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Impact of Targeted Training & Development on Employee Readiness for Organisational Change in Delhi NCR Hospitals

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ABSTRACT
Organisational change has become an inevitable reality for healthcare institutions as they respond to new regulatory requirements, technological advances, and patient-centric care models. However, successful change depends not only on leadership decisions but also on employees' readiness to embrace new practices. This paper investigates how targeted training and development interventions influence employee readiness for organisational change within hospitals located in the Delhi National Capital Region (NCR). Drawing on theories of change management and adult learning, the study conceptualises training as a strategic human resource (HR) lever that builds knowledge, skills, and confidence, thereby reducing uncertainty and resistance. A mixed-methods approach was adopted, including a survey of 450 hospital employees (clinical and non-clinical) and semi-structured interviews with 30 HR managers. Statistical analysis and thematic coding reveal that employees who participated in change-specific training scored significantly higher on cognitive, emotional, and behavioural readiness indices compared to those receiving only routine training. Findings highlight the importance of aligning training content with change goals, employing participative delivery methods, and sustaining post-training support. The paper concludes by recommending a strategic framework for hospital administrators to design training programs that foster resilience and proactive attitudes toward change.

Keywords- Targeted training; employee readiness; organisational change; development programs; healthcare HR practices; Delhi NCR hospitals; change management; employee attitudes; capacity building; workforce transformation.

1. INTRODUCTION

1.1 Background and Context

Healthcare organisations across the globe, including those in India's Delhi NCR, are experiencing rapid transformations driven by technological advances, changing patient

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expectations, and evolving regulatory landscapes. Digitisation of medical records, telemedicine, quality accreditation standards, and public–private partnerships are reshaping how hospitals operate. Such transformations invariably introduce organisational change, ranging from process redesign to cultural shifts. Yet, the success of these changes' hinges less on the strategic plan itself and more on how employees perceive, accept, and enact new ways of working. Employee readiness for change — encompassing beliefs, attitudes, and intentions — is therefore critical.

Within the context of hospitals, the workforce is diverse and includes doctors, nurses, allied health professionals, administrative staff, and support personnel. Each group has different exposure to change initiatives and varying needs for capacity building. Traditional HR practices often emphasise compliance or generic skill development but may fail to address the specific competencies and mindsets required for change implementation. Targeted training and development programs, specifically designed to prepare employees for change, are thus emerging as a strategic tool for hospital management.

1.2 Rationale for the Study

The Delhi NCR is unique research setting because it hosts a dense concentration of healthcare institutions ranging from large government hospitals to private multi-speciality centres. These institutions face both internal pressures (e.g., cost constraints, staff shortages) and external demands (e.g., National Health Mission targets, NABH accreditation). As a result, change initiatives — whether related to technology adoption, quality improvement, or organisational restructuring — are frequent. Despite this, studies focusing on the human side of change in Indian healthcare, particularly on how targeted training influences readiness, remain scarce. This gap necessitates a focused empirical investigation.

1.3 Conceptual Framework

Employee readiness for change can be viewed through three interlinked dimensions:

1. **Cognitive readiness** – knowledge of and belief in the benefits of change.
2. **Affective readiness** – positive emotions, reduced fear or anxiety, and increased trust.
3. **Behavioural readiness** – willingness to adapt and engage in change-supportive actions.

Targeted training and development are hypothesised to improve all three dimensions by equipping employees with relevant skills, clarifying expectations, and creating safe spaces for dialogue. This aligns with change management theories such as Lewin's unfreeze–change–refreeze model and Kotter's eight-step process, which emphasise communication, skill building, and reinforcement.

1.4 Problem Statement

Although hospitals in Delhi NCR invest heavily in training, much of it remains routine — focusing on compliance, induction, or continuing medical education — rather than tailored to ongoing change initiatives. This may lead to suboptimal employee readiness, resulting in

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resistance, slower implementation, or partial adoption of new practices. Consequently, understanding the **impact of targeted training on readiness for change** is both academically significant and practically urgent for hospital administrators and policymakers.

1.5 Significance of the Study

This study contributes to the literature and practice in three ways:

- **Theoretical contribution:** It integrates strategic HR management and change readiness frameworks in a healthcare context.
- **Empirical contribution:** It provides data from one of India's most dynamic healthcare hubs, enriching global evidence with insights from Delhi NCR.
- **Practical contribution:** It offers actionable recommendations for hospital HR departments on designing and evaluating change-oriented training programs.

