West Northamptonshire Council

Crisis and Resilience Fund: Building Resilience & Tackling Poverty Across West Northamptonshire

This is a walkthrough of the Crisis and Resilience Fund, what it means in practice, and what it means for partners.

Some of the later slides, particularly the checklists, are quite detailed. They're there as a resource for you to work through afterwards.

We'd like to take you through why this matters, how the approach is changing, what the fund is aiming to achieve, and how this translates into the delivery model going forward.

Glossary of Terms

Fund and Payments

CRF - Crisis and Resilience Fund

HSF - Household Support Fund

DHP - Discretionary Housing Payment; previous extra help with housing costs.

Crisis - A sudden, unexpected event that could not be planned for, which puts basic needs, health or safety at immediate risk.

Crisis Support Payment - One-off payment to support immediate needs over the next few days.

Crisis Housing Payment - Extra help with housing costs.

Money outcomes

Financial resilience - Ability to withstand and recover from financial shocks.

Financial wellbeing - Confidence and control over day-to-day money.

Financial Inclusion - Fair access to advice, services and tools.

Income Maximisation - Increasing income through benefit and entitlement checks.

Budget maximisation - Reducing costs so money goes further.

Negative Budget - Expenses & essential costs exceed total income.

Support offer

Resilience Services - Debt, benefits, budgeting, energy and practical support.

Wraparound support - Extra advice offered alongside immediate help.

Cash-first - Cash or cash-equivalent support where appropriate.

No Wrong Door - Any entry point guides residents to the right help.

Warm Referral - Active handover to another service, with consent and context.

Signposting- Guiding an individual to another service, for the individual to contact the new organisation themselves.

Delivery model

System-based - Partners act as one coordinated support system.

Place-based - Support through trusted local places.

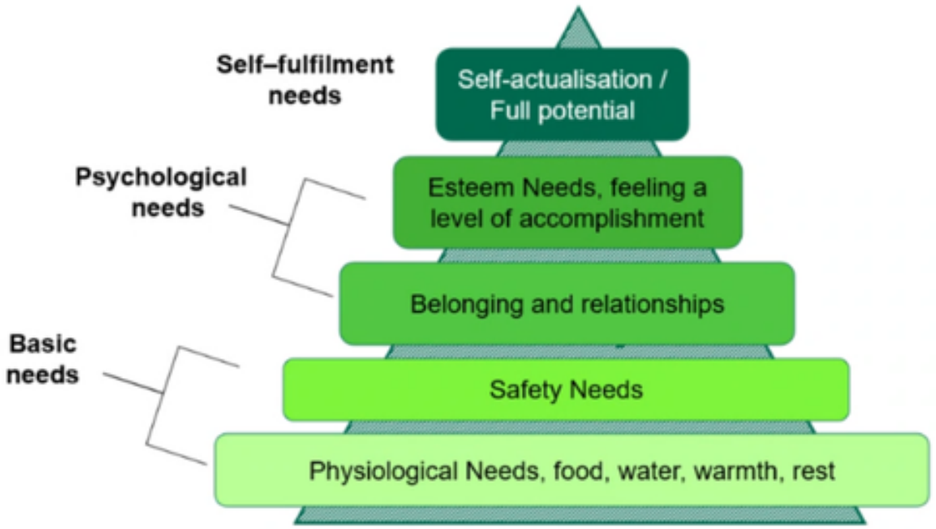
Community Coordination - Networks and directories that simplify local support.

Hub-and-spoke - Main hubs linked to smaller local access points.

There are a number of terms using throughout the session, some of which you may already be familiar with, and some which are used in the context of this presentation to have a specific meaning. These are here as a reference for you to come back to.

Why This Matters: Poverty and Health Are Closely Linked

Poverty doesn't sit in one service; it affects everything



When finances are under pressure, the impacts are wide-reaching:

•Basic needs at risk
Food, heating, housing and essentials become harder to maintain

- Mental health pressures increase

Ongoing stress, anxiety and uncertainty

- Physical health deteriorates

Delayed treatment, worsening long-term conditions

- Access to services reduces

Barriers to transport, digital access and early help

- Resilience is weakened over time

Small shocks become crises more quickly

What this means for services:

- Demand increases across multiple systems
- Issues present later and are more complex
- No single service can resolve these challenges alone

If we want to reduce crisis, we must address the financial drivers early, and in a joined-up way

For most of us, this is what we see every day in the work that we do.
When finances are under pressure, the impacts don't sit in one place. They show up across people's lives, whether that's food, housing, energy, health, or access to support.

We see people making difficult decisions day to day; delaying bills, skipping meals, struggling to maintain stability across multiple areas at once. Alongside that, we see the wider impacts; on mental health, on physical health, and on people's ability to access help early.

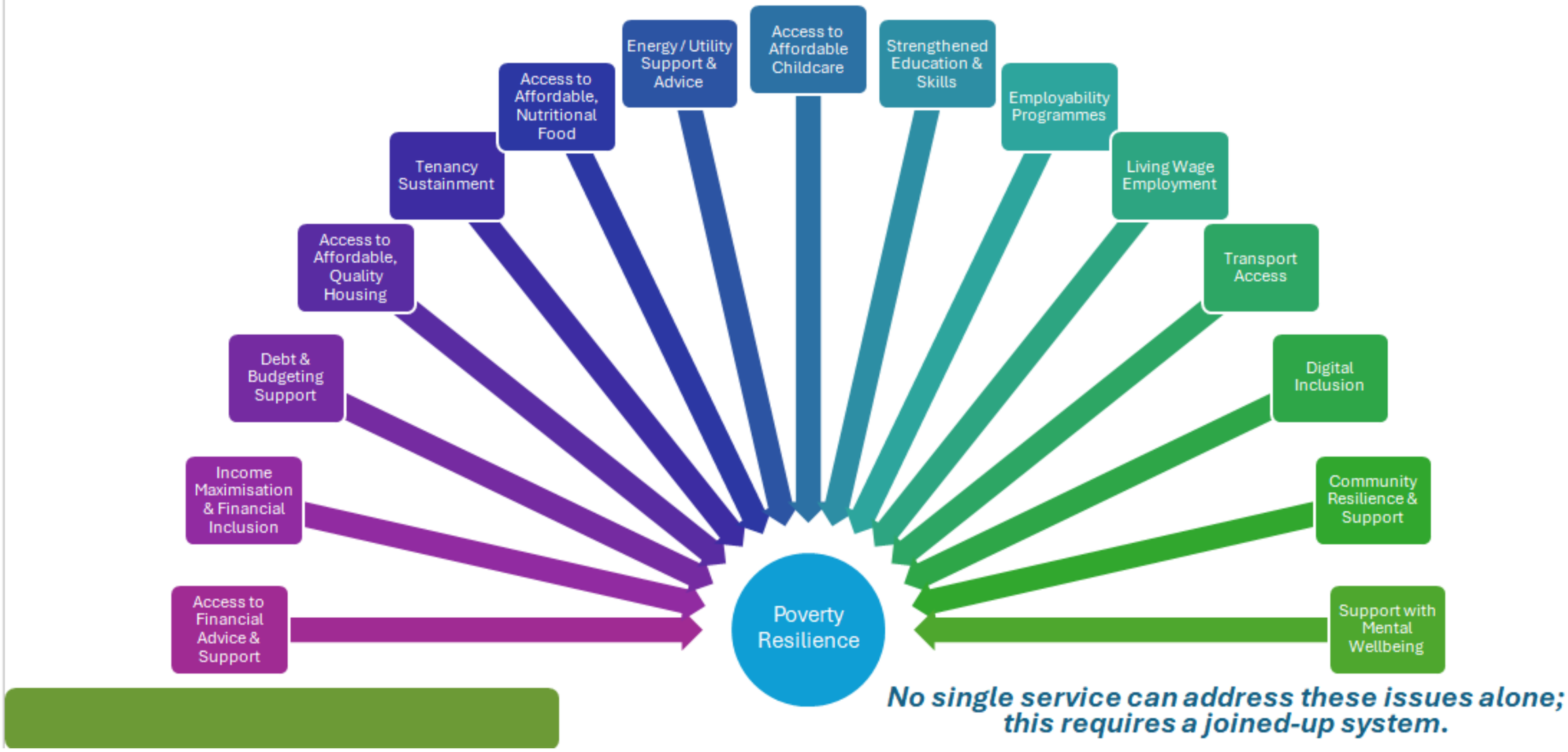
This isn't about highlighting anything new; it's about reminding ourselves of the scale and nature of what we're responding to. Because if we're going to design support that works, we need to look at this not just from an emotional perspective, but in a way that allows us to respond consistently, fairly, and effectively across the whole system.

That means understanding that poverty doesn't sit within one service, and that no single organisation can resolve it in isolation. We see; demand increasing across multiple services, people presenting later (often when situations are more complex), and more pressure on frontline services as a result.

If we want to reduce crisis, we need to address the financial drivers earlier, and in a more joined-up way.

Poverty resilience is shaped by the wider determinants of health

The impacts highlighted on the previous slide are driven by a range of interconnected factors, not one single issue.



Building on that are the wider determinants of financial wellbeing.

Again, this is the reality we're already working within. This visually reinforces the sheer range of factors that can impact someone's financial situation. This is only a small selection, but you can see it spans; income, debt, housing, food, energy, skills, employment, access to services, and wider wellbeing.
When we talk about financial hardship, we're not talking about one issue, we're talking about a combination of interconnected pressures. And that's why no single service on its own can resolve this.
This is about recognising the scale and complexity of the system we're operating in, and being realistic about what it takes to respond effectively. It's also why a joined-up approach isn't just helpful, it's essential.

