and fuel that growth by managing our costs and improving our cash generation.

A key change will be a stronger focus on execution driven first by much better internal alignment, including of incentives, with integrated strategies for each of our three businesses including across R&D, Commercial, Supply Chain and any Corporate support.

We will implement one P&L of one strategy with innovation, performance and trust priorities for each business. We will be much more disciplined in our focus on priority markets and make operating model changes where it will improve results. Simon is going to talk much more on our improved capital allocation later, but essentially we are prioritising resources to the strongest assets and geographies in our portfolio and moving capital and resources away from those that offer more limited opportunities for the company.

As you saw last week, we have initiated a strategic review of our cephalosporin antibiotic business with an option to sell and announced the divestment of some smaller nutrition brands in Consumer.

We have also decided to exit *Tanzeum*. We shall progressively withdraw support to allow us to complete necessary clinical studies and allow prescribers to transfer patients onto alternative treatments.

We have decided to terminate our rights to sirukumab as part of our efforts to focus our portfolio and reshape our Pharma business.

Across the whole company, we need to fuel our growth with renewed cost discipline. Overall, we believe we can generate a further £1 billion in annual cost savings from existing and new programmes, and a key part of this will be driven by improved efficiency in our supply chain. We have already announced plans to reduce our site network across the Group by nine sites, and we are continuing to review and look for further opportunities to simplify the network in coming years where it makes sense.

Simplifying our portfolio is a key enabler of improving our network efficiency. In the next 12 months, we expect to divest or exit more than 130 non-core tail brands within Pharma alone, brands that could create complexity for our supply chain, and these brands just in Pharma account for around £400 million in annual sales. The plans are already in place for 90 brand exits. Overall, we are looking for a 22% reduction in the number of Pharma brands. We are also looking to reduce our overheads in manufacturing across the

whole Group with a simpler network and improved productivity, and we will reduce our supply base in manufacturing by 25% by 2020.

We are also going to generate greater year-on-year savings through better procurement, which we are going to unify for the first time in a single company-wide procurement organisation across all three businesses.

At the same time, we want to invest in our performance. We intend to put commercial support behind our upcoming critical launches and we are deploying capital in our supply chain behind our core growth areas. As we announced last week, for example, we expect to invest more than £140 million just here in the UK at sites supporting production of HIV and Respiratory medicines.

Performance is, of course, driven by people. You will have already seen that we have made a number of new leadership appointments and I expect more to come across our top 200 leaders as we look to strengthen capabilities across the Group. One of the key capabilities I shall be most focused on is digital, data and analytics. Our priorities here are to improve clinical outcomes and reduce time and cost to discover and develop drugs. We are investing in several partnerships on large-scale genetics data and are seeing with learnings from the pioneering Salford Lung Study many possibilities in real world evidence and investing in digitally-enabled clinical trials.

We want to develop valued real world data at scale and, of course, step change our customer and consumer engagement across all of our businesses. This will be the starting point for a much wider intervention across the Group as we look to harness technology to improve our performance. I was very excited yesterday to announce the appointment of Karenann Terrell as part of my team as our new Chief Digital Technology Officer. She comes to us after being CIO of Walmart and will be a key partner to accelerate and modernise our capabilities here.

### **Changes to the pharmaceuticals business to improve performance**

It is true to say that the biggest change in our company is going to be felt across our Pharma business, which didn't benefit from the catalyst for change that Vaccines and Consumer had with the 2015 deal. Of course, Luke, when he arrives, will layer onto this Pharma change in due course as he appoints his own new leadership team.

We are focusing our commercial efforts on driving an improved performance in the US which is, without doubt, the priority market but the biggest change geographically in fact is going to be about being more competitive in our Emerging Markets business. This has been an historic strength for GSK given our footprints, our strong brands and the very talented people we have working in these countries.

However, global and local competition have impacted our returns and we need to structure more effectively and efficiently for long-term profitable growth. We need a model that can competitively drive what is today a largely classic branded product business with brands like *Augmentin*, but also one that can successfully launch more new innovations such as the *Ellipta* portfolio or *Nucala*. To do this we are going to create a new, single, dedicated, end-to-end operating model for Emerging Markets spanning Commercial, Supply and R&D for life-cycle management. The Group will have its own dedicated governance model and the right commercial structure for each market whether that is a standalone business, a cluster of similar markets or a distributor-led model. Each market will be resourced accordingly and we remain very committed to the access of our medicines.

### **Cost discipline to fuel investment for growth**

Successful delivery of our performance priority also requires an improvement in our cost base. The £1 billion of annual cost savings by 2020 will be used to support investments in strengthening the pipeline and commercial execution. The savings will also help protect our margins which we expect to face sustained pressure as a result of pricing pressure, in particular in our inhaled respiratory business.

### **Build trust in our operations and in the way we work**

Our third and final priority is trust. We have to acknowledge there is a trust deficit in the world be that in governments or in business, and in our industry where trust matters more than most, if we don't close that gap, it will impact long-term value creation, and it has to start by getting our fundamentals right. The most important thing we can do for trust is to discover and make great medicines that people need. Then we must get our medicines to the people who need them, which means improving reliability of supply and our customer service levels.

Commitment to quality and safety across GSK is critical. We will continue to invest in people and capabilities to deliver competitive and top levels of performance here. After some difficult compliance issues in recent times, we are also committed across the company to doing our best to prevent breaches and, should they occur, to respond to them swiftly and transparently.

To build trust beyond the basics, the fundamentals, we are very focused on the way we engage with stakeholders, and our contribution and responsibilities to access to medicines. It is absolutely critical that our partners, customers and society trust our science and our intentions. The way we engage with health care professionals is something we are both proud of and believe in. We have evolved it already several times since its introduction and we will continue to do so, to make sure our engagement is competitive and trusted.

We also want to keep improving transparency with our other key stakeholders and that, of course, includes our investors. I have much appreciated your transparency with me as I begin this job, and the team and I look forward to building a constructive and transparent dialogue over the years ahead.

I have already referenced the tough pricing environment and it is clear that we have to deliver differentiated innovation to achieve value and returns in this context. When it comes to setting our prices, we have consistently taken a balanced approach with the recent launches of our new products. This will continue. We will look to support access where we can *and* generate sufficient returns.

We are very proud of our reputation and our long-term commitment to global health, but we will focus our resources to drive more global impact, especially in needs such as malaria and HIV.

And for our people, who are our greatest ambassadors and on whose talent and teamwork it all depends, to support their everyday engagement, we intend absolutely to increase efforts to adopt modern, progressive employer practices, focused on improving diversity and inclusion, supporting their personal wellbeing and being a flexible, life-friendly workplace.

### **Values and performance based culture to support delivery of priorities**

Everyone in the room, or listening or watching, knows about the power and the importance of company culture. There are many special elements of GSK's culture which include very deep attachment to our values and our purpose, but there are also some dynamics that we have to change. To be successful, we need to have a culture that is driven in equal measure by competitive performance and strong values; a culture where we always bring the 'outside in' and we learn from the very best – wherever they are in the world - and a culture that is focused on better decision-making, and cost and cash discipline.

So there are some key changes that we will be making. This will include new appointments, some of which we have already announced, with more to come over the next 12 months. I have also highlighted some of the operating structure changes that we are making. We are changing how we set objectives internally and how we manage and measure performance. We will be introducing new company-wide incentives next year, better aligned to our IPT priorities and our overall business performance – for example, including cash flow measures across the company.

While we will be keeping our values, we will be changing the company expectations of employees, with four new expectations for everybody working at GSK. We will expect

courage of decision making; accountability for results; the prioritising of people development, and effective teamwork. Expectations, of course, that have to start at the top of the house.

### **Capital allocation framework**

Before I conclude, I want to outline our capital allocation framework. These choices will be key and, again, start with the IPT focus driving improved cash generation. Our priorities for use of cash are laid out here.

First, will be to invest in the business, in three key areas:

- The Pharma pipeline – organic, but also early stage inorganic;
- Realisation of the consumer put option, should come, which, as I said earlier, would strengthen our position in Consumer Healthcare; and
- Further investment to expand capacity in our Vaccines business.

Our second priority will be to deliver returns to our shareholders through payment of dividends. We continue to expect to pay a dividend of 80 pence for 2017 and we have also announced our intention to pay 80 pence in 2018. This is as part of a new dividend policy established for 2018 and beyond, where regular dividend payments will be determined primarily with reference to free cash flow, generated after meeting our requirements for investment in the business.

Lastly, we will use cash for business development purposes, with M&A obviously dependent on the right kind of return profile.

### **Our aim is to deliver benefits to patients, consumers and shareholders**

In conclusion, we are setting out a clear path forward over the next three years. Across the whole company, we will prioritise and focus on innovation, performance and trust, and by striving to get the right balance of change and strong commercial execution. We expect to deliver the outlooks set out for 2020, with adjustments to the Pharma margin targets and the Consumer sales growth rates. This will reflect good execution of the plans we have laid out today, combined with investments we expect to make in R&D and the divestments and exits we have also outlined.

We will navigate some near-term pressures and the structural portfolio changes through the next couple of years especially, and at the same time build a new platform for future growth for the decade beyond that.

Our aim is to have all three of GSK's businesses delivering competitive performance with clear pathways for delivery of long-term, sustainable growth. Improved R&D and strengthened innovation will be at the core of this, using our science, technical know-how and our talented people to produce differentiated and much needed medicines, vaccines and

brands that will make meaningful differences to patients and consumers, and achieve good returns for our shareholders.

With my colleagues here today, and on behalf of everybody else working at GSK, I want to say to our investors that we are committed to achieving this.

With that, I am going to hand over to Simon, who is going to take you through the detail of our Q2 performance and the financial implications of these longer-term outlooks.

Thank you. Simon, over to you.

## **Q2 and financial outlook**

**Simon Dingemans (CFO):** Thank you, Emma.

Before moving to the outlook for 2017 and 2020, I am going to comment briefly on our Q2 results. As a reminder, I have covered these results in detail in a video issued alongside our press release earlier today, both of which you can find on our website, so I will keep my Q2 commentary over the next few minutes at a relatively high level in order that we can focus time on the future and the implications of the announcements we have made today on our financial outlook.

### **Headline results**

So, first, on our total results, these include some significant charges that reflect better prospects for the Group and the implementation of our new business priorities. Specifically, we have again increased the estimated valuations of our Consumer and HIV businesses, as well as the level of contingent consideration we expect to pay to Shionogi in relation to the HIV business and to Novartis as the next vaccines milestone becomes more likely. Just as a reminder, this relates to non-US sales of *Bexsero* which are clearly growing strongly.

Total results this quarter also include charges of approximately £450 million relating to our decision to withdraw support for *Tanzeum* over the next 12 months or so.

The rest of my comments will be on our adjusted results.

The results we have reported today reflect another quarter of strong operational delivery as well as continued investment behind key future growth drivers in each of our businesses, particularly new product support and R&D investment in Pharmaceuticals.

Over the last several quarters we have stepped up Pharma R&D spending as we advance our pipeline. As Emma has highlighted, HIV is one of our core therapy areas and during the second quarter we took the decision to invest, for the first time, in a Priority Review Voucher to accelerate the FDA's review of a key asset – our first two-drug regimen



in HIV. The £106 million cost of the PRV was charged to R&D expenses in Q2 and, with an impact of 5% on adjusted earnings per share in the quarter, was the key driver of the reported decline in adjusted earnings per share of 2%.