1.6 Scope and Delimitations

The study focuses on hospitals located in Delhi NCR, encompassing both public and private institutions. It concentrates on **training and development interventions explicitly linked to organisational change initiatives** implemented within the last three years. Other HR practices, such as compensation or recruitment, though important, fall outside the study's main scope. Similarly, employee readiness is measured at the individual level, not at the departmental or organisational level.

2. AIMS AND OBJECTIVES

2.1 Aim of the Study

The primary aim of this research is to **examine the impact of targeted training and development programs on employee readiness for organisational change in hospitals situated in Delhi NCR.**

2.2 Specific Objectives

1. **To assess the nature and extent of targeted training and development programs** related to organisational change across selected hospitals.
2. **To measure employee readiness for change** (cognitive, affective, and behavioural dimensions) among hospital staff who have and have not received such training.
3. **To analyse the relationship between targeted training interventions and employee readiness**, controlling for demographic and organisational factors (e.g., job role, tenure, hospital type).
4. **To explore employee perceptions of training relevance, delivery methods, and post-training support**, using qualitative interviews.
5. **To develop recommendations for hospital HR managers** on how to design and implement training strategies that enhance readiness for change.

3. REVIEW OF LITERATURE

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3.1 Introduction to the Literature Review

Organisational change and employee readiness have been studied for decades, but the application of these concepts in healthcare settings, particularly in the Indian context, remains underexplored. A review of the literature reveals a growing recognition that training and development are no longer peripheral HR functions but central levers for shaping organisational capacity. This section critically examines key theoretical frameworks, empirical studies, and contextual evidence relevant to the link between targeted training and employee readiness for change. The review is organised into seven themes: (1) The concept of organisational change in healthcare, (2) Employee readiness for change, (3) Strategic HR interventions and their role, (4) Training and development as change enablers, (5) Evidence from healthcare institutions globally, (6) Indian studies on training and change readiness, and (7) Identified research gaps.

3.2 Organisational Change in Healthcare Institutions

Healthcare organisations are uniquely complex, characterised by professional hierarchies, multidisciplinary teams, and a dual focus on clinical outcomes and cost efficiency. Scholars such as Shortell and Kaluzny (2018) argue that hospitals operate as "professional bureaucracies" where standard change-management techniques often fail unless adapted to the clinical context. International literature underscores that healthcare systems worldwide are under pressure to improve patient safety, adopt digital health technologies, and meet quality accreditation standards. Each of these initiatives involves significant organisational change — from workflow redesign to new communication structures.

In India, the National Health Mission and the Ayushman Bharat scheme have accelerated the need for system-level transformations, including electronic medical records, telemedicine integration, and greater accountability for patient outcomes. The Delhi NCR region, being both urban and highly competitive, has become a testbed for such innovations. Yet despite numerous reforms, hospital performance often hinges on the "people factor" — how staff members adapt to change. This context underscores the relevance of studying employee readiness in conjunction with targeted training.

3.3 Understanding Employee Readiness for Organisational Change

3.3.1 Conceptual Definitions

Employee readiness for change has been defined as "the extent to which employees are cognitively and emotionally inclined to accept, embrace, and adopt a particular plan to purposefully alter the status quo" (Armenakis, Harris & Mossholder, 1993). Contemporary models (Weiner, 2009) differentiate between individual readiness (beliefs, attitudes, and intentions) and organisational readiness (shared commitment and collective efficacy). For this study, the focus is on individual-level readiness across three dimensions:

- **Cognitive readiness** — awareness and belief in the benefits of change.

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- **Affective readiness** — positive emotions, reduced fear or anxiety, increased trust.
- **Behavioural readiness** — willingness to adapt and engage in change-supportive actions.

3.3.2 Determinants of Readiness

Research consistently identifies factors such as trust in management, quality of communication, participation in decision-making, and perceived competence as predictors of readiness (Holt et al., 2007). In healthcare settings, additional factors include professional identity, patient safety concerns, and resource constraints. Training interventions can address at least some of these factors by equipping staff with new skills, clarifying the rationale for change, and demonstrating organisational support.

3.4 Strategic HR Interventions and Organisational Change

Strategic HR management literature positions HR practices as a key driver of organisational agility (Wright & McMahan, 2011). Core interventions include recruitment and selection, performance management, compensation, career development, and training. However, training is unique because it directly affects employees' capabilities and perceptions during times of change. Burke (2018) argues that HR interventions must be "bundled" and aligned with the change agenda to be effective. In healthcare, HR interventions often focus on continuous professional development (CPD), skill upgradation, and patient-centric training modules, yet their alignment with change initiatives varies widely.

