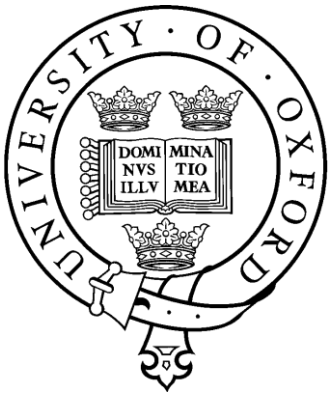
‘Hospitality, Chantries, and Other Works of Piety’: A Select Study of the Functions and Longevity of Hospitals in Small Towns and Villages in Medieval England, *c*. 1150-*c*. 1450



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Submitted for the degree of Doctor of Philosophy in History
University of Oxford
Trinity Term 2020

Short Abstract

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In the high to late Middle Ages, hospitals were ubiquitous. It has been estimated that by the fourteenth century more than 500 hospitals were scattered across the English landscape. Yet to date, hospitals located in small towns and villages in England have received little scholarly attention. This study seeks to contribute to the field by offering a wide-ranging assessment of 72 lesser-known hospitals. It considers whether these houses can be defined by the functions they performed as opposed to the guests they served. And it seeks to establish the extent to which they were reliant on patronal support throughout the core period of the study. The project combined the results generated from its bespoke database with an in-depth appraisal of the hospitals in Aynho and Brackley, Northamptonshire. In addition, it incorporated material concerning obscure hospitals into its analysis.

The results found that the hospitals can be defined by their core functions of hospitality, chantries, and other works of piety which were offered to a variety of guests. Such was the importance of the provision of hospitality, it was implicit within their most commonly-used name. A main finding was that hospitals were remarkably resilient: at least 50% were viable in the sixteenth century. The minimum average lifespan of these houses was 238 years, and the evidence revealed a degree of specialisation in their functions in the later Middle Ages. During this time, many successfully mitigated both internal and external threats through a wide-ranging network of support. This included monarchs and bishops in their role as temporary patrons and reformers. However, the study concludes that it was in the gift of the legal patron to ultimately seal their fate.

Long Abstract

‘Hospitality, Chantries, and Other Works of Piety’: A Select Study of the Functions and Longevity of Hospitals in Small Towns and Villages in Medieval England, *c.* 1150-*c.* 1450

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The purpose of this thesis is twofold: to consider the *raison d’être* of medieval hospitals and to ascertain why some houses survived while others did not. The research project was designed to shed a light on hospitals in small towns and villages in England in the later Middle Ages. It set out to gain a better understanding of the lesser-known houses in what have been termed the many small and obscure places at the base of the urban hierarchy. The present project, accordingly, sought to draw attention away from the oft-cited higher-ranked towns, such as London, York, Bristol, and Norwich. The hospitals in this study were mostly founded in the twelfth and thirteenth centuries – a momentous time in the history of English hospitals. The increase in the number of hospitals in England is often associated with the growth of towns, population expansion, and the monastic boom of the twelfth century. However, very little is known about hospitals in quasi-urban locations – one definition of a small town being a location with between 300 and 2,000 inhabitants and a predominance of non-agricultural trades. There were over 350 hospitals in these locations which were founded before 1350; it is, therefore, important that the historiography of hospitals in England reflects this fact. In addition, the main period under review in this study – 1150 to 1450 – first saw population and economic expansion, followed by contraction. The project assesses what happened to a select sample of these lesser-known early hospitals. It builds on Sethina Watson’s work which looked at foundation charters for early hospitals from a constitutional perspective. This study considers how hospitals were understood by contemporaries over 300 years, and it employs a broad range of primary source material to do so for the 72 houses within its remit.

The sample comprised hospitals founded prior to the mortmain legislation of 1279. Leper hospitals were removed from the sample as they are often considered in isolation from the main body of hospitals in the categories of houses defined by historians. In addition, contemporary legislation – canon 17 of the Council of Vienne which commenced in 1311 – differentiated between leper houses and hospitals. The final sample size, after removing those which were in the same location as another religious house, comprised 72 hospitals in total – an appropriate number of houses to assess for a project of this nature. It was hoped that this sample-selection method would return a sample of hospitals scattered across England which would form the basis of a comparative study, and this was indeed the case.

A relational database was designed and constructed to manage two specific aspects of the project. In the first instance, summaries of the medieval deeds, charters, and other estate papers housed at Magdalen College, Oxford, in respect of the hospitals located at Aynho and Brackley were reviewed using the detailed calendars of William Dunn Macray. There are in excess of 1,300 manuscripts in the collection which can be dated within the core period of this study (1150-1450); however, when a piece of evidence was deemed of pivotal importance, it was consulted in the original form. Information was extracted and entered into the database to answer questions concerning, for example, the impact of the aforementioned mortmain statute on these houses. Further information derived from other sources, which can be linked back to the two hospitals through its hospital master data table and the overall design of the database, was entered into the relevant tables with the remaining hospitals in the sample. These examples comprised royal grants of land or licences, as well as refoundation dates, and information concerning their location.

The second way in which the database formed an important part of the project was to control data concerning hospital dates of foundation or dates of first reference, and their dates of dissolution or dates of last reference. The data for patrons of first and last reference were also noted in this way. Clearly it would not have been possible for a project of this nature spanning 300 years to consult all extant manuscript material. Thus, the project was heavily reliant upon the calendared

works of other scholars comprising, for example, printed bishops' registers, calendars of Close and Patent Rolls, and the *Victoria Country History* summaries in the religious house volumes. In addition, the original antiquarian works were consulted wherever possible as they often contain detailed translations of the original source material some of which has not survived the passage of time. Thus, a very large quantity of material was reviewed, allocated unique reference numbers, and deployed to create an overview of each of the 72 houses in the first instance. This source material was also managed through the construction of detailed appendices, summaries of which are contained within the thesis. Full details of this work are included within Chapter One.

There are five main chapters which follow the introductory chapter just discussed. The first, Chapter Two, considers the importance of the provision of hospitality to medieval society; why it might be that hospital patrons considered it to be a pivotal service for their newly founded institutions, and to whom it should be offered. Within the analysis, attention is given to what constituted hospitality, the question of duty, and the importance of their location. The aim of the chapter is to establish whether early *hospitalia* can be defined by the services they offered as opposed to their type of inmate or guest. This is then further explored in Chapter Three which investigates the second potential unifying service: care of souls – be they of the living or dead. Access to a chapel is put in the spotlight, as well as descriptions of religious paraphernalia and archaeological evidence to enhance the pictures painted by the documentary evidence. In a similar way to Chapter Two, it looks at who the intended recipients of these services were. Both chapters are concerned with ascertaining how contemporaries used and perceived these *a priori* diverse institutions through an assessment of their core functions. They are not, however, concerned with the demand for these services and changes over time – those are discussions reserved for the final chapter in this study.

The study then turns to the question of longevity and the perceived ephemeral nature of the lesser-known houses in small towns and villages. Chapter Four evaluates the role of the legal and temporary patrons including the role of the advowee paramount in assisting, or not, these houses

to endure. Historians of monastic history have identified waning aristocratic interest in their institutions during the later Middle Ages. And ecclesiastical historians have noted the diminishing role of the patron. The question that therefore arises is the extent to which this applied to hospitals in this period – both in theory and in practice. Having established the role of the patron, Chapter Five moves forward to look at a potential threat to the longevity of hospitals in the form of the Statute of Mortmain of 1279. The idea that an institution's ability to amass land to fund its operations and to form an ongoing bond with its donors could be placed in jeopardy is potentially of vital significance in their ability to endure. Here, the material under review is drawn from the database and the detailed evidence for the hospitals at Aynho and Brackley: thus, a quantitative and qualitative approach is adopted.

A wider range of external threats is given due consideration in the final main chapter, Chapter Six. Here, the question of demand for hospital services and their ability to supply them is examined. Several factors are considered such as the Great Famine, the Black Death, competing institutions, legislation, the role of masters, and the protection of assets. Much of the evidence concerns the fourteenth and fifteenth centuries when calls to reform these houses were made. The evidence is surprisingly rich and will leave the reader in no doubt just how valuable a study of the lesser-known hospitals can be. Throughout each chapter an attempt is made to shed light on as many hospitals as the evidence will permit; to look for unifying features and correlations, but not to overly generalise as to the findings; and to employ both the aforementioned quantitative and qualitative approaches to a series of thorny issues and questions which arose over a timeframe of 300 years. The thesis makes the case that hospitals can indeed be defined by their core functions of hospitality, chantries, and other works of piety.

There is no doubt that these houses were unified by their services as opposed to their type of guest. Their visitors were wide-ranging and not limited to the sick and the poor – nor were they ever intended to be limited in this way. Customary obligations to provide hospitality to patrons or their nominees arose on the creation of the endowment or subsequent gifts. This is also known

to have applied to general benefactors who donated land in order to share in the benefits of the house. Over time, such was the burden of the provision of hospitality that legislative measures were put in place to protect these and other institutions. Some were able to reduce the financial pressures by tailoring their provision of hospitality to fee-paying guests, be that on a long- or short-term basis. This has been regarded by some scholars as an imposition on these houses or a distraction from their main purpose, but this study takes the view that the primary function of a hospital was to care for those in need – rich or poor.

A key finding to emerge from the research was that these houses were remarkably institutionally resilient. Hospitals for which founders are known had a minimum average lifespan of 316 years, and even those for which little is known produced a minimum average of 151 years. One of the reasons for the success of many houses was their ability to specialise their services in order to compete in the mixed economy of care. The provision of hospitality was a form of care which could be adapted to meet the needs of specific individuals. Thus, some hospitals tailored their functions to cater for passing travellers and were described as hospitals or inns. Others appear to have focused on their spiritual services and were termed hospitals or chapels. In the latter case, however, the study did not find that the poor lost out to the performance of chantry masses. Time and again, the poor figured prominently in reforming visions.

Many hospitals were able to function over prolonged periods of time as a result of the systems within which they operated. This comprised a support network of temporary patrons. Bishops were permitted to issue corrections to hospitals within their diocese which were largely designed to ensure the competency of the masters and to protect the hospital's assets. The general system of presenting candidates for induction to their office, or collation if the bishop was the legal patron, was designed to ensure that individuals were vetted before taking up their post. Masters held responsible positions, and it was essential that patrons selected them with care. This, unsurprisingly, did not always occur. Yet the system was designed to correct abuses. That could be through secular or ecclesiastical visitations or legal action to recover grants of land which had

been misappropriated. What is most evident, however, is that without the patron's support, problems could persist.

At the head of the system of protection was the ultimate patron, the king. The king held the right to act as a temporary patron at pivotal moments in a hospital's life. That kings could argue that time did not run against them and sought to extend their rights of appointment to office demonstrates that monarchs wanted to assist these houses. Of course, it could be argued that kings were merely providing an income to their favoured servants, but it seems there was often something more behind these actions. The care of an injured soldier sent to a hospital, the gifts of fuel and timber to provide hospitality to the inmates, and the timely interventions when accusations of abuses were received add weight to this line of thought. These beneficial interventions were not only extended to royal hospitals in this study. For non-royal houses, they might have comprised modest grants of land, exemptions from taxation, letters of protection, or grants of mortmain licences; nevertheless, they mattered and assisted these houses to function.

That assistance is more apparent when the patron was a tenant in chief of the king. There is evidence which requires further exploration over a wider sample base that suggests that when a house was associated with a beneficial intervention by the king, it survived for a longer period of time. In addition, when the identity of a founding patron or earliest patron is known, the minimum average lifespan of a house exceeded that of those with unknown equivalent patrons. Known patrons were unsurprisingly more likely to be higher-ranking nobility who have left a trace in the records. That is not to suggest that the king was directly responsible for a hospital's ability to endure throughout the period in question. Even when the axe fell during the Reformation, three houses within this sample managed to escape immediate suppression. Yet there is no doubt that the system could be used to rectify abuses and issue reforming statutes, albeit sometimes on behalf of the king. Within that system, the significance of archbishops and bishops, whose duties also comprised the facilitation of the provision of hospitality and obviously spiritual services to all in

need, is plain to see. When a hospital was in the patronage of a bishop, 80% survived into the sixteenth century. This figure fell to 33% for monastic houses.

Several patrons looked to find alternative uses for hospital endowments when they decided to terminate their relationship with their house and agree to their inevitable closure. This could comprise their appropriation to another hospital, a monastery, or a university college. Some hospitals sought to endure through the specialisation of their activities into either of the two core functions – hospitality or chantry masses. Yet, the evidence has shown that regardless of how many visitations took place, refoundations, corrections, and legislative measures put in place, a legal patron held the metaphorical keys to the house. Masters were invested with quotidian responsibilities, but the patron could prevent an institution from functioning by preventing the appointment of a master, thereby taking direct responsibility for the hospital endowment. There is evidence that patrons contemplated these decisions and that they did not come to fruition at that time, but the fact remains it was their decision to offer a stay of execution. This thesis, therefore, concludes that hospitals in small towns and villages can be defined by their provision of hospitality, chantries, and other works of piety, and that their ability to ultimately endure rested upon their patron.