What Good Looks Like in West Northamptonshire

A system that supports people early, connects services, and improves outcomes over time.

In West Northants, financial wellbeing should mean:

Early help, not just crisis response

Residents can access timely support before problems escalate.

Crisis Support that connects

- Immediate help meets urgent need and links directly into longer-term support.

One joined-up system

- Services work together, with clear roles, pathways and referrals with no duplication.

Simple, accessible, person-centred support

- Support is easy to access, consistent, and built around people's real lives and needs.

Real, measurable and sustainable, outcomes

- Support leads to tangible improvements in financial stability.

This is not about creating new services, it's about connecting what already exists and making it work as one system

The next step is thinking about what a more effective system looks like in practice.
A lot of this already exists across West Northamptonshire. This is about bringing those elements together in a way that works more consistently for residents.
At its core, what we're aiming for is a system that: supports people earlier, connects services more effectively, and improves outcomes over time.
That means; early help (not just responding at the point of crisis), crisis support that connects people into longer-term help (not a standalone intervention), and services working together as one system, with clear roles and pathways.
It also means that support should feel; simple to access, consistent, and built around people's actual lives and needs, not around how services are structured.
Importantly, it's not just about activity, it's about outcomes. That is being able to say; people's financial situations have improved, crises are reduced over time, and support is making a measurable difference.
This is not about creating new services, it's about making better use of what's already there, and connecting it in a way that works as a system rather than as separate parts. The good news is a lot of this is already in place locally, so the next step is to build on that.

Building on What We've Achieved Together

Across West Northamptonshire, significant progress has already been made towards this system

What we've already achieved	What's already in place	What this tells us	The next step
• £13.9m delivered to residents through over 500,000 awards • 380,000+ households supported • Over £5m invested in VCSFE services • Strong community offers including welcoming spaces, larders and energy support	• Established advice and support services • Strong VCSFE partnerships • Community-based delivery through hubs, outreach and trusted spaces • Multi-year funding and data insights	• We already have the building blocks of a joined-up system • Strong partnerships are in place • There is a clear opportunity to go further	• Strengthen coordination across services • Create clearer, more consistent pathways • Embed "no wrong door" approaches • Integrate financial, health and community support

The Crisis & Resilience Fund provides us with the opportunity to support this next step

It's important to recognise that we're not starting from scratch. Across West Northamptonshire, a significant amount of support has already been delivered over the last few years. We've supported hundreds of thousands of households, delivered millions of pounds of support, and invested heavily in VCSFE provision and community-based services.

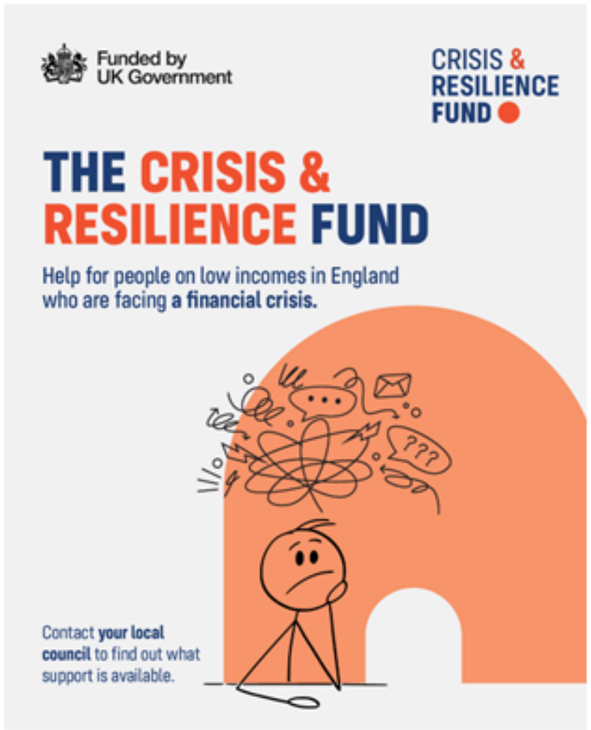
That has made a difference to residents, but at the same time, it's important to be realistic about where we are. Due to funding constraints, changes in the National and Local political landscapes and responses to International disasters and crises, that support has often been reactive, inconsistent across the system, and not always fully connected.

While we've delivered a huge volume of activity, we haven't always been able to consistently measure the longer-term outcomes of that support. There is a lot of good practice in the system, but we're still some way from a fully joined-up, outcomes-led model.

What does put us in a strong position locally, is that over the last three years, we've taken a public health approach to anti-poverty. That means we've already started to shift towards prevention, towards earlier intervention, and towards more sustainable, longer-term support.
This is important, because it means we've already begun moving in the direction that 'good' requires. In practice, that has helped to mitigate some of the risks around funding cliff edges, build stronger local partnerships, and develop more sustainable approaches to support.

We're not where we want to be yet, we are on that trajectory. And the Crisis and Resilience Fund gives us the opportunity to take that next step in a more consistent, structured and outcomes-focused way.

Introduction to CRF



What is the Crisis and Resilience Fund (CRF)?

- 3-year funding from Central Government.
- £4.9m per annum in West Northamptonshire to provide:
  - Support for low-income households who encounter a financial shock – CRISIS
  - Activities and services that build financial strength for individuals and communities - RESILIENCE

Crisis Support

Supports essential living costs, emergency items, and short-term financial aid for residents in need.

Resilience Services

Ensure support not only provides relief but also promotes sustainable long-term outcomes.

Complementing Existing Services

CRF works alongside existing statutory services, local advice partners, Housing Associations, VCSFE organisations and community groups to fill gaps efficiently.

It's important to be clear about what the Crisis and Resilience Fund is, and the position we're working within as a local authority.

The Crisis and Resilience Fund is a three-year programme from central government, providing £4.9 million per year in West Northamptonshire to support residents facing financial hardship, both at the point of crisis, and in building longer-term resilience.

While we do have flexibility to design the model around local need, the funding comes with national guidance, expectations, and required outcomes. We are required to demonstrate how funding is used, and critically, what outcomes it delivers for residents.

It's also important to say clearly, this is not simply a continuation of, or replacement for the Household Support Fund. HSF was primarily a cost-of-living response focused on providing immediate support during a period of acute pressure.
CRF is a different programme. It brings together crisis support, resilience services, and community coordination, into a longer-term, more strategic approach that has financial resilience at its heart.

The expectation is not just that we respond to need, but that we demonstrate how support is helping to reduce repeat crisis, improve financial stability, and connect people into the right support over time. And that's why the National model is structured around both crisis and resilience. Crisis support responds to immediate need, resilience ensures that support doesn't stop there.

Crisis and Resilience Fund: A different funding model

Through CRF, funding is linked to real outcomes, showing how support improves people's financial situation over time.

What this means nationally

- Moving from short-term crisis help to preventing problems and building financial resilience

What this means locally

- Services working together as one joined-up system, not in silos

What this means for residents

- Easier access to the right help, with support that looks at the full situation, not just the immediate crisis

What this means for partners

- More focus on collaboration, shared referrals, and being part of a wider network

This slide sets out what that means in practice, and how the model operates differently as a result.
At a national level, the shift is from short-term crisis response to preventing problems and building financial resilience over time. Locally, that means moving away from services operating in isolation, and towards a joined-up system, where support is coordinated.

For residents, the aim is that support becomes easier to access, more connected, and focused on their whole situation, not just the immediate issue. And for partners, this means a greater emphasis on collaboration, shared referral pathways, and being part of a wider system rather than operating standalone.

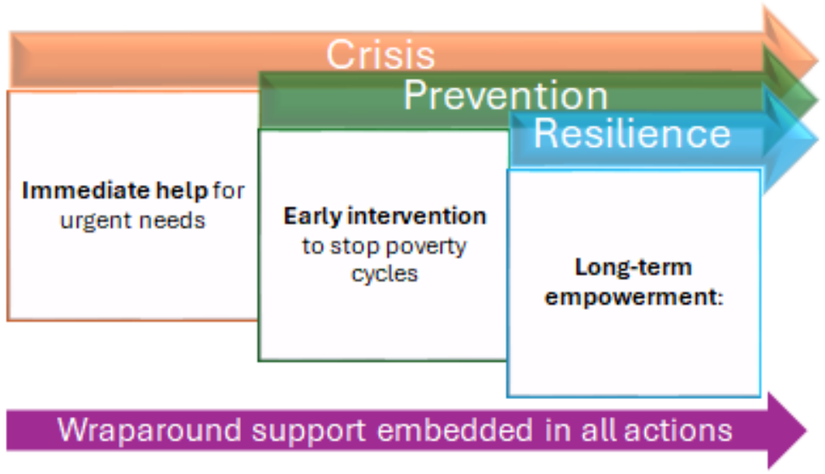
The key shift here is from activity to outcomes, and from individual services to a connected system.

From Crisis to Resilience: Mandatory Strands

The Crisis and Resilience Fund introduces a strategic, preventative approach to reduce poverty-related crises over time.

This means:

- Support doesn't stop at the crisis
- People should be supported into longer-term help
- Services must work together, not in isolation



Crisis Payments
Immediate support for urgent needs, cash-first where appropriate and linked to further support through referrals

Housing Payments
Housing Payments replicate the support previously provided through Discretionary Housing Payments but sit inside the CRF.

Resilience Services
Focus on reducing repeat crisis and improving financial stability, delivering measurable outcomes. Authorities must use a significant proportion of funding for Resilience Services.