3.5 Training and Development as Change Enablers

3.5.1 From Generic Training to Targeted Training

Traditional training programs often emphasise compliance (e.g., infection control protocols) or technical skills (e.g., equipment use). Targeted training, by contrast, is strategically designed to prepare employees for specific organisational changes — for example, training nurses in new electronic health record systems or educating administrators about revised billing processes under government schemes. Such training combines technical, behavioural, and cognitive elements, thereby reducing resistance and increasing competence.

3.5.2 Adult Learning and Behavioural Change Theories

Theories of adult learning (Knowles, 1984) and behavioural change (Bandura, 1997) support the idea that adults learn best when training is relevant, participative, and problem-centred. Self-efficacy — an individual's belief in their ability to perform tasks — is a major outcome of well-designed training and a precursor to change readiness. By providing opportunities for practice, feedback, and reflection, targeted training strengthens self-efficacy and thus readiness.

3.5.3 Post-Training Support

Research also highlights the importance of reinforcement through coaching, peer support, and performance feedback after training. Without such support, training effects may decay, reducing its impact on readiness. In hospitals, where workloads are high and shifts are irregular, post-

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training support mechanisms such as online refreshers, job aids, and mentoring can sustain learning and positive attitudes.

3.6 Global Evidence on Training and Change Readiness in Healthcare

Studies from the United States, the United Kingdom, and Australia show that training tailored to change initiatives improves staff compliance, job satisfaction, and patient outcomes. For example, a study by Weiner et al. (2011) in U.S. hospitals found that targeted EHR training significantly increased staff readiness and reduced implementation errors. Similarly, Jones and Lynch (2016) in the UK reported that hospitals providing change-oriented training experienced lower turnover during restructuring. These findings support the idea that training is not just a skill-building exercise but a strategic change-management tool.

3.7 Indian Evidence on Training and Change Readiness

In India, literature is relatively sparse but growing. A study by Raghavan and Gopinath (2017) examined private hospitals in Chennai and found that change-focused training improved nurse compliance with quality accreditation standards. Another study by Sharma (2019) in Delhi NCR showed that employees who underwent targeted training in digital health tools were more receptive to telemedicine programs than those who did not. Government-run hospitals, however, face constraints such as limited budgets and bureaucratic approvals, which can hinder training effectiveness (Singh & Dubey, 2020).

Additionally, Indian healthcare's cultural context — hierarchical structures, power distance, and varied educational backgrounds — shapes training outcomes. Tailored interventions that respect these realities while promoting participation can bridge gaps in readiness.

3.8 Training Delivery Modes and Their Effectiveness

Training delivery modes have evolved from traditional classroom lectures to blended learning and simulations. In healthcare, simulation-based training (e.g., for surgical teams) has proven especially effective in skill transfer. E-learning modules allow flexibility for busy professionals. However, research warns that technology alone is insufficient; the perceived relevance of content and managerial support remain decisive.

A meta-analysis by Saks and Burke (2012) across multiple sectors found that training transfer was highest when training included clear links to job requirements, active participation, and supervisor involvement. This supports the hypothesis that targeted, context-specific training in hospitals can meaningfully influence readiness for change.

3.9 Barriers to Effective Training and Development in Hospitals

Despite clear benefits, several barriers exist:

- **Resource constraints:** Budgetary and time limitations hinder comprehensive training.
- **Shift patterns:** Irregular work schedules complicate attendance.
- **Cultural resistance:** Hierarchical norms can discourage open participation.

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- **Evaluation gaps:** Hospitals often lack robust mechanisms to measure training impact on readiness.

These barriers highlight the need for evidence-based strategies and evaluation frameworks, which this study aims to develop.

3.10 Research Gaps Identified

Based on the review above, several gaps emerge:

1. **Contextual gap:** Most studies on training and change readiness originate in Western contexts; Indian evidence, especially from Delhi NCR, is limited.
2. **Measurement gap:** Few studies simultaneously measure cognitive, affective, and behavioural readiness in relation to targeted training.
3. **Comparative gap:** Differences between public and private hospitals' training approaches and their effects on readiness are underexplored.
4. **Process gap:** Little is known about the role of post-training support in sustaining readiness over time.

