GSK presentation at the 42nd Annual J.P. Morgan Healthcare Conference on Tuesday, January 09, 2024 at 7:30 AM PST

Introduction | James Gordon

Good morning. I'm James Gordon, J.P. Morgan European pharma and biotech analyst. Today, I've got the pleasure of introducing the GSK presentation. You're going to hear from GSK CEO Emma Walmsley. Thanks a lot for joining us today, Emma. I look forward to the presentation.

Presentation | Emma Walmsley

Thank you so much, James. Good morning. A very Happy New Year to you all. It is absolutely wonderful to attend today's conference and to share with everybody the progress that GSK is making. Please turn to slide two.

This is, of course, the usual cautionary statement. We'll comment on our performance and forward-looking statements using constant exchange rates, or CER, unless stated otherwise. Please turn to slide three.

GSK is a global biopharma company focused on the prevention and the treatment of disease, with clear performance momentum as we head into 2024.

In the first nine months of 2023, we delivered double-digit sales and adjusted operating profit growth, with strong performance from all of our key products, including an outstanding US launch of Arexvy, the world's first-ever vaccine for RSV, a vaccine that is firmly on track to be a blockbuster in its first year on the market.

Recent approvals for Apretude in HIV, together with two important oncology medications, Jemperli and, most recently, Ojjaara, have also strengthened our new product portfolio. New products launched since 2017 contributed nearly £8 billion of sales in the first nine months of 2023, reflecting our ability to bring breakthrough products to market and execute competitively.

This portfolio demonstrates the delivery of the strategic choices we've made to invest in vaccines and specialty medicines, which, at Q3, now represented 70 percent of our business and offer meaningful sources of long-term profitable growth. Please turn to slide four.

Our current momentum is also providing us with a strong platform to deliver on the commitments to growth we've previously set out to shareholders. As you can see from this slide and the many green ticks, we are well on track to hit all of our targets that we set out for 2026. We are increasingly confident too in our prospects for longer-term profitable growth. Next slide, please.

Our first priority for capital allocation remains to invest in pipeline delivery, both organically and with continued targeted business development. Our innovation is focused on our four core therapy areas. We now have a pipeline of 67 vaccines in specialty medicines, two-thirds of which is in infectious diseases and HIV.

Infectious disease affects billions of people and remains a growing burden for society, including in the developed world. Our programs are focused on seasonal respiratory viruses, bacterial and fungal infection -- these include pneumococcal and meningococcal disease -- and chronic viral infections such as hepatitis B.

In HIV, we remain world leaders and are entering into an important period with clinical development plans for potential ultra-long-acting treatments and prevention options. These spearhead the transition we expect to deliver in our HIV portfolio over the coming years.

In respiratory and immunology, we're building from our decades-long respiratory heritage with next-wave innovation and long-acting treatment options for asthma, COPD, and refractory chronic cough.

Additionally, of course, we were very pleased to announce the agreement to acquire Aiolos Bio, providing us access to a potentially best-in-class, long-acting anti-TSLP monoclonal antibody ready to enter Phase 2 for asthma.

In oncology, we are initially prioritizing development of novel medicines to treat blood and gynecologic cancers. We recently announced an exclusive licensing agreement with Hansoh for the Phase 1 B7-H4 targeted antibody-drug conjugate that we believe has best-in-class potential in ovarian and endometrial cancer, with opportunities in other solid tumors.

We've just added a second ADC for further indications. Let me briefly guide you on the significant growth opportunities we see for each of these areas. Next slide, please.

Focusing first on the opportunities in infectious disease. This is a market estimated to be worth more than £100 billion. For GSK, it's an area of extensive strength underpinned, of course, by our vaccines business. As you can see from this slide, we have a portfolio of current and future assets with the potential to make significant peak-year sales contributions.

I've already referred to Arexvy. We also continue to add to the outstanding clinical profile for Shingrix, our vaccine to prevent shingles, with results of a large post-marketing study in China demonstrating 100 percent efficacy. Alongside this, we announced plans to significantly expand the availability of Shingrix in China with an exclusive partnership with Zhifei, supporting our goal for Shingrix's annual sales to reach more than £4 billion by 2026.