### **Sales growth**

Turning to sales growth.

In Q2, sales from new products continued to drive good growth in Pharma and Vaccines, more than offsetting the declines from older products, including *Advair* and despite a 2% drag from divestments to reported Pharma growth in the quarter.

Consumer had a more disappointing quarter with sales flat overall after an estimated 2% impact from divestments and de-stocking in India ahead of the introduction of GST. The flat result was despite some strong performances from our power brands. However, this was not enough to offset a broader slowdown in consumption in key categories, particularly in International but also the US. Our US Consumer performance was also impacted by tougher competition in our allergy business, which particularly affected *Flonase*.

While we are taking steps to address these changed market conditions and improve our competitiveness over the balance of the year, we also expect to face additional pressure in the second half from the introduction of generic competition to one of our legacy Novartis products. The impact of this on second half sales is expected to be up to about £40 million and a full-year impact in 2018 will be around £80 million.

Given these various factors, we are not now expecting much growth at the top line from the Consumer business this year. Also, unless the market backdrop improves, we would not expect more than low single digit growth in sales next year, especially when you factor in the drag from divestments, GST and the ex-Novartis generic. The slower growth we are seeing this year and the impact on 2018 are key drivers of the updated outlook for the Consumer business out to 2020 where we now expect a top-line percentage CAGR over the five years of low-to-mid single digits.

We are controlling costs tightly, while ensuring we continue to invest in our power brands. We still expect to make significant progress this year towards our operating margin target for Consumer of 20%+ by 2020.

### **Adjusted operating margin**

Onto operating margin more broadly for the Group.

As I have mentioned before, the PRV investment is a big one-off impact in the quarter, taking 1.6% percentage points off our adjusted operating margin for the Group in Q2 at constant exchange rates.

Across the rest of the cost base, we are driving operating leverage in the P&L, with a 90-basis point CER improvement excluding the PRV, by driving sales growth in Pharma and Vaccines in particular, as well as a benefit in mix and continued tight cost management in all three businesses, even while we invest behind our new product launches and priority assets in R&D.

In the quarter, royalties were up and we continue to expect around £300 million for the full year.

### **Improving cash conversion**

From a free cash flow perspective we have driven an improvement of over £300 million compared to the first half last year, even after investing in the PRV. This has been through a stronger operating performance, tight management of capex, lower payments for restructuring and continued currency gains offset by some catch-up in dividend payments to minorities.

As we saw last year, the first half has seen a significant build in inventory as we prepare for seasonal sales but also this year an additional impact as we get ready for our upcoming launches, particularly in *Shingrix* and the closed triple.

We are continuing to improve the efficiency of inventory utilisation with working capital balances ten days lower than they were this time last year. As the inventory build unwinds, we expect free cash flow to be significantly higher in the second half of this year as we saw last year. This was very much the pattern and reflects the changing mix of the business post the Novartis transaction.

### **Updated 2017 guidance**

So where does that leave us for the year? We did not want to fund the PRV by cutting back on other key priorities and drivers of future growth and as a result, the PRV and other accelerated launch spend for the two-drug regimen will impact our previous expectations for growth in adjusted earnings per share this year by around 2% and we are updating our 2017 guidance range accordingly.

With no *Advair* generic expected this year, we now anticipate adjusted earnings per share to grow by 3% to 5% in 2017 on a constant currency basis. If exchange rates remain at current levels then we would expect a full year FX tailwind of around 8% to adjusted EPS.

Looking further ahead, the commercial environment remains highly competitive, especially in our Respiratory business where we are also seeing continued pricing pressures. We are in the middle of the contracting round for 2018 and every indication suggests that as we move into next year, there is going to be no let-up in the pricing

pressures we have been seeing for *Advair*, but also the new *Ellipta* Respiratory products as payers anticipate an *Advair* generic sometime in 2018.

Against this market backdrop it is critical we continue to invest to grow the market share of our recent launches as well as prepare for those that we expect to launch shortly if regulatory approval is given on the timelines expected. It is also important that we can continue to invest in the newly prioritised pipeline.

### **The financial architecture aligns our strategy to clear financial goals**

We are going to use our financial architecture to ensure that the delivery of our strategic priorities of innovation, performance and trust translate into clear financial goals that we can embed across the company. The goals of our financial architecture are

- to drive stronger growth in sales through improved innovation across all three businesses
- to drive earnings per share faster than sales through better performance, driving operating leverage through the business from tight cost control and continued financial efficiencies; and
- to convert more of those earnings into cash which can either be reinvested in the business or returned to shareholders.

All of this achieved the right way, consistent with our values and our objective of building trust in GSK.

We will use the architecture and its common goals to help create a step-change in the alignment of our operations around three fully integrated businesses. This will enable new end-to-end emphasis on cost discipline and cash consciousness. It will also allow us to be clearer both strategically and operationally on how we invest and allocate our capital between our different businesses.

I would now like to run through each of these goals in a bit more detail.

### **Cost discipline to fuel investment for growth**

#### **Additional £1bn of annual savings at CER**

We have already driven annual cost savings of more than £3 billion from our combined integration and restructuring programme. This has helped offset major headwinds over the past few years from pricing and the decline of profitable older products such as *Seretide/Advair*, *Avodart* and *Lovaza*. It has also allowed us to restructure our cost base to create significantly greater flexibility to reallocate our resources to where we see the greatest returns before we have to add additional funding.

The continued stability in SG&A expenses and the leverage that this produces, despite significant promotional investment going in behind our new products, is evidence of the effectiveness of these efforts but there is clearly more that we can do.

We anticipated at the time of the Novartis transaction that we would invest approximately 20% of the savings, and our tracking since that time suggests we have invested slightly more at around one-third of the benefits. This has gone mainly to promotional support and supply chain improvements and then more recently to R&D.

Two-thirds has been used to offset the margin pressures we have been experiencing from pricing and the decline of the older products.

We have now identified another £1 billion of annual savings from the same programme, primarily in the Pharma business through supply chain efficiencies, simplifying our operations, improved procurement savings and a more streamlined functional model aligned to the new business priorities that Emma has outlined today.

We again intend to reinvest approximately one-third of these savings into supporting our already launched new products, key near-term launches and the R&D portfolio. Similarly, the rest will be applied to protecting our margin by offsetting some of the pricing and competitive pressures we continue to face in the Pharma business.

### **Cost discipline**

While those pressures will remain a meaningful drag on our operating margin over the next several years, particularly in the year in which an *Advair* generic in the US does arrive, we expect to begin to see a better balance going forward as the operating margin benefits from stronger sales growth for new products and the drag from *Advair* reduces.

Remember though that we have always said that we would manage the margin to deliver more sustainable earnings per share growth for the longer term, and so margins may move around quarter-to-quarter as we invest to drive that growth.

### **Cost discipline to fuel investment for growth**

#### **Funding new product launches, R&D pipeline and protecting margins**

Important to delivering a sustainably better margin is that the tailwinds also go beyond restructuring benefits, even though those have been a significant contribution. Across our three businesses as well as at the centre we plan to ratchet up cost discipline with a particular focus on improved supply chain efficiency to drive a more competitive cost of goods, tighter control of SG&A, including capping growth in functional and other support capacity and strengthening our procurement capabilities.

In our supply chains we are reducing complexity by divesting some of the tail, cutting the number of manufacturing sites and lowering the number of SKUs. Beyond our internal manufacturing network, we are also focused on simplifying the number of contract manufacturers we use, which will improve utilisation and contracting terms as we leverage better scale with the contractors that remain. Generating additional savings from procurement will be a significant focus for us, and we have announced today that we shall consolidate all of our procurement activities into one unified organisation to leverage scale and best practices, and we are targeting this organisation to deliver mid single digit percentage savings in material and indirect costs, as well as non-production spend, to improve our cost of goods and to allow us greater investment flexibility across the P&L.

In establishing our new business priorities, we have also identified opportunities to reduce non-working SG&A further, simplifying and hubbing the 'back office' elements of support functions including medical and regulatory, and to reinvest this behind customer or patient-facing SG&A. We expect that this will enable us to cap the growth of our non-working spend behind sales growth, improving operating leverage, to move us into a more competitive position relative to our peers and other relevant benchmarks.

To underpin this additional cost discipline, we shall govern the performance of each of our three businesses through a fully integrated P&L. While we have had this in place for Consumer Healthcare for the last couple of years, this is very new for Pharma and Vaccines and it has driven a step change in decision-making for Consumer and should do the same for Pharma and Vaccines, mainly by aligning supply chain, commercial, R&D and functional teams to a single set of objectives, and allowing clearer trade-offs, improving performance and profitability as a result.

### **Cash consciousness**

We also need to improve our cash generation and to do so we shall build cash metrics more directly into employee incentives. We will also implement end-to-end cash flow accountabilities within each of the businesses to allow us to drive cash consciousness much deeper into the organisation. We will ensure that the three businesses have specific cash targets and are accountable for managing their cash flow directly. We will focus particularly on driving further working capital efficiency, managing our capex in a more integrated way - more closely aligned to the priorities of the three businesses - and reducing restructuring spend.

As an example, we plan to reduce our holdings of inbound raw materials by more than 30% by 2020 by shifting to a much more vendor-managed or consignment stock model.

On capex, we are now prioritising pipeline investments and capacity expansion for new products much more directly, and turning off other investments around older products.

We have also recently established new ways of working in our procurement of capital to ensure not only competitive purchase costs but also more standard equipment and infrastructure. For example, we previously announced increased investments behind *Ellipta* and have leveraged our strong and strategic relationships with preferred suppliers for manufacturing equipment across all of our *Ellipta* producing sites. This drives better capital efficiency, ease of technical transfers and an improved capability with this equipment internally. As the equipment is now identical across all of our Respiratory sites, we know how it performs better, resulting in less deviations and waste and reductions in unit cost for each *Ellipta* device. We have a specific programme for *Ellipta* that is targeting a 20% reduction in unit cost for an *Ellipta* device by 2020.

### **Capital allocation**

To strengthen our allocation of capital across the Group and ensure that it is allocated to where the best returns are available, we are implementing a clearer set of priorities for our capital and creating a new Board to govern the allocation of capital between our businesses.

To support this new approach, we have for the first time allocated all of our invested capital between the three businesses, so that we can track the overall returns each of them makes and be able to allocate between the three much more deliberately.

The priorities for the new Board are, first, to invest in the business and drive growth by

- strengthening the Pharma pipeline and backing winners as data read out;
- taking opportunities to strengthen the company such as the Consumer put, should it come; and,
- thirdly, expanding capacity in Vaccines, particularly in support of our new meningitis and *Shingrix* products.

Secondly, to improve shareholder returns, which I shall return to later and, thirdly, to pursue targeted business development focused on bolt-ons and partnering.

Managing these capital allocation priorities will all be done with the parallel objective of continuing to strengthen our credit profile and protect our target short-term ratings of A-1/P-1.

We will expand the use of cash flow-based return metrics beyond individual project assessments, which is how we have used them previously, and we have now introduced a

consistent cash return on invested capital (CROIC) methodology to prioritise investment across the Group as a whole, so that we can compare the returns from each of the three integrated businesses as we allocate capital between them. We shall regularly benchmark ourselves to our peers.