Community Coordination
A new mandatory strand to build a joined-up local system, improving navigation, enabling warm referrals, and increasing visibility of support.

Considering how that is structured in the National guidance, this slide introduces the four strands that make up the Crisis and Resilience Fund.

These are set out in the national guidance, and they form the framework that we are required to deliver against locally. This structure isn't something we've developed in isolation, it's been directed nationally, and it underpins how the programme is designed.

The four strands are: Crisis Payments, Housing Payments, Resilience Services, and Community Coordination. Two of these focus on immediate crisis support, and two focus on longer-term resilience and system coordination.

All four are expected to work together as part of one connected approach, rather than as separate elements. And wraparound support is expected throughout, so that support doesn't stop at the point of crisis.

Crisis Support Payments (Delivered by WNC)

What is a crisis?	***"A sudden and unforeseen event that has created an immediate risk to health, safety, or basic living conditions."*** • Crisis support is for immediate, urgent situations only, not ongoing financial hardship. • Crisis support is short-term help that bridges the gap until longer-term support is in place.
What crisis support provides	• One-off, short-term support for essential needs • Cash-first approach by default, supporting choice, dignity and faster access to essentials • Costs must arise directly from the crisis • Support must be immediate and unavoidable
Delivered by West Northamptonshire Council	• All applications assessed by WNC internal teams • Decisions based on evidence and policy criteria • We call all applicants to understand their needs and tailor our offers of support. • Support awarded within 48 hours of receiving a complete, eligible application.
Role of partners	• Recognise when a situation meets crisis criteria • Support residents to access the correct route • Provide context or verification where appropriate • Link residents into wider support
What this is not	• Ongoing cost of living support • General low income or affordability issues • Routine or predictable expenses

Starting with the first strand, Crisis Support Payments. This is one of the two elements delivered directly by West Northamptonshire Council.

To support this, we've developed a clear definition of what we mean by a crisis within this scheme. A crisis is a sudden, unforeseen event that creates an immediate risk to someone's health, safety, or basic living conditions.

This is about urgent, immediate situations, not ongoing financial pressure or longer-term affordability issues.
There are a few key principles that sit behind this: Support must be immediate (DWP require that we issue support within 48 hours of a complete application). It follows a cash-first approach by default. And it is short-term support, designed to bridge the gap until more formal or longer-term support is in place.

This is not ongoing support, it's a short, immediate intervention at a point of crisis.

All applications are assessed by WNC, and we take a consistent, evidence-based approach to that assessment. That includes checking applications against available data for fraud prevention & verification and contacting applicants directly to understand their situation.

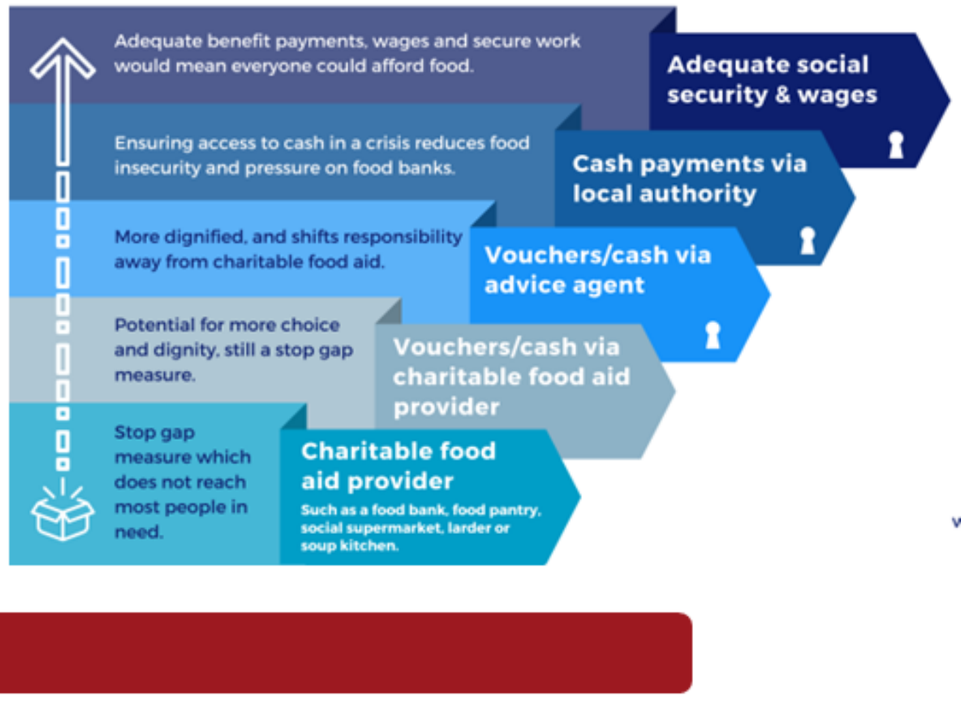
That allows us to ensure that any support is person-centred, proportionate, and the most appropriate option available. We'll also ensure that crisis support is not duplicating other support that is already available or more appropriate.

Just to bring that to life with a simple example of an application that we received:
A resident experienced a house fire, other statutory services provided temporary accommodation. A Crisis Support Payment was issued within hours to allow them to purchase essentials like clothing, food, and immediate necessities. That support was able to bridge the gap until insurance funding became available.

The role of crisis support here is very focused, it's addressing that immediate gap, not providing longer-term relief. From that point, residents can then be supported into longer-term help, whether that's housing advice, financial support, or help to rebuild stability. Crisis support is the entry point, not the end of the journey.

Cash-First: The Evidence-Based Approach to Crisis Support

Cash-first is a core principle of CRF guidance developed with input from VCSFE organisations, including Trussell Trust and IFAN



Advice is key...

Adequate advice and support is fundamental to a cash first approach. Properly funded advice services and referral pathways will ensure everyone can access their full entitlements.

INDEPENDENT FOOD AID NETWORK

www.foodaidnetwork.org.uk

Why cash-first?

- Supports choice, dignity and flexibility
- Enables people to prioritise their most urgent needs
- Addresses the root financial issue, not just the symptom
- Reduces reliance on emergency food as a default response

This represents a shift in approach

- Moving away from defaulting to food parcels and vouchers
- Towards meeting financial need directly

Where alternatives may be used

- Safeguarding or vulnerability concerns
- Where cash cannot be accessed (e.g. no Post Office/ATM access)
- Where goods can be provided more quickly in an emergency

Cash-first is not about limiting support, it's about providing the right support, in the most effective way.

We want to pause briefly to introduce "cash-first", because this is one of the areas that may feel like the biggest shift.

This is the first time we've had such a clear cash-first directive in national guidance, but it has not been developed in isolation. It reflects co-production and engagement with national VCSFE organisations, including those working in food aid, advice and financial inclusion.

DWP have also provided sessions for local authorities to understand the evidence and thinking behind this approach. From attending these, we are very aware that this is an area that has raised questions and, in some cases, concerns. Given the size of the audience today, it's likely that those views are represented here as well, so it felt important to address this directly

The intention behind cash-first is to move away from what can sometimes be a sticking-plaster response, towards support that is more flexible, more meaningful, and more effective by being tailored to address someone's situation.

But cash-first does not mean cash only. In West Northamptonshire, the usual cash offer will be Post Office payouts or ATM cash-out vouchers, depending on access and suitability. Where there are safeguarding concerns, vulnerabilities, or practical barriers, vouchers or goods in kind may be more appropriate. The key point is that this is always discussed with the applicant. We work with people, not do to them.

Cash-First, What the Evidence Shows

People do not need to be directed to meet their own needs, they are best placed to prioritise what matters most in a crisis.

Leeds Cash-First Pilot

- **94%** preferred cash to food parcels
- **78%** improved ability to afford essentials
- **86%** did not need a food bank while receiving support
- **90%** improved overall financial position

What people actually used the money for

- Food and essentials
- Energy and utilities
- Transport to work
- Clothing and school items
- Debt repayment

What the evidence shows

- People use support to meet essential needs
- Cash reduces reliance on emergency food
- Cash supports stability, not dependency
- There is no evidence of widespread misuse

Real experience:

"The cash grant relieved a lot of stress… I was able to pay for gas, electric and get to work."

"The risk isn't that people misuse support. The risk is that we give the wrong type of support that doesn't solve the problem."

This slide sets out some of the evidence behind this approach, including real-world examples. This is provided for you to explore in more detail, as I appreciate not everyone will be familiar with it.

To highlight a couple of key points;
Where cash-first approaches have been tested in practice, they consistently show that people use support to meet their essential needs, are better able to stabilise their situation, and are less likely to need repeat crisis support. There's also strong evidence that people overwhelmingly prefer cash, as it gives them the flexibility to respond to their own circumstances.
The overall message from the evidence is that cash-first: supports better outcomes, reduces reliance on emergency provision, and helps people address the actual issue they're facing.

If you're interested in this in more detail, there are links to the full studies and supporting articles on the reference slide at the end.

Housing Payments (Delivered by WNC)

Housing Payments build on Discretionary Housing Payments, now integrated within the wider CRF approach.

What this is	What it can support	Key principles	What this is not
Financial support for housing costs, aligned to existing DHP principles	Rent shortfalls and arrears prevention	Needs-based and case-by-case assessment	Ongoing or indefinite housing support
Supports residents receiving Housing Benefit or Universal Credit housing element	Rent deposits, rent in advance, and moving costs	Aligned with trauma-informed and "no wrong door" approaches	Costs outside Housing Benefit / Universal Credit rules
Now delivered as part of the Crisis & Resilience Fund	Support to remain in or secure suitable accommodation	Linked to wider support where needed (e.g. advice, income maximisation)	Long-term affordability issues without a defined need
	Temporary financial shocks affecting housing stability		

Housing Payments provide targeted, short-term support to stabilise housing situations and prevent escalation into crisis.