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Abbreviations

CCR	*Calendar of the Close Rolls Preserved in the Public Record Office*
CEPR	*Calendar of Entries in the Papal Register Relating to Great Britain and Ireland: Papal Letters*
CFR	*Calendar of Fine Rolls Preserved in the Public Record Office*
CIM	*Calendar of Inquisitions Miscellaneous (Chancery) Preserved in the Public Record Office*
CIPM	*Calendar of Inquisitions Post Mortem*
CLR	*Calendar of Liberate Rolls Preserved in the Public Record Office: Henry III*
CPR	*Calendar of Patent Rolls*
CR	*Close Rolls of the Reign of Henry III Preserved in the Public Record Office*
DMLBS	*Dictionary of Medieval Latin from British Sources* (online edition)
EEA	*English Episcopal Acta*
K&H	D. Knowles and R. N. Hadcock
L&P	*Letters and Papers, Foreign and Domestic of the Reign of Henry VIII: Preserved in the Public Record Office, the British Museum, and Elsewhere in England*
Macray	W. D. Macray, Unpublished Calendars of Medieval Deeds and Charters by County, held at Magdalen College, Oxford
MCA	Magdalen College Archives, Oxford
No.	Calendared manuscript number (with respect to footnotes and the unpublished calendars of W. D. Macray)
ODNB	*Oxford Dictionary of National Biography*
OED	*Oxford English Dictionary*
PR	*Patent Rolls of the Reign of Henry III Preserved in the Public Record Office*
s	Shillings
TNA	The National Archives, London
VCH	[*Victoria County History*], *A History of the County of*

Chapter One: Introduction

In the high to late Middle Ages, hospitals were ubiquitous. It has been estimated that by the fourteenth century more than 500 hospitals were scattered across the English landscape.[1] Yet to date, hospitals located in small towns and villages in England have received little scholarly attention. When these houses are discussed, they often form part of a regional study and serve as an adjunct to the better-documented establishments in larger neighbouring towns.[2] The present project, accordingly, sought to draw attention away from the oft-cited higher-ranked towns, such as London, York, Bristol, and Norwich. It considers the role of hospitals in areas which are not deemed to be wealthier and larger towns: that is to say, locations not listed in the top 60 towns based on estimated population size in *c*. 1290, or in the top 100 towns based upon the 1334 lay subsidy returns.[3] Nor were these houses in definitively rural areas, in other words villages which were located in excess of three miles from a town.[4] As a group, they represent institutions situated in villages within the immediate hinterlands of towns, or in small towns – to put it another way, areas that could be described as 'the lesser trading places'.[5]

The hospitals in this study were mostly founded in the twelfth and thirteenth centuries – a momentous time in the history of English hospitals. The increase in the number of hospitals in England is often associated with the growth of towns, population expansion, and the monastic boom of the twelfth century.[6] However, very little is known about hospitals in quasi-urban

[1] N. Orme and M. Webster, *The English Hospital, 1070-1570* (London, 1995), p. 11.
[2] See for example S. Sweetinburgh, *The Role of the Hospital in Medieval England: Gift-Giving and the Spiritual Economy* (Dublin, 2004) which considered hospitals in Kent; P. Cullum, 'Hospitals and Charitable Provision in Medieval Yorkshire, 936-1547' (PhD Thesis, University of York, 1989); E. M. Phillips, 'Charitable Institutions in Norfolk and Suffolk *c.* 1350-1600' (DPhil Thesis, University of East Anglia, 2001).
[3] A. Dyer, 'Ranking of Towns by Taxable Wealth: The Subsidy of 1334', in D. M. Palliser (ed.), *The Cambridge Urban History of Britain: Volume 1, 600-1540* (Cambridge, 2018), pp. 747-70, at pp. 755-7; B. Campbell, 'Benchmarking Medieval Economic Development: England, Wales, Scotland, and Ireland, *c.* 1290', *The Economic History Review*, 61/4 (2008), pp. 896-945, at pp. 908-9.
[4] M. Satchell, 'Towards a Landscape History of the Rural Hospital in England', in J. Henderson, P. Horden, and A. Pastore (eds), *The Impact of Hospitals 300-2000* (Oxford, 2007), pp. 237-56.
[5] Campbell, 'Benchmarking', p. 907.
[6] S. Watson, 'City as Charter and the Lordship of English Towns, 1170-1250', in C. Goodson, A. E. Lester, and C. Symes (eds), *Cities, Texts and Social Networks, 400-1500: Experiences and Perception of*

locations – one definition of a small town being a location with between 300 and 2,000 inhabitants and a predominance of non-agricultural trades.[7] It is often extremely difficult to categorically state that a village on the outskirts of a town, particularly a larger town, was definitively rural or that a small town was an urban location. Thus, these areas are difficult to define, but the 'many small and obscure places at the base of the urban hierarchy' will suffice for the purposes of this study.[8]

There were over 350 hospitals in these locations which were founded before 1350; it is, therefore, important that the historiography of hospitals in England reflects this fact.[9] In addition, the main period under review in this study – 1150 to 1450 – first saw population and economic expansion, followed by contraction. During this period, hospitals in small towns and villages might have adapted to external threats in diverse ways in different areas.[10] The project will assess what happened to a select sample of these lesser-known early hospitals. It will build on Sethina Watson's work which looked at foundation charters for 70 early hospitals from a constitutional perspective.[11] This study considers how hospitals were understood by contemporaries over a longer period of 300 years, and it employs a broad range of primary source material to do so for the 72 houses within its remit (21 of which formed part of Watson's early work).[12] Those houses, as can be seen in Appendix II, were located across England.

The first objective of this project is to elucidate the understanding of these lesser-studied houses by comparing the services they provided and to whom. This is necessary, as it is thought that

Medieval Urban Space (Farnham, 2010), pp. 235-62; A. J. Davis, 'The Social and Religious Meanings of Charity in Medieval Europe', *History Compass*, 12/12 (2014), pp. 935-50; J. Langdon and J. Masschaele, 'Commercial Activity and Population Growth in Medieval England', *Past and Present*, 190 (2006), pp. 35-81; E. Prescott, *The English Medieval Hospital, 1050-1640* (London, 1992), pp. 6, 23.

[7] C. Dyer, 'Small towns, 1270-1540', in D. M. Palliser (ed.), *The Cambridge Urban History of Britain: Volume 1, 600-1540* (Cambridge, 2018), pp. 505-6, 511.

[8] Campbell, 'Benchmarking', p. 907.

[9] R. M. Clay, *The Mediaeval Hospitals of England* (London, 1966), pp. 278-337.

[10] For an up-to-date summary of debates concerning decline and bibliography see B. Jervis, 'Decline or Transformation? Archaeology and Late Medieval "Urban Decline" in Southern England', *Archaeological Journal*, 174/1 (2017), pp. 211-43.

[11] S. Watson, 'The Origins of the English Hospital', *Transactions of the Royal Historical Society*, 16 (2006), pp. 75-94, at p. 84.

[12] Additional information concerning the sample selection method is in Section II of this chapter.

services provided to the poor suffered in the later Middle Ages when hospitals turned their attention to the provision of chantry masses and ever more elaborate liturgical services. In addition, consideration will be given to whether hospitals should be defined by the services they provided as opposed to the type of visitor they served. This is a difficult task as for some houses there is copious extant evidence, while for others only a single source has survived the passage of time. Therefore, the analysis combines results in overview derived from the project's database queries for the total sample and detailed individual qualitative examples. The study then moves to assess why some hospitals within this sample survived and not others. The traditional view is that many hospitals were ephemeral.[13] The research, thus, considers the role of legal patrons, ultimate patrons, and masters in their ability to endure, as well as the quotidian management of resources and the effects of legislation, famine, and plague. In doing so, it assesses how their functions might have changed over time, how they mitigated risk, and their place in the mixed economy of care in the later Middle Ages.

I: The Historiography of Medieval Hospitals in England

The word hospital is deemed to be an umbrella term used to describe an array of charitable institutions which provided welfare services: 'they varied widely, in staffing and routines, in scale, and in who they served and how'.[14] Scholarship in this area tends to classify hospitals by inmate type. For example, Martha Carlin identified four main categories of medieval hospital: leper houses, almshouses, hospices for poor wayfarers and pilgrims, and institutions which cared for the sick poor.[15] The oft-used listings of religious houses compiled by Knowles and Hadcock

[13] S. Watson, 'Fundatio, Ordinatio and Statuta: The Statutes and Constitutional Documents of English Hospitals to 1300' (DPhil Thesis, University of Oxford, 2004), p. 177; P. Horden, 'Small Beer? The Parish and the Poor and the Sick', in C. Burgess and E. Duffy (eds), *The Parish in Late Medieval England*: *Proceedings of the 2002 Harlaxton Symposium* (Donington, 2006), pp. 339-64, at p. 357.
[14] S. Watson, 'Hospitals in the Middle Ages', *Oxford Bibliographies*, https://www.oxfordbibliographies.com/view/document/obo-9780195396584/obo-9780195396584-0233.xml (24 Sept. 2019).
[15] M. Carlin, 'Medieval English Hospitals', in L. Granshaw and R. Porter (eds), *The Hospital in History* (London, 1990), p. 21.

(K&H) also categorised hospitals by these types of inmate. As will be seen, this work, despite its well-documented limitations, forms the basis of most statistical data in this area.[16] Classifications by the expected predominant visitor type are useful, but they oversimplify the range of people who came into contact with hospitals and shed little light on their daily functions. In addition, they underplay their ability to adapt to changes within society and to diversify or specialise their activities over time.

An alternative classification system, classification by date range, goes some way to overcoming these difficulties. Rotha Mary Clay's seminal study split hospitals into three categories comprising those for wayfarers, houses for the destitute, and leper houses. However, she also summarised key periods in their history. For example, hospitals for wayfarers were grouped into four key periods based on need as shown in Table 1 below.

Table 1: Wayfarer Hospital Development by Period (Based on Clay)[17]

Year	Summary Description
925–1170	Works of charity largely confined to monasteries, obligation to receive strangers and pilgrims as if they were Christ himself.
1170–1270	To serve the great pilgrimage shrine of St Thomas at Canterbury hospitals were founded in southern England as both guesthouses and infirmaries to support the poor, weak, infirm, and travellers.
1270–1470	Increasing concern within society regarding vagrancy. Hospitals start to discriminate against non-worthy inmates.
1470–1547	Attempts to resolve problems through statutory measures and the creation of almshouses.

These four categories are informative but are still too general to gain a good understanding of the purpose of these houses and the issues they encountered. They have an underlying assumption that people and institutions within the grouping acted in the same way at the same time. Houses for the destitute were not analysed in this manner, and lazar houses were described by century

[16] K&H, *Medieval Religious Houses: England and Wales* (London, 1953); K&H, *Medieval Religious Houses: England and Wales* (London, 1971); K&H, 'Additions and Corrections to Medieval Religious Houses: England and Wales', *The English Historical Review*, 72/282 (1957), pp. 60-87. K&H types are listed on pp. 310-1 (1953) and include in general terms: the sick, lepers, the poor, almshouses, pilgrims, and hospices.
[17] Clay, *The Mediaeval Hospitals of England*, pp. 1-14.

with a particular focus on the post-Black Death period of 1350-1400.[18] However, in her appendix, which listed hospitals by county, Clay only differentiated between leper and non-leper houses.[19] This is a point to which this study will return as it considers what constituted a 'hospital' and why the word *hospitalia* was deployed by contemporaries to describe them.

Clay is deemed to have held the field for over 80 years as subsequent historians felt disinclined to produce a new general synthesis and instead focused upon individual or regional studies. Nicholas Orme and Margaret Webster – Clay's eventual successors – judged Clay to have set the basis for future scholarship and described her general study as 'one of the best Antiquary's Books'.[20] Much of Clay's work drew upon the *VCH* series which contains a summary of hospitals by county and provides a useful entry point into the topic. It is, however, limited in scope as it does not give the reader an insight into the context of the information and rarely compares its findings to other locations. Its value lies in its use of bishops' registers, many of which were consulted in the original manuscript form. Within this regional survey, hospitals often received less attention than monasteries, and the overall work is variable in quality. It follows the work of William Dugdale in this respect which itself contained useful transcripts of hospital charters and summaries of the work of earlier antiquarian and local historians, such as John Leland's sixteenth-century itineraries.[21] In addition, it covered a broad historical timeframe. In recent years, additional work has been published as part of the *VCH* series, but with respect to medieval hospitals it adds little to our overall understanding of the field.

Elizabeth Prescott, when viewing the subject from the perspective of the style of buildings, narrowed the chronological focus suggested by Clay. The period 1200–1350 was noted for the

[18] Ibid., pp. 1-69.
[19] Ibid., pp. 277-337.
[20] Orme and Webster, *The English Hospital, 1070-1570*, p. 9.
[21] W. Dugdale, *Monasticon Anglicanum: A History of the Abbies and Other Monasteries, Hospitals, Friaries, and Cathedral and Collegiate Churches, with Their Dependencies, in England and Wales.*, vol. 6, part 2 (London, 1846).

infirmary hall design, followed by a shift in focus to private dwellings in the period 1350–1547.[22] This work places a marker at the Black Death. The potential impact on this type of institution must form part of any general survey or comparative study of medieval hospitals – the shock of witnessing death on a grand scale, sickness and suffering, a monumental decline in the population, and generations of families being wiped out are events that should not be underestimated.[23] The shift in building types or redesign of extant houses not only reflected concerns, arguably, with able-bodied beggars but also the treatment of the sick.