R&D spend will be subject to the same allocation process to ensure we are looking at R&D returns in the context of the three integrated businesses. As a result, we shall no longer publish a separate measure of R&D returns.

### **5-year outlook to 2020 maintained at a Group level**

Turning to the 2020 outlook, to start with at a Group level we are maintaining the overall outlook for sales and earnings that we gave you back in May 2015. This reflects the overall balance of positive and negative factors that we have seen since then, including higher new product sales, earlier delivery of the original integration and restructuring benefits and the extension of that programme, offset by greater pricing pressures in the Pharma business particularly in Respiratory, lower Consumer sales growth, as well as upward pressure on the tax rate. The benefits to the upside are also partly offset by the minority interest in the additional growth we have seen in HIV.

When reviewing this outlook, it is important to understand that we have kept the same goalposts. The 2020 outlook we are giving you today uses exactly the same methodology we used in May 2015, and that includes assuming that,

- the sales and earnings compound growth rates are at constant exchange rates over the five-year period;
- the exchange rates we have used to estimate the 2020 position, including the 2020 margins, are therefore 2015 rates.
- If sterling stays at current levels, we would estimate a positive tailwind to the five-year EPS CAGR outlook we have given you of around 5%.
- We are also continuing to assume *Advair* will encounter generic competition between now and 2020 and will only have £200-300 million of residual sales in the US by then.

Hopefully, this gives you a clearer idea of what has and what has not changed, but you should also note that this unchanged outlook is despite an impact on Group sales of around £900 million from divestments and exits over the period, including the withdrawal of *Tanzeum*.

### **Pharma 2020 outlook**

Looking at each of the businesses briefly. Firstly, in Pharma we have made good progress with new products more than offsetting the decline in *Seretide/Advair* so far. We continue to expect this shift to continue over the five years, with a low single-digit CAGR for sales, despite higher headwinds from divestments and exits over the period than we originally expected.

We also originally expected 2020 margins to be flat at just under 30% at constant exchange rates, with leverage from sales growth being offset by other factors. We now expect that we can do better on margins and deliver low-30s at 2015 exchange rates, thanks to the additional cost efficiencies that I have already talked about, as well as additional leverage from new products performing ahead of expectations.

### **Vaccines 2020 outlook**

Next, Vaccines continues to be on track with our original expectations, both for sales, growth and margin. You have seen the strong result Vaccines has driven over the first part of this five-year period. Looking forward, we have high expectations for *Shingrix* in particular, as we move through 2018.

This key launch will clearly require significant investments in both supply chain and the necessary sales support, which may impact margins in the short term but we still expect our 2020 margins will be 30%-plus. So that is an improvement of at least 5% compared to where Vaccines' proforma margin was in 2015.



## **Consumer Healthcare 2020 outlook**

The Consumer business continues to be an attractive business, with clear synergies within the Group. However, given the expected impact from the market slowdown that I have already discussed, as well as the impact of shorter-term competitive challenges, divestments and GST, we now expect the five-year CAGR in sales to be low to mid-single digits.

Importantly, our margin: we are still targeting to get to the operating margin of 20%-plus that we previously indicated, by 2020.

### **Financial efficiencies**

In the bottom half of the P&L, we are continuing to drive financial efficiencies. On tax, we now expect moderate upward pressure over the next few years and we have already seen some of that this year, given the Group's changing mix – particularly the geographical mix – and the more challenging tax environment.

Overall, we continue to expect adjusted EPS to grow mid- to high-single digits over the five years to 2020 in constant currency terms.

### **Dividend policy from 2018**

We understand how important regular dividends are for many of our shareholders. As a result, returns to shareholders are a key priority for capital allocation, but after first meeting the investment requirements of the business necessary to support long-term future growth.

We continue to expect to return an 80 pence dividend for 2017 and we have also announced today an expectation that, subject to any material change in the external environment or our performance expectations, we will pay a dividend of 80 pence per share in 2018 as part of a new dividend policy for 2018 and beyond. This new policy sets out our objective to distribute regular dividend payments that will be determined primarily with reference to free cash flow generated after funding the investment necessary to support growth.

Over time, the Group intends to build free cash flow of the dividend to a target range of 1.25 to 1.5 times before returning the dividend to growth.

Starting in 2019, we will return to our previous approach of setting dividends on a quarterly basis, rather than continuing to provide a medium-term outlook.

## **Our aim is to deliver benefits for patients, consumers and shareholders**

Going back to our overall vision out to 2020 and beyond, we will focus our efforts around new priorities to strengthen innovation, improve performance and build trust for all three businesses. Emma has set out some of the specific actions that we are taking to do this. Based on these plans, we continue to expect to deliver our 2020 financial targets at a Group level, reflecting the balance in upsides and downsides that we have covered.

Importantly, we are also laying a clear platform for growth beyond 2020, including continued cost discipline, a deeper cash consciousness across the company, and a clearer capital allocation framework to enable investment behind the continued success of our new products and the development of a stronger pipeline.

### **15 minute break: Q&A to follow**

With that, thank you for your attention. We will now take a short break for about 15 minutes, after which we will return to take your questions. There are refreshments outside. Thank you very much.

## **Question & Answer Session**

**Emma Walmsley:** Welcome back. We are now moving into the Q&A session for up to an hour and a half, or longer if you have got more questions. As you can see, I am joined by my team here, on the stage, and perhaps just to remind you, in case you don't recognise them from their photos, from right to the left, we have got Simon, our FD, Patrick Vallance, Head of R&D, David, who is Chair of our HIV business and the Chief Strategy Officer, Deb and John who lead our HIV business, Luc and then Brian, Luc runs our Global Vaccines business and Brian Global Consumer, then we have Jack, who is President of our US both Vaccines and Pharma business, and last, but not least, Eric Dube who runs our Global Respiratory business. So, I will be chairing the Q&A session, but obviously sharing out the answers to your questions with them and then, in the front row on both sides, we have many of our R&D leaders as well.

Just in terms of the logistics of this session, you are probably all extremely familiar with them, but for those of you that are in the room, could you please raise your hand and then switch on the red button in front of you when I signal to you to ask your question and then please do switch it off so that we can answer and then move on to the next person. I will also be taking questions that are going to come in online and on the telephone line and

via the webcast. Last request, please do, as usual, try to restrict your questions to two to three at a time, so we can get round as many people as possible.

Okay, so who would like to kick us off? Let me start in the front row, please, Andrew, go ahead.

**Andrew Baum (Citi):** Thank you, two areas. First of all, you highlighted Oncology as a potential platform, pending the read-out of the data, does that preclude any significant transactions within the Oncology space ahead of that time? Then, the same vein, could you give some further colour on the divestments of the Established Products business in terms of the consideration you may expect to get, financial consideration, from the sale of those revenues, just thinking in terms of financing a bolt-on transaction and strengthening what you could do with your balance sheet?

Then, a question for John and apologies for the predictability given the IS data on the resistance mutations that were shown, particularly the integrase resistance mutation, particularly from a competitive perspective with Gilead being able to leverage that data and to shy people away from adopting it, how do you deal with that, especially in the US where your traction with the KOLs for the two-drug regimen is somewhat less than it is in other territories in the world? Thank you.

**Emma Walmsley:** Thank you very much, Andrew. We will come back to John and maybe Deborah also talking, in terms of the commercial competitiveness question, in terms of our HIV business.

Simon, do you want to comment on the divestment consideration at all?

**Simon Dingemans:** There is a pretty wide range of businesses within that mix, but typically for that profile you would expect one to two times sales, something like that.

**Emma Walmsley:** And in terms of your question on Oncology, you are right we have very clearly highlighted that as a potential area dependant on data and we do want to see whether we have an anchor asset for us, ourselves, or whether or not we should move out with any other partners, and there are several either that we are already in partnership on certain clinicals with that we could consider, or indeed, as you are aware Novartis has a right of view on an asset-by-asset basis, so I don't think we would be looking at any material transactions ourselves proactively until we have seen more data there.

Shall we just get to the answer on the expected and important HIV question, John, would you like to respond to that, first?

**John Pottage (Chief Scientific & Medical Officer, ViiV):** Sure, I will give a little perspective. So, you are asking about the ACTG 5353 study that was presented at IAS yesterday, and this is a pilot study that actually followed the first pilot study that went forward for the two-drug regimen of dolutegravir plus 3TC treating treatment naïve patients, that was the PADDLE study, and actually at the meeting we saw the 96-week data and of those 20 initial patients, really the durability has really stood up over the 96-week period.

Following the first report of that, the ACTG went forward with a larger study of 120 patients being treated with dolutegravir+3TC and they reported on 24-week data at this meeting. The data that was presented was pretty spectacular because you had 90% of patients at 24 weeks with the two-drug regimen being fully suppressed.

Now, as you note there were three patients that did have virologic failures, one of whom who the investigator described as 'chaotically non-adherent' to paraphrase him, did develop resistance or emergence of resistance mutations to both the 3TC and also to the integrase drug with what we would describe as a minor resistance mutation.

I think it's notable for all the previous treatment-naïve studies with dolutegravir we have not had a patient develop that. We have had reports of patients who were treatment-naïve develop integrase resistance mutations but that's been a very rare event and, as I said, not in association with clinical trials.

This is a pilot study and I think the real telling of the tale here will be looking at the results of the Gemini study which will be over 1200 patients being studied with this. It is obviously always disappointing to us to see a patient develop that, but clearly someone who is not adherent it's not that unexpected and it's something we take in and really look to see the larger body of evidence as it develops going forward.

I do think you have really to come back to the overall performance of the regimen compared to that before you really can assess how it stacks up against other regimens along the line because development of resistance occurs with all regimens, so I think that we will just have to see the data as it plays out, but I think that overall the data there is very encouraging and pretty exciting to us.

**Emma Walmsley:** Do you want to comment on the competitiveness?

**?Deborah Waterhouse:** Yes, sure. I don't believe that the failure that John has just talked about will be grasped by our competitors but I also believe that Gemini is a very, very important study and that is where you will really see the strength of dolutegravir + 3TC.

From my perspective, we have a pipeline of two-drug regimen products with rilpivirine and dolutegravir coming out first followed on by dolutegravir + 3TC and then we move into

the long-acting era with cabotegravir, so I think we've got a very strong proposition. Gemini will be key. We have obviously already got SWORD 1 and 2 which we shared at CROI.

For me, we have a very competitive offering in the US and globally, and I think we are very much prepared to match our competitor share of voice-wise with our salesforce, in the marketing space with our medical sales forces which are the same size if not in a few places even larger than our competitors, so I think we are set up to be very, very competitive both in the US and beyond. The feedback I heard yesterday both from KAEs in Europe and the US is that they are very excited about the two-drug regimen portfolio we have but they are very much waiting for Gemini and I think Gemini now becomes a much more important milestone from a data perspective for us to judge how successful we will be with dolutegravir + 3TC.

**Vincent Meunier (Morgan Stanley):** The first question is a follow-up on oncology. How do you think you can become a top oncology company in the context of you re-starting investing in that area after the divestment quite recently to Novartis and quite a very competitive landscape with many big companies investing in new technologies for several years. What is your value proposition here?

The second question is on the dividend. Can you explain to us how really does it work? I mean, should we consider that the 80 pence for 2018 is the base, maybe a floor? Should we expect at some point maybe a dividend cut at the end of the decade if you do not cover the dividend or if you, for instance, make a big acquisition and then the free cash flow is impacted? Thank you.