The second strand delivered directly by WNC is Housing Payments.

This will be familiar to some, as it builds on the support previously provided through Discretionary Housing Payments. This is targeted financial support for housing-related costs, for residents who are already receiving Housing Benefit or the housing element of Universal Credit.

Housing Payments can be used to support situations such as rent shortfalls, rent arrears prevention, deposits or rent in advance, and helping people remain in, or secure, suitable accommodation. It can also be used where there has been a temporary financial shock that is putting someone's housing at risk.
It is needs-based, assessed case-by-case, and focused on preventing housing instability or escalation into crisis. As with crisis support, this is not ongoing or indefinite funding, it's designed to provide targeted, short-term support where it can make a difference. This is not a long-term solution to affordability issues, or support outside of Housing Benefit or Universal Credit housing rules.

From a partner perspective, the role here is to recognise when someone may be eligible, understand the types of situations this can support, and help residents to access the scheme where appropriate. If you're working with someone struggling with rent shortfalls, at risk of arrears, or needing help to secure or maintain accommodation, this is a route to consider.

And as with crisis support, this should also link into wider support for example tenancy sustainment, income maximisation, or advice services. It's not a standalone intervention, it's part of a wider pathway.

Strand 3: Resilience Services

Resilience Services are about reducing repeat crisis by improving financial stability, not simply funding general wellbeing activity.

What Resilience Services are

- Targeted support that helps residents move from crisis response to longer-term stability.
- Services that address the financial drivers of hardship, such as debt, low income, benefit issues, energy costs, budgeting pressures and material deprivation.
- Support that can show measurable impact against DWP outcomes.
- A route into quality advice, practical help and casework where residents need more than a one-off payment.

What Resilience Services are not

- General wellbeing, social or community activity without a clear financial resilience outcome.
- One-off crisis responses (these sit within Crisis Support Payments).
- Standalone signposting with no follow-up, referral pathway or measurable outcome.
- Funding for activity that cannot show how it reduces hardship or future crisis.

Required outcomes include:

- Reduced priority debt
- Reduced material deprivation
- Reduced need for emergency food aid
- Income maximisation
- Increased savings
- Increased access to quality advice services

If a service cannot clearly evidence and report on these outcomes, it does not meet the CRF Resilience Services requirement.

This is where the programme starts to connect much more directly with the support delivered by partners. And this is also where the expectations from DWP are very clear. Resilience Services are about reducing repeat crisis by improving people's financial stability over time. This is not about general wellbeing activity, it's about support that is clearly linked to financial resilience.

DWP have set out a number of required outcomes that we must be able to demonstrate through this funding. These include:
reducing priority debt,
reducing material deprivation,
reducing the need for emergency food,
increasing income,
increasing savings,
and improving access to quality advice.

These aren't optional, they are the outcomes that WNC is required to evidence to access and retain this funding. It's also important to say that DWP expect the majority of CRF funding to be spent on resilience services.

While crisis support is an important part of the programme, the longer-term focus is very much on prevention and stability. From a delivery perspective, this means that any service funded through this strand needs to be able to clearly show how it improves someone's financial position, and how that impact can be measured. It's not enough to demonstrate activity alone, we need to be able to evidence what has changed for residents as a result of that support.

What Good Looks Like: Resilience Services

Good resilience support does not just tell people where to go; it helps them get there.

Person-centred and realistic	Support starts with the resident's actual situation, not assumptions about what they should need.
Warm, not passive, referrals	Residents are actively connected to the right support, with consent, context and follow-up where needed.
Financially focused	Support links clearly to income, debt, housing stability, essential costs, budgeting or access to advice.
Joined-up across partners	Services understand their role in the wider system and avoid duplication, gaps and "bouncing" residents between organisations.
Measurable and accountable	Partners can show what changed for residents, not just how many people attended.

The aim is not to create more services in isolation.
The aim is to create clearer routes through the support that already exists and strengthen the gaps where needed.

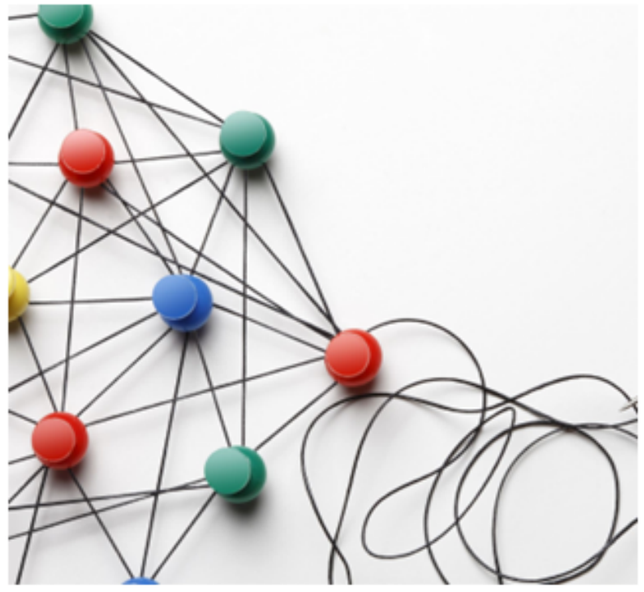
Let's look at what good resilience support looks like in practice. This is not about creating new services in isolation, it's about strengthening how support is delivered, and how services connect with each other.

At its core, good support doesn't just tell people where to go, it helps them actually get there. That means support that is person-centred, starting with the individual's actual situation, active rather than passive, with warm referrals instead of just signposting, and clearly linked to improving someone's financial position.

It also means services working as part of a joined-up system, understanding their role, and connecting people into the right support where needed. Importantly, it also means being able to demonstrate what has changed for residents, not just how many people have been seen or supported. The focus here is on quality of support, connection between services, and measurable outcomes.

Driving Resilience Through a Three-Tier Model

Different residents need different levels of support. The tiered model helps us match need to the right type of help.



Tier 1: Specialist Casework

For residents needing structured advice or casework, including FCA-accredited money and debt advice, housing advice, welfare benefits, income maximisation and regulated support.

Tier 2: Money & Wellbeing Hubs

Place-based hubs where residents can access a consistent mix of support in trusted community settings.

Tier 3: Local Spokes

Smaller local access points and connected groups of support, helping residents access early help and move into hubs or specialist services where needed.

The tiers are not a hierarchy of importance; they are different parts of one connected system.

Cross-cutting principles across all tiers:

- Same DWP reportable outcomes
- Warm referral pathways
- Clear roles and accountability
- Consistent data and impact reporting
- No wrong door into support

This slide introduces our local delivery model for West Northamptonshire. This is how we're structuring the system to bring together the different types of support we've talked about.
This model has been designed to maximise opportunities for residents and create opportunities for a wide range of partners to be involved in delivery. At its simplest, the model is based around three tiers: specialist casework, place-based hubs, and local access points.

The purpose of this model is to make sure that support can be tailored to where someone is on their journey. Some people will need more structured, in-depth support, some will need accessible, local entry points, and others may need a mix of both over time.

This allows us to match people to the right level of support, rather than trying to fit everyone into the same offer. It also creates opportunities for a broader range of organisations to be involved, recognising that different organisations bring different strengths, whether that's specialist advice, community-based access, or practical support.

But at the heart, is not the tiers themselves, it's the connections between them. For residents, the expectation is that they experience: smooth transitions between support, and a system that feels joined-up, rather than fragmented. And that relies on strong referral pathways, clear roles across the system, and partners working together, not in isolation.

Tier 1: Specialist Financial Resilience Services

Tier 1 is for structured casework and specialist advice where residents need more in-depth support.

Who this includes

- WNC internal resilience-building and money support.
- FCA-regulated debt advice providers.
- Welfare rights and income maximisation services.
- Housing Associations and housing advice providers.
- Energy debt / fuel poverty specialists.
- Other quality-assured providers able to accept warm referrals for casework.

What Tier 1 must be able to do

- Accept warm referrals from Crisis Support, hubs and spokes.
- Provide structured support, not one-off signposting only.
- Work with residents to address underlying financial hardship.
- Track and report measurable outcomes.

Mandatory, reportable outcomes

- Reduced experiences of material deprivation
- Reduced need for emergency food parcels
- Reduction in priority debt
- Increased access to appropriate and quality advice services
- Increased savings
- Maximisation of individuals' income

Tier 1 is where residents go when they need more than information; they need advice, advocacy or casework.

This tier is for organisations delivering structured, regulated, in-depth support, where residents need more than information or short-term help. This is where people go when they need: advice, advocacy, or ongoing casework to resolve more complex issues.