This is a point considered by one of the most prolific writers in this field – Carole Rawcliffe. In a discussion of small hospitals in Norwich, Rawcliffe noted how even though many hospitals leave only fragmentary traces in the historical record, the small houses were probably more representative of this field than their better-known counterparts. The wide-ranging services of these smaller houses catered for pilgrims, poor travellers, the sick, and the local rural poor. However, Rawcliffe noted how the provision of hospitals in Norwich was greatly reduced after 1380 and posed the question that perhaps citizens actively discriminated against sick paupers or preferred to use fewer formal systems of relief. Her closing view was that they did not appear to last long, perhaps years rather than decades.[24] Chapter Six, therefore, questions whether the Black Death had a long-lasting effect on these institutions and whether informal systems rendered their services redundant.

Both formal and informal systems of relief have been considered by historians as part of the mixed economy of care – that is care provided by individuals and a variety of institutions.[25] Within this

[22] Prescott, *The English Medieval Hospital*, pp. 5-47.
[23] See R. Horrox, *The Black Death* (Manchester, 1994) for an in-depth study; J. Hatcher, *Plague, Population and the English Economy, 1348-1530* (Basingstoke, 1977); for a global perspective see B. Campbell, *The Great Transition* (Cambridge, 2016), especially Chapter 4, pp. 267-331; J. Hatcher, 'England in the Aftermath of the Black Death', *Past and Present*, 144 (1994), pp. 3-35; R. Britnell, 'The Black Death in English Towns', *Urban History*, 21 part 2 (1994).
[24] C. Rawcliffe, 'Small Hospitals Before the Reformation', in C. Rawcliffe, *The Hospitals of Medieval Norwich* (Norwich, 1995), pp. 135-152.
[25] Horden, 'Small Beer?', p. 355; P. Horden, 'A Discipline of Relevance: The Historiography of the Later Medieval Hospital', *Social History of Medicine*, 1 (1988), pp. 359-74.

work, questions have been raised concerning the role of the parish in the provision of poor relief in the later Middle Ages. It is well known among scholars in this field that hospitals had to negotiate with parish clergy and bishops to secure permission to offer spiritual services to their inmates and visitors.[26] This study will assess the extent to which the role of the parish affected the ability of hospitals to offer their services. Were they in competition, for example, or did they complement each other? To a certain extent, this will build on Watson's work which touched upon this area by considering the types of agreement which were secured with parish officials in order to complete the foundation of a hospital in accordance with the founder's requirements.[27] It was anticipated that the evidence for the hospitals selected within this study would not permit a full analysis of their place within the mixed economy of care – informal charitable support, such as neighbourly assistance, is notoriously difficult to uncover. Nevertheless, the assessment will consider individual points of contact with the various co-providers of relief throughout the period in question – what one historian has termed 'a spectrum of overlapping agencies of relief'.[28]

It was not only the parish church and wider officialdom which could affect a hospital's ability to provide services: there were other establishments in operation which Beat Kümin has labelled sub-parochial. These comprised chapels, chantries, and fraternities, which Kümin discussed with reference to the parish.[29] These sub-parochial institutions had the potential to create strained relationships within parishes, but equally they could enhance and complement pastoral provisions – a point which became apparent after the Dissolution.[30] For instance, fraternities on occasion contributed to local building projects but also offered more specialist forms of divine service such

[26] Watson, 'Fundatio, Ordinatio and Statuta', p. 151.
[27] Ibid.
[28] Horden, 'Small Beer?', p. 356.
[29] See also: V. Bainbridge, *Gilds in the Medieval Countryside: Social and Religious Change in Cambridgeshire, c. 1350-1558* (Rochester, 1996); G. Rosser, *The Art of Solidarity in the Middle Ages: Guilds in England, 1250-1550* (Oxford, 2015); D. Postles, 'Lamps, Lights and Layfolk: "Popular" Devotion Before the Black Death', *Journal of Medieval History*, 25/2 (1999), pp. 97-114; C. Rawcliffe, 'Communities of the Living and the Dead: Hospital Confraternities in the Later Middle Ages', in J. Reinarz, T. Huguet-Termes, and C. Bonfield (eds), *Hospitals and Communities, 1100-1960* (Oxford, 2013), pp. 125-54.
[30] B. A. Kümin, *The Shaping of a Community: The Rise and Reformation of the English Parish, c. 1400-1560* (Aldershot, 1996), pp. 148-82.

as the burial and celebration of mass for their deceased members.[31] The creation of chantries often had the added benefit that a chaplain was available within a small local community to assist the parish clergy. That could take the form of educational services or the keeping of canonical hours.[32] Moreover, small chapels, perhaps in areas without a parish church, could assist in the provision of the sacraments to the sick or fulfil spiritual needs in cases of a non-resident rector.[33]

All three of these sub-parochial structures have strong links to hospitals in this period. For example, Rawcliffe has noted how in the later medieval period lay confraternities and guilds developed formal associations with hospitals, and in some instances housed them within their precincts.[34] The importance of chantry services was a point raised by Rubin who noted the dual benefit offered by hospitals comprising the prayers of the ordained and the poor.[35] Such was their significance that Alexander Hamilton Thompson observed 'at the basis of all medieval pious foundations lies the idea of continual intercession for the living and the departed'.[36] These functions will be considered in Chapter Three. The chapter will also consider the use of chapels by the hospitals in this study and if they were housed within their precincts. It is anticipated that they played an important role in the salvation of the soul of inmates and benefactors: they were so significant in royal foundations that royal hospitals were often simply termed chapels.[37] Nevertheless, it remains a point to be proved for those located in small towns and villages. A further institutional similarity can be seen in the guise of colleges. Their activities were primarily focused upon intercessory services, but it is acknowledged that this also encompassed the provision of assistance to the poor.[38] In fact, Patricia Cullum has called for historians not to draw

[31] Ibid., pp. 148-58.
[32] Ibid., pp. 159-67.
[33] Ibid., pp. 167-73.
[34] Rawcliffe, 'Communities of the Living and the Dead', pp. 125-54, at pp. 146.-8.
[35] M. Rubin, *Charity and Community in Medieval Cambridge* (Cambridge, 1987), pp. 184-92.
[36] A. H. Thompson, *The English Clergy and their Organization in the Later Middle Ages* (Oxford, 1947), p. 132.
[37] J. H. Denton, *English Royal Free Chapels 1100-1300: A Constitutional Study* (Manchester, 1970), p. 5.
[38] P. H. Cullum, 'Medieval Colleges and Charity', in C. Burgess and M. Heale (eds), *The Late Medieval College and its Context* (Woodbridge, 2008), pp. 140-53, at p. 142.

the boundaries between these types of institutions too tightly.[39] The precise nature of a hospital's functions and its *raison d'être* is a key question which this thesis explores.

Within the following analysis, the study seeks to ascertain the extent to which hospitals were intended to cater for a variety of people, not only those individuals who resided within the parish in which they were located. There is, therefore, merit in considering the role of hospitals within the parish, their relationship with other sub-parochial institutions, and how this evolved over time – there was clearly the potential for a great deal of similarity in the provision of services to the laity. But there is also merit in considering their unique potential as useful and adaptable institutions *per se*. In other words, hospitals not only had the potential to play a pivotal role within their local communities: hospitals in small towns and villages might have also played a pivotal role serving the public at large. Christopher Dyer has made the point that hospitals in small towns were of such importance that they can be viewed in a similar way to the friaries in larger towns.[40] Thus, these seemingly individually insignificant houses might have formed the backbone of a countrywide welfare structure. Consequently, this study seeks to establish who used the services of hospitals in small towns and villages, and whether hospitals were able to adapt their services to ensure that they continued to be in demand.

However, it is difficult to differentiate between small towns and villages – hence why this study does not try to do so – and they are often overlooked in the wider work of historians. For example, the work of Broadberry *et al.* has demonstrated that the urban population, while experiencing periods of significant growth and decline, never exceeded that of the rural population. Their study defined the urban population as those living in towns with a total population of more than 10,000 people.[41] Christopher Dyer, on the other hand, preferred a range of 300 to 2,000 people.[42] The Broadberry *et al.* study, thus, focused its attention upon the larger towns in the medieval period –

[39] Ibid., p. 152.
[40] Dyer, 'Small towns, 1270-1540', p. 530.
[41] S. N. Broadberry, *et al*., *British Economic Growth, 1270-1870* (Cambridge, 2015), p. 153.
[42] Dyer, 'Small towns, 1270-1540', pp. 505-37, at p. 505-6, 11.

that is to say, London, York, Bristol, Lincoln, and Norwich if Campbell's *c.* 1290 population calculations are used.[43] Using their figures, it is undeniable that the growth in larger towns in percentage terms between 1086 and 1270 was enormous: it grew by 525%. But the rural population grew by 151% from a higher base point. Thus, while the population of towns grew by 93,400 people, the rural population increased by 2,556,600 people. And when the population fell between 1290 and 1377, the urban population figures witnessed a fall of 46%, 56,400 people. Yet the rural population shrank by a remarkably similar percentage, 47%. However, the effect of the Black Death here is not comparable: the rural population fell by 2,193,600 people. Thus, the need to study hospitals in small towns and villages cannot be understated.

Margery McIntosh has calculated that there were at least 1,247 hospitals which are known to have existed in the period to 1599.[44] However, that number includes almshouses as a category of hospital – almshouses being seen as a successor to hospitals.[45] An almshouse, as defined by McIntosh, was 'a dwelling for the poor, supported by the alms or charitable gifts/bequests of others', but it was also her view that it was difficult to differentiate between hospitals and almshouses.[46] McIntosh calculated that of the houses founded prior to 1350 which continued to endure after this date, 100% were termed hospitals, whereas the figure for those founded between 1350 and 1539 falls to 40%.[47] Thus despite the stated view, there is an implication that early hospitals (*hospitalia*) were perceived as discrete and separate entities to almshouses.[48] This is relevant to the discussions herein as it is possible that the incorporation of the distinct later

[43] Campbell, 'Benchmarking', pp. 908-9.
[44] M. K. McIntosh, *Poor Relief in England, 1350-1600* (Cambridge, 2012), p. 69, total number = 242 + 1005.
[45] W. H. Godfrey, *The English Almshouse: With Some Account of its Predecessor, the Medieval Hospital* (London, 1955).
[46] McIntosh, *Poor Relief in England, 1350-1600*, p. 61.
[47] Ibid., p. 69.
[48] For a discussion of very small houses see P. H. Cullum, 'Cremetts and Corrodies: Care of the Poor and Sick at St Leonard's Hospital, York, in the Middle Ages', *Borthwick Papers*, 79 (1991), pp. 1-35; P. Cullum, 'For Pore People Harberles', in D. J. Clayton, R. G. Davies, *et al*. (eds), *Trade, Devotion and Governance: Papers in Later Medieval History* (Stroud, 1994), pp. 36-54.

medieval almshouse into calculations concerning hospitals might have skewed the results. This study will argue that the early hospital in England merits attention in its own right.

There is a definite implication in the historiography of hospitals that many struggled to endure, and as suggested by Rawcliffe these are deemed to be the smaller houses. This is a point which Max Satchell concurred with: 'The ease with which different sorts of hospitals could disappear from the historical record needs careful consideration, especially given the importance of the survival of hospital charters for indicating the existence of short-lived rural hospitals and smaller urban hospitals'.[49] Thus, there is also a tendency to associate smaller houses with small towns and villages. McIntosh noted that of the institutions in her study founded before 1350, 242 closed before 1350. That represented 34% of her sample – a not insignificant number.[50] This study will consider whether the hospitals in its remit did indeed disappear from the historical record and why this might have been. However, merely assessing the life of individual houses has received criticism. In 1985, John Guy bemoaned antiquarian approaches to the writing of hospital histories and the tunnel vision of certain writers who failed to compare their studies to other houses or place their hospitals into a local or national context. His study, aptly entitled 'Of the Writing of Hospital History there is No End', criticised endless chronological pieces of writing which listed names and gifts.[51]

One of the ways in which historians have sought to overcome this problem is by compiling regional studies.[52] This approach has the added benefit of offering a corrective to the lists compiled by K&H owing to the specialist local knowledge which is required to produce such a comprehensive study. One such example is the general study of Orme and Webster which considered a variety of hospital themes such as education or inmates and is seen as a successor to

[49] Satchell, 'The Rural Hospital in England', pp. 251-2.
[50] McIntosh, *Poor Relief in England, 1350-1600*, p. 69.
[51] J. Guy, 'Of the Writing of Hospital History there is no End', *Bulletin of the History of Medicine*, 59 (1985), pp. 415-20.
[52] See for an example Sweetinburgh, *The Role of the Hospital in Medieval England* which considered hospitals in Kent and Cullum, 'Hospitals and Charitable Provision in Medieval Yorkshire'.

the work of Clay. However, as a general study it is unable to provide an in-depth appraisal of their wide-ranging themes. The second half of their book comprised a regional study of Cornwall and Devon which aimed to rectify this imbalance, but the wealth of detailed information concerning each known hospital in this region, helpfully listed at the rear of the work, feels under-explored in the relation to the earlier thematic chapters.[53] Thus, this study has a smaller number of hospitals to compare and contrast, and fewer themes. This permits an in-depth analysis of the external threats these houses faced, such as legislation and competition, in respect to their functions. This in turn permits an appraisal of their longevity. Functions can relate to the services hospitals provided but also to their operations and ability to supply those services.