**Emma Walmsley:** Okay, thank you very much for the questions. I will respond on the dividend and we also have a question online from Marco about giving an outlook on the dividend after 2018, so I shall be combining those two together and then I will give a quick word on oncology and will perhaps ask Patrick as well to pick up on that.

On the dividend, we know it matters. We are expecting 80 pence in 2017 and we expect it in '18 because we know that was a key question for today and we wanted to give visibility on it. We also wanted to give visibility by announcing a policy where distribution will be based off free cash flow with a target cover of 1.25 to 1.5, so we give clarity that we are working towards rebuilding that cover before increasing the dividend. That's really a very important message that we want to have understood, that we want to keep investing in the business for its future growth and our intention is to be rebuilding that cover off an 2018 base.

That said, I am not going to stand here and say the dividend will never be cut if some circumstances happen to say that that is required and appropriate, but that will be a Board decision at the time. Our intent is absolutely to be rebuilding the cover, as I said, from that basis and we are not going to be pronouncing on the dividend in the medium-term.

Having said this we will then move back from 2019 into quarterly declarations, so I hope that is crystal clear for everybody.

And then on the oncology question, in the deal with Novartis which we all feel was a fantastic way to get value for the commercialised oncology assets that we had, and build up to world-leading scale business in Vaccines and Consumer, it is important to say, which perhaps was not sufficiently understood at the time, that we retained our R&D capability in oncology with some great R&D talent and some exciting early stage assets that we think that do have the potential to bring real value for GSK.

As I have said already, how we get that value is still to be confirmed depending on what the data say. Patrick, I don't know whether you would like to comment further specifically on the assets. Obviously, Luke Miels will have a meaningful role to play here as far as thoughtfulness around what is possible and what is right, in terms of our right to win, in terms of commercialisation in a specialty area which is a little different as far as building commercial capability. Patrick, I don't know if you want to add to that?

**Patrick Vallance:** When the Novartis deal took place, we kept our discovery effort in Oncology and we kept it in a very focused place, which is where we thought we had deep expertise: first, in epigenetics where we were early in the field and remain very deep in the science we have and, secondly, in immuno-oncology based on the very strong immunology presence at GSK and the immuno-oncology expertise of Axel Hoos as the leader of that area. Those are the two areas we are in, we are not trying to be an all-encompassing oncology play. We are pursuing largely those two areas and, Axel, I don't know whether you want to comment on any of the recent things, because our pipeline is now beginning to declare itself in terms of where we are in our clinical readouts and in terms of the combinations that we have, which are either unique or at the forefront of the next wave of some of these areas.

Do you want to comment on anything specific, Axel?

**Axel Hoos:** What I can say is that our pipeline is entirely based on innovation. We have delivered a lot of value in a relatively short period of time. If you think about the way this deal was structured with Novartis, there were only discovery assets left in the Oncology pipeline, post-Novartis. Now, two and a half years later, we have 11 assets in the clinic, we have several of those that carry a lot of promise and a lead asset is just

revealing itself to have a level of efficacy that you could call potentially blockbuster efficacy. So with an approximately 60% response rate in refractory multiple myeloma with our BCMA antibody drug conjugate, we have already doubled what daratumumab had shown at the same stage of development, and daratumumab has become a blockbuster asset.

If you compare it with other combination work, pomalidomide, dexamethasone and daratumumab together achieve about the same level of response rate that we have as a monotherapy. If this continues, which is what we are expecting, then once we enter combinations, I think we will have a strong stance for multiple myeloma patients.

Having said that, that is the lead asset in the portfolio and we clearly have efficacy data now that are meaningful, and there are other assets pushing to produce additional value, where, as Emma says, we still have to wait for more readouts.

**Emma Walmsley:** Thank you. I am going to the phone. Tim from Bernstein, can you ask your question please? [*No response*] There is one question on line that, Simon, I shall ask you to pick up on whether the slowdown in Consumer makes us think that the probability has increased of Novartis bringing the put to us next year? Probably a question for Joe. If so, are we comfortable we can fund this as well as retain flexibility for other M&A, whether that is in Consumer.

**Simon Dingemans:** Thanks, Emma. Clearly, the first part of the question is a question for Novartis and they have made their position pretty clear in their own recent earnings call, but they will have to decide when they want to exercise their put. It is their put, not our call. We have been very clear that we would like to acquire the rest of the business as and when they decide to exercise, and we are very comfortable that we can fund it but as to exactly how we choose to fund it, it is very premature to get into that discussion as that put could be some way away.

**Emma Walmsley:** Questions from the room?

**Keyur Parekh (Goldman Sachs):** First of all, congratulations and thank you for a frank and honest assessment of GSK's execution over the last few years, well done on that.

I have two questions. First, you spoke a lot about what you are changing but my question is about what you are not changing, and that is your financial targets for 2020. A lot has gone in your favour since you first issued those targets. You have announced an incremental billion dollar cost savings programme today and yet what we are seeing is

unchanged EPS expectations. Can you help us with this: are you running faster just to stand still, or is there inherent conservatism in what you are laying down today?

My second question, apologies, the dividend thing is still not crystal clear to a lot of us so I am going to come back to that. The press release says building dividend cover over time but I would like to understand what "over time" actually means in your mind. If one looks at the way you define free cash flow for 2016, the dividend cover was 0.8 times free cash flow. To take it to 1.25 times on consensus numbers is unlikely to get there by 2020, so is that an appropriate context to think about over time, or should we be thinking about a longer-term cycle than that? Thank you.

**Emma Walmsley:** Thank you very much, Keyur. Again, to reiterate, part of an assessment of where we are came from listening to a lot of very transparent shareholders and lead analysts, so I should thank you for that and request it on an ongoing basis. It is perhaps easier when the CEO is new but I am counting on it for the long term.

I shall ask Simon to come back on the definition of "over time", but just to give you my headlines on the 2020 guidance, it is very important to remind you - and he did have it on his slide on the puts and takes that make up landing on the same outlook - that since 2015 we have taken out £900 million of turnover and divestments versus what the base was in 2015, of which £500 million is still to come I believe and £400 million of which is within Pharma, in terms of the 'to go'.

We are talking about investing more in R&D. There is a big focus agenda in R&D but whether you look at Q2, or the assets – and we have taken that into account – the assets that we think we want to bet on, that will continue to be invested in. There is slight pressure on the tax rate and some slowdowns or pressures, whether that is an adjustment in Consumer both for environmental and one-offs. There is also the pricing pressure which, is near-term, is still very real, particularly in inhaled respiratory.

We are making some important and quite aggressive changes, to make sure that we can still provide a reasonably competitive outlook for 2020, when we look at it through our three individual business units – with a marked move forward on margin expectations within Pharma. Most importantly, we are investing in where we create the strongest value for the long-term, which is delivering a pipeline that is valued not only by patients but by the markets.

Simon, would you like to comment on the dividend over time question?

**Simon Dingemans:** Yes, and I will just pick up on the point we had earlier also, about the 2019 position. What we are saying in terms of how we are trying to indicate or guide people on the dividend going forward is that, from 2019, we will go back to what is



normal, in declaring and telling people about our dividends each quarter as we go forward. That is what we used to do. We created this bridge across the Novartis transaction and now, today, we have announced a new policy to set the framework for declaring dividends, going forward, against the baseline that, as Emma described, we are establishing for 2018.

The intent is then that we will grow into cover, over time – and I think that is probably several years rather than one year, and I will not get into specifically exactly how many years – but it is important, against the other priorities we've got.

As we have said, our first and foremost priority is to make sure that we are investing behind the future growth of the business, so that we secure that cycle of growing into the cover, going forward. Against that expectation, you should not expect the dividend to grow in the short term. Clearly, none of us can say that we will never ever consider a reduction in the dividend if some reason dictates that we should do that, but, what we are not saying is that is in some vacuum in 2019: there is a very clear framework to guide how we go forward here and, hopefully, that is clear. If not, then we should go through it again, just to make sure that everyone is clear.

**Emma Walmsley:** There is a question for Patrick that has come up online.

With regard to our targets to reduce drug development times relative to peers – and we are looking to reduce them to be more competitive with peers – can you talk about balancing these reductions with your third long-term priority of trust? Patrick?

**Patrick Vallance:** I am not quite sure what this question is getting at, and whether the implication is that we are going to cut corners to do it, or whether it is about our trust priority to deliver medicines. Clearly, we are not going to cut corners.

I will talk about what we are going to try to do to reduce our development time. We know that we do very well in Respiratory and HIV, and we know that a lot of the reasons why we have longer timelines in other areas are to do with things like how we have got our R&D/Commercial interface, which is being addressed head-on; and decision-making, to try to reduce the white space between trials.

Point No. 1 is that we are going to address the R&D/Commercial interface, particularly when we are thinking about areas where we have not traditionally had that strong interface that we need to get right. We have processes coming into trials which are reducing trial time and Emma has alluded to one, which is in the *danirixin* study. There, we had real-time data capture, which allowed us to make a decision about a year earlier than we otherwise would have done on what we thought the result was, and therefore trigger the next phase of study. So expect to see more in the way of real-time data capture, and real-time

information from multiple outputs from patients, and the use of digital also, to do things like site selection and the ability to time the delivery of drug substance – where, in one study, we have reduced trial times by six months.

When we look forward, it is a combination of decision-making, R&D partnership with Commercial in order to make sure that we don't circle – particularly in Phase II – and some strong digital approaches to try to improve performance of trial delivery and time to delivery. It is absolutely not about trying to reduce the standard of the data we generate in the evidence we are putting together –quite the opposite, in fact - and we want to increase that.

**Emma Walmsley:** Okay, let's come back to the room.

**Matthew Weston (Credit Suisse):** I have two quick US Commercial questions, if I can, and then one bigger picture on R&D.

A couple of the points, Emma, that you made around US Commercial where, I think, an increase in investment and support, and also you talked about changing incentives. Your predecessor clearly went out on a limb with a new Commercial structure in the US, confident that the industry would follow, but it didn't seem that they did. Could you let us know whether or not we are now seeing a change back at GSK to a more traditional, incentive-led sales force model in the US, or whether or not you are just tweaking the existing one?

Also, I was surprised to hear about the *Ellipta* pressure across the board in 2018. One of the arguments previously on *Ellipta* was that doctors loved it and that it was better for payors because you could switch patients much more efficiently and you could save costs. I wonder, Jack, whether there is any real change in terms of, is it really just *Advair*, and is that *Ellipta* story still holding up? Or is something changing?

Then finally, just on R&D, Emma, again you referred to a lot of focus on improving output. You talked about leadership changes in the top 200 of the business, but are you sure that you have the right people on the ground in R&D to actually deliver all these changes? Or will we actually see some quite significant turnover of employees, to really get the maximum efficiency and output out of the GSK R&D organisation?

**Emma Walmsley:** I will make a couple of comments and then I will ask Jack to comment on the competitiveness, both of the *Ellipta* portfolio and also our Commercial policy.

Quickly, in terms of R&D, as I have said, people drive performance and we all know that. We have made some changes and I think more will come, although you wouldn't

expect those to be announced ahead of time. We absolutely know that we have some fantastic scientists in the company and undoubtedly we will see some renewal, as across many of the areas of leadership.