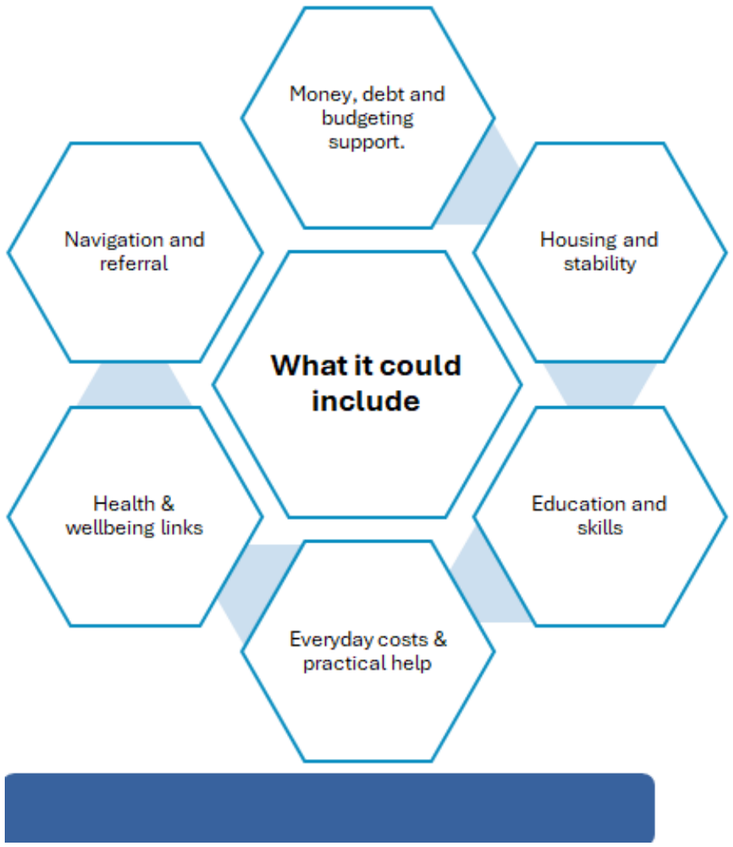
This will include services such as debt advice and write-off, welfare rights and income maximisation, housing advice, and other specialist support linked to financial stability. The expectation within this tier is that support is structured, ongoing where needed, and focused on addressing the underlying causes of financial hardship.

This goes beyond signposting. It's about working with someone over time to improve their situation. Tier 1 services are a key part of the wider system. They need to be able to accept warm referrals from crisis support, hubs and spokes, and where appropriate, refer people back into other support for ongoing help. This is a central part of how the system connects.

And as with all resilience services, support in this tier must be able to demonstrate the outcomes set by DWP, particularly around reducing debt, increasing income, and improving financial stability.

Tier 2: Money & Wellbeing Hubs

Money & Wellbeing Hubs are the place-based front door for joined-up financial resilience support.



What a West Northants Money & Wellbeing Hub is:

- A trusted local place where residents can access multiple types of support without having to navigate the system alone.
- A consistent, visible offer that brings partners together around financial resilience and wider determinants of hardship.
- A route into specialist advice where residents need more in-depth support.

A hub does not have to mean a new building. It could be delivered through existing trusted spaces, libraries, community venues, family hubs or temporary community roadshow-style models during the phased rollout.

Money and Wellbeing Hubs are where we move into a more place-based approach, bringing support into the heart of the communities that need it. The aim here is to make support visible, accessible, and easier to navigate for residents.

Many of you will have been involved in, or seen, our cost of living roadshows in recent years. What this model does is take that concept further. So rather than one-off or occasional events, the ambition is to create a consistent, predictable offer that residents can rely on.

A hub is not necessarily a new building. It's a trusted local place where residents can access multiple types of support in one place and be connected into further help where needed. The key difference here is consistency.

Residents should know what support they can expect, where they can access it, and that it will be available regularly and reliably. This moves away from more ad-hoc availability, towards something that feels stable and predictable for residents.

We are also starting to align this approach with other complimentary system-wide offers. These are still developing, but it's important to start thinking about how this fits together, particularly in terms of accessibility and availability over time.

While this isn't something that is fully established today, it's the direction we are actively working towards. At this stage, it's about opening the conversation, understanding what already exists locally, where there are opportunities, and who wants to be part of developing this offer.

The Opportunity: CRF and Neighbourhood Health

CRF gives us a practical route to bring financial resilience into the wider ICB Neighbourhood Health model.

Neighbourhood Health is moving services towards:

- More personalised, convenient and joined-up support.
- Prevention and proactive care.
- Reduced duplication across organisations.
- Community-based access points.
- Stronger partnerships between NHS, local authorities, social care, housing and VCSFE services.

What this means in practice:

- Residents do not have to tell their story repeatedly.
- Financial hardship is recognised as part of health and wellbeing.
- Services can make active, warm referrals instead of passive signposting.
- Community organisations are visible partners in prevention.
- The system can respond earlier, before hardship escalates into crisis.

A hub should feel practical, welcoming and useful, not like another referral maze.

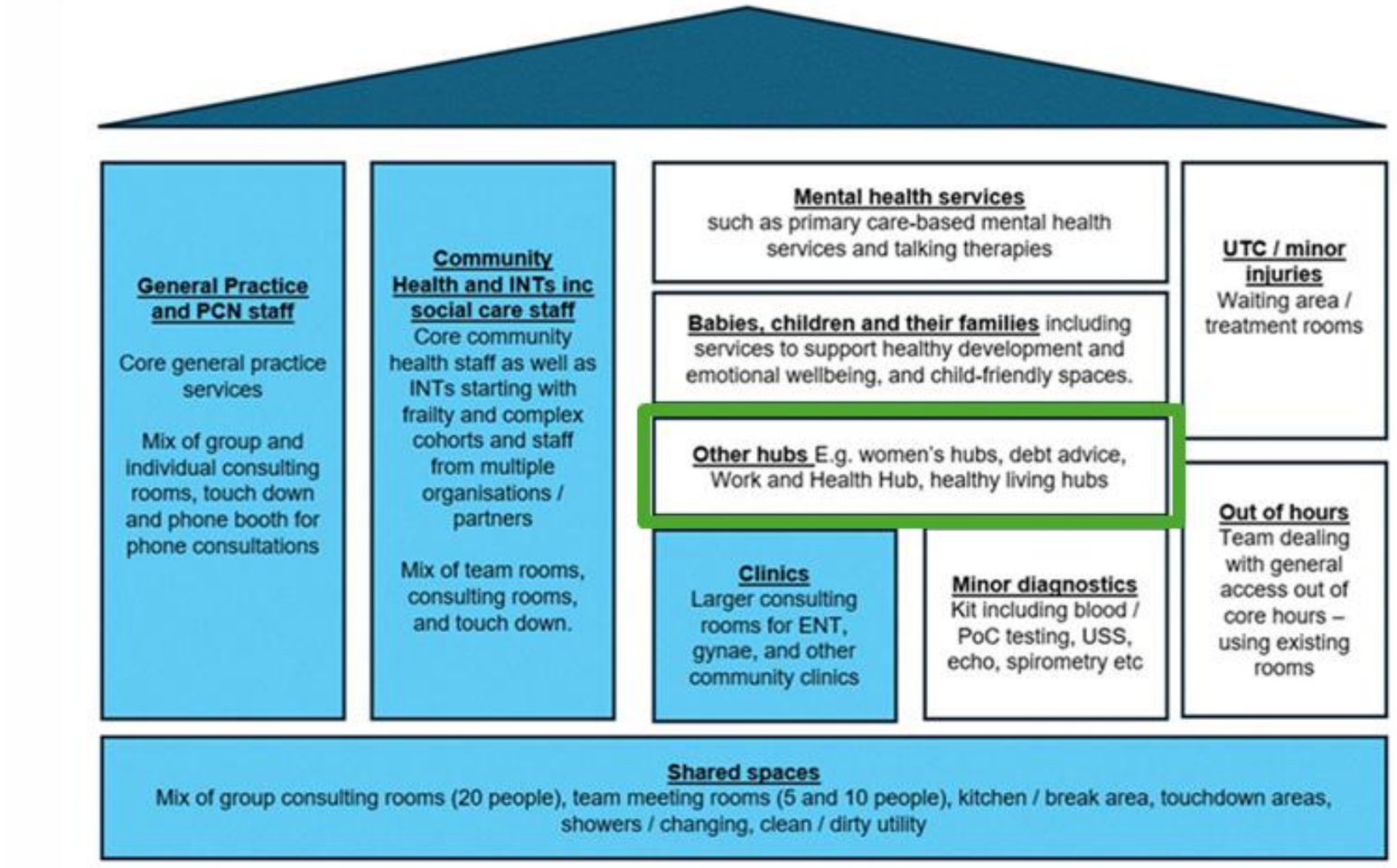
Neighbourhood Health is part of the wider NHS and Integrated Care Board approach, bringing services together at a local, community level. The aim is to create more joined-up support, more preventative services, and easier access for residents, all based around local neighbourhoods. So rather than services being delivered separately, the focus is on bringing health, local authority, and VCSFE support together.

And this is where there's a strong alignment with CRF, because CRF is focused on financial resilience, and financial hardship is a major driver of health and wellbeing outcomes. This gives us a clear opportunity to make financial support part of that wider, joined-up system rather than something that sits separately.

Another important element of this is that Neighbourhood Health comes with capital investment. Which means there is the opportunity to design and develop spaces and models collaboratively, ensuring that financial wellbeing support is considered as part of that design, rather than added in later.

This is still developing, and we're not at a point where everything is in place. But the direction of travel is very clear, and it's something we need to start planning for now. Over time, this is about moving towards more accessible, consistent, community-based support, aligned with how wider services are being delivered locally. So from a partner perspective, this is: an opportunity to be part of a wider, integrated system, and to help shape how financial wellbeing support is delivered in those spaces.

Where CRF sits in a Neighbourhood Health Centre



CRF strengthens this approach by ensuring standardised offer of money, debt, housing and practical support are part of the local neighbourhood offer.

This is the opportunity to make financial wellbeing part of neighbourhood prevention, not separate from it.