We have several other vaccines of note in clinical development, including a multivalent, mRNA-based flu vaccine with Phase 2 data expected in the first half of this year and our five-in-one MenABCWY vaccine for US adolescents, which we're on track to file in the first half of this year.

We're also pressing forward with clinical development of candidate pneumococcal vaccines using MAPS, a highly innovative Multiple Antigen Presenting System designed to allow the highest serotype coverage and robust immune responses. These would open up significant new US market opportunities for us.

Beyond vaccines, I'm going to highlight bepirovirsen, an antisense oligonucleotide which has the potential to establish a new standard of care for chronic hep B. This is a disease which impacts an estimated 300 million people and causes close to a million deaths annually.

We also have a portfolio addressing several resistant bacterial infections. Our most advanced asset is gepotidacin, which has the potential to be the first novel antibiotic for uncomplicated urinary tract infections in more than 20 years.

Also in earlier stages of development, we have a potential suppressive therapeutic intervention for herpes simplex virus. The unmet need in HSV is also very significant, with lifelong incurable infections impacting around 500 million people globally.

Turning to slide seven. on HIV, we are pioneering innovation for treatment and, again, the prevention of disease. As a result of strong commercial execution with our current portfolio, we've upgraded our '21 to '26 sales CAGR from mid-single digits to a higher range of six to eight percent. As we move into the second half of the decade, we are confident in cabotegravir, the world's first and only approved long-acting integrase inhibitor, becoming the foundational medicine in our HIV portfolio.

Registrational chart trials for the selective dose of cabotegravir every-four-month dosing are expected to start in the prep setting in 2024, with regulatory submission and potential launch planned for 2026. Pivotal work on a four-monthly treatment regimen is expected to begin in '25, with submission and launch planned for '27. Please turn to slide eight.

Turning to respiratory. Here, we have three key late-stage growth opportunities. Firstly, Nucala. Launched to treat severe asthma, this first-in-class biologic medicine is now on a path to support clinical remission there, helping patients who suffer from asthma to be exacerbation- and oral steroid-free and to live with symptom control and stabilized lung function. Our ultimate goal is to change the course of disease by slowing it down, stopping progression and even reversing previous damage. Later this year, we'll get the results from the pivotal study of Nucala in chronic obstructive pulmonary disease, COPD, where 40 percent of patients still experience exacerbations.

Building on Nucala, we are developing depemokimab. This is a potential new medicine with anticipated peak-year sales of more than £3 billion, with more potent pharmacology and a longer half-life, and ultimately an improved, twice-yearly dosing interval. We've progressed straight to Phase 3 from Phase 1 in four indications. We have our first readouts in severe asthma in the first half of 2024. Thirdly, camlipixant for refractory chronic cough. With 28 million patients diagnosed globally and nearly half of them having suffered for over a year, RCC is one of the last common areas of respiratory medicine without treatment. It is a true area of unmet need. Camlipixant provides potential efficacy and tolerability benefits and could be a first- and best-in-class medicine.

The Phase 2b SOOTHE trial showed a greater than 40 percent reduction in 24-hour cough frequency, with low rates of taste-related adverse events, which is an important differentiation versus the competition. Pivotal data from our development program is expected in the second half of 2025. Based on the high prevalence, unmet need, and the potential for a differentiated profile, we see peak-year sales potential for camlipixant at more than £2.5 billion.

Now please move to slide nine. Lastly, oncology. Here, our initial focus is on hematologic malignancies, gynecologic cancers, and with options in other solid tumors. Jemperli is a backbone for our research, in both monotherapy and in combination with standard of care and future novel agents, particularly in patients with limited treatment options. Data from the RUBY study demonstrated the potential of Jemperli plus chemotherapy to redefine the treatment of primary advanced or recurrent endometrial cancer versus chemotherapy alone. We anticipate data in monotherapy endometrial cancer and non-small cell lung cancer and rectal cancer in 2027.