In terms of the incentives, the incentives I was talking about actually was much more broadly across the whole company, as opposed to specifically Sales rep incentives, and we do plan to announce internally for 2018 some fairly significant adjustments to help align behind both the strategic priorities and the performance objectives there, to really make sure we are all pulling much more strongly to be competitive versus the marketplace. There is definitely a big opportunity on that.

What you allude to in terms of our salesforce policies, as I have said, GSK has been quite proud of its Patient First principles to try and remove any perceived conflict of interest. At the same time we have already evolved those policies, not least under Jack's leadership, to make them more competitive and, frankly, simpler and easy to execute against, particularly in line behind critical launches and we will continue to do that, but the fundamental principles of us being a values-based, trust-based company, where people can trust our science and our intentions and having very productive relationships with HCPs are absolutely critical to who GSK is and will continue to be.

Jack, do you want to comment, please?

**Jack Bailey (President US Pharmaceuticals):** Yes, thank you, Matthew. Just to underscore on the Patient First, we continue to be very values-orientated, but we are going to balance it with competitive performance and so we monitor and we will continue to adjust, as we have for the last two and a half years on that.

Speaking specifically to the *Elliпта* portfolio, it has performed well. I think when you look at the overall portfolio over the past year nearly doubling, products like *Breo* more than doubling. *Breo* is now the number one prescribed ICS/LABA with pulmonologists, we had our best semester ever in Q1 and Q2 of this year with *Breo* and our second best with our AC-containing products, *Anoro* and *Incruse*, so performance is very good.

The reality is both driven by market pressures, potential regulatory changes and potential legislative changes, both at the Federal and State level, I think that is what the industry is exposed to. We know it is exercised on a class-by-class basis, and those classes that tend to be more retail orientated and tend to have multiple products in it tend to be under the most pressure, so I think that is what you have heard from Emma and Simon. It is recognition that that isn't going away, but in the meantime we will drive, continue to drive, strong share of market performance across the entire *Elliпта* portfolio.

Thanks.

**Emma Walmsley:** Thanks, Jack.

Right, back to the room, please.

**Graham Parry (Bank of America Merrill Lynch):** Thanks. Just a first question on the guidance, you qualified your reiteration of the mid-term guidance with the potential need to invest in R&D, which implies that should the right opportunities come along that guidance could potentially come down, so how should we handicap the potential for that need? Do you think current R&D spendings are sufficient to achieve long-term objectives? If you bought in external assets would that mean you have to lower guidance and how much of the £1 billion of savings do you think would be allocated to offset that?

Secondly, another question on R&D, GSK has made much noise in the past about R&D structures, processes, we have CEDDs, we have had DPU, we have had R&D Investment Boards, so in your analysis of what hasn't worked in R&D, why didn't they work and can you just help us to understand what has changed this time, because for those of us who have followed the stock for a long time, it feels like we are hearing some of the same messages again that we have heard under previous new CEOs as they started?

Then, thirdly, you said you are interested in owning all of Consumer Health, including the Novartis stake, and that has previously been viewed from the lens of Novartis putting that stake to you. Their latest communication seems to be tilted more towards 'Let GSK come to us', so in the context of that could you help us understand your desire to pursue Novartis for a transaction rather than the other way around and give us some kind of reassurance of the value that you would get for GSK shareholders in such a transaction? Thanks.

**Emma Walmsley:** Okay. I think we have already said this, it is their put to us and that is going to be their decision.

I think Patrick would be best placed to say what you think is going to be meaningfully different in terms of the operating changes, because we are quite deliberately not choosing to do major structural resets which we think will just cause more delays, as opposed to improve output. Then, I will ask Simon to comment on your first question, please.

**Patrick Vallance:** Yes, so I think we are absolutely not changing the DPU model and we believe the output from those DPUs has been extremely good, so the Discovery organisation I think continues to innovate and produce really high-quality output and we have some of the DPU Heads here who can speak to that. John Bertin, for example, I think is an absolutely recognised world leader in his field. I think where we haven't done as well, and it was clear from some of the statistics shown, is in some of the areas of

development, where I think we have failed to focus enough and, as a result of that, we have had too many things progressing too slowly in the development organisation. Not only have they developed too slowly, but I don't think we have had the partnership right between R&D and Commercial, which meant they landed in a prepared partnered organisation that could drive them to full value. So, by focusing down – and it is a very significant focus down on the two areas, plus two emergent - I think it gives us a vertical integration all the way from target selection through to Commercial ability to deliver on it, in which we can drive things through in a way where we have a recipient and partner organisation. I do think the R&D/Commercial interface is very much tighter in this new design and, obviously, the arrival of Luke is going to help further with that.

In Development we also absolutely need to not only make sure that we do things fast, which we have talked about, but we make sure the evidence generation is aligned with what is really required, and by spreading more thinly and going across too many therapy areas I think we often had quite good molecules which didn't end up getting the right evidence generation to be commercially successful. I think that narrowing of commercialisation and development is a very key change to how we are thinking about things.

**Emma Walmsley:** Thank you. Simon, do you want to –

**Simon Dingemans:** Yes, Graham, I think the answer to your question started with Keyur's point earlier that, in terms of looking at the outlook to 2020 a key part of the trade-offs we have described is making sure we have flexibility to invest behind the newly prioritised R&D pipeline, so there is a reasonable amount of allowance in there for R&D spending. You have seen R&D spending coming up quite quickly over the last several quarters. Clearly we are going to start annualising some of that and so I think the way you should think about it is that we will make specific investment decisions if the data justifies it and there is a clear evidence point to bring in front of you and we will adjust accordingly with an obvious opportunity sitting in front of us. I wouldn't build in other adjustments at this point, I think it is all within the outlook to 2020 that we have given you.

**Philippe Lanone (Natixis):** First, could you update on the reason why you divested sirukumab which seemed a reasonably solid asset and now you are more dependent on a few late-stage assets after the choices, so do you include some buying or in-licensing of late-stage assets in addition to the effort you are making internally in R&D?

**Emma Walmsley:** I am going to be very brief on those. Our focus on R&D is really going to be on early-stage stuff but we are planning to revitalise our R&D BD Team

fairly meaningfully and should the scans that we do suggest that a late-stage asset is worth us looking at, then we will, but our priority is on early-stage strengthening.

In terms of sirukumab, it is simply a question of with our allocation of resources, what do we think we are the best commercial leaders of in terms of it being the most competitive thing that we are capable of executing against and our judgment was that was not to be the case. We are still supporting very strong partners, Janssen in terms of the work that lies ahead but we think that's the right decision for us. I don't know if you want to add anything, Patrick on that?

**Patrick Vallance:** No, I think that's exactly right, and it's just about us putting our resources where we can make them most successful.

**Naresh Chouhan (New Street Research):** Thanks for taking the questions. Sorry to go back to the dividend but as I am sure you are aware, it's very important to the current valuation. If it is going to take a number of years to grow into the dividend and free cash flow is going to have to grow by about 50% to get you to within the dividend target range would it be fair to assume, and would you agree, that you are over-distributing and do you think that that current situation is sustainable for a number of years to come?

And then secondly on R&D, would it be fair to assume that your return on R&D has fallen since you last updated us on the IRR. I know you are not going to update us on the IRR, but just to be able to understand directionally where that's gone. Obviously we have had *Breo* and *Anoro* sales performance being somewhat disappointing and late-stage failures offset by better ViiV performance, and if so, can you help us understand how you came to the capital allocation decisions you got to with Vaccines and Pharma and R&D is obviously not your choice, as you stated? Thanks.

**Emma Walmsley:** Okay, so Simon, I would like you to comment on the IRR and the capital allocation choices.

Just on the 'have we distributed ahead' – yes, I think I said that in my opening comments, we did distribute ahead, but we are really focussed as Simon has said several times on rebuilding our cash flow and our cover and I am not going to reiterate again the principles that we are working towards, but we do want to get our balance sheet back into a stronger position and we are quite focussed on the A1P1 rating at the same time concurrently. That would be my comments on that.

Simon, do you want to discuss -?

**Simon Dingemans:** Just to be clear, we are not saying there is no cover for several years; we are saying we don't get comfortably into the range that we have set out and that is going to take some time and then clearly we have to also along the way make sure we are funding the investments we were just talking about in terms of R&D pipeline, managing our balance sheet, strengthening our credit profile so we have flexibility if other things come along. I think trying to balance those while also maintaining something that shareholders have said to us is very important. I think is why you get the picture that you get, but that's not to say there is no cover for the next several years.

I think in that context when you look at the capital allocation framework, we want to look at R&D for each of the businesses within an integrated return for each of Vaccines, Consumer and Pharma because they all look quite different. The relative returns on Pharma and Vaccines R&D compared to the numbers we have previously published are not coming down as new products kick in to that mix.

Clearly as we go through the next wave post the upcoming launches we have of dual *Shingrix* and the closed triple then you might expect to see a dip, but that again is why we want to look at it in the context of the business as a whole and Vaccines and Pharma from a return point of view over the medium term look relatively similar.

Clearly today Vaccines is still dealing with some quite big investments behind relatively new products which we are putting a lot of capacity behind. We inherited a significantly loss-making business from Novartis, so it didn't stop in 2015 in a very good place but it is moving pretty quickly through that and that's why we think it's right to allocate capital because fundamentally, as Luc will tell you, we can sell pretty much every dose we can make.

**Sam Fazeli (Bloomberg Intelligence):** I have three questions, if I may – knowing that you said two. The first one is on Consumer in terms of what drives the put value. You have had a quarter which wasn't particularly strong and you have this generic that has come along, where I don't know whether you were aware of it before or not, but it is eating into the growth profile. How does this lead to still an up-valuation for the put option?

The second one is would your guidance be different if there was a second and a third generic *Advair*, because I think you have said you are assuming a generic *Advair* launch in the guidance, or maybe it's at least a generic *Advair* launch?

**Emma Walmsley:** Yes, that would be a better correction on that one.

**Sam Fazeli:** Okay, it's at least.

**Emma Walmsley:** Yes.

**Sam Fazeli:** Okay, and thirdly, on *Tanzeum*, what do you think was done wrongly or what happened there in terms of the process of developing it and taking it to market. I think most observers were probably viewing the product not as the strongest product in its class, which is something that you have learned from taking forward? Thank you.

**Emma Walmsley:** I'll take that down to two questions. On the put, and Simon can answer in more detail, the revaluation is related to FX on some of the smaller currencies and the valuations of Consumer companies that have moved up a little bit. I don't know, Simon, whether you want to add anything more in terms of the put?

**Simon Dingemans:** The valuation is based on forecast for the business, not just for the next 12 months but medium-term forecasts, and we have seen a big swing in the main trading currencies last year. We are seeing more benefit than we previously planned for from a lot of the smaller currencies, so we have done a bit of catch-up in this quarter as well as quite a big shift in the comparable multiples, which is why we have seen a significant move this quarter.

**Emma Walmsley:** To your question on *Tanzeum*, I am going to ask Patrick to pick that up because it is a really important one, and to the earlier point about what is going to be different now, we did quite a detailed review of where we haven't necessarily got this right. *Tanzeum* would be a good one as far as having a truly competitive asset with the right kind of full alignment of what winning looks like between the developers and the commercial executers. Therefore, we did spend some time looking into that. Do you want to comment a little more on lessons learned from *Tanzeum*?