Notwithstanding Guy's point, other regional studies have also received criticism. Rubin's analysis of the provision of charity in Cambridgeshire is valued for setting a regional study in a European context. Yet, much of the discussion is focused upon the better documented hospital of St John in Cambridge – a general problem within the ongoing scholarship which Peregrine Horden called to be addressed in 1988.[54] Horden emphasised the point that a discipline of relevance is 'one in which appropriate comparisons are drawn' and suggested that regional studies did not necessarily achieve this.[55] Nevertheless, the idea of a regional study endures, and it endures in recent years through the consideration of European houses.[56] For example, as recently as 2018 Sally Mayall Brasher published a regional study of hospitals in northern Italy primarily in the Lombard region.[57] And during the final stages of this project, Davis published a regional study of hospitals in the Champagne region of France.[58] This study of hospitals in the twelfth and

[53] Orme and Webster, *The English Hospital, 1070-1570*, pp. 169-266, quote at p. 185.
[54] Rubin, *Charity and Community in Medieval Cambridge*; Horden, 'A Discipline of Relevance', pp. 359-74.
[55] Horden, 'A Discipline of Relevance', p. 365.
[56] J. W, Brodman, *Charity & Religion in Medieval Europe* (Washington, 2009), see Chapter Two pp. 45-88 for a useful overview.
[57] S. M. Brasher, *Hospitals and Charity: Religious Culture and Civic Life in Medieval Northern Italy* (Manchester, 2017).
[58] A. J. Davis, *The Medieval Economy of Salvation: Charity, Commerce, and the Rise of the Hospital*, (London, 2019).

thirteenth centuries built upon his earlier work and explored the relationship between the commercial revolution and the explosion of hospital foundations at this time.[59]

Another widely-anticipated book is Watson's forthcoming publication which explores the relationship between hospitals and Western law – a book which, unfortunately, this study could not engage with.[60] Nevertheless, Watson's earlier contributions to the field which encompassed both urban and national studies were studies which this project sought to build upon.[61] That work comprised in the first instance a doctoral thesis, followed by an award-winning article.[62] By analysing foundation charters and ordinances created as part of the foundation process and subsequent corrections issued following episcopal or royal visitations in the period to 1300, Watson demonstrated that hospitals were discrete legal entities. This is an important point which needs to be emphasised – Watson argued for the very physicality of a hospital, that it was not just a concept.[63] Furthermore, the study differentiated hospitals from monasteries: monasteries had a specified internal vision and spiritual identity, whereas hospitals had a form and use created by a founder and enforced by subsequent patrons. The role of the founder was to acquire a site, provide an endowment, and specify a use for that endowment. However, Watson's work only considered patrons, estates, general management, and the internal life of a hospital in so far as they related to its constitution – she was not concerned with 'how they were understood'.[64] Subsequent patrons could amend the founding vision but not significantly alter it. Nonetheless, the questions of how these houses were perceived, used, and the potential for perhaps cunning or creative manipulation of these founding visions are points which will be examined.

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[59] A. J. Davis, 'The Economic Power of a Hospital in Thirteenth-Century Provins', in K. J. Janson, G. Geltner, and A. E. Lester (eds), *Center and Periphery: Studies on Power in the Medieval World in Honor of William Chester Jordan* (Leiden, 2013), pp. 121-34; A. J. Davis, 'Hospitals, Charity, and the Culture of Compassion in the Twelfth and Thirteenth Centuries', in S. A. Falmer (ed.), *Approaches to Poverty in Medieval Europe* (Turnhout, 2006), pp. 23-41; Davis, 'The Social and Religious Meanings of Charity in Medieval Europe', pp. 935-50.
[60] Forthcoming, S. Watson, *On Hospitals: Welfare, Law, and Christianity in Western Europe, 400-1320* (Oxford, 2020).
[61] Watson, 'City as Charter', pp. 235-62.
[62] Watson, 'Fundatio, Ordinatio and Statuta'; Watson, 'The Origins of the English Hospital', pp. 75-94.
[63] Watson, 'The Origins of the English Hospital', p. 78.
[64] Watson, 'Fundatio, Ordinatio and Statuta', quotation p. 24, see also pp. 77-117, 269.

Over time, Watson did note that the provision of spiritual services greatly increased, but that a hospital's primary duty was not replaced. This, for example, differed from a monastery whose patrons were not formally able to influence its duties, personnel, or use of resources. As part of her research, consideration was given to economic forces and external threats and the response of patrons, but this was very brief in nature owing to the aforementioned focus of the thesis.[65] It is the view of this study that this merits further attention in order to assess the pivotal factors at play regarding a hospital's ability to endure. Watson's study was predominantly concerned with rules and regulations issued in the period to *c*. 1300, whereas this study is mostly concerned with the provision of hospital services and the people who came into contact with these houses in the period to *c*. 1450. Watson identified the importance of the will of the founder. When, for example, a bishop carried out a visitation, one of his first acts was to establish that will – whether that be in manuscript form or using local knowledge.[66]

The founding documentation and subsequent amendments were undoubtedly of importance; however as noted above, this study further probes the extent to which they reflected what actually happened. To gain an insight into these matters, a wider selection of primary source material needs to be employed, and, thus, this will form a key aspect of this study. These sources permit the study of subsequent hospital patrons and their patronage rights. In general, this is an area which remains not fully explored.[67] Sweetinburgh considered royal patrons in Kent but largely in a regional context which focused upon the gift and counter-gift, and this was predominantly based upon a post-mortem relationship rather than an in *vita* one.[68] And Rawcliffe further probed the

[65] Ibid., pp. 167, 204, 224.
[66] Ibid., pp. 59-62.
[67] Orme and Webster, *The English Hospital, 1070-1570* contains brief overviews at pp. 75-8.
[68] S. Sweetinburgh, 'Royal Patrons and Local Benefactors: The Experience of the Hospitals of St Mary at Ospringe and Dover in the Thirteenth Century', in J. E. Burton and E. Jamroziak (eds), *Religious and Laity in Western Europe, 1000-1400* (Turnhout, 2010), pp. 111-29; Sweetinburgh, *The Role of the Hospital in Medieval England.*

relationship through motives such as social display in the form of the actual buildings and, in Europe, pieces of art.[69]

Patronage is a prime example of an area in which additional work can be undertaken in order to contribute to scholarship to date concerning contemporary institutions and broader historical thematic debates – a point of which Guy would doubtless approve. For example, Susan Wood's work concerning patronage and monastic houses suggested that patrons could also support houses through general assistance or by indulgences.[70] Another fruitful line of inquiry which will be undertaken is to consider the findings of Karen Stöber and Benjamin Thompson who both concluded that the king and upper levels of the aristocracy took little or no interest in the less valuable monastic houses.[71] Finally, a further area of comparison to the wider field of study will be the relationship between the Crown and patronage rights in the form of advowsons in the thirteenth century. This has been explored in depth by Elizabeth Gemmill, but this work did not concern these rights with reference to hospitals. Advowsons were valuable to patrons as ways of rewarding loyal servants (through their presentation to parish churches) and as such were taken seriously by patrons.[72] Chapter Four of this study places both the founders and subsequent legal patrons of hospitals in small towns and villages in the spotlight, whereas Chapters Five and Six consider specific internal and external threats which, understandably, might have caused hospitals to draw on the support of their patrons.

It is now over 30 years since Horden drew attention to the need to consider the lesser-known hospitals within this field: 'If we are to understand the later medieval hospital – and, indeed, the

[69] C. Rawcliffe, 'A Word from Our Sponsor': Advertising the Patron in the Medieval Hospital', in J. Henderson, P. Horden, and A. Pastore (eds), *The Impact of Hospitals 300-2000* (Oxford, 2007), pp. 167-93; see also C. Rawcliffe, *Medicine for the Soul: The Life, Death and Resurrection of an English Medieval Hospital, St Giles's, Norwich, c. 1249-1550* (Stroud, 1999), pp. 115-9.
[70] S. Wood, *English Monasteries and their Patrons in the Thirteenth Century* (London, 1955), pp. 136-60.
[71] B. Thompson, 'Monasteries and their Patrons at Foundation and Dissolution: The Alexander Prize Essay, Proxime Accessit', *Transactions of the Royal Historical Society*, 4 (1994), pp. 103-25; K. Stöber, *Late Medieval Monasteries and their Patrons: England and Wales, c. 1300-1540* (Woodbridge, 2007), pp. 27-8.
[72] E. Gemmill, *The Nobility and Ecclesiastical Patronage in Thirteenth-Century England* (Woodbridge, 2013).

hospital in earlier centuries too – it is with St John's, not S. Maria Nuova, that we must first come to terms'.[73] It is still, in the view of the present project, an area which is unclear. There is, too, as has been implied throughout this chapter by means of the ranking systems and urban-centric focus of studies, an implication in the historiography that hospitals located in small towns and villages were inferior to houses located in larger urban areas – to recap, 'the obscure places at the base of the urban hierarchy'.[74] Rawcliffe has explored 'small' hospitals located in Norfolk and suburban hospitals with a particular focus on the larger centres of Bristol, Norwich, and London.[75] And Satchell has considered 67 definitively rural hospitals from a topographical perspective.[76] But these studies are rare. Within broader discussions, statements such as 'Even a town of a mere 1500 inhabitants like Whittlesey (Cambs.) could accommodate ten fraternities and a single church' add to the general inference that the larger the area, the better the services.[77]

This thesis will argue that these houses, and of course especially those located in small towns and villages, be more fully incorporated into broader thematic debates – that they be taken seriously as a group of religious houses which were of fundamental importance to medieval society. It is true to say that hospitals are becoming more prominent within thematic discussions, but there is much still to be done. One recent example is a doctoral thesis which considered how indulgences functioned within England and devoted a whole section to the role of hospitals within its analysis.[78] Yet the point Davis raised in 2014 that medieval charity was not just an urban phenomenon, it was a rural one too, still stands: more work needs to be undertaken in this area 'despite the challenges of finding source material'.[79] This study hopes to contribute to the aforementioned challenges and the plea of Horden by looking at a sample of the oft-overlooked

[73] Horden, 'A Discipline of Relevance', at p. 366.
[74] Campbell, 'Benchmarking', p. 907.
[75] C. Rawcliffe, 'The Earthly and Spiritual Topography of Suburban Hospitals', in K. Giles and C. Dyer (eds), *Town and Country in the Middle Ages: Contrasts, Contacts and Interconnections, 1100-1500* (Leeds, 2005), pp. 251-74; Rawcliffe, 'Small Hospitals Before the Reformation', pp. 135-152.
[76] Satchell, 'The Rural Hospital in England', pp. 237-56.
[77] Kümin, *The Shaping of a Community*, p. 151.
[78] A. Brodeur, 'Indulgences and Solidarity in the Later Middle Ages' (DPhil Thesis, University of Toronto, 2015), pp. 115-57.
[79] Davis, 'The Social and Religious Meanings of Charity in Medieval Europe', p. 944.

hospitals. The project therefore relied heavily upon the sample-selection method to avoid inadvertently drawing evidence from a wide range of hospitals to suit its arguments; it is to that method that this chapter now turns.

II: Sample Selection, Sources, and Data Management

One of the first problems historians face when trying to answer research questions concerning medieval English hospitals is – where to start? A single cursory glance at the data contained within the listing of K&H can strike fear in the heart of even the intrepid researcher.[80] The original work published in 1953 is littered with question marks with reference to dates, hospitals noted in italics owing to the uncertainty surrounding their existence, and questions concerning whether the hospital was dependent upon another religious house.[81] In 1957, additions and corrections were published; the overwhelming majority related to hospitals.[82] The impossible nature of the task is palpable within the text with additional contributions being kindly proffered by individuals who had access to local records that were not widely known. For example, Mary Fair provided information concerning a hospital in Ravenglass based on her photostat of a charter.[83] The use of this type of material is, therefore, not without risk. Orme and Webster voiced their scepticism in 1995 when using the K&H list in both their general survey of hospitals and their regional work: 'This has been widely used by scholars as a basis for constructing statistics of hospital numbers and their fluctuations at different periods. In fact, the list presents a temptation rather than an opportunity, for it falls short of an accurate census in several respects'.[84] They then proceeded to note the errors which they identified as part of their detailed local study of Cornwall and Devon but used the K&H listings to provide statistics nonetheless.[85]

[80] K&H, *Medieval Religious Houses* (1971).
[81] Ibid., pp. 250-324.
[82] K&H, 'Additions and Corrections', pp. 60-87.
[83] Ibid., p. 82.
[84] Orme and Webster, *The English Hospital, 1070-1570*, p. 10.
[85] Ibid., pp. 10-11.