Ojjaara was approved and launched in the US late last year as the first and only treatment indicated for myelofibrosis patients with anemia, a key unmet need, again, with limited treatment options. We expect EU marketing authorization also early this year. Combinations and future indications are currently under evaluation.

Zejula is a once-daily oral PARP inhibitor for ovarian cancer. We're also assessing activity across multiple tumor types and in combination with other therapeutics. Given the number of key oncology readouts expected this year, we do expect to update on the portfolio approach during 2024. Now let's turn to slide 10.

Lastly, for ESG, we do continue to make excellent progress on delivering impact across our six key areas that we prioritize. We note on this slide some recent highlights on how we're using our science and technology to improve our sustainability. We were delighted to announce last quarter that we're starting Phase 3 trials of a low-carbon version of Ventolin using a next-generation propellant this year. If successful, it has the potential to reduce greenhouse gas emissions from the use of this inhaler by about 90 percent. It will significantly contribute to our net zero climate targets. Next slide, please.

As shown on this slide, we have undoubtedly made great progress on our investor roadmap. We are well-positioned heading into 2024, with several late-stage pipeline events anticipated. We continue to focus together on execution, our pipeline, capital allocation and investor engagement. We'll keep investors updated on the progress that we're making, of course. Final slide, please.

To summarize, we are delivering strong and sustained momentum as we head into 2024. We are confident in delivering on our growth commitments. We continue to progress with the development of meaningful innovation in our core therapy areas.

All of this underscores our confidence to sustain profitable growth through this decade, delivering scale, health impact, and attractive returns for shareholders, combining science technology, and the talent of GSK's people and partners to get ahead of disease together. Thank you very much. Now Tony and Luke are going to come and join me for Q&A with James. Thank you.

Q&A

James: As a reminder, you can ask questions through the app. I believe you can also raise your hand. Someone can bring you a microphone as well.

James: Maybe to start, you mentioned Arexvy. Product had a very strong start in Q3. It looks like it may even be doing better than your guidance for the full year '23. I think you might have even commented on that. How are you thinking about Arexvy? Is that a bit of a one-off in Q3? Can we extrapolate that? How do we think about Arexvy for '24?

Emma: I'll ask Luke to add color because he's been responsible, with the team, for a launch that we're absolutely delighted with. No one will be surprised to know that we're not about to bring any new information around '23 or outlooks for '24 today.

Delighted with the launch, delighted with the market share, and very confident in that ambition of more than £3 billion around the world. This is an enormous disease. There's never been a solution to it before. We welcome the fact it's a competitive arena. Luke, perhaps do you want to give...

Luke: Sure. It's always difficult to project a new product, particularly in a new area. The uptake has been encouraging. The profile of the patients that have elected to get a shot was what we thought. 85 percent of those people are 64 and above, as you would expect.

We're now lining up for the contracting process this year. Over time, we feel very confident in the £3 billion peak sales that we've indicated.

Emma: Looking forward to adding that 50 to 59 cohort, hopefully, which is another scale opportunity.

James: In terms of moving parts, you could have an extra competitor because you could have Moderna as well. Then, as you say, you could also have a different age demographic. In terms of contracting as well, did you get lucky in Q3 last year?

Emma: Make your own luck.

James: Should we worry about that, or are you confident that we could have strong growth even with more competition?

Luke: Ultimately, this is a very large segment. The best correlate is the high-dose flu market, which is several orders higher. It's the same patient population, essentially. We have another competitor. I'm sure the competition will reflect, as we are, on what we learned last year. Higher activity is going to also expand the pie itself.

Remember, we had ACIP approval in June and essentially entered the flu season a couple of months later. It all had to happen quite quickly. We've got more time to prepare. Two-thirds of physicians recognize Arexvy by name. Let's see. We try and make our own luck as much as possible.

Emma: This point about creating a market is absolutely fundamental. Three years ago, I don't know how broadly the awareness was of the general public about RSV for older adults, even though it's a scale disease that hospitalizes tens of thousands of Americans every year. Sadly, 15,000 die.