**Patrick Vallance:** *Tanzeum* went through a rather interesting different development path in GSK which was set up as a different vehicle, which I think we won't do again. I believe there was a specific way of doing it which was outside lots of the normal governance process. The simple answer to your question, Sam, is that it wasn't called earlier enough when the data told us that it wasn't going to be commercially successful in our hands. I believe we should have called it much earlier. It was evident after some of the early trial readouts and, at that point, we should have called it and stopped it.

**Kerry Holford (Exane BNP Paribas):** Three questions please. First, can we just go back to the incremental price pressure? Clearly, this has been a reason to trim the guidance for 2017 but I am keen to better understand what has become incrementally more difficult. Since the beginning of the year, you have referenced Respiratory a number of



times but, generic *Advair* is not coming until next year now, so what has become more tough this year? In the context of that, could you talk to us a little about rebating in HIV specifically today, and how that looks out into 2018?

Secondly, a question for Simon on Pharma margins. Mid-term margins guidance is now for that to be in around the low 30s, and that was based on 2015 FX rates, if I understand correctly. You referenced the earnings growth over that period if you were to adjust for currency; I wonder if you might also do the same for your expectations for Pharma margins on today's currency in 2020?

Thirdly, a question for Patrick: on the pipeline refocus, I guess it makes sense, given your historical strength in HIV and Respiratory, to continue to focus here. However, I might argue that those two disease categories are relatively well-served by medicines on the market today. Where is there room for disruptive therapies in those two indications?

**Emma Walmsley:** We'll come back to Simon and Patrick for your second and third questions. On the update to this year's guidance, just a slight correction. The adjustment for this year's guidance is related to the investment in the PRV and the associated costs with launching, therefore pulling forward a bit the launch behind the dual therapy. We have referred to pricing pressures several times, because they are very real and we now have a little more visibility on 2018 contracting as well. However, I shall let Jack and then Deborah comment on the Respiratory and then HIV environment.

**Jack Bailey:** As far as the pricing pressures we talked about earlier, it is really multifactorial. The environment is as dynamic as we have ever seen it: 25 years in this industry to see the competitive landscape and the market-driven pricing pressures with ongoing payor consolidation etc. As I said, regulatorily, just as recently as the last few days, obviously CMS has put out its own proposed rule as it relates to 340B. Then, legislatively, we have over 30 states that are trying to enact legislation on drug price either transparency or procurement law. Therefore, it really is multifactorial and it will continue to be intense given everything from state budgets, to the federal deficit, to the ongoing market structure in terms of consolidated payors and some of the actions of competitors. That is what we continue to see going forward, especially in some of the classes, as Emma mentioned, like retail inhaled respiratory.

**Deborah Waterhouse:** HIV is a very different marketplace. It is still a therapy area where what medicine each patient receives is extremely individualised. In terms of how the market is split for us, you have 6% of patients in government-funded schemes and then 40% sitting with the commercial insurers. So, for us contracting pressure is completely different in the commercial insurers. In the government-funded space at the moment, we are obviously watching what is happening in the emerging American healthcare

environment. Potentially, there could be pressure on Medicaid but, as I am sure many of you know, if there is pressure on Medicaid and the expansion of Medicaid in some states is reversed, people don't fall out of care; they go into the 'Ryan White' safety net programme. Therefore, what you see is a commercial space that is currently not contracted and then you will see a government space where there is some uncertainty due to the healthcare environment within the US. There may be some pressure in Medicaid but due to the safety net system that we have, patients will still receive their medicine. I think it is very important that we understand the difference in this particular disease area, not only about the individualised choices that physicians need to make per patient, but also the very active patient groups that we see, who are very active in lobbying across the world, but particularly in the US. That is something that payors have been reluctant to face up to.

In terms of a paradigm shift in HIV from a treatment perspective, John, why don't I let you handle that one?

**John Pottage:** I would just comment – you might say yes, that the market, HIV patients, are well served today, but there are actually two dynamics that one really worries about. As an infectious disease physician, I am always worried: we are up against a very tough foe that replicates very rapidly and very sloppily, and develops resistance. We are always worried about the emergence of resistance and we don't want to be behind the eight ball so to speak, of that. We are always learning about that, so that we can develop a new drug to treat the development of resistance as that comes forward.

The second thing is that we have turned this disease from a death sentence, where no one was able to be treated and survive with it, to one where people live for many, many decades – 60 years is often talked about now, if someone is infected in their late teens or early twenties. So this is a different population and, as they live longer, you are now having to deal with all the comorbidities of ageing – diabetes, hypertension and other diseases - which actually require other medicines. We also have a real need to develop medicines that have no interactions, or which don't have effects going forward with that.

It is a dynamic disease, and I worry that people are lulled into thinking that everything is done here, so let's go and look at something else – because this is something will move forward. I think that is really what drives us as we try to produce better and better medicines.

**Emma Walmsley:** Patrick, would you add anything in terms of a paradigm shift?

**Patrick Vallance:** It is precisely why discovery is broader than development, because new areas come from discovery for 15 years' time, so we retain that broader discovery.

In terms of respiratory, it is true that there are many areas of asthma and COPD where needs are met, but there are many areas that still aren't. Sub-categories, like severe asthmatics not driven by eosinophils remains an unmet need; or such as the needs for oral treatments to simplify treatment regimens are not met. So I think there are categories of both asthma and COPD where there is still quite significant need, and particularly in smaller patient groups, where I think there is an opportunity for areas where there won't be the same pricing pressure.

In respiratory, we are looking very carefully outside those two areas as well. We recognise that there is an increasing number of medicines coming through in asthma and COPD. Pulmonary fibrosis is an area that we are very interested in growing in the Respiratory field, as well as acute lung injury.

Just to add on HIV, long-acting is clearly making a difference. There is clearly the possibility of things like broadly neutralising antibodies coming along. Ultimately, people are working on something which may be very, very difficult, but will change, which is obviously whether you can get to very long-term remission and cure. So there are still other areas to go after.

As Emma said, we are including in HIV also the broadening into other infectious disease areas, and hepatitis B is one that I would highlight there.

**Emma Walmsley:** And Simon?

**Simon Dingemans:** On the margin, it is slightly dependent on how the mix of the business plays out between now and 2020 but, if you assume a similar mix to what we have today and you take the quarter end rates at the end of Q2, you would be about 2.5% on top of the margin guidance that I gave. So it is somewhere between 2% and 3%.

**Emma Walmsley:** Okay. More questions?

**Richard Parkes (Deutsche Bank):** Firstly, I just have to push you a little more on the capital allocation and dividend policy. If you look at the framework that you gave, I think the Consumer put option was prioritised ahead of dividends. Obviously, that is a known potential cost and you have said that you can fund that through your current balance sheet. Would it be your intention to fund that through your current balance sheet *and* maintain the dividend? That is my first question.

The second question is just on R&D productivity, perhaps for Patrick. There has been a great deal of discussion about streamlining your focus and improving decision-making, but perhaps the bigger challenge is in improving the scientific leadership and thought leadership within R&D in Pharma within Glaxo. Is improving that just a function of increasing the investment behind your core areas of focus, or is that something that you can also improve through business development and in-licensing acquisitions?

**Emma Walmsley:** Patrick and Simon?

**Simon Dingemans:** On the Consumer put, it is clearly on the chart as a capital priority and we do not know when it will arrive, but we have anticipated that it might arrive from the spring of next year, and so we have anticipated it also in terms of thinking about the funding structure going forward, and the outlook for the dividend that we have described. While it is a little early to say precisely how we will fund it, we would not expect it to have any impact on the dividend profile that we have just already described to you.

Over time, we have an expectation of building balance sheet capacity to fund the different things that we have talked about today. When it arrives is obviously a key part of exactly how we choose to implement it.

**Patrick Vallance:** Scientific leadership is a key part of R&D. We have some outstanding scientists – some of them are here, and you can speak to them afterwards. We have some real world leadership positions, but we have some other areas where we need to bring in new scientists. We have already indicated one such hire, Tony Wood, who is coming in, who I think is an outstanding medicinal chemist and leader in his field in the area of product development, in terms of CMC and so on, and we know that we have very broad connectivity across certain areas in academia that we are going to build on, in terms of accessing new science. Accessing new science, whether it is through BD, which we have already alluded to, we are going to revamp our BD organisation, in terms of connectivity, whether it is through the sorts of deals we have with venture capital firms, where we are limited partners and seeing access to new things started, the academic links we have and models we have which are leading to, I think, significant inflow of new ideas or the leaders in our own DPUs, I think continually refreshing our science is an absolutely key thing. I think we have got strong leadership positions in some places, as I have said, and some areas where we do need to look and make sure that we have cutting-edge science, and that is always going to be the case and we will refresh and continue to refresh the leadership there.

**Emma Walmsley:** Thank you. So, we have got Tim, I think, back on the phone unmuted – Tim, would you like to ask your questions, please?

**Tim Anderson (Bernstein):** Yes, thank you. You talked about ongoing price pressure at various points, some companies give us price/volume foreign exchange information when they report results like Lilly did yesterday. Can you say or quantify what pricing was for Glaxo across your whole book of business for Q2 and first half?

Second question is on late stage pipeline opportunities with close triple and zoster vaccine. It would be great if Glaxo could put a stake in the ground, and give us a rough indication of how good you think those product opportunities could be. It seems especially tricky with the closed triple given the pricing pressures and generic entrants coming in respiratory.

Last question, slide 20 Emma, in your deck, has one mention about new emerging market operations, I'm not sure what that means, but I think that's a level of disclosure by Glaxo in emerging markets - it's gone down I think since the start of 2016, and I'm wondering what's going on in that part of the business, and what's going to change going forward, and if you're going to start to disclose some granularity so we can track performance. Thank you.

**Emma Walmsley:** Okay, so I am going to ask Eric in a minute to comment on closed triple competitiveness and probably also Luc on *Shingrix*, but just to say that we don't forecast value sales for our assets. We have said that *Shingrix* will be a contributor, around a third of our growth and we do believe that could be our biggest vaccine. We are very excited about that, but we will hear from both of them on those assets. Simon could maybe give you the net price and volume numbers.

**Simon Dingemans:** Across the Pharma portfolio as a whole it is about minus 1, in terms of net price, we have indicated that in the most recent quarters, Tim, so you expect us to keep giving you some guidance on that, but obviously at an aggregate level.

**Emma Walmsley:** Coming back on the Emerging Market point, Tim, as I said in my opening words, this continues to be an important business for us and it has contributed to growth, although in certain countries, as you well know, we have had some difficult times in recent years, but we expect it to continue to contribute to growth for the company. It is around a quarter of the business, but we need it to do so more profitably, without removing in any sense the access to medicines that we know is part of our responsibility and purpose. We just need to have a much more fit-for-purpose – particularly from a cost structure point of view – operation there, because 90% of the business is still in branded generics, it is also noticeable that we haven't been as good as we should have been at launching some of our innovations, so I want us to be better at rolling out innovation,

but have cost structures and typology and archetypes of markets with appropriate structures around them.

We are going to be making some meaningful shifts there as well as running it on, basically, an integrated P&L with supply chain. This is an area where, frankly, our supply chain both in terms of service levels and probably flow and number of factories has not been where it should be, so we are going to be doing a lot of work on that. As Luke appoints his leadership, we should see ongoing contribution, but more profitable growth from that part of the world.