This slide brings that concept to life a bit more and looks at where CRF sits alongside wider Neighbourhood Health delivery.

Rather than thinking of financial support as something separate, this is about embedding it as part of the wider neighbourhood offer. Alongside health, care, and community services, you would also see access to money support, debt advice, housing support, and practical help with everyday costs.

Financial wellbeing becomes part of prevention, not something that sits outside of it. For residents, that means they don't have to seek out support separately, they can access help in one place, and their financial situation can be recognised as part of their overall wellbeing. For services, it means stronger links between different types of support, more opportunities for warm referral, and a more coordinated response to need.

The opportunity is to ensure that financial resilience is built into that model from the outset, rather than added in later.

What Could a Money & Wellbeing Hub Offer?

A Money & Wellbeing Hub should be able to offer frequent access to a minimum of 5 core support services. Those activities in these services could include:

Money and debt

- Debt advice
- Budgeting support
- Income maximisation
- Benefit checks
- Affordable credit / savings support

Housing and stability

- Tenancy sustainment
- Rent arrears prevention
- Homelessness prevention
- Housing Association support

Education and Skills

- Financial Education
- Employment support
- Development of practical money-saving skills

Everyday Costs

- Energy advice & accessing social tariffs
- Affordable childcare
- Transport costs
- Making your money go further

Practical help

- Affordable food and essentials pathways
- Affordable furniture / white goods
- Digital access and support

Health and wellbeing links

- Mental wellbeing support
- Gambling-related harm support
- Substance misuse support
- Social prescribing
- Carer support
- Domestic violence & coercive control support

Navigation and referral

- Warm referrals into Tier 1 casework
- Supported access to Crisis Support
- Clear pathways into local community support
- Follow-up where appropriate

All support must demonstrate and measure all the following outcomes:

- Reduced priority debt
- Reduced material deprivation
- Reduced need for emergency food aid
- Income maximisation
- Increased savings
- Increased access to quality advice services

The consistent offer matters more than the label. Residents should know what help is available, when, and how they will be supported to access it.

This slide gives more detail on what could sit within a Money and Wellbeing Hub.

It also highlights the services that we consider to be core support areas (the headings in each box), the bullet points underneath are example activities that may form part of that service.

Initially, we would expect hubs to offer at least five core support services, plus navigation and referral support.

That does not mean every organisation has to deliver everything. It means that, collectively, the hub provides a consistent and accessible mix of support, so residents know what help is available, when it is available, and how they will be supported to access it.

Tier 3: Local Spokes and Community Access Points

Spokes are trusted local access points that connect residents into the wider resilience system.

What Tier 3 spokes are

- Local groups, venues or partnerships offering accessible support close to where residents live.
- Trusted community connectors that can identify need early.
- Part of the wider CRF pathway, not standalone activity.

Minimum expectation

Tier 3 spokes should be a collaboration of at least **two organisations** who can provide and connect residents into at least **three types of support**, as outlined on the previous slide.

What makes it a spoke

- Services do not all have to be in the same building.
- Support should be conveniently accessible and joined up for residents.
- There must be clear referral routes into Tier 1 and Tier 2 where residents need more complex or multiple forms of support.
- Outcomes must still be reported against the same CRF requirements.

Tier 3 is about reach, trust and connection, making sure residents can enter the system through places they already know.

Tier 3 is Local Spokes and Community Access Points. This tier is about trusted, community-based organisations, and for many, this is likely to feel the most familiar. These are the services that are already embedded in communities,
often acting as the first point of contact for residents.

The role of Tier 3 is early identification of need, accessible local support, and helping residents navigate into the wider system. What is different within this model is the expectation around partnership and connectivity. Rather than services operating independently, Tier 3 is expected to be delivered as a collaborative offer.

And the reason for that is to strengthen referral pathways, increase the range of support available to residents, and ensure people can access wraparound support in one place. To ensure residents are not just receiving one type of help, but are being supported across multiple areas where needed.

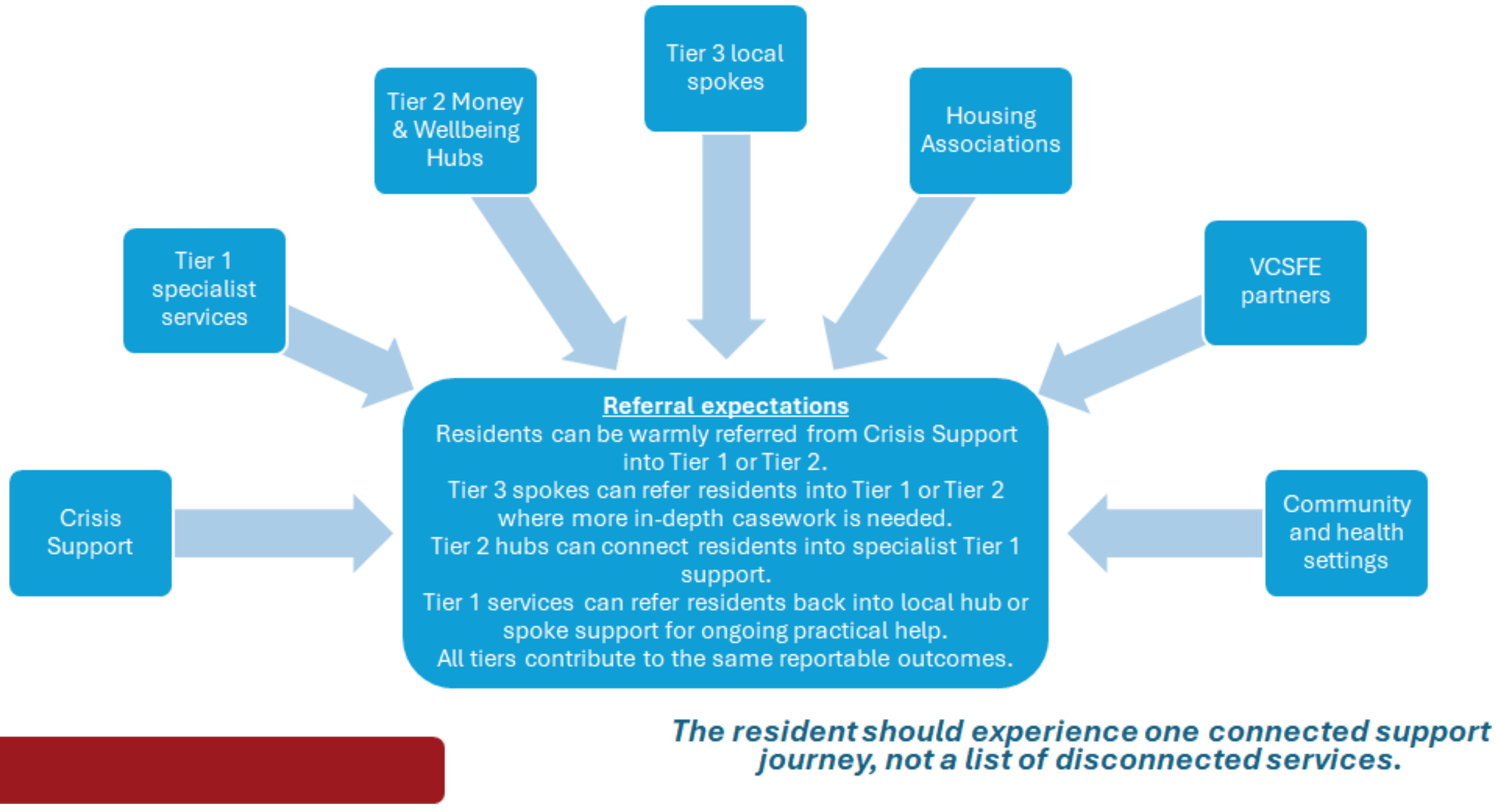
That does mean that partnerships need to be genuine, active, and designed around how services work together in practice. Not solely basing decisions on historic relationships, it's about building partnerships where services are complementary, connected, and able to provide a coherent experience for residents.

From a resident perspective, the expectation is that support feels joined-up and seamless. That may not mean everything is in the same building, but it does mean services are easy to move between, well connected, and accessible in a way that makes sense locally.

Tier 3 is about building on what already exist in communities but strengthening how those services connect and work together.

How the Model Works for Residents

No wrong door only works if every door is connected.



The resident should experience one connected support journey, not a list of disconnected services.

This slide brings all of this together and looks at how the model works from a resident's perspective.

What this model is aiming to create is a single, connected journey for residents, not a series of disconnected services. At the heart of this is the no wrong door approach.

Regardless of where someone enters the system, whether that's crisis support, a local spoke, a hub, or a specialist service, they should be able to access the right support, at the right time. This diagram shows how those different parts of the system connect, with referrals flowing between crisis support, specialist services, hubs, and community access points.

But the most important point is the experience for residents. They shouldn't be bounced between services, have to repeat their story multiple times, or struggle to find the right support.
And achieving that relies on strong referral pathways, clear communication between services, and partners working as part of one system.

While the model looks quite structured, the goal is to make the experience simpler and more joined-up for residents.