We're at very early stages of penetration of the market. Competition and awareness is a good thing. We're really pleased with the market share so far. We'll keep going.

James: How do you think about the build to £3 billion-plus? Do vaccines launch very slowly? Could this be 10 years to build there, or could this be quite a rapid one?

Luke: Our expectation is that we'll get high-risk 50 to 59 population. It's more of a slower build, classically, because it takes time for people to become comfortable. We've said multiple times the PCV analog is probably the most appropriate. COVID was an outlier. Even if you look at Shingrix, we're about a third penetration. This is a product that launched in 2017.

It does take time, but it's very durable once it's established. Our working assumption is it's an every-second-year shot. Once people get into the habit, in their 60s and 70s, of presenting for a regular RSV vaccine, this population is going to be very compliant over time.

James: How do you think about combos? For instance, Astra recently licensed a vaccine combining with MPV. Do you think it's going to be a combo market? Is that something you need to do?

Tony: Again, the sensible combos are with viruses that share similar plasticity, if you like, or stability in that context. Human metapneumovirus, clearly one. Parainfluenza virus, another.

Emma: The other thing to remember is, in pediatric vaccines -- we've got many decades of experience of combos are a good idea -- efficacy will always trump convenience. You also have to be thoughtful about what the frequency of whatever that dosing is required. As Luke said, we have data on two years. That needs to be brought in mind.

James: Makes sense. Maybe switching to another vaccine, so Shingrix. Is Arexvy going to take up where Shingrix stops growing? I know the US has been growing more slowly. Do you still see a long growth runway for Shingrix, maybe from outside the US?

Emma: Luke should comment. Again, as I said in my opening remarks, we still see growth ahead for Shingrix. He did the very exciting deal with Zhifei in China. More of the growth is ex-US, but this is just part. You should talk more Shingrix.

One of the most important things to understand, if you're betting on GSK, is that we have a very strong portfolio and pipeline of adult vaccination. It's an extremely strategic choice to commit meaningfully more investment in R&D, but also in manufacturing, technology platforms, know-how.

You've got Shingrix with growth. We're adding RSV. We've got the MenABCWY to add with that. Then you have mRNA. Then we should add pneumococcal. We're exploring HSV. There's this whole portfolio of something which is fundamentally...

I will allow Luke to then get back to Shingrix. You just step back. Governments around the world are under huge pressure for their healthcare budgets. Healthcare systems are squeaking with workforce and overloading. You've got the demographic imperative.

The reality is there is no better return on healthcare budget investments than investing in vaccines that stop disease before it starts. That's why you're seeing a regulatory environment that, in the IRA, has been removing copays.

That's why you're seeing governments approve RSV around the world, at least for private access, at a faster pace. It's a really exciting time for the growth of the full portfolio, but still plenty of room in Shingrix, if you want to comment on that...

Luke: We're following the strategy that we outlined a couple of years ago, with Shingrix, which is essentially to maximize the US. If you look, typically, at an adult population, 60 percent of them present for a regular vaccine each year. That's probably the peak penetration under the current label. We have around 33 percent. We add one percent a quarter. There is still growth.

Obviously, the first half is harder than the second half, but there's still potential there. As we've said, there's a three-phase process with Shingrix. The next phase was Europe. We're picking up contracts there. Access is expanding. Then entry into emerging markets, of which the deal with Zhifei was very important.

As everyone knows in this room, Zhifei has done a brilliant job with Gardasil in China. We have very high confidence with our partnership with that company. Then you've got the life cycle elements. This year, we get the 12-year data for Shingrix. That will provide some insight as to when you can expect a potential for a booster.

There's also some interesting emerging data in terms of the relationship potentially between zoster vaccination and dementia that needs more exploration. Either one of those could also propel growth for a number of years beyond that, back in the US population, once we reach that saturation point.

James: Thank you. One other thing mentioned in the presentation was the targets. You previously set targets out to '26 and also '31.