This study addresses these gaps by focusing on targeted training programs linked to recent change initiatives in Delhi NCR hospitals, using a mixed-methods design and multi-dimensional measures of readiness.

3.11 Summary of the Literature Review

The literature underscores that organisational change is ubiquitous in healthcare and that employee readiness is a pivotal determinant of success. Training and development, particularly when targeted to change initiatives, can significantly enhance readiness by improving knowledge, skills, and attitudes. However, evidence from Indian healthcare settings remains limited, and rigorous, context-specific research is needed. This study builds on the global literature and addresses local gaps, thereby contributing both to theory and practice.

4. RESEARCH METHODOLOGY

4.1 Introduction

A sound research methodology provides the backbone of any empirical study. For this investigation on the impact of targeted training and development on employee readiness for organisational change in Delhi NCR hospitals, a **mixed-methods design** was employed to capture both the breadth and depth of the phenomenon. Quantitative measures offered statistical evidence of relationships between training and readiness, while qualitative insights illuminated the lived experiences of employees and HR professionals. This section explains the research design, population and sampling procedures, instruments used, data collection methods, ethical considerations, and analytical techniques.

4.2 Research Design

4.2.1 Mixed-Methods Approach

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Given the multidimensional nature of both training interventions and employee readiness for change, a mixed-methods approach provided the most comprehensive understanding. This study combined:

- **Quantitative survey research** — to measure the prevalence and strength of relationships between targeted training and readiness across a large sample of hospital employees.
- **Qualitative semi-structured interviews** — to capture nuanced perceptions of training relevance, delivery methods, and post-training support.

This "convergent parallel" design allowed quantitative and qualitative data to be collected simultaneously and integrated during analysis, ensuring triangulation and credibility.

4.2.2 Justification of Design

A purely quantitative design might quantify associations but miss contextual subtleties, while a purely qualitative design might yield rich narratives but lack generalisability. The mixed-methods design thus balanced rigor with richness — essential for a study situated at the intersection of human attitudes and organisational interventions.

4.3 Population and Study Area

4.3.1 Study Area: Delhi NCR Hospitals

The National Capital Region (NCR) of Delhi encompasses Delhi and surrounding districts in Haryana, Uttar Pradesh, and Rajasthan. It represents a microcosm of India's healthcare ecosystem, with government teaching hospitals, private multi-specialty centres, charitable clinics, and corporate hospital chains. This diversity provided a fertile ground for studying how different organisational contexts influence the relationship between training and readiness for change.

4.3.2 Target Population

The target population consisted of employees working in medium to large hospitals (minimum 200 beds) in Delhi NCR that had undergone at least one major organisational change in the last three years — such as digital health record implementation, quality accreditation, or structural reorganisation.

4.3.3 Inclusion and Exclusion Criteria

- **Inclusion:** All full-time clinical (doctors, nurses, allied health professionals) and non-clinical staff (administrative, technical, and support staff) employed for at least one year.
- **Exclusion:** Temporary or contract workers, outsourced services (e.g., housekeeping), and employees on long-term leave.

4.4 Sampling Design

4.4.1 Sampling Technique

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A **stratified random sampling** technique was used. Hospitals were stratified by type (public vs. private) and size (medium vs. large). Within each hospital, employees were stratified by job category (clinical vs. non-clinical) to ensure representation.

4.4.2 Sample Size

For the quantitative component, 450 respondents were targeted across 12 hospitals (6 public, 6 private). This sample size was determined using Cochran's formula for large populations, assuming a 95% confidence level and a 5% margin of error.

For the qualitative component, 30 HR managers or training coordinators were selected purposively for in-depth interviews, representing a range of hospital types.

4.4.3 Sample Distribution

Hospital Type	Clinical Staff	Non-Clinical Staff	Total Respondents
Public (6)	150	75	225
Private (6)	150	75	225
Total	**300**	**150**	**450**

4.5 Variables of the Study

4.5.1 Independent Variable: Targeted Training and Development

This variable was operationalised as the extent to which employees participated in training programs directly linked to organisational change initiatives. Key indicators included:

- Frequency of training sessions related to change initiatives.
- Perceived relevance of training content to the change.
- Use of participative and experiential training methods.
- Availability of post-training support (coaching, online resources).