The Ask: Building the Resilience System Together

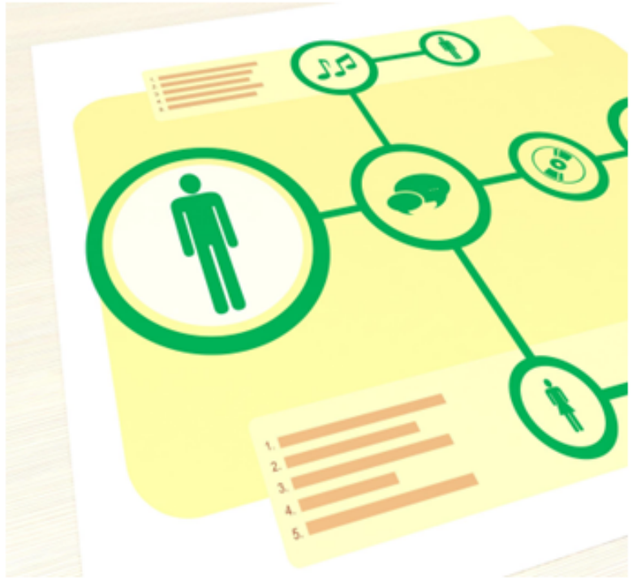
CRF is an opportunity to build on what already exists, but in a more coordinated, outcomes-led way.

What we are asking partners to consider

- Where does your organisation naturally fit: Tier 1, Tier 2, Tier 3?
- What outcomes can your service evidence against the DWP requirements?
- Who do you already work with, and where could partnerships be strengthened?
- How could your service support warm referrals, not just signposting?
- What would help you to be able to participate in a Money & Wellbeing Hub or spoke model?

What this creates

- Clearer routes for residents.
- Stronger collaboration between statutory, housing, health and VCSFE partners.
- Better evidence of impact.
- More sustainable use of CRF funding.
- A shared approach to reducing repeat crisis and improving financial resilience.



The opportunity is to move from individual services doing good work separately, to a connected local system that residents can navigate.

What this means for partners. This is an opportunity to move from individual services doing good work, to a connected local system that residents can navigate more easily. And CRF is a key part of enabling that shift.

This isn't something that can be delivered by WNC alone. It relies on strong partnerships across the VCSFE sector, housing, health, and statutory services. This is very much about building the system together.
At this stage, we're asking organisations to start thinking about a few key areas:
Firstly, where your organisation naturally fits within the model, whether that's Tier 1, Tier 2, Tier 3, or potentially across more than one.

Secondly, what outcomes your service is already delivering and measuring, and how well those align with the CRF requirements.

Third how you're currently working with other organisations, and where there are opportunities to strengthen those partnerships.

And finally, how your service could support warm referrals and be part of a more connected pathway for residents.
This isn't about having everything in place today. It's about starting that process of reflection, and identifying where you already align, and where there may be opportunities to develop.

Ultimately, what this creates is clearer routes for residents, stronger collaboration across the system, better evidence of impact, and more sustainable use of funding. And importantly, a shared approach to reducing repeat crisis and improving financial resilience over time.

Strand 4: Community Co-Ordination

Community Coordination is what makes the whole system work; connecting services so residents can access the right help at the right time.

What Community Coordination is

- Building and maintaining a **joined-up local support network**
- Enabling **warm referrals across services**, not just signposting
- Making it **easier for residents to navigate support**
- Improving **visibility of what exists locally**
- Supporting services to work as **one system, not in silos**

How this overlaps with Resilience Services

- Resilience Services deliver **support outcomes**
- Community Coordination ensures residents can **access those services**
- Both require:
  - Strong referral pathways
  - Partnership working
  - Clear roles across the system

We cannot deliver effective resilience services without effective coordination

What this is not

- A separate programme running alongside services
- General community activity without a role in the CRF pathway
- A replacement for frontline delivery

Community Coordination is the infrastructure that turns good services into a functioning system.

There has been a heavy focus on resilience services, due to the importance of measurable outcomes, but it's important not to overlook this strand, because it's what enables the rest of the model to function. Effective resilience services cannot be delivered without effective community coordination. There is a lot of overlap between the two. Resilience services are about delivering support and outcomes, whereas community coordination is about making sure people can access that support.

This includes things like building and maintaining partnerships, enabling warm referrals between services, improving visibility of what's available locally, and helping both residents and services navigate the system more easily.

Without that coordination, we risk having good services that are difficult to access, poorly connected, or duplicating effort.
With it, we have a system that is: easier to navigate, better connected, and more effective overall.
This isn't about creating a separate programme alongside everything else, it's about the infrastructure that holds the system together.

While resilience services deliver the outcomes, community coordination is what makes those outcomes possible.

Working with Voluntary Impact Northamptonshire (VIN)

VIN will act as the connector between CRF and the VCSFE sector, supporting collaboration, development and sustainability.

Connecting organisations ("matchmaking")

- Supporting VCSFE organisations to form partnerships
- Bringing together complementary services (e.g. advice + community access + practical support)
- Helping build hub and spoke models, not isolated bids

Strengthening the sector

- Supporting organisations to:
- Understand CRF requirements
- Develop their offer to meet outcome expectations
- Build confidence in data, referrals and partnership working

Not everyone needs to be ready on day one , this is a supported, phased approach

Identifying and filling gaps

- Working with WNC to:
  - Identify gaps in provision across the system
  - Engage organisations who may be able to step into those gaps
  - Support development where needed

Supporting long-term sustainability

- For organisations not currently aligned to CRF:
- Sharing alternative funding and grant opportunities
- Ensuring no organisations are excluded from the wider system
- Supporting a sustainable, resilient VCSFE sector

VIN is not an additional layer. It is the support mechanism that helps the system function and grow.

This brings us to the role of our Local Infrastructure Organisation - Voluntary Impact Northamptonshire (VIN) within this model.

VIN's role is as the enabler and connector for the VCSFE sector. This is not about adding another layer into the system. It's about providing the support needed to help the system function effectively and grow over time.

This is a developmental approach, we're not expecting everything to be fully formed from day one. VIN will play a key role in supporting organisations to understand the model, develop their offer, and build the partnerships needed to participate effectively.

In practice, that includes helping organisations connect and form partnerships, bringing together complementary services, and supporting the development of hub and spoke models. As well as helping organisations understand CRF requirements, strengthen their offer where needed, and build confidence around things like outcomes, referrals and data.

Not everyone needs to be ready immediately. This is about building the system over time, with support in place to help organisations get to that point. VIN will also work with WNC to identify gaps in provision, support organisations to step into those gaps where appropriate, and ensure the system develops in a balanced way.

The role of VIN is really to support collaboration, strengthen the sector, and help turn a group of individual services into a connected system. Importantly, this approach is about bringing organisations into the system, not excluding them. Even where services don't immediately align to CRF, there is still a role in the wider system, and support available to develop over time.

What Community Coordination Looks Like in Practice

For residents

- Clearer routes into support
- Fewer hand-offs and repeated referrals
- Access to the right help, first time
- Support that connects across needs (money, housing, wellbeing)

For organisations

- Clear understanding of where you fit in the system
- More opportunities to partner and collaborate
- Support to develop and strengthen your offer
- Access to shared learning, networks and opportunities

For the system

- Better coverage and fewer gaps
- Reduced duplication
- Stronger referral pathways
- Improved outcomes and reporting
- A more sustainable, coordinated support landscape

This is about making the most of what already exists and connecting it in a way that works for residents.

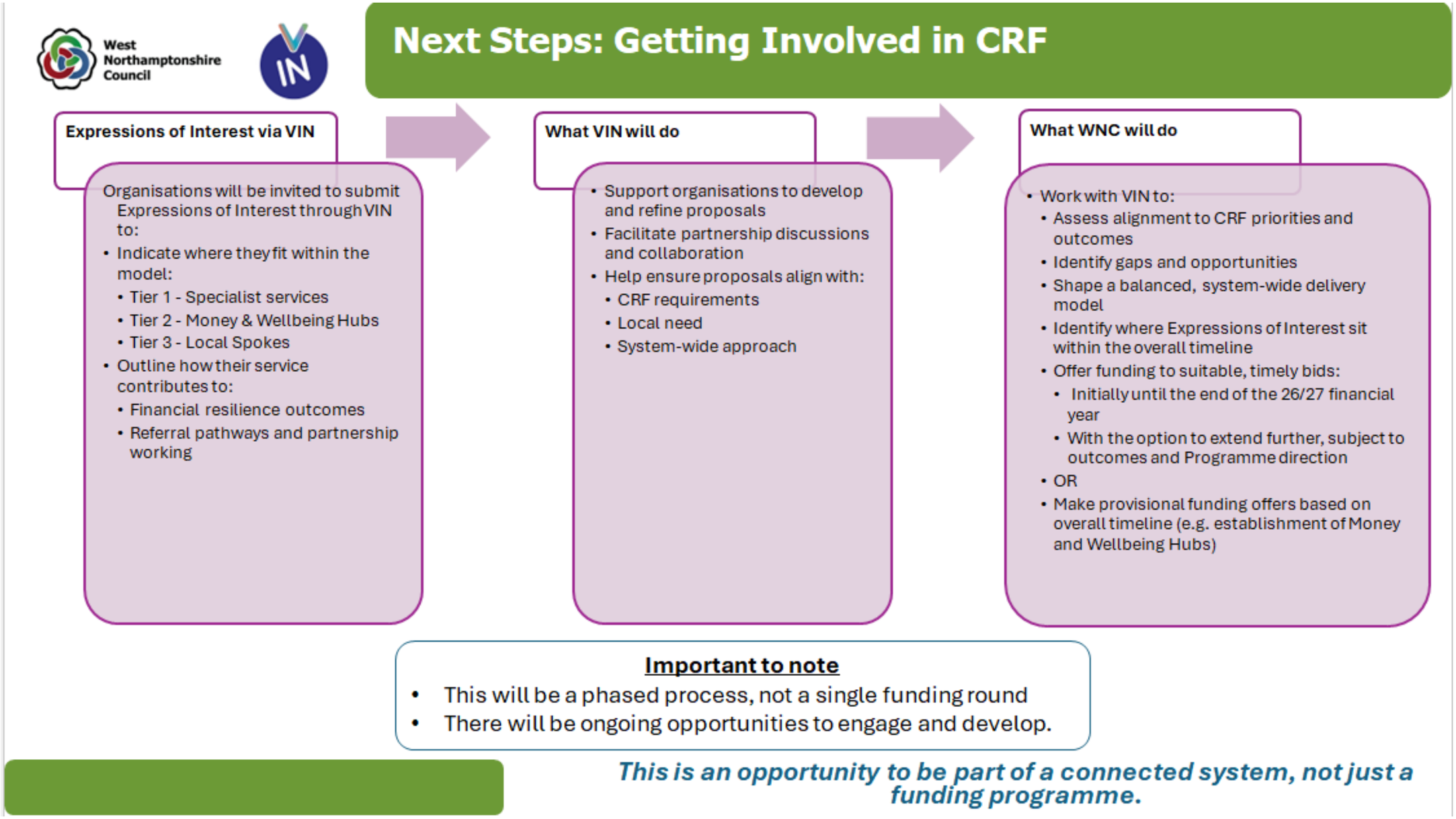
The next slide considers what community coordination looks like in practice.