Emma: Yeah.

James: A lot of things have happened since then. Some things have worked in the pipeline. Some haven't. You've upgraded the guidance for some constituents, like HIV, recently. Are those targets still accurate, or might it be time to update some of those?

Emma: First of all, I want to just clarify that we've laid out guidance for '26. We've given some vision and ambition around '31. That's an important distinction. We are, as I said, absolutely thrilled with the

momentum and the progress to date. Remember, 2023 is the first full year that GSK has been a focused, pure biopharma company.

Even through the seismic structural change of the demerger in '22, we had the great '22. You've seen our results in '23 and the upgraded guidance, again, there. We feel very good about the, if I can say, more than 5 and more than 10 topline and operating margin CAGRs.

Obviously, join us on 31st of January, I think it is, for our Q4 results. We've also said that we will reflect on what we laid out and our progress against those goals that we talked about in 2021.

Where you're absolutely right is an enormous amount has gone on. We've made tremendous progress since that '21 update also on the pipeline. Actually, the majority of the key assets, whether it's the approval of RSV or the approval of Apretude long-acting, the progress we've made on Jemperli, the hep B progress, the antibiotics.

We've also had some disappointments. Otilimab, we stopped. That's the reality of our business. We've had some ups and downs. We're very conservative on our outlook for Blenrep as well.

Then we've added. BD is absolutely core to the way we now do our R&D. We've added Affinivax. We've added camlipixant. We've added Sierra Oncology. We've added, this morning, another very exciting addition to our early-stage respiratory portfolio. There's a whole bunch. The ADCs. These are early. None of that was part of where we were two years ago.

What we've achieved in two years in progress, we're just going to keep doing together. We'll keep you updated along the way, through the roadmap and through the data that comes through.

James: Is 2026 and 2031 still the years you're focused on? If you were to update the targets, would it be those years, or are you looking even further out now?

Emma: Yeah. The periods that we're focused on...Like all big companies in our industry, it's a long-term industry. You want to make sure you deliver the quarters. We guide for the year.

We think it's really important to have had that five-year outlook, which was really demonstrating a step change in performance for this company. We haven't delivered like we're delivering now for a very long time.

We have the next period, simply because the question that people have asked, as we always do in the sector, is "What happens when dolutegravir comes off patent?" That's why we think it's important to lay out that ambition, which is a snapshot of our risk-adjusted outlook.

That's probably where people are more focused, in terms of what's coming. We want to make sure we bring visibility to those building blocks. That's why you've seen both Deborah, for HIV, and these two guys do the series of "meet the management" meetings, not some big, grand investor day on all of R&D, but "meet the management" meetings by core therapy area.

We did one at the beginning of the year on infectious diseases. We did HIV. We did respiratory. This year, we'll do one on oncology, to give people just a sense of those building blocks of what's coming for later in the decade.

Of course, Tony's research work looks beyond that again. I don't know how far the models run, James, but we're conscious on what's got to be done a bit nearer than the mid-'30s now.

James: Makes sense. If you did have some upside to the revenue number, might Tony get some more to spend on R&D? Would that necessarily drop down, or might you reinvest more on all the pipeline?

Emma: Our job is to grow competitively and profitably to impact patients at scale around the world. The core of what we do is to prioritize innovation and capital allocation to innovation. We want to make sure we're also delivering returns for shareholders. It's very important.

We have a really clear capital allocation framework. We've set our guidance and our outlooks on a "more than" basis to retain some flexibility, but there are no surprises coming from this company in terms of maintaining the commitments that we've laid out.

James: Thank you. You mentioned the different "meet the management" events. I believe we have an oncology one this year. What will we learn there?

Emma: You guys can...You'll learn more, as I laid out. In the interim, perhaps, Tony, you can pick up. We've got quite a lot of data coming this year.

Tony: The way to look at it is we'll continue to embroider the pathway that we have for Jemperli on top of the women's cancer indications. Emma mentioned some of the exciting results that we've seen for RUBY in the Part 1 study in the dMMR setting. We'll see the ITT results for that group as well.