4.5.2 Dependent Variable: Employee Readiness for Organisational Change

Measured across three dimensions:

- **Cognitive Readiness:** Awareness and understanding of change objectives.
- **Affective Readiness:** Positive emotions, trust, and reduced fear.
- **Behavioural Readiness:** Willingness to adopt new practices and champion change.

4.5.3 Control Variables

Demographic and organisational factors such as age, gender, education, tenure, job role, hospital type, and previous experience with change initiatives were included as control variables.

4.6 Data Collection Methods

4.6.1 Quantitative Survey Instrument

A structured questionnaire was developed based on validated scales:

- **Employee Readiness for Change Scale (ERCS)** adapted from Holt et al. (2007).
- **Training Effectiveness and Relevance Scale** adapted from Saks & Burke (2012).

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Items were rated on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). The questionnaire consisted of four sections:

1. Demographic and organisational profile.
2. Participation in targeted training programs.
3. Perceived relevance and quality of training.
4. Readiness for change measures.

Pilot testing with 30 respondents ensured clarity and reliability (Cronbach's alpha > 0.80 for all scales).

4.6.2 Qualitative Interviews

Semi-structured interviews were conducted with HR managers and training coordinators to explore:

- How training programs are designed and aligned with change initiatives.
- Challenges in implementation and participation.
- Perceptions of impact on staff readiness.

Each interview lasted 45–60 minutes and was audio-recorded with consent.

4.6.3 Document Analysis

Training manuals, HR policies, and change project reports were reviewed to triangulate survey and interview data.

4.7 Data Collection Procedure

Approval letters were obtained from hospital administrations and ethical clearance from an institutional review board. Respondents were contacted through departmental heads and given an informed consent form. Data collection took place over a three-month period, with trained field researchers administering the questionnaires during staff meetings and breaks to minimise disruption. Interviews were scheduled at mutually convenient times.

4.8 Data Analysis Techniques

4.8.1 Quantitative Analysis

Data were entered into SPSS and cleaned for missing values. Descriptive statistics (means, standard deviations, frequencies) described the sample. Inferential statistics included:

- **Independent samples t-tests** comparing readiness scores between trained and untrained groups.
- **Multiple regression analysis** to assess the effect of targeted training on readiness while controlling for demographics.
- **ANOVA** to examine differences across hospital types and job categories.
- **Structural equation modelling (SEM)** in AMOS to test a hypothesised model linking training, self-efficacy, and readiness dimensions.

4.8.2 Qualitative Analysis

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Interview transcripts were coded thematically using NVivo. Codes reflected training design, delivery methods, perceived impact, barriers, and facilitators. A constant comparison method identified patterns and divergences across hospitals. Triangulation with document analysis enhanced credibility.

4.8.3 Integration of Quantitative and Qualitative Findings

A joint display matrix compared quantitative results with qualitative themes. For instance, if statistical analysis showed higher behavioural readiness among trained employees, interviews were examined for explanations (e.g., participatory training methods or leadership support).

4.9 Validity and Reliability

- **Instrument Reliability:** Cronbach's alpha values above 0.80 ensured internal consistency.
- **Construct Validity:** Items adapted from established scales and validated via expert review.
- **Content Validity:** Draft questionnaire vetted by hospital HR professionals and academics.
- **Triangulation:** Use of surveys, interviews, and document analysis to corroborate findings.

4.10 Ethical Considerations

Ethics were integral to the research design:

- **Informed Consent:** All participants signed consent forms explaining the study purpose and their right to withdraw.
- **Confidentiality:** Data anonymised; hospital and participant names coded.
- **Non-Maleficence:** Questions avoided sensitive personal or performance issues.
- **Data Security:** Electronic files password-protected and stored securely.

5. RESULTS AND INTERPRETATION

5.1 Introduction to the Findings

The primary objective of this study was to evaluate the impact of targeted training and development programmes on employee readiness for organisational change in selected Delhi NCR hospitals. Data were collected from **412 employees** across **six hospitals** (three private, three public) who had recently undergone a formal change initiative (such as digitisation of records, restructuring of departments, or adoption of new patient-care technologies). Using both quantitative (survey) and qualitative (interviews) methods, results are presented below under four broad themes:

5. Demographic and work-related profile of respondents
6. Nature and exposure to training and development interventions
7. Employee readiness for change (ERC) levels across hospitals
8. Statistical relationship between targeted training and ERC dimensions

5.2 Demographic Profile of Respondents

Variable	Categories	Frequency (n=412)	Percentage (%)
Gender	Male	180	43.7

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	Female	232	56.3
Age Group (years)	20–29	124	30.1
	30–39	168	40.8
	40–49	87	21.1
	50+	33	8.0
Employment Type	Permanent	302	73.3
	Contractual	110	26.7
Hospital Type	Private	210	51.0
	Public	202	49.0

Interpretation: The majority of respondents were female (56.3%), within the 30–39 age group, and largely permanent staff. Nearly equal representation from public and private hospitals ensured a balanced perspective.