However, this problem should not preclude the study of these frequently elusive institutions. Thus, a selection method was required which would fulfil the aim of this study: to compare and contrast a manageable selection of independent hospitals located outside larger towns and cities, and not necessarily located in the same region, in order to address the aforementioned problem in the historiography. Again, this simple objective is difficult to achieve. In the first instance, there is the ever-present problem of changing population sizes, fluctuating levels of urban wealth, towns which move up and down urban ranking tables, towns recorded with or without their suburbs in those rankings, incomplete or inconsistently compiled results or returns, and even hospitals which were relocated. Clearly decisions were required at every juncture of the sample-selection process. Acknowledging the inherent weaknesses in any listing of hospitals and sample-selection method, this study based its sample, in the first instance, upon the work of Clay: a pioneer in the study of hospitals and whose work is presented by county in a clear and simple format.[86] Clay's listing placed an emphasis on the founder and patron as opposed to the rather cluttered work of K&H which is difficult to navigate and emphasised associations with other religious houses and hospital types: two aspects of the historiography with which this study is not overtly concerned – the preoccupation with the need to constantly label and classify hospitals by inmate being deemed one of the key weaknesses within that historiography. In addition, K&H did not record the founder or patron, instead they referred the reader to the work of Clay and the *Victoria County History Series* (*VCH*).

Data were extracted from Appendix I of Clay's work and entered into a spreadsheet. This was then matched to the K&H data to search for omissions or amended entries. For example, Clay recorded Bawtry, and K&H amended this to Martin-by-Bawtry.[87] The information was compared to the 1334 ranking-of-towns-by-taxable-wealth list compiled by Alan Dyer; towns located in the top 100 were removed in order to divert attention away from wealthier towns.[88] The results were

[86] Clay, *The Mediaeval Hospitals of England*, pp. 278-337.
[87] Ibid., p. 312; K&H, *Medieval Religious Houses* (1953), p. 290.
[88] A. Dyer, 'Ranking of Towns by Taxable Wealth: The Subsidy of 1334', pp. 747-70.

then checked against Campbell's *c*. 1290 population-figure rankings (64 in total) as implied by the number of tax payers in 1327/32 and 1377.[89] As discussed at the start of this chapter, the results should highlight areas which had not achieved significant amounts of growth in wealth or population size.[90] Hospitals in Middlesex were excluded from the sample owing to their close proximity to London. Hospitals known to be in Cinque Port areas or Durham or Cheshire, which met the selection criteria at this point, were added to the list as they were excluded from the 1334 listing.

Leper hospitals were removed from the sample (as identified by Clay) as they are often considered in isolation from the main body of hospitals, and there is excellent specialist work in this area.[91] However, it is acknowledged that leper houses catered for non-lepers and *vice versa*, and as leprosy died out it is certainly true that their role in society changed or they simply disappeared – hospitals were not static entities.[92] Nevertheless, there does appear to be an accepted difference between these houses, if perhaps an unwitting acceptance. For example, the recent work of Davis repeatedly referred to 'hospitals and leper houses' as though in his mind they were different.[93] Clay, as discussed, regarded them as a distinct category too. For this study, the fact that there were on occasion two hospitals in a small town or village – for instance at Brackley, one specifically noted as a leper house and the other not, the hospital of St Leonard being the former – adds some weight to this idea.[94] In addition, the separate word, *leprosaria*, may prove to be of relevance in future debates and research. Indeed a rare piece of directly relevant canon law – canon 17 of the Council of Vienne which commenced in 1311 and is known as the decretal *Quia*

[89] Campbell, 'Benchmarking', pp. 908-9.
[90] A. Dyer, *Decline and Growth in English Towns, 1400-1640* (Cambridge, 1995), pp. 29-42; J. F. Hadwin, 'The Medieval Lay Subsidies and Economic History', *English Historical Review*, 36 (1983), pp. 200-17; P. Nightingale, 'The Lay Subsidies and the Distribution of Wealth in Medieval England, 1275-1334', *The Economic History Review*, 57/1 (2004), pp. 1-32; P. J. P. Goldberg, 'Urban Identity and the Poll Taxes of 1377, 1379, and 1381', *The Economic History Review*, 43/2 (1990), pp. 194-216; C. Briggs, 'Taxation, Warfare, and the Early Fourteenth Century 'Crisis' in the North: Cumberland Lay Subsidies, 1332-1348', *The Economic History Review*, 58/4 (2005), pp. 639-72.
[91] C. Rawcliffe, *Leprosy in Medieval England* (Woodbridge, 2006); M. Satchell, 'The Emergence of Leper Houses in Medieval England, 1100-1250' (DPhil Thesis, The University of Oxford, 1998).
[92] Rawcliffe, *Leprosy in Medieval England*, p. 44.
[93] Davis, *The Medieval Economy of Salvation*, pp. 2, 3, 14, 22, 23, and 26.
[94] Clay, *The Mediaeval Hospitals of England*, p. 309.

contingit – identified four separate institutions: '*Quia contingit interdum quod xenodochiorum, leprosariarum, eleemosynariarum seu hospitalium rectores...negligunt*'. Here, then, those in charge of places for strangers, leper houses, almshouses, and hospitals stood separately accused of disregarding these different institutions.[95] This study will only concern itself with *hospitalia*. The 194 leper houses identified by Clay as being in small towns and villages were removed from the list of houses under review.

The data were further reduced by removing hospitals noted as being in rural locations by Satchell.[96] This topographical analysis concerned 67 definitely rural hospitals, that is to say hospitals located in excess of a three-mile radius of a town and which were not named after a town.[97] The significance of this extraction from the sample can be found in the introduction to this chapter; but to briefly recap, the hospitals in this sample are designed to represent independent houses in the vicinity of trading areas or lesser-trading areas in their own right. Independent is taken to mean that these houses were not formally associated with a monastic rule and house on foundation. A point which will be explored is whether their patrons had the potential to continue to significantly influence their operations in the post-foundation period.

All hospitals located within the same town or vill as another religious house, except for another hospital, were removed from the sample to provide a manageable number of houses to research. This work was based upon the *VCH* religious-house volumes, and maps were consulted as an additional visual check.[98] Again, the inherent difficulties within this method are acknowledged due to the number of hospitals and religious houses under consideration, coupled with the variations in the recording and spelling of hospital locations. Further consideration was also given to Clay's and K&H's suggestions that the hospitals were dependent on another religious house.

[95] *Corpus Iuris Canonici*, vol. 2, eds E. Friedberg and A. L. Richter, (Leipzig, 1879), pp. 1170-1.
[96] Satchell, 'The Rural Hospital in England'.
[97] Ibid, p. 237.
[98] The bibliography contains a comprehensive list of the *VCH* volumes consulted but in the main the relevant county volume was volume two. *Ordinance Survey Map of Monastic Britain: North Sheet* (Southampton, 1955); *Ordinance Survey Map of Monastic Britain: South Sheet* (Southampton, 1954).

If a house was clearly dependent on an abbey, for example it was founded by an abbot and there was no initial reference to any external influences, or the evidence was ambiguous, it was excluded from the study.[99]

Finally, all those hospitals founded post-1279 were removed. The year 1279 is deemed to be of particular relevance to the history of the English hospital as it was the year in which the Statute of Mortmain was enacted.[100] Part of the statute was intended to prohibit the alienation of lands to religious houses and thereby protect the Crown's entitlement to feudal services and incidents.[101] In reality, the system quickly evolved to licence the alienation of land, often following an *ad quod damnum* inquisition held in order to ascertain the potential damage to the Crown or lord's interests.[102] Sandra Raban's work in this area has demonstrated that religious houses experienced a reduction in the growth of gifts of land following 1279 and that religious received less than 50% of the newly granted licences, with hospitals being the main beneficiaries.[103] Chapter Five explores the effect of this legislation on the hospitals within this study.

The sample-selection work was completed in a spreadsheet to maintain an audit trail as each step was undertaken. Although every attempt was made to ensure that the sample-selection method was reasonable in the light of the study's objectives, it is a possibility that additional information may come to light, and an argument could be made that a hospital should or should not have been included within this study. Given the fleeting nature of some religious houses, evolving definitions of what exactly constituted a town, the period of time under consideration, dependency debates, and the timing and associated extent of that subordination, an omission is unlikely to have had a material effect on the results of this study – i.e. an impact which would distort the reader's view of the results.

[99] This study adopts the approach used by Watson that regards hospitals as a distinct category of house that did not emerge out of monastic houses, see Watson, 'The Origins of the English Hospital'.
[100] *Statutes of the Realm*, vol. 1 (London, 1810), p. 52.
[101] Gemmill, *The Nobility and Ecclesiastical Patronage*, pp. 149-56.
[102] Ibid., p. 151.
[103] S. Raban, *Mortmain Legislation and the English Church, 1279-1500* (Cambridge, 1982), p. 169.

This method produced a sample of 72 hospitals which was deemed to be a manageable number for a project of this type. Full details can be found in Appendix I.[104] The final list was then compared to the tax paying numbers in the 1377 Poll Tax returns to ensure none of the hospitals were located in towns with an excess of 500 taxpayers – i.e. they were potentially in areas containing less lay wealth.[105] And, as noted earlier in this chapter, the sample was also compared to the *c*. 1290 population figures to ensure that the sample comprised places which are thought to have had a population of less than 2,000 people – that is to say small towns and villages.[106] The final sample also represented a good geographical spread as depicted in Appendix II. This was an added bonus as one desired objective of the present project was to meet Horden's request that hospitals as widely spread as possible be juxtaposed.[107] The random-sample method described above, albeit with certain restrictions, could have produced a sample, for example, whereby the hospitals were all located in the Midlands region. On occasion, however, within the ensuing discussions it will be necessary to cite evidence from hospitals which did not form part of this project sample in order to shed light on contemporary thinking and use of hospitals where the evidence herein is difficult to decipher owing to its fragmentary nature. When this occurs, it is clearly signposted as such. One of the purposes of selecting a sample in the manner thus described is that it avoids the risk of cherry-picking examples to fit an argument.

Having selected the sample, a review of the primary source material was undertaken using a variety of finding aids but especially online search engines of archival repositories.[108] The objective was to classify sources in order to answer the research questions concerning the

[104] It could be argued that one hospital, Ivychurch, should be removed from the sample as Clay might have made a typing error. See Appendix I. The database entry method produced a date of 1280 and the decision was made not to remove the house from the sample – given the nature of the evidence concerning these hospitals in general and the overall aim of the study it was felt that this would not be detrimental to the results of the study. In addition, K&H recorded the date as 1229.
[105] A. Dyer, 'Ranking of Towns by Taxable Wealth: The Subsidy of 1334', pp. 747-70, at pp. 758-60.
[106] Campbell, 'Benchmarking', pp. 908-9.
[107] Horden, 'A Discipline of Relevance', p. 365.
[108] For example, The National Archives at www.nationalarchives.gov.uk provided a useful entry point and has continued to evolve throughout the course of the present project, as did Medieval and Early Modern Sources Online at www.tannerritchie.com/memso.php. For bishops' registers see D. M. Smith (ed.), *Guide to Bishops' Registers of England and Wales* (London, 1981) brought up to date in D. M. Smith (ed.), *Supplement to the Guide to Bishops' Registers* (London, 2004).

longevity of hospitals and their functions. The most notable body of evidence yielded by these searches was deeds of gifts, usually in the form of local land holdings, although the searches also outlined a variety of alternative manuscript source material such as indulgences and mortmain licences. In addition, a search of the printed bishops' registers was undertaken based upon the *Guide to Bishops' Registers of England and Wales* in conjunction with university search engines.[109] This evidence combined with the evidence recorded within the calendars of Close and Patent Rolls, *ad quod damnum* inquisitions, and inquisitions post mortem was recorded by hospital and by county and then allocated a unique reference number. Online searches of archaeological evidence were also performed, and this proved to be a vital source of information, most especially in Chapter Three.[110]

Hospitals were then grouped by the amount of identified primary source material into three groups in order to facilitate further analysis and manage the project: those groups were labelled Core, Semi-Core, and Ancillary. The Core group represented seven hospitals for which the primary source material is varied and contained, for example, several deeds or rich archaeological evidence; the Semi-Core group comprised eighteen hospitals with a variety of material but not in large quantities when compared to the Core group; and the Ancillary group contained the remaining sample for which it was expected only an occasional manuscript or note in a calendar survived. Further information came to light throughout the project, such as entries in printed chronicles or transcripts of primary source material in printed antiquarian works, and these were also logged using the same procedure. The aim was to ensure as wider coverage as possible to answer the two key research questions posed for this study.

A relational database was designed and constructed to manage two specific aspects of the project. In the first instance, summaries of the copious deeds and charters housed at Magdalen College,

[109] Smith, *Guide to Bishops' Registers of England and Wales*; Search Oxford Libraries Online, https://www.solo.bodleian.ox.ac.uk.
[110] For example, The Archaeological Data Service at https://archaeologydataservice.ac.uk; Taylor Francis Online https://www.tandfonline.com for online journals.