You should expect by that point in time, we'll also have a clearer view of how we're positioning Jemperli and the CD226 axis agents into lung relative to a competitive environment at that point...

And perhaps data looking at other cancer types, colorectal, as we continue to expand, again, the transformational results that we've seen in ISS studies for Jemperli in rectal cancer into colorectal, so a clearer position on the IO portfolio.

Obviously, by that point in time as well, we'll also be able to be giving you a firmer foundation of our interpretation and regulatory feedback on the results that we're now generating for Blenrep. I suspect that will be the major component of what we talk about.

We may also have early updates on the two exciting ADC programs that were the subject of business development deals at the end of last year.

James: Thank you. How are you thinking about Blenrep? We had a negative study, but then more recently, DREAMM-7 was positive. Is there a scenario where you get approval on that study and come back to market, or would you wait for the DREAMM-8 study?

Tony: It all depends on the continued maturation of the data in the DREAMM-7 study and, in particular, on reaching statistical significance for OS data. As I'm sure you're aware, DREAMM-7 and DREAMM-8 have slightly different designs. They're looking at different comparators.

DREAMM-7 was head-to-head with daratumumab and chemo. DREAMM-8 will be against Velcade. At this stage, it's important to recognize that we're very pleased with the results, but we need to see stat sig on OS. There's a journey to be traveled this year in terms of regulatory interactions on the DREAMM-8 package.

James: Thanks. Blenrep, clearly one ADC, but you mentioned other ADCs. Where is GSK on ADCs?

Tony: First of all, of course, because of Blenrep, we've established a pretty sophisticated development and supply chain. Proposition for ADCs in that is going to be an important factor in determining

penetration. I'm very pleased in terms of the capabilities that we've built there, particularly in partnership with Regis and his team.

Then you should look at the two B7-H3 and H4 deals as, first of all, being about building out in women's cancers. The way to think about these in general terms is increasingly, particularly the new generation of topo-based ADCs, they're occupying a position which is coming subsequent to or in partnership with IO.

We have two assets, one that's certainly in our focus in women's, particularly gynecological, cancers and then the broader opportunity presented by the recent deal with B7-H3 that, again, will probably be focused initially in colorectal. Let's see how the IO landscape that I described earlier shapes up this year first.

James: Thanks. Quite a lot going on in the respiratory pipeline as well. I saw a deal today. It looks like you've got, potentially, a six-month TSLP. How does -- I know it's early -- the early data look versus existing TSLPs like Tezspire?

Tony: Let me just remind you, if you were in the respiratory "meet the management" event, what we said was we were looking for a low-T2 option. Obviously, we cover the high-T2 population extremely effectively. That's about 60 percent of severe asthmatics. The low-T2 option gives us access to 40 percent.

We know from the work that we've done with depe -- Luke, you might comment on this if I don't do it justice -- that both patients and healthcare providers tell us they want longer-acting agents. They want earlier treatment as well. I very much see this as being something that is a relatively straightforward fit with our portfolio.

Just like depe as well, the advantage in the area is one can model out from early data from PK/PD and have pretty good confidence in terms of the translation of the pharmacology. That's what we've got going on with the deal that we've just announced. It's really not more complex than that.

Emma: It would be good, Luke, for you to comment on the patient and physician demand for long-acting, whether it's on depe or on this. This is another way of keeping people out of hospital.

Luke: There's no argument that biologics are a superior solution for the severe spectrum of asthmatics. Access is excellent, yet we're only seeing around what's less than one-third of patients who are eligible being treated for biologics. That is a combination of factors. In contrast to, say, TNS or RA, where you're looking at two-thirds of patients.

One of the elements is shot frequency. What attracted us to the deal that we announced this morning is, clearly, it's the most competitive profile in terms of being two shots a year. Physician preference, patient preference is very compelling.

Either in naive patients -- there's a proportion of physicians that are comfortable doing that straight off the bat -- or, as we've developed in the depemokimab program, patients who have stabilized on an existing therapy in that class, an IL-5 in the case of depemokimab, then switching those patients off.