So, maybe I can ask Eric to comment on closed triple, please?

**Eric Dube:** Yes, thank you for that question. We are very excited about the closed triple opportunity. If we look at a lot of the emerging evidence within COPD, it addresses one of the major challenges that we have, which is these patients continue to progress and remain symptomatic, continue to have a high rate of exacerbations. We believe that the future treatment of COPD, just as many experts reiterate, is dual therapy, the LAMA/LABA class, as well as the triple therapy, and we have seen an incredible profile begin to emerge with our closed triple from our FULFIL study and we eagerly await a landmark study, the IMPACT study, later this year to be able to further reinforce that profile.

If we just look at how patients are treated today, about a ~~third~~ quarter\* of patients are on triple therapy now and so we believe that that is a strong base of business to be able to shift to closed triple. However, when we look more broadly at patients that are on ICS/LABA, which now has been demonstrated inferior to closed triple, as well as LAMA/LABAs that is a base of business and a big segment of the market that is still symptomatic and can benefit from either *Anoro* with the LAMA/LABAs or the closed triples. With the efficacy profile as well as the challenge of complexity that these patients face, many patients that are on open triple today are on two different devices, oftentimes one once a day, one twice a day. It is a real challenge and we believe that this meets a very significant need that both physicians and patients have expressed for us.

I don't know, Jack, if you want to talk a bit about the pressures on pricing that you would expect and how we can address that?

\* post transcript edit.

**Jack Bailey:** Actually, I would like to just build on the closed triple and our excitement in the US affiliate for it. This is the last piece, if you will, in terms of our inhaled portfolio, we will be the only company to be able to run the breadth and gambit in terms of these products, all on the same *Ellipta* platform. Certainly, when we look back at *Breo* launch versus this launch, first of all, we will be first to market with this one versus the fourth ICS to market. Second we will experience a much stronger installed base of *Ellipta* users. One in four patients in this country who needs an ICS/LABA is started on *Breo*. As I said, *Breo* is now the number one pulmonologist-prescribed ICS/LABA. One in three patients who need a dual is started on a GSK *Ellipta* product, so you have this much more installed base of *Ellipta* users which makes the jump up to closed triple in the same device platform much easier and much more attractive, so certainly from a logistic standpoint we won't get into the details, but we will be fully resourced to make sure we are highly competitive from a share of voice standpoint.

And the last thing is, because the FDA change in guidance, we have engaged payors much earlier than we did with our earlier *Ellipta* products because of the new guidance and so that's enabled us to really get a good 'B' from a payor perspective and there is a lot of excitement there, just like the physicians. The number one term we hear from physicians in market research is 'Finally'. Finally they have a closed triple option.

**Emma Walmsley:** Thank you, and Luc on *Shingrix*.

**Luc Debruyne:** As you said, we will not share any specific forecast, but let me give you a bit of a perspective of the potential here. We said it will deliver one-third of our growth from 2015 until 2020 and we are well on track on delivering this mid to high single digit growth with the Vaccines business overall.

If you know that today with the current used product vaccine in the US only they make \$780 million a year and only 30% of the potential population is covered with that and, as I said, 80% of that is US only whereas we will do a first in the US launch but then a global launch of *Shingrix*, and it really responds to what Emma laid out as the criteria for the real innovation. It is a highly efficacious, sustained efficacy of 90% across all ages and highly differentiated versus what is today, so it really has the potential to set a new standard.

If you have seen all the press releases around the June ACIP where we shared our revaccination data and telling you that we are on track actually on every single milestone as to work towards launch, that should give you the confidence, that gives us the confidence that this is indeed a potential of a big vaccine.

**Michael Leuchten (UBS):** Just going back to your cost consciousness slide, you mentioned that at the moment only Consumer has its own P&L. Does that mean ViiV does not?

And then for the businesses that don't have their own P&L at the moment, what systems are required to make that happen and how long will that take?

**Emma Walmsley:** Good catch on ViiV. Simon, do you want to talk about the systems?

**Simon Dingemans:** You are absolutely right that ViiV does have its own P&L, not least because there are two other shareholders sitting in there. It was more a question about thinking about the integrated Pharma and Vaccines businesses which we have not pulled together in that way before. We don't need any systems upgrades to do that. We are using the model that we developed for Consumer now to have that capability in place and we will have implemented by the end of the year, so we are ready to go.

**Marietta Miemietz (Primavenue):** A follow up question on the Novartis put. Are you actually ruling out negotiating the terms? And if so, why? Would that be because you are so enthusiastic about the asset that you would want it as early as possible and the reason for the question is really that the CEO of Novartis has stated publically that the company is in no hurry to put as long as the business is going well. So presumably for a small fee you could actually move back the first time that they can put by quite a bit and thereby buy a lot of flexibility for that period when you might not have ideal dividend cover and that would then enable you to actually commit to a progressive dividend which is very much the norm in the industry and actually the reason why a lot of investors invest in this industry as opposed to just having to live with that risk of a potential dividend cut.

The second question just quickly on cost-cutting. It does sound like you are finally getting to the stage where you might be taking some risks with regards to the business, so for example cuts to regulatory or cuts to changes to the manufacturing of commercial drugs to reduce the COGs.

Is that a correct perception that you feel that you need to take some risks to prop up the margin or is that a misperception and how do you generally mitigate that risk?

And if I could, just a very quick follow-up on R&D where I really, really appreciate your candour. I just want to make sure I understand correctly, you don't think there are any issues with the science itself, so all of the problems were upstream and you think that the R&D engine is actually broad enough to deliver a continuing flow into the pipeline. I am just asking because listening to some of your competitors speak, it just sounds like they have a



lot more technologies, a lot more internal databases whereas listening to GSK it always sounds very focussed around specific areas of expertise like epigenetics, but maybe that's just a communication issue, so any clarity there would be great. Thank you.

**Emma Walmsley:** Okay, so perhaps, do you want to respond on the put question first of all, Simon?

**Simon Dingemans:** It's a great question on Novartis but you might imagine if we want something, then they are going to react, okay? So we have to make it clear that it is an important capital allocation priority for us that we would like to own the whole business, so you set up then a public dynamic which it is probably not very helpful to try to resolve it sensibly for both sides to continue to debate it in the open. At the right point, they will be ready to sell and we will be ready to buy and we need to buy it at the most effective price for our shareholders and vice-versa.

I am not sure we can really go backwards and forwards very much more on this other than to make it clear that we are very happy with how it sits today, they are very good partners, we don't need to do something tomorrow but if they want to exit we are very happy to buy it.

**Emma Walmsley:** I would like to correct the point that we are taking risks with regulatory or quality in manufacturing. That is absolutely not our intent. In fact, when you look back over the last few years of history where both us and others in the industry have suffered from some major supply issues which frankly are extremely expensive, much more than any benefit you get by kind of cutting short-sightedly, that has often been because it was under-invested in these fundamentals.

Please do not walk away with the thought of us taking risks on quality or safety or regulatory. What we are trying to do is get more competitive around our costs, around our working capital, around the productivity of our factories and around an end-to-end view of our supply chain. That for me is not about risk-taking, that is about understanding what good looks like and holding that bar in the right place for us and we have a very mobilised supply chain organisation looking at a lot of detail in that.

That said, I have alluded to the fact a few times that I would like us to be a little more of a courageous company in placing some of the bets fully, and the most obvious area in that will be in R&D. Coming back to your question on R&D, I shall ask Patrick to overlay. We have been and are very focused on our development processes, because the reality is that after this period up until 2020, I would like you to be able to have a renewed confidence in and valuation of our pipeline for the next wave, which, as a reminder, doesn't need to

come through until the mid-20s - great if it does and we like to advance things as much as possible, that would be part of the work. So we are very focused on development.

Patrick has mentioned the ongoing quest for renewal of scientific expertise, whether it is internally or in our connectivity externally. We have also alluded to a few areas in terms of platform technologies at a more fundamental level where we think we are competitive, and you might like to comment on those, whether that is going after targeting much more efficiently in terms of genetic evidence, or whether that is in our medicinal chemistry or in fact some of our more advanced manufacturing technologies. I don't know whether you want to comment on the expertise from a discovery point of view as well?

**Patrick Vallance:** I do and I think you are right, we haven't spoken about it as much as we should have done and I want to pick up on a few things there. If I pick up on chemistry, we are the first company to get encoded library technology working for screening, which has made a big difference to screening. We are very advanced in terms of the Protac technology, which allows you to pull out proteins in cells chemically, which is a hot area in medicinal chemistry. We have, I believe, the world-leading proteomic organisation in our Cell Zone part of the organisation in Heidelberg, which is well recognised as being able to do things as far as looking at proteomic interactions with molecules that isn't available elsewhere. They have, as do many other parts of GSK, multiple publications in *Nature* covering that.

In terms of genetics and genomics, we undoubtedly have the biggest collaboration which we stimulated with the European Bioinformatics Institute and the Sanger Centre around genetics, which has led, together with what we are doing with UK Biobank, to do a deal where Regeneron have joined us to do a screening, and I believe that Regeneron are seen as leaders in that. So, I think in terms of the science infrastructure, we have very leading platforms across chemistry in particular, less good in some of the antibody technologies but we are definitely competitive - I wouldn't claim we are absolutely out there at the front on those. In cell and gene therapy, we are at the cutting edge of what is being done there with the first product to prove in some quite interesting approaches as to how you make them.

I would bring that through also to some of the approaches in big data from things like the Salford Study but, more importantly, two years ago we appointed a lead for data across R&D from another industrial sector completely who has moved us from being able to access 20% roughly of our internal data to now over 95% of our internal structured data in a way that scientists can access it through one place. If you ask around, I don't think that anyone has managed to achieve that yet; that is a huge data resource as far as scientific input.

Therefore, we are very focused. We clearly have not spoken about it enough as far as the discovery platforms we have with some really cutting edge science.

**James Gordon (JP Morgan):** I have three short questions please. First, commercial, about China: can that return to being a big growth driver and, if so, what is the plan there? The second question is about doublets: we have the first doublet approval coming up quite soon, but what does that do to the ViiV profitability within Pharma, or is it fair to assume they will be significantly lower priced? Then you will have a significant pay-away to J&J as well and more of the growth will come from ex-US or from Europe, so are we going to see significant margin pressure there, and are there ways in which you can offset that?

The third question is about divestment today. You talked about it in terms of revenues but will it be a very high profitability?: does that create a bit of a free cash flow gap, and is this the streamlining done, or could it be an ongoing part of GSK for the next few years to have more streamlining?

**Emma Walmsley:** Thank you very much, James, for your brief questions. Simon, could you pick up the divestment please and then I shall come over to Deb on the doublet.

**Simon Dingemans:** Generally, below average profitability and also in the disposals we are making, we are divesting more capital-intensive businesses than our average, so we are saving ourselves on capex going forward. They should be net-net material contributors to cash generation.

**Deborah Waterhouse:** The two drug regimen assets that we have coming through the pipeline, so there is an impact on the margin overall but we shall be driving a greater volume of ViiV business. So we are really focused on our top line sales number and driving that up from a share perspective as far as we can. What I would say is that, versus where we are today as far as our dolutegravir share, when you add in dolutegravir plus rilpivirine and then you add in dolutegravir plus 3TC, we aim to have a higher overall share for dolutegravir after those two assets are launched on top of *Tivicay* and *Triumeq* where we shall still have significant business. It is a real share/volume/sales play which, ultimately, will drop positively to the bottom line but the margin does take a little bit of a hit.