Oxford, in respect of the hospitals located at Aynho and Brackley were reviewed using the detailed calendars of William Dunn Macray. These unpublished calendars are also housed in Magdalen College and comprise a detailed overview of each deed in English. Each entry lists the manuscript's original reference number, the sequential manuscript number within the calendar (which is given in all citations herein as No. x), Macray's estimated date if a precise date was not available, and a summary of the original manuscript content. There are in excess of 1,300 manuscripts in the collection which can be dated within the core period of this study (1150-1450); however, when a piece of evidence was deemed of pivotal importance, it was consulted in the original form.[111]

The data-entry process occurred at the start of the project, and, thus, potentially relevant data to the research questions were extracted from Macray's summaries – for example: witness names, locations, evidence of seals, pricing, location information, type of gift, the nature of the document (as not all of the documents were property deeds), financial consideration, whether the document was created by the hospital, who the contracting parties were, and the reason why the grant was made. This analysis of the hospitals' series of documents underpins the ensuing discussions concerning the mortmain legislation of 1279. Further information derived from other sources, which can be linked back to the two hospitals through its hospital master data table and the overall design of the database, was entered into the relevant tables with the remaining hospitals. The database, then, was designed in such a way as to facilitate a variety of analyses of the 72 hospitals in the total sample for which, in most instances, rather less evidence has survived the passage of time. This centred around a unique hospital number (a Hospital Standing-Data table) and existing collated primary source material. For example, information concerning the masters listed in the *VCH* religious house volumes, mortmain licences and letters of protection contained in the *CPRs*,

[111] Macray's calendars were of assistance during the process as a guide, as were the dictionaries and reference guides listed in the bibliography. In addition, Macray's summaries were useful when manuscripts had deteriorated in quality over recent decades.

information concerning the existence of markets or fairs, the online *Taxatio* database of 1291 extracts, and the 1334 lay subsidy data were entered against each hospital in the database.[112]

Information concerning the nature of the material or data entry rules were recorded in the Design View option. The tables were linked using either the unique hospital reference number or unique document numbers. In order to avoid logical errors and to protect the database, options such as Enforce Referential Integrity were deployed which, for example, created a rule that a deed could only be allocated against a code from the Hospital Parent table. Other examples included the existence of a valid deed number to enter an individual in the Witness table or a rule which prohibited duplicate manuscript numbers in the Deeds table. To facilitate this type of process, various drop-down menus, check boxes, and bespoke data input forms were also created. It is a simple and therefore robust design which at its core was based upon accounting-system structures but tailored for the specific needs of academic study. These tables were then combined using the query functionality within the software to compare, for example, longevity and mortmain-licence occurrences, or longevity by founding-patron type. The queries were exported into spreadsheets and converted into the graphs and charts which are discussed throughout this thesis.

Two sets of appendices, or data-input forms with referenced primary source material per hospital, were compiled as part of this project. A 'start appendix' and 'end appendix' contain detailed information concerning the start and end dates of these houses, information regarding their patrons, refoundation dates, pivotal moments in their history, and attempts to gauge the status of their patrons. These two appendices totalled more than 20,000 words and, therefore, could not be incorporated within this document. However, a summary of the key database entry information and evidence of significance to the study has been summarised and is contained within Appendix I. The purpose of the appendices is twofold. In the first instance, they provide a hard copy (and

[112] 'Gazetteer of Markets and Fairs in England and Wales to 1516', http://www.history.ac.uk/cmh/gaz/gazweb2.html (29 June 2018); *The Lay Subsidy of 1334*, ed. Glasscock; Taxatio Database, University of Sheffield, https://www.dhi.ac.uk/taxatio.

therefore permanent and futureproofed) record of the decisions made concerning data which were entered into a database. Secondly, as the data were drawn from a wide range of primary source material this method of recording the evidence facilitated the data management process.

The starting point of the decision-making process, with reference to start and end dates, were the data contained within the work of Clay, K&H, Watson, and the *VCH* series. To a certain extent, it could be argued that this is merely repeating existing work. However, it quickly became apparent that the outputs of the aforementioned work were not consistent nor fully documented, and thus reliance solely upon this work risked invalidating the database outputs. For example, Table 2 is an extract from the Detailed End Appendix for the hospital at Bagby which demonstrates the discrepancies in the scholarship to date. It clearly shows that there is doubt as to whether this remained an independent hospital, and there is disagreement as to when it ceased to function. Upon further investigation, the *VCH* date information was based upon Dugdale's work and appears to be a typing error – Dugdale's date is 1200 not 1290.[113] Thus, the decision was made to use the verifiable date of independent operation being 1200. Where an example such as this occurred, it is clearly marked against the hospital in Appendix I.

Table 2: Extract Concerning Bagby Hospital from the Detailed End Appendix

Source	**Key Event**	**Dependency**	**Patron**	**Year**
K&H 1953*/1957*		St Leonard's Hospital, York		16 c.?
K&H 1971	Not extant 1535	St Leonard's Hospital, York		-1535
VCH	1974 farmhouse at Spittle Hill			1290
Database decision			**Unknown**	1200 = **1200**

In order to prepare the charts and graphs which are contained within this thesis, a method was required to standardise the start and end dates which were entered in the database and ultimately exported into the spreadsheet package to create the figures. This is due to the timespan of the study, the number of start and end years, and for the ancillary houses a lack of evidence. The

[113] Dugdale, *Monasticon Anglicanum*, vol. 6, part 2, p. 780.

method used replicated in part that used by McIntosh; the following table provides a summary of the decision-making process used to establish the entry date. Without such a process, the charts would be so detailed as to become incomprehensible.

Table 3: Database Foundation and Closing Date Rules (Based on McIntosh) [114]

Foundation or end date example (Or date of first/last reference)	**Date entered into project database**
1427	1420
c. 1427	1420
Pre 1427	1410
Post 1427	1430
Pre 14th Century	1250
Post 14th Century	1450
Between Two Dates	Mid-Decade

Checking the data against the amalgamated uniquely referenced evidence was a time-consuming process, and to a certain extent the attached appendix does not reflect this as it appears in a summarised form. The exercise was not merely a question of mining sources for the last-known date: consideration was given to the individual circumstances of each house, whether the data appeared to be reasonable in light of all of the available evidence, and the fact that the terminology employed could be fluid. As discussed above, as hospitals began to tailor their services within their founding guidelines they were often referred to as, for example, hospital or chapel. Nevertheless, the predominating description within the source material and the history of the site usually settled the issue. Validating the data even if only to demonstrate that it can be relied upon (i.e. amendments were not required) was deemed to be necessary to add credence to the database outputs which are incorporated within this thesis.

One of the central problems faced when undertaking an analysis of this type is the difficulty in pinpointing the actual foundation and dissolution dates which provide the basis for further discussion concerning the longevity of these houses. Watson's thesis argued the case that the foundation process took place over several years with the founders' heirs often continuing the

[114] McIntosh's methods are contained in Appendix 1 of McIntosh, *Poor Relief in England, 1350-1600* at https://www.cambridge.org/files/8313/6680/3708/online_appendix_1.pdf (18 May 2019).

said process. To recap: the process comprised acquiring a site, providing an endowment, and specifying a use for that endowment.[115] The hospital at Clyst in Devon is a case in point which also demonstrates that this foundation method continued into the fourteenth century. Although Orme and Webster noted the foundation date as 1309–12 and attributed it to Walter Stapledon, bishop of Exeter, this study, and that of Clay and K&H, took the view that the originating decision of Walter Bronescombe of 1276 is the key date.[116] This follows Watson's format that the foundation process could take place over several years and generations – that is to say, securing the site and endowment could take time as permissions to do so were obtained. For other hospitals, the foundation ordinances and statutes have not, it is assumed, survived the passage of time; alternatively, of course, they were not always made. In cases which lack officially documented foundation and refoundation ordinances, or subsequent patronal amendments to regulations, fleeting glimpses of these houses contained within the historical record must be scrutinised for the valuable insights they reveal into these frequently elusive institutions.

Closure dates are often equally difficult to establish. For example, if the hospital ceased to exist prior to the compilation of the *Valor Ecclesiasticus* survey in 1535 or the survey of chantries in 1547, it is sometimes difficult to ascertain precisely when it ceased to function (and even in the cases of the aforementioned surveys it is not always clear cut as Appendix I demonstrates). It is from time to time the case that the final piece of documentary evidence (for earlier dates of last reference) is that contained within the bishops' registers (i.e. the institution of masters or records of visitation findings). Wherever possible, this study sought to adhere to Watson's technical definition. The problem of when was a hospital a hospital and when was it just a chapel with non-resident masters is considered in Chapter Three.

[115] Watson, 'Fundatio, Ordinatio and Statuta', pp. 79-84.
[116] Orme and Webster, *The English Hospital, 1070-1570*; K&H, *Medieval Religious Houses*; Clay, *The Mediaeval Hospitals of England*, p. 286.

This method combined a quantitative and qualitative approach to the data in the selected sample. It permitted the comparison of 72 hospitals over 300 years which comprised houses with voluminous data and those with scant records. The primary source material was diverse, and this facilitated consideration of various themes and debates throughout the coming chapters. The core data comprised a mix of property deeds (local administrative records which were largely land and building transactions, but these could take the form of gifts, confirmations, quit claims, or leases), records of central government, and printed bishops' registers. The deeds and other local agreements such as corrodies touched upon unexpected aspects of an individual's relationship with a house. There is some debate as to what extent the witness lists can be relied upon, but these too provided useful information concerning, for example, family relationships or whether local members of the church had contact with these hospitals.[117] The manuscripts were scattered across various archives as noted in the bibliography. However, the majority which were consulted related to the hospitals at Aynho and Brackley – two hospitals which have received little scholarly attention. Those manuscripts were consulted for key parts of this study and used to verify the information contained within Macray's summary calendars. Within this thesis, extracts of the transcripts are provided to elucidate important points. Omitted letters are provided within square brackets.

The calendared and/or published records of central government which were incorporated into the research contain a wealth of information, especially for those houses which have fragmentary or non-existent local material. The letters of protection, for example, revealed a hospital existed, and that can be a ground-breaking piece of evidence, and that it needed assistance. Grants of mortmain licences can be compared to local detailed manuscript evidence – and perhaps more importantly add credence to those local records. On occasion, the sixteenth-century Patent Rolls, Letters and Papers of Henry VIII, and the *Valor Ecclesiasticus* yielded useful assistance in the attempt to calculate the longevity of a house. Printed bishops' registers elucidated a great deal of

[117] E. Gemmill, 'The King's Companions: The Evidence of Royal Charter Witness Lists from the Reign of Edward I', *Bulletin of the John Rylands University Library of Manchester*, 83/3 (2001), pp. 129-46.

untapped internal procedural information – or lack of procedures – as well as insights into the broader problems which these hospitals faced. The sources, although widely available for many years, can reveal worthwhile new findings. A study such as this which relies upon the accumulation of varied sources would not be possible without these publications. Furthermore, when they are combined with other source material, they can unravel historical events which individual sources cannot. Thus, the results of this research were often surprisingly enlightening. Finally, these sources were reviewed for counter evidence to ensure that any concluding claims made by this study did not misrepresent that evidence.

In a similar way, it was deemed necessary to reconsider many of the data contained within the *VCH* series in light of new debates which have emerged in recent years and changes in the approaches to the writing of history. The same reasoning applied to the use of printed antiquarian works which also provided a record of sources which no longer survive. A great debt is owed to those individuals who sought out evidence, transcribed it, translated it, and published it – it would be a shame if historians stopped referring to it, albeit with a watchful eye. There are often gems of information tucked away in the copious calendars that line the library shelves. A good example is the Yearbook of Edward III: in it is one of the rare detailed pieces of evidence regarding the hospital at Gedney in Lincolnshire. It contains information concerning a legal action brought by the patron against an abbot.[118] The patron was Margaret Roos who brought the action as the abbot of Creake Abbey had failed to provide the agreed services for over two years. Nothing more is known of the hospital, but it seems the patron at least attempted to protect her house.

Many of the aforementioned documents, unless combined, merely provide a snapshot in time. Even for those that provide narrative accounts, comparisons with other sources often prove to be fruitful. The archaeological evidence consulted as part of this study assisted in the process of understanding who the people were that associated with these houses, their possessions, and how

[118] *Year Books of the Reign of King Edward the Third: Year XV*, ed. L. O. Pike (London, 1891), pp. 448-51.

the buildings were used or maintained. Passing reference in chronicles or literary works also added to the emerging picture and on occasion provided pivotal pieces of information. The many sources employed reduces the risk of distorted views developing which can occur when, for example, only wills are consulted. Most importantly for this study, they shed light on the people who were associated with hospitals and why.

III: Thesis Structure

There are five main chapters within this thesis which accompany this introductory chapter. The first, Chapter Two, considers the importance of the provision of hospitality to medieval society: why it might be that hospital patrons considered it to be a pivotal service for their newly founded institutions and to whom it should be offered. Within the analysis, attention is given to what constituted hospitality. The aim of the chapter is to establish whether early *hospitalia* can be defined by the services they offered as opposed to their type of inmate or guest. This is then further explored in Chapter Three which investigates the second potential unifying service: care of souls – be they of the living or dead. Access to a chapel is put in the spotlight, as well as descriptions of religious paraphernalia and archaeological evidence to enhance the pictures painted by the documentary evidence. In a similar way to Chapter Two, it looks at who the intended recipients of these services were. Both chapters are concerned with ascertaining the *raison d'être* of *hospitalia* and how contemporaries used and perceived these *a priori* diverse institutions.