We think that 75 percent of those patients are likely to come from other antibodies apart from Nucala. That same hypothesis has held up when we look at TSLP.

Entering into Phase 2, we expect that TSLPs, as Tony said, will be dominant in about 40 percent of the patients that we can access, in terms of that T2-low. The market will be prime for a conversion to a long-acting solution that we intend to provide.

James: Thank you. Maybe one other respiratory. You've got Nucala COPD coming up this year. I know there's been some mixed data historically for IL-5s for COPD. Do you have similar high confidence there? Is that still quite high-risk? Why might the study be different to some of the other studies we've seen historically?

Tony: Let me deal with that in two different parts. First of all, I think the accumulation of data in the effectiveness of agents that address eosinophilic COPD is adding increasing confidence to that as being an important area.

Within that group of patients, you can think about two different sets. The bronchitics, who are largely eosinophilic, have reactive airways, and respond most effectively to these treatments. That's what you see from the Sanofi data.

About 30 percent of COPD patients have emphysema. That's a group that is more difficult to reach, but nevertheless an important aspect of building out a broader label. My overall confidence in the approach of reducing eosinophilia in high Eo-driven COPD is high.

For those who haven't followed this, where we stand is we ran two previous Phase 3 studies. One succeeded. One was a narrow failure on the basis of hierarchy of testing of stats. We had a CRL for that. The criticism, that we've addressed carefully, was with regards to recruitment of patients who were clearly COPD patients in that study.

If you consider that plus the powering of the study with regards to the challenge that I just mentioned and also selection of patients with high Eo counts, we're increasingly confident in the outcome there.

What I should add is that, although we haven't talked about this a lot, if you look at some of our earlier Phase 2 studies where we were able to cut patient populations by bronchitics and Eo counts, then we see efficacy which is very much in line with the results that you're seeing from Sanofi.

James: Thank you. One earlier project that was mentioned in your presentation was HSV and Phase 1/2 data. What is it we're going to see this year? How big an opportunity is that?

Tony: What you'll see is a POC readout looking at both transmission and shedding. Asymptomatic shedding is very important for HSV. You can think about this as a logical extension of the science underpinning Shingrix, with regards to the approach that we've taken in design of the antigen and an adjuvanted vaccine.

It's important though to stress that although they're part of the same virus family, the nature of the virological life cycle between the two viruses is different. I'd hate anyone to come away thinking this is a slam dunk. It's a sensible experiment for us to run. We can talk about the outcome when I actually see it.

James: This would be a therapeutic for people who already had the virus?

Tony: Correct.

Emma: Yes. Which is 500 million people and not a great virus to live with and, obviously, a field, in terms of STDs, that we have quite a lot of know-how in. Let's see. Early days. More to come when we know.

James: Maybe one other question would be business development. You've been busy this morning already. How is GSK now thinking about business development? Are you potentially in the market for doing a very big deal, or is the deal that you announced this morning the sort of deal that we should think of GSK doing?

Emma: We're in the market for strengthening our pipeline and delivering good returns for the capital that we invest.

It's one of the most important changes that we made for this new chapter of delivery for GSK, was to set ourselves up with the balance sheet, the capacity, the organization, the talent in the teams, and the working governance to bring more ambition, agility, competitiveness, and, frankly, unbiased view across internal, external, across core TAs of what the returns could look like.

That's why you've seen us increase the percentage of our pipeline that comes externally. I would say, in general, you should expect more of the kinds of things we've been doing because we have really good growth prospects.

We're interested in stuff that's going to be delivering more for the end of the decade in our core TAs, in vaccines and specialty medicines, but also technology platforms that can add to the flywheel of development. That can be acquisition. It can also be partnerships. More and more, we like to work on collaborative efforts and are very much open for business for anybody here.

James: Maybe that's a nice place to end this. We're just out of time. Thank you very much for joining us today.

Emma: Wonderful. Thanks, everybody.

[*Ends*]