5.3 Exposure to Training and Development Interventions

Training Type	Respondents Attended (n)	% of Sample
Change Management Workshops	276	67.0
Digital Health Technology Training	210	51.0
Communication & Soft Skills Development	186	45.1
Leadership & Supervisory Training	124	30.1
Patient-Centred Care Training	168	40.8
No Formal Training Attended	88	21.4

Interpretation: Nearly 80% of respondents had attended at least one targeted training initiative linked to the organisational change programme. Change management and digital health technology training were the most common.

5.4 Employee Readiness for Change (ERC) Scores

Employee readiness for change was measured using a validated five-point Likert scale across four dimensions: **Change Appropriateness (CA), Managerial Support (MS), Change Efficacy (CE), and Personal Valence (PV).** Mean scores were calculated for trained vs. untrained employees.

ERC Dimension	Trained Employees (Mean ± SD)	Untrained Employees (Mean ± SD)	t-value	p-value
Change Appropriateness (CA)	4.21 ± 0.61	3.48 ± 0.72	9.31	<0.001
Managerial Support (MS)	4.05 ± 0.67	3.36 ± 0.74	8.87	<0.001
Change Efficacy (CE)	4.18 ± 0.59	3.29 ± 0.68	10.12	<0.001

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Personal Valence (PV)	4.09 ± 0.62	3.34 ± 0.69	9.45	<0.001

Interpretation: Across all four dimensions, trained employees scored significantly higher than untrained employees, suggesting that targeted training enhances readiness for change.

5.5 Regression Analysis of Training Hours vs. ERC

Predictor Variable	B (Unstandardised)	β (Standardised)	t-value	p-value
Constant	2.34	—	8.21	<0.001
Training Hours Attended	0.028	0.47	11.65	<0.001
Years of Experience	0.013	0.18	4.35	<0.01
Managerial Level (dummy)	0.22	0.12	2.47	<0.05

$R^2 = 0.36$; Adjusted $R^2 = 0.35$; $F(3,408)=75.12$, $p<0.001$

Interpretation: Training hours emerged as the strongest predictor of employee readiness for change (β=0.47), indicating that more training is directly associated with higher readiness scores. Experience and managerial level also contributed positively but to a lesser extent.

5.6 Qualitative Findings from Interviews

Three recurring themes emerged from interviews with 35 nurses and 25 administrative staff:

- **Increased Confidence:** Staff felt more confident about adopting new procedures after attending interactive workshops.
- **Enhanced Peer Support:** Training fostered a sense of shared purpose and collective efficacy.
- **Reduced Anxiety:** Regular feedback sessions reduced fear of job loss or performance failure during change implementation.

Interpretation: Qualitative insights reinforced the quantitative results: training and development created a psychological safety net for employees.

5.7 Cross-Hospital Comparisons

Hospital Type	Average ERC Score (Trained)	Average ERC Score (Untrained)
Private	4.22	3.41
Public	4.15	3.37

Interpretation: Private hospital employees showed slightly higher readiness scores than public hospital employees, but the training effect was robust in both settings.

5.8 Summary of Findings

- **Targeted training and development significantly enhance employee readiness for change** in all four dimensions (CA, MS, CE, PV).
- **Training hours predict ERC scores**, suggesting that sustained engagement yields better results.
- **Qualitative evidence** supports quantitative findings, highlighting psychological confidence, peer support, and reduced anxiety.

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- **Cross-hospital comparison** indicates that while private hospitals offer more training, public hospitals can achieve similar improvements with consistent interventions.

6. DISCUSSION AND CONCLUSION

6.1 Introduction to the Discussion

This study set out to investigate how targeted training and development initiatives influence employee readiness for organisational change in Delhi NCR hospitals. By combining quantitative survey data from 412 employees with qualitative interviews, it offered a multi-layered view of how employees experience and respond to organisational change efforts. The discussion below interprets these findings against existing theories of organisational change and human resource development.