At its simplest, this is about making the most of what already exists and connecting it in a way that works better for residents. For residents, this should mean clearer routes into support, fewer hand-offs between services, and being able to access the right help first time.

It also means support that is connected across different needs, whether that's money, housing, or wider wellbeing. For organisations, this means: a clearer understanding of where you fit within the system, more opportunities to collaborate, and support to strengthen and develop your offer.

It also creates access to shared learning, networks, and opportunities rather than working in isolation. And at a system level, it helps us to: reduce duplication, fill gaps in provision, strengthen referral pathways, and improve the overall impact of support.

This isn't about creating something new it's about making the existing system more coordinated, visible, and effective. And ultimately, it means moving from: a collection of good individual services to a system that works together to deliver better outcomes for residents.



These final slides set out what happens next, and how organisations can start to engage with this process.

This is an information-gathering stage. Please don't rush into applications. This is not a one-off funding opportunity.

At this stage, we want to understand four things: are you interested, where do you fit, are you ready, and what support would you need?

Initial funding will be offered up to March 2027, with the potential to extend where outcomes are being achieved. This programme will adapt as we learn, and we want to walk before we run.

If your offer fits later in the timeline, we still want to know, because that helps us plan and develop the model.

This is also not a single allocation of funding, so Expressions of Interest will ask for anticipated monthly costs, particularly where additional resource or scaling is needed. And where support involves physical items, for example white goods or similar, these would need to be clearly linked to identified need, sit alongside wider support, and be offered at cost or subsidised. Rather than being provided as standalone, free provision, which would sit within crisis support instead.

Identifying Your Role in the CRF Model

Use the checklists to identify where your organisation best fits, and what you may need to develop.

A few important points before you start

- Organisations may operate across more than one tier, especially in partnership models
- You do not need to meet every criterion today. VIN will support development
- Strong applications are likely to:
  - Be clear on their role
  - Show how they connect to other services
  - Demonstrate how they contribute to outcomes

This is about building a system together, not assessing organisations in isolation

The next steps are about reflection, understanding where you fit, and starting to think about how you might be part of this model.

To help you with this, we have some additional slides which contain summary details of what is needed for each tier. Please take the time to look through these and consider each point carefully.

Tier 1 Checklist: Specialist Services

Tier 1: Specialist Financial Resilience Services.

You are likely to be Tier 1 if most of the following apply

Your service delivers structured casework

- ❑You provide in-depth support, not just one-off advice or signposting
- ❑You work with residents over time to resolve issues
- ❑You can support residents with complex or multi-disciplined support needs

You specialise in financial resilience

- ❑Debt advice & write – off (including FCA-regulated where required)
- ❑Welfare benefits / income maximisation
- ❑Housing advice / tenancy sustainment
- ❑Energy debt / fuel poverty support
- ❑Other support clearly linked to financial stability

You can accept warm referrals

You have capacity to take referrals from:

- ❑Crisis Support
- ❑Hubs (Tier 2)
- ❑Spokes (Tier 3)

❑You can respond in a timely and coordinated way

You can evidence outcomes

You can measure and report:

- ❑Reduced experiences of material deprivation
- ❑Reduced need for emergency food parcels
- ❑Reduction in priority debt
- ❑Increased access to appropriate and quality advice services
- ❑Increased savings
- ❑Maximisation of individuals' incomes

You can be part of a wider system

- ❑You understand where your service fits
- ❑You actively refer into other support where needed

For your EOI, you are likely to need to show:

- ❑Type of specialist support that can be offered
- ❑Quality assurance (e.g. FCA, accredited advice standards)
- ❑Evidence of ability to meet outcomes
- ❑Details of casework systems used for monitoring
- ❑Referral pathways (in and out)
- ❑Capacity and demand – current and potential
- ❑Anticipated monthly costs for additional resource / upscaling

Tier 2 Checklist: Money & Wellbeing Hubs

Tier 2: Money & Wellbeing Hubs

You are likely to be Tier 2 (or part of a hub) if most of the following apply

You can deliver services within a place-based hub setting

- ❑ You are open to being part of a WNC-led hub model, rather than leading or managing the hub itself

You can contribute to a consistent, multi-service offer

- ❑ You provide at least one core support type that contributes to a wider hub offer

You understand that the hub must deliver:

- ❑ A minimum of 5 core services
- ❑ Covering different support themes

- ❑ This will be achieved collectively across organisations, not individually

You can deliver support regularly

- ❑ You can offer services frequently and consistently throughout the week
- ❑ You contribute to a predictable and reliable offer for residents

You can evidence outcomes

You can measure and report:

- ❑ Reduced experiences of material deprivation
- ❑ Reduced need for emergency food parcels
- ❑ Reduction in priority debt
- ❑ Increased access to appropriate and quality advice services
- ❑ Increased savings
- ❑ Maximisation of individuals' incomes

You can be part of a wider system

- ❑ You understand where your service fits
- ❑ You actively refer into other support where needed

For your EOI, you are likely to need to show:

- What service you would bring into a hub and how it contributes to a mixed service model.
- Locations that you could readily provide a service in
- How often you could deliver the service (capacity)
- Your experience of working with partners or in a shared setting
- Evidence of ability to meet the outcomes
- Details of systems used for monitoring
- Your ability to support referral pathways (in and out)
- Anticipated monthly costs for additional resource / upscaling

Tier 3 Checklist: Local Spokes

Tier 3: Local Spokes

You are likely to be Tier 3 if most of the following apply

You are a trusted local access point

- ❑You already engage with residents in your community
- ❑You are often a first point of contact

You offer or connect to multiple types of support

You can provide:

- ❑at least 3 types of support
- ❑via at least 2 organisations
- ❑more than twice a week.

You help residents navigate support

You can:

- ❑Identify needs early
- ❑Guide residents through available options
- ❑Support access to other services

You are open to working in partnership

- ❑You work with other organisations locally
- ❑You are willing to be part of a hub-and-spoke model

You can evidence outcomes

You can measure and report:

- ❑Reduced experiences of material deprivation
- ❑Reduced need for emergency food parcels
- ❑Reduction in priority debt
- ❑Increased access to appropriate and quality advice services
- ❑Increased savings
- ❑Maximisation of individuals' incomes

You can make warm referrals

You are able to:

- ❑Refer into Crisis Support
- ❑Refer into Tier 1 or Tier 2 services
- ❑You are willing to be part of a connected pathway

For your EOI, you are likely to need to show:

- A joint application with at least one other complementary organisation
- Type of support that can be offered
- Your reach into the community
- Evidence of ability to meet outcomes
- Details of systems used for monitoring
- How you will connect residents into other services (referral pathways)
- Capacity and demand – current and potential
- Anticipated monthly costs for additional resource / upscaling

Not Quite There Yet?

Support is built into the model

You do not need to meet every requirement today. VIN will help organisations move towards readiness through practical support.

1. **Develop the offer**
   Shape the support you can provide and identify what needs strengthening.
2. **Build partnerships**
   Connect with hubs, referral pathways and complementary local organisations.
3. **Strengthen outcomes**
   Improve monitoring, evidence and reporting so impact is clear.

If CRF isn't the right fit, right now

VIN will share alternative funding opportunities and provide support, so organisations stay involved and ready.

The aim is to strengthen the whole system, not leave organisations behind.

Importantly, we also have a reminder of the support that will be available as the Programme progresses.

References

- Crisis and Resilience Fund Guidance - GOV.UK
- Trussell & Policy in Practice recommendations for CRF
- Why Cash First? – Independent Food Aid Network
- Cash first and the Crisis and Resilience Fund – Cash first but not cash only
- Crisis and Resilience Fund: Supporting people with food

We have also included links to further information about some of the National Guidance and Policy Influences

Future communications will come from a dedicated CRF email address hosted by VIN.

We ask that all CRF-related queries are directed to this inbox to ensure they are managed and responded to efficiently. Emails sent to WNC or individual contacts at VIN may be treated as duplicates or redirected to the CRF inbox for action.

The key message to leave you with is that this is about building a connected, outcomes-focused system together, not delivering services in isolation. And there is a role for a wide range of organisations within that, at different stages, and in different ways.