Discussions then turn to the question of longevity and the perceived ephemeral nature of the lesser-known houses in small towns and villages. Chapter Four evaluates the role of the legal patron including the role of the advowee paramount in assisting, or not, these houses to endure. Historians of monastic history have identified waning aristocratic interest in their institutions during the later Middle Ages. And ecclesiastical historians have noted the diminishing role of the patron. The question that therefore arises is the extent to which this applied to hospitals in this

period – both in theory and in practice. Having established the role of the patron, Chapter Five moves forward to look at a potential threat to the longevity of hospitals in the form of the Statute of Mortmain of 1279. The idea that an institution's ability to amass land to fund its operations and to form an ongoing bond with its donors could be placed in jeopardy is potentially of vital significance in their ability to endure. As is often the case, over time dispensations were granted and U-turns made, but the question of why and how merits further exploration as does the ability of an institution to adapt to external threats. This is a topic which is also given due consideration in the final main chapter, Chapter Six. Here, the question of demand for hospital services and their ability to supply them is examined. Several factors are considered such as the Great Famine, the Black Death, competing institutions, legislation, the role of masters, and the protection of assets. Throughout each chapter an attempt is made to shed light on those hospitals for which very little is known; to look for unifying features and correlations, but not to overly generalise as to the findings; and to employ both quantitative and qualitative approaches to a series of thorny issues and questions which arose over a timeframe of 300 years.

Chapter Two: Services for the Living

In 1995, Orme and Webster's general study of hospitals in England stated 'it is important to realise that contemporaries did not conceive of hospitals as a uniform group or describe them by a single common term to the extent that we do'.[1] This view remains prevalent in current scholarship: a recent doctoral thesis stated that medieval hospitals cannot be seen as 'a unitary or clearly bound phenomenon' owing to their wide-ranging clientele including travellers, the poor, the sick, the elderly, orphans, students, and lepers.[2] The problem is best described in *A Companion to the Medieval World* published in 2009 which concluded that hospitals were a 'large and complex phenomenon, yet one strangely difficult to quantify – in short something messy'.[3] The research, herein, considers whether hospitals as denoted by the Latin noun *hospitalia* can be defined by the services they provided – in this chapter to the living and in the following chapter to the living and the dead. The present chapter explores the idea that their non-spiritual services to the living can be unified under the term hospitality in its varying forms as identified in contemporary sources. This is significant as the importance of this service has yet to be considered in the historiography of medieval hospitals.

In the first instance, consideration is given to the term hospital. The Latin term, *hospitale*, and its associated forms such as *hospitium* and *hospitalitas* (deployed as a noun) were all associated with the provision of hospitality. The discussions then move to review the development of the term during the foundation process to elucidate contemporary understanding of what constituted the provision of hospitality in the context of a hospital. It is vital to gain an insight into the founding patron's intentions when these houses were formed and, crucially, subsequently used to understand their *raison d'être*. This work differs to the constitutional objectives identified by

[1] Orme and Webster, *The English Hospital, 1070-1570*, pp. 39 and 41.
[2] M. Leahy, ''To Speke of Phisik': Medieval Discourse in Late Medieval English Culture' (PhD Thesis, Birkbeck College, University of London 2015), p. 184.
[3] C. Lansing and E. D. English, *A Companion to the Medieval World* (Chichester, 2009), p. 265.

Watson which focused upon the development of the succinct *ad* clause to indicate a founder's intent.[4] Here, attention is given to whether there were customary services which patrons also expected to be implemented, how these houses were actually used, and whether these services can be defined as the provision of hospitality. The provision of hospitality was an important Christian duty, and, thus, its relevance to founders, patrons, and other individuals tasked with protecting these houses could be instrumental when seeking to ascertain what constituted a hospital. To date, the great household provides evidence of the recognition of this pivotal duty for magnates and prelates. Therefore, the chapter explores the extent to which they made provision for its exercise as patrons in their hospitals.

The second half of the chapter focuses its attention upon the intended recipients of these services. Insights into their potential guests and inmates could be revealed through their location and its accessibility. This, in part, addresses the points made in Chapter One concerning the ability of rural inhabitants to access hospitals and the importance of the provision of these services to the poor. However, the discussions challenge the notion that the provision of assistance to the needy always indicated those in need were poor. The concluding section concentrates on detailed examples of the exact nature of those services as performed through hospitals – often by unknown persons and not necessarily on site. In doing this, the chapter seeks to ascertain how contemporaries perceived hospitals and their services to the living. This differs to the content of Chapter Six which considers the demand for these services, a hospital's ability to fulfil that demand, and whether change in focus occurred over time. Here, the intent is to simply ascertain the range of services on offer, whether they can be united under the term hospitality, and who used these services – officially or otherwise.

[4] Watson, 'The Origins of the English Hospital', pp. 75-94, at p. 90.

I: The Etymology of *Hospitale/-is* and the Connection with *Hospitalitas/-tis*

At the start of the wave of hospital foundations in England, hospitals were originally referred to as *domus*. This can be seen in the foundation charter for the hospital at Brackley which described the construction of a house (*ad domu[m] [con]struendam*).[5] The charter is early in terms of documented English hospitals at *c.* 1160, and it did not contain the word *hospitale.* Another early foundation within this sample was that at Blean. In this case, the hospital was described in 1187 as *de domo quadam hospitali* (concerning a certain hospitable house).[6] And the statutes issued for Kepier (*c.* 1170–84) repeatedly used the word *domus.*[7] Sethina Watson identified the evolving terminology employed prior to 1200 and noted that when Eadmer described Archbishop Lanfranc's two foundations at Canterbury (*c*. 1085) he was unable to find a single word to describe his hospital. By 1200, *hospitale* had replaced *domus* as the most frequently used word.[8] However, consideration has not been given as to why the terminology developed and why contemporaries decided to deploy a word to describe these institutions of varying services and clientele.

In the medieval period, the noun *hospitale* could be defined as 'hospital, guesthouse, guestroom'.[9] Its development appears to have emanated from the classical Latin adjective *hospitalis* which is defined as 'of or connected with hospitality'.[10] Watson recorded the first time the word hospital was used in England (in Kepier's aforementioned foundation charter), '*hospitali domo*', which she translated as 'hospital house'.[11] In other words, the classical Latin adjective was deployed

[5] MCA, Brackley 39; Macray, Northamptonshire I, No. 2; Watson, 'The Origins of the English Hospital', p. 79.
[6] *Chronicles and Memorials of the Reign of Richard I, Volume II. Epistolae Cantuarienses, The Letters of the Prior and Convent of Christ Church, Canterbury, from A.D. 1187 to A.D. 1199*, ed. W. Stubbs (London, 1865), p. 169.
[7] *EEA 24: Durham, 1153-1195*, ed. M. G. Snape (Oxford, 2002), pp. 45-6.
[8] Watson, 'The Origins of the English Hospital', pp. 75-6, 79-80.
[9] '*Hospitale*', R. E. Latham, *Revised Medieval Latin Word-List from British and Irish Sources* (Oxford, 1965), p. 229.
[10] 'Hospitalis/-e', J. R. V. Marchant and J. F. C. Charles (eds), *Cassell's Latin Dictionary* (London, 1910), p. 254.
[11] Watson, 'The Origins of the English Hospital', p. 79.

and, thus, it can also be translated as 'hospitable house' or, and this study's preferred option, a 'house of hospitality'. Hospitality is derived from *hospitalitas* which is defined as the 'entertainment of guests or provision thereof' or 'hospitality'.[12] It can also be defined as an 'inn' or a 'hospital, hospice'.[13] These definitions are taken from the *Dictionary of Medieval Latin from British Sources* (*DMLBS*). Notably, there is also an entry which defines *hospitalitas* as a 'hospital, hospice (for poor or infirm)' which is contained in the chronicle of Henry Knighton and pertains to a description of the foundation of the aforementioned hospital at Brackley: '*Iste Robertus Mellent etiam hospitalitatem de Bracheleye fundavit et dotavit*'.[14] It could be argued that the translation concerning Brackley should read Robert 'founded and endowed the provision of hospitality'. However, other near contemporaneous uses suggest that it was indeed intended to signify an institution. For example, in 1300 it was used in conjunction with other welfare structures: *ad elemosinarium, hospitalitatem, seu infirmitorium*.[15] The interplay of language and association with hospitality is clear to see.

The development of the term can be seen in the rare collection of founding manuscripts concerning the hospital at Aynho, Northamptonshire. These manuscripts provide irrefutable evidence of its founder's intent and how these houses were perceived. The hospital is a relatively early foundation in *c.* 1180 by Roger son of Richard.[16] Further information contained within the charter such as the reference to the founder's overlord, earl William, and his wife Aliza, indicate that the founder was Roger Fitzrichard, lord of Warkworth, constable of Newcastle, and lord of Clavering. A subsequent confirmation issued by William Mandeville, earl of Essex, established the identity of the feudal lord in question.[17] The foundation charter itself does not contain the word *hospitale*, instead it described the vision of the founder and what constituted a hospital in

[12] 'Hospitalitas', *DMLBS* (21 June 2019).
[13] Ibid.
[14] Henry Knighton, *Chronicon Henry Knighton, vel Cnitthon, Monachi Leycestrensis*, vol. 1, ed. J. R. Lumby (London, 1889), p. 64. Knighton was incorrect in his statement as Robert Mellent was not the founder of the house, rather it was his father, the second earl of Leicester.
[15] 'Hospitalitas', *DMLBS* (21 June 2019).
[16] MCA, Aynho 71.
[17] MCA, Aynho 49.

his view. Before proceeding to describe this vision, it is first necessary to state why it is certain that the founder was describing a hospital when he did not use the said terminology in the charter. The charter referred to the associated confirmations made by the founder's two sons and the feudal overlord concerning their interest in the donated lands – these documents categorically described the institution as a hospital (*hospitali S[an]c[t]i Jacobi*). In addition, the confirmation issued by Hugh, bishop of Lincoln, not only named the hospital but unequivocally stated the purpose of the foundation: *ad hospitand[um] paup[er]es q[ue] ibi hospitiu[m] pro amore d[e]i petierint.* Thus, contemporaries clearly viewed the establishment, which was about to be founded, as a hospital whose purpose was to provide hospitality to the poor from its *hospitium.*[18] By referring to the confirmations issued by these individuals within the foundation charter, the founder was clearly aware of that terminology too.

The foundation charter described a gift to God, St Mary, and St James in hospitality (*Sciatis me dedisse in hospitalitate[m] d[e]o et S[anc]te Marie et S[anc]to Jacobo*). The ultimate intention of the founder was that the land should be used to build a *hospitium* for the love of God. The use of the word *hospitium* is noteworthy: this was a term associated with feudal tenure and *hospitia* owed to a feudal overlord. This often equated to one night's accommodation and one meal the following day.[19] It could be limited to a specified number of times per year or continue at a charge. Entertainment was expected and this comprised fire, straw, and candles as well as fodder for horses.[20] That in the example at Aynho the feudal overlord's consent was obtained prior to the hospital's foundation provides further reassurance of the connections within the founder's mind and contemporary expectations. In the late twelfth century the actual *hospitium* – as opposed to the service owed to the feudal overlord – denoted lodgings, a hospice for the poor or infirm, or a

[18] MCA, Aynho 22.
[19] D. Walker, 'Hospitium: A Feudal Service of Hospitality', *The Transactions of the Bristol and Gloucestershire Archaeological Society*, 76 (1957), pp. 48-61, at p. 57.
[20] Ibid., p. 54.

royal or ecclesiastical household.[21] In this case, the founder stated that the hospitality was to be provided to the poor brethren (*ad hospitand[um] paup[er]es fr[at]res*).[22]

In addition to the founding examples at Blean, Brackley, and Kepier, there are other examples which demonstrate that hospitals continued to be associated with hospitality. For example, when hospitals were under investigation or struggling to survive, a description of their services were often recorded. For instance, an *ad quod damnum* inquisition during the reign of Edward I concerned the hospital of St John the Baptist in Buckingham. In *c*. 1290, it was recorded that the hospital had been founded to receive sick people in the name of hospitality (*ad recipiend[um] paup[er]es inf[ir]mos no[m]i[n]e hospitalitatis*).[23] In another example, when the hospital of St Nicholas at Portsmouth came under attack from alien enemies in 1340 and its manors and possessions were burned and destroyed, the warden sought the assistance of Edward III as he was 'unable to maintain the hospitality, chantries, and other works of piety established in the hospital'.[24] And this type of evidence was still utilised and relevant in the late fifteenth century. Thus, in 1487 when Pope Innocent VIII gave consent to the prior of Newark to 'unite and appropriate' the hospitals of St James and St John in Aynho and Brackley to Magdalen College, Oxford, the reason cited was that 'hospitality had not for a long time been observed, and was not being observed'.[25] In summary, then, it can be seen that terms associated with various forms of hospitality were used during the foundation process, and that hospitals continued to be associated with the concept during the later Middle Ages.

[21] 'Hospitium', *DMLBS* (21 June 2019).
[22] MCA, Aynho 71.
[23] TNA C 143/14/5 as published in P. K. Poornan, *The Royal Latin School, Buckingham* (Marsh Gibbon, 2001), pp. 162-73 – contains photographs, transcripts, and translations of the instruction to the sheriff by Edward I and the subsequent *ad quod damnum* investigation.
[24] *CCR: 1339-1341, Edward III*, vol. 5 (London, 1901), p. 637.
[25] *CEPR: 1484-1492*, vol. 14, ed. J. M. Twemlow (London, 1960), p. 183.

