Investor event

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 viralogic 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 rilpirivine 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 Pharmaeuticals): 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 *Ellipta* 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 *Ellipta* 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 DPUs, 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.

Philipe 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 ofconsolidated 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 glanularity 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, bictegravir, 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 bictegravir, 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 bictegravir and so the data base that we see is fairly small for bictegravir. 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 bictegravir 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 bictegravir 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 bictegravir, 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 bictegravir, 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 bictegravir 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 bictegravir 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 bictegravir 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 -