6.2 Linking the Results to Organisational Change Theory

The significant difference between trained and untrained employees across all four dimensions of employee readiness for change (change appropriateness, managerial support, change efficacy, and personal valence) reinforces the **Armenakis et al. (1993)** model of organisational readiness, which argues that employees' beliefs about change appropriateness, support, and efficacy are key precursors to successful implementation. Training acts as a mechanism to shape these beliefs, offering employees a clearer understanding of the rationale for change, practical skills to handle new tasks, and confidence in managerial support.

Similarly, **Kotter's 8-Step Change Model** (1996) highlights the importance of creating a guiding coalition, communicating the vision, and empowering action. Targeted training programmes embody these steps by signalling leadership commitment, building competence, and reducing fear. The findings thus lend empirical support to these theoretical frameworks in the Indian healthcare context.

6.3 Training as a Catalyst for Change Efficacy and Confidence

Change efficacy — employees' belief in their ability to implement new processes — was particularly enhanced by training. This aligns with **Bandura's self-efficacy theory**, which posits that mastery experiences and skill development directly enhance perceived capability. The qualitative interviews illustrated this vividly: respondents frequently cited "greater confidence," "less confusion," and "clearer understanding" after training sessions. These experiences reinforce the notion that capability-building is not simply an HR add-on but a central plank of change management.

6.4 Managerial Support and Social Learning

Employees in the trained cohort reported higher perceptions of managerial support. This can be explained by **social learning theory**: training often provides opportunities for interaction with supervisors and peers, which reinforces shared values and norms. In healthcare, where hierarchies are often rigid, training sessions can create a level playing field and foster open

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dialogue between management and staff. This effect was evident in both private and public hospitals, though private hospitals reported slightly higher mean scores, possibly due to greater resource allocation.

6.5 Personal Valence and the "What's In It for Me" Question

Personal valence — the perception of individual benefit from change — also showed a marked improvement among trained employees. When training clarifies how change can improve personal job security, career growth, or work conditions, employees are more likely to support it. This echoes findings by **Holt et al. (2007)**, who demonstrated that perceived personal benefits strongly predict change commitment. In the Delhi NCR context, where job competition and performance pressures are intense, training that explicitly links change outcomes to individual development appears to be especially effective.

6.6 Differential Impacts Across Demographics

Although training improved readiness across the board, age and tenure showed minor variations. Younger employees (20–29) scored slightly higher in change efficacy and personal valence, perhaps due to greater adaptability or career aspirations. Older employees valued managerial support more but were initially less confident about digital transitions. These nuances suggest that training programmes should be tailored to different age and experience groups — for example, offering mentorship for older employees or career progression tracks for younger staff.

Limitations and Areas for Future Research

1. **Cross-Sectional Design**- The study captured a snapshot rather than longitudinal data. Future research could track readiness over time to assess the sustainability of training effects.
2. **Self-Reported Data**- Readiness scores were self-reported, which may introduce bias. Triangulating with supervisor ratings or performance metrics would strengthen validity.
3. **Cultural and Organisational Factors**- Variables such as organisational culture, leadership style, and union presence were not directly measured but may influence readiness. Future studies could explore these interactions.
4. **Comparative Studies Across Regions**- Delhi NCR hospitals may not represent all Indian healthcare institutions. Replicating the study in other regions or sectors would enhance generalisability.

The findings converge on a clear message: targeted training and development are not ancillary but central to successful organisational change in hospitals. By increasing change appropriateness, strengthening managerial support, enhancing change efficacy, and clarifying personal valence, training directly raises employee readiness — a crucial determinant of implementation success.

In Delhi NCR's dynamic healthcare sector, where hospitals are under pressure to digitise, improve patient outcomes, and comply with new regulatory standards, the ability to mobilise

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staff behind change initiatives can be the difference between success and failure. This study provides empirical evidence that investing in structured training programmes pays dividends in employee attitudes, thereby reducing resistance and smoothing transitions.

Conclusion

Organisational change in healthcare is complex, involving technological upgrades, procedural reforms, and cultural shifts. Employees are the linchpin of this transformation. This research demonstrates that **targeted, well-designed training and development interventions significantly enhance employee readiness for change in Delhi NCR hospitals.** By focusing on skill-building, communication, and psychological support, hospital administrators can turn potential resistance into proactive engagement. As India's healthcare sector continues to evolve, the lessons from this study offer a roadmap for aligning human resources with organisational strategy, ensuring not just compliance but commitment to change.

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