**Emma Walmsley:** As far as your question on China, we took a big hit in China and we are absolutely delighted that the Board continued to support investment in the market. For obvious reasons, it is important that we participate not just commercially but from a manufacturing point of view, and from an R&D point of view, in China, with China, for

China. We have to be patient in terms of seeing materiality of the contribution, but we are still very much supporting our progress there.

Back to the room for any more questions, otherwise we will go back online.

Online, we have a couple of questions. First of all, for Simon, a repeat question from Weston Asset Management, on 'What is our view on large M&A and the rating commitment: are we more focused on bolt-ons?'

**Simon Dingemans:** As we made clear in the presentation, the focus is very much on bolt-ons, partnership-type deals. We think we can accommodate the likely flow of those within the current balance sheet capacity. Big scale – you would never rule out, but we have talked before about the disruptive nature of those and so the bar is very high for those. Certainly, that is not something that is on the immediate agenda.

**Emma Walmsley:** And then Steve Scala, could we have question from you, please?

**Steve Scala (Cowen):** In July 2008, Andrew laid out a strategy of growing a diversified global business, delivering more products of value and simplifying GSK's operating model. He also focused on improving shareholder value and focusing on new strategic priorities to address the changing healthcare environment.

Today, you mentioned that the DPU strategy is not changing. How is the big picture strategy you are providing today different from that of nearly a decade ago? Or are you saying that the strategy is the same but the execution needs to improve?

My second question is, what initiatives would GSK put in place to blunt an *Advair* generic, such as multi-year contracting and/or authorised generics? Thank you.

**Emma Walmsley:** I will come back to your very important first question in a moment, but I will ask Jack to pick up on the *Advair* generic question, please, because he is leading the US business.

**Jack Bailey:** I appreciate the question. As Simon had referenced in multiple meetings, there is still uncertainty around when a generic *Advair* will come but certainly – especially with the Mylan and Hikma Complete Response letters about the acceptance of the Sandoz ANDA. At some point, it will arrive. We have a whole array of different tactics that we will employ, leading up to and through the presence of any generic *Advair*, when and if it does come. It feels like we have the whole toolkit at our disposal.

**Emma Walmsley:** On your first question, you are right that there is a key part of this that is execution based and, particularly the near-term, we need to be very

competitive in our execution focus with the three launches that we have talked about, and then the ongoing shifting environment.

I would probably highlight the two most important shifts. The first one is about putting innovation first, and innovation within Pharma first. It is never right to comment on previous leaders' strategies but, when we talk about more products of value, there was quite a strong push around the volume agenda across a full, diversified business. We want to make sure that we are really focusing on building growth through volume and value that is driven through innovation. We want to put R&D and science absolutely front and centre of GSK for its next period, and that will be visible in our capital allocation and focus on getting that business to competitive performance.

That is the second big shift, I think, which is bringing more edge to the culture and the performance focus of the company through more focused choices, particularly in the portfolio, through the people that we put in place and the changes that we want to make with the culture. So it is a portfolio of therapy areas, assets and markets – unashamedly putting the US front and centre, while putting in a fit-for-purpose operating model for the emerging markets to drive the access that we have the responsibility to deliver.

Are there any more questions in the room?

**Question (Bank of America):** I have just a couple of product questions. Daprodustat: I am wondering where that fits in the new strategy – it doesn't fit into any of your core areas. If you get a positive outcomes data read-out on that, is that something that you would be looking to partner out on that data? Or would you look to rebuild a new franchise around that product?

Secondly, *Bexsero* – you previously, as a firm, alluded to that as a potential multi-billion dollar vaccine. It wasn't on your list of key products.

Thirdly, just going back to the IAS data and the *Tivicay/Triumeq* competitor from Gilead, bicitgravir, the physician feedback there was very much focused on softer issues that may be harder to detail against in the commercial market, such as patient-reported CNS symptoms; the tolerability of backbone, and CV concerns, which I guess have been disproved over time. Could you just run us through your commercial strategy for pushing back against that perception issue that is out there in the market. Thank you.

**Emma Walmsley:** I am sure that there is only a degree to which we want to run through our commercial strategy, for competitive reasons, but I will ask Deb to comment on that in a moment.

On *Bexsero*, it wasn't listed on the products, because that was just the development products and not the assets that were listed on that chart – not the assets that are currently in market. It is absolutely key for us and our meningitis portfolio – we expect it to contribute: we said a third on *Shingrix*, and we expect a third to come from our meningitis portfolio, which is performing extremely well. Maybe Luc, I will ask you to add a comment on that.

Let's start with Patrick on that great question, to explain why we decided that that was potentially still an asset that could bring real value to GSK.

**Patrick Vallance:** We have a very good molecule there. If you look at the dose, it is about 5mg that most patients will end up on, which is substantially lower than competitor molecules. We know that it works and we know that we can dial up and down haemoglobin. We are in the Phase III trials, and those Phase III trials are recruiting faster than expected and so we are ahead of time on that. We believe that we have a very clean molecule in terms of its on-target and off-target effects. For example, there is nothing on prolyl collagen hydroxylase. I think we have a good molecule and it will read out in due course.

In terms of how we best commercialise that, that is an ongoing discussion as to how we best achieve that, whether we do it alone or in partnership.

**Emma Walmsley:** Thank you, Luc, do you want to comment on *Bexsero*, and then we will finish with Deb.

**Luc Debruyne:** Let me just share with you how it contributes actually to this one-third of growth for the future, so it is the Meningitis portfolio, so it is *Menveo*, *ACWY* and Meningitis B, *Bexsero*, so it is growing 30% year-to-date versus last year and if you know that before the acquisition of Novartis we were actually only selling less than 900,000 doses, year-to-date we have supplied already more than 15 million doses, so every dose we make – and, as Simon laid out, we are investing in capacity here to make sure we can support that demand. In the R&D space, we are also working on the lifecycle management of providing a combination production, *ABCWY*, the full alphabet of meningitis, so which is the pentavalent vaccine, so it is absolutely a key priority for Vaccines, to the one-third.

**Emma Walmsley:** Thank you and then Deb or maybe John, actually, on the HIV questions from IAS, do you want to do that?

**John Pottage:** Okay, let me just give a couple of principles and then we can work the arguments through that.

So, when we talk about CNS adverse events, it is usually a mixture of symptoms, whether it is insomnia, sleep disorders, depression, headaches and there is a whole list of things that often go to that list and you will find that different companies, different groups,

define that differently. In terms of the integrase inhibitors, which we are talking about dolutegravir and bicitegravir, it is a class effect and you do see it with all of them at around the same percentage.

So, what we saw at IAS were the first two of four Phase III studies for bicitegravir and so the data base that we see is fairly small for bicitegravir. Now, the two studies they presented were in treatment naïve patients, I think the interesting one is more of a direct comparison of dolutegravir and bicitegravir both with the same backbone, which was TAF and FTC, and so when you look at the CNS adverse events and look at the long list of them, actually the two drugs were fairly similar, but it is interesting, in terms of patients discontinuing therapy, there was one patient in the bicitegravir group who left therapy because of sleep abnormalities and none in the dolutegravir group.

The one that is a little more difficult to really get to a handle on was the comparison of bicitegravir, TAF and FTC against *Triumeq*, and so in this study they presented a patient reported outcome instrument. Now, the investigator who was presenting the study didn't go into great detail, I do believe they then listed a whole host of symptoms where they looked at on particular days and it almost looks like you could be cherry-picking a little bit of what was going on with the patients. I think we really have to get a better handle on that and to take a look at the data there to see if there are any real differences, but I think at the end of the day my opinion is I don't think you will, once we see additional data coming with bicitegravir, we do have this huge database that we have dolutegravir, where it is really well established and again we need to see a much more detailed approach there.

So, I will turn it over to Deborah –

**David Redfern:** Why don't you just comment on the bicitegravir data generally at IAS?

**John Pottage:** Yes, I think that, obviously, statistically it was not inferior to dolutegravir, but if you look at these two studies – and the first one I commented on, which was the more direct comparison – in terms of treatment effect, dolutegravir was numerically better than what you saw with bicitegravir for both the studies, and so I think it really showed really what we know very well with dolutegravir, with it being a very substantial drug for patients.

**Deborah Waterhouse:** I just want to spend two minutes on competitiveness, because it has come up a couple of times this afternoon.

So, with dolutegravir we have delivered a very strong data package, this is a therapy area where data is really the key driver, along with guidelines, as to how physicians choose to treat their patients, so dolutegravir has a significant Phase IIIb/IV programme which we

have almost completed, five studies where we demonstrate superiority versus competitors within the integrase class, but also versus the other kind of third agents that are used. So, really strong data that ultimately drives, within HIV, physician behaviour.

However, if we talk about on top of that competitiveness, you have now seen BIC-EF-TAF versus *Triumeq* and you have seen bicitgravir versus dolutegravir, and actually they look fairly comparable, but we are moving the market on again with the two-drug regimen pipeline that we have, starting with rilpivirine and dolutegravir, moving into dolutegravir 3TC and then moving into long-acting injectables with cabotegravir and rilpivirine, so we feel that we are moving forward with our pipeline, that we will move the market forward, whilst our competitor is still in the three-drug regimen paradigm.

Now, let's see how that plays out and then, obviously, in the future we have other strong molecules in our Discovery portfolio which, again, we believe will continue to move things further on and we do believe long-acting is going to be phenomenally important and on that basis I think that plus very strong performance commercially is going to lead us to be winning from a market share perspective.

**John Pottage:** Yes, truly these innovative options that we are developing, rather than more of just little incremental changes.

**Emma Walmsley:** Thank you very much, so I am going to take one more question from online, a last question coming to Simon, but, of course, we are all available to pick up on any other further questions that you may have.

So, the last question is from Paul Carthy: Can you please provide some colour behind the revised outlook for upward pressure on the Group tax rate over time? What has changed?

**Simon Dingemans:** So, I think as I highlighted in the presentation, as the mix of the business changes and particularly given the prioritisation to the US that Emma commented on, we are putting more of the revenues and profit streams into a higher tax jurisdiction and that, obviously, puts to one side whether there might be tax reform in the US or not, but on the current tax rates that is creating this upward pressure. Plus, in a post-BEPS world we are seeing much more activity from tax authorities and challenges and disputes which ultimately we will seek to resolve in an appropriate way and a balanced way but they will quite often require provisions in anticipation of quite long periods of dispute so I think that will also be part of the drag going forward, but it's mainly about the shift to the US.

**Emma Walmsley:** Thank you, Simon. Thank you to you all for coming here today or listening in or watching. Thank you for your thoughtful questions. We can



obviously continue some more discussions now but I just wanted to say a couple of very brief words on how you should expect us to be updating you on our performance going forward.

You are obviously going to hear from me but also consistently members of the Leadership Team on our quarterly earnings calls and we will be holding more regular 'Meet the Management' sessions so that you have the opportunity to meet and get to know the broader team from different parts of the business.

And lastly obviously critically we will be updating you as to our pipeline progress, particularly around the assets that we have highlighted today, sharing any important data as it comes through and making specifically our R&D leaders available to you all for questions.

So thank you very much and please do join us for some more refreshments.  
[Applause]

- Ends -