II: The Question of Duty

Hospitality was an important Christian duty in the medieval period. It was of such importance to the role of a bishop, for example, that the twelfth-century canon lawyer, Gratian, proclaimed 'Hospitality is so necessary for bishops, that, if they may be found strangers from it, the law forbids [them] to be ordained'.[26] Brian Tierney's work concerning medieval poor law has noted that there was an especially close association between the provision of poor relief and parochial responsibilities, and that this was often described as *tenere hospitalitatem.*[27] And Felicity Heal has stated that while hospitality enjoined on all men through Hebrews 13 – 'forget not to show love unto strangers; for thereby have some entertained angels unawares' – it was a particular duty of the clergy and bishops as descendants of the early church who were tasked with the care of local communities.[28] These definitions appear to stem from the parable of the sheep and goats contained in the Gospel of Matthew in which Jesus explained to his followers how on the day of judgement people will be separated into two groups – the believers who will go to heaven, and the non-believers to hell. The following verses from Matthew 25 describe how, by welcoming and providing hospitality to strangers, individuals were hosting Christ, albeit unwittingly:

> 'For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me'. **Matthew 25:35-6**

Thus, when hospitals were receiving guests – and most notably feeding, watering, and accommodating them – they were following the teaching of Christ.

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[26] Dist. 85, '*Hospitalitas vero usque adeo episcopis est necessaria, ut, si ab ea inveniantur alieni, jure prohibeantur ordinari'*, in *Corpus Iuris Canonici*, vol. 1, eds E. Friedberg and A. L. Richter (Leipzig, 1879), p. 297.
[27] B. Tierney, *Medieval Poor Law: A Sketch of Canonical Theory and its Application in England* (Berkeley, 1959), pp. 68-9.
[28] F. Heal, 'The Archbishops of Canterbury and the Practice of Hospitality', *The Journal of Ecclesiastical History*, 33 (1982), pp. 544-63 at p. 545.

The importance of the provision of hospitality is signified by its incorporation into episcopal statutes as the following table demonstrates:

Table 4: References to Hospitality in Episcopal Statutes[29]

Bishop	**Year**	**Statement**
Stephen Langton, Canterbury	1222	Prelates have honourable clerics as almoners and be **hospitable** (*sint **hospitales***).[30]
Richard Poore, Salisbury	1223	Priests and beneficed clergy be **hospitable** (*sint **hospitales***) according to their revenues and resources, and not miserly to the poor.[31]
Walter Cantilupe, Worcester	1240	We command that all clerics and especially monks, shall exercise **hospitality** (*sectentur **hospitalitatem***).[32]
Richard Wych, Chichester	1244-53	We decree that [parsons] shall reside in their own churches, paying attention to **hospitality** (***hospitalitati** pro modo facultatum*) and other works of charity according to their resources.[33]
John Pecham, Canterbury	1281	We decree that rectors of churches who do not reside in their churches nor have vicars should exercise the grace of **hospitality** (***hospitalitatis** gratiam exhibeant*) through their agents, according as the resources of their churches suffice and so that at least the extreme need of the poor parishioners is relieved.[34]

The table undeniably emphasises the centrality of the poor and the local poor at that. However, Heal found that many local clerics struggled to be able to provide these services based upon their

[29] Tierney, *Medieval Poor Law*, pp. 98-101. Tierney's translations have been checked against individual sources as listed in the notes to Table 4 as cited by Tierney. The cited texts in footnotes 30 to 34 below were also compared to the work of F. M. Powicke and C. R. Cheney (eds), *Councils and Synods: With Other Documents Relating to the English Church, A. D. 1205-1313*, 2 vols (Oxford, 1964), the corresponding pages being (in order of the entries of Table 4), pp. 106, 64, 311, and 461 of vol. 1, and p. 967 of vol. 2. There were some minor textual differences, but these are not relevant to the discussions here.

[30] *Concilia Magnae Britanniae et Hiberniae: a Synodo Verolamiensi A.D. CCCC XLVI. ad Londinensem A.D. M DCCXVII. Accedunt Constitutiones et alia ad Historiam Ecclesiae Anglicanae Spectantia*, vol. 1, ed. D. Wilkins (London, 1737), p. 585.

[31] *Charters and Documents Illustrating the History of the Cathedral City and Diocese of Salisbury in the Twelfth and Thirteenth Centuries*, eds W. R. Jones and W. D. Macray (London, 1891), p. 135.

[32] *Concilia Magnae Britanniae et Hiberniae:* vol. 1, Wilkins, p. 672.

[33] Ibid., p. 691.

[34] *Concilia Magnae Britanniae et Hiberniae: a Synodo Verolamiensi A.D. CCCC XLVI. ad Londinensem A.D. M DCCXVII. Accedunt Constitutiones et alia ad Historiam Ecclesiae Anglicanae Spectantia*, vol. 2, ed. D. Wilkins (London, 1737), p. 57.

ecclesiastical revenues – some even tried to gain an exemption from providing it.[35] Canonists, although usually preferring the broader definition of hospitality to refer to need in general, also considered a narrower definition regarding the reception of travellers as strangers. When Gratian introduced St John Chrysostom's text on indiscriminate charity, he made it clear that guests were not to be treated differently.[36] It is, therefore, not surprising that hospitals, given that many were founded by bishops (six in this study alone), served a variety of visitors including the local poor, travelling poor, and wealthier guests too. As will be seen in subsequent chapters, bishops also formed links with certain hospitals in this study; and given the prominence of the religious aspect of this duty it should be of no surprise that some hospitals developed relationships with the parish church in the later Middle Ages.

Hospitality was an important virtue which magnates and prelates exercised in the great household. This was evident in the mid thirteenth century when Bishop Grosseteste, or an individual at the behest of the bishop, issued rules to assist the recently widowed countess of Lincoln, Margaret de Lacy (d. 1266) to manage her estates and household.[37] Within those rules, an emphasis was placed upon displays of lordship and honour which in many instances centred upon the provision of food and associated rituals. One such ritual concerned the provision of alms to the poor.[38] These were to be closely guarded to ensure that only worthy recipients benefitted from the countess's generosity. Another rule stated that the household (*ostel*) should be served two large amply filled dishes of food in order that alms could be increased.[39]

It was undeniably important for members of the aristocracy to be seen to assist the poor – and, of course, a hospital represented the perfect vehicle to fulfil this duty. As part of the displays of

[35] F. Heal, 'The Duties of the Pre-Reformation Clergy', in F. Heal, *Hospitality in Early Modern England* (Oxford, 1990), pp. 223-56, at p. 252.
[36] Dist. 42 c.2, '*In recipiendis hospitalibus nulla debet esse distinctio*', in *Corpus Iuris Canonici*, vol. 1, p. 152; Tierney, *Medieval Poor Law*, pp. 151-2.
[37] *Walter of Henley and Other Treatises on Estate Management and Accounting*, ed. D. Oschinsky (Oxford, 1971), pp. 387-407.
[38] Ibid., p. 401.
[39] Ibid., p. 405.

lordship and control, one of the rules concerned the importance of seating arrangements and procedures at the dining table – the countess occupying the most visible position in order to emphasise her presence and to observe the proceedings.[40] These ideas appear to have been replicated at the hospital at Brackley where a rare glimpse into the internal procedures can be seen in a corrody granted to William Koc in 1320. William was allocated a place to eat on a daily basis at the table of the carpenter in the refectory after whom he shall have first place (*Videl[ice]t q[uo]d comedet cotidie ...ad mensaliu[m] carpentarii in refectorio n[ost]ro post que[m] p[r]im[um] locu[m] h[ab]ebit*).[41] Seating arrangements and who was permitted to sit with whom suggests a system which was designed to differentiate between individuals and their status within an institution. And the passing reference to the carpenter provides another example of the provision of hospitality by hospitals to various individuals in the form of food.

Scholarly analysis of the household rules has demonstrated that they were based on *statuta* issued to the bishop of Lincoln's household.[42] These were much shorter in length and not so concerned with the finer details of estate management. They were, however, concerned with the protection of alms and their generous distribution (*Quod elemosina fideliter custodiatur et liberaliter prudenter et modeste distribuatur*).[43] It is also thought that the detailed rules issued in French to the countess were subsequently translated into Latin for use within the bishop's wider estate.[44] That the said countess of Lincoln, Margaret Lacy (d. 1266, née Quincy) was the niece of the patron of the hospital of Brackley, Roger de Quincy (d. 1264), raises the possibility that this lay patron might have had sight of the rules too. And given that the rules are thought to be based on a bishop's household, episcopal hospital patrons or guardians might have been influenced by them too. For example, an emphasis was placed on the correct reception of guests into the great

[40] Ibid., p. 403.
[41] MCA, Brackley B242.
[42] *Walter of Henley*, Oschinsky, p. 193.
[43] Ibid., p. 408.
[44] Ibid., p. 194.

household.[45] One of the rules issued for the countess of Lincoln advised the countess how her staff should behave when welcoming guests:

> 'Order emphatically that all your guests, secular and religious, are received by porters, ushers, marshals promptly, courteously, frankly, and with good cheer. And... all are in the same way lodged and served'.[46]

This rule might have influenced the guidance to hospitals. By 1290, Bishop Godfrey Giffard issued the following instruction to the hospital at Lechlade:

> 'that the hospitality...be observed with charity and cheerfulness; that two kind and courteous brothers be chosen for this, and the same for the sick brothers and sisters and others received into the said hospital'.[47]

What is clear is that the magnates and prelates recognised the importance of hospitality and provided for it in their household. It is natural, therefore, that these individuals acting in their capacity as hospital patrons might have adapted these practices to suit their foundations, some of which might have been associated with their households.

Christopher Woolgar has described the great household of the Western Middle Ages as an institution which is 'central to the study of medieval history' and 'the backdrop for many aspects of life'.[48] Lavish displays of hospitality, distributions to the poor, and ceremonies were important aspects of lordship in life executed by the household. Even in death, Woolgar noted the continuing importance of the household. To date, the relationship between independent medieval hospitals, their legal patrons, and their aristocratic or episcopal households remains not fully explored. There are occasional passing references to the significance of wider aristocratic networks in respect of titular patrons, but these are usually regarding estate management and hospital endowments.[49] The idea of viewing a hospital as a miniature household which was

[45] J. Kerr, 'The Open Door: Hospitality and Honour in Twelfth/Early Thirteenth-Century England', *History*, 87/287 (2002), pp. 322-35, at pp. 327-8.
[46] *Walter of Henley*, Oschinsky, p. 402-3.
[47] *Episcopal Registers, Diocese of Worcester: Register of Bishop Godfrey Giffard, September 23rd, 1268 to August 15th, 1302*, vol. 1, ed. J. W. Willis Bund (Oxford, 1898), p. 391.
[48] C. M. Woolgar, *The Great Household in Late Medieval England* (London, 1999), p. 1.
[49] Watson, 'Fundatio, Ordinatio and Statuta', pp. 225-9; Orme and Webster, *The English Hospital, 1070-1570*, pp. 75-9; Clay, *The Mediaeval Hospitals of England*, pp. 70-90.

influenced by the practices of the great household has yet to be considered. Hospitals are usually associated with quasi-monastic models where the Rule of St Augustine provided the backdrop to a bespoke set of rules usually issued by the diocesan bishop.[50] Giving consideration to an alternative exemplar does not preclude the influence of monastic houses. Instead, it provides an insight into why hospitals provided services, the nature of those services, and to whom they were provided.

Hospitality in the Middle Ages could take various forms and was not limited to the direct Christian duties already discussed. The concept of differing types of hospitality was a subject considered in depth by Matilda Tomaryn Bruckner in 1980.[51] Bruckner analysed eight French romances for the period 1160-1200 to produce a literary model of the convention of hospitality. To achieve this, Bruckner focused upon small narrative units rather than the plot of each work. There are several points within Bruckner's study which are of direct relevance to this study. In the first instance, the timeframe (1160-1200) corresponds to the estimated foundation dates of 20 hospitals within this sample including the hospital at Aynho. Secondly, guests were seen as undeserving and deserving – the former received *bourgeois* hospitality which required payment; the latter received courtly hospitality commensurate with their status at no charge.[52] This is similar to the discussions in Section I above regarding the provision of hospitality to the poor and the customary requirement to provide hospitality to a feudal overlord – both being provided without charge to deserving guests.

This study has also uncovered one direct payment for these services in its sample concerning Queen Isabella in 1316, and the recent work of Adam Davis concerning hospitals in Champagne

[50] Orme and Webster, *The English Hospital, 1070-1570*, pp. 69-75.
[51] M. T. Bruckner, *Narrative Invention in Twelfth-Century French Romance: The Convention of Hospitality (1160-1200)* (Kentucky, 1980).
[52] Ibid., pp. 117-8.

identified evidence of payments by merchants.[53] Over and above this, what is plainly discernible in the historical record, as will be shown in Section III, is the use of payments in kind for the provision of hospitality to varying individuals in need. This is a slightly different way of viewing what has long been identified as the reciprocal arrangements in place within hospitals when gifts were made in anticipation of the receipt of spiritual benefits.[54] In fact, the process of founding a hospital, it will be argued, represented the start of a relationship whereby gifts were made in return for a variety of benefits, including that of hospitality. This differs from on the spot payments and could take the form of, for example, crops or land, but the intended outcome was the same.

Thirdly, Bruckner noted the differing periods for which hospitality could be provided and the services which comprised that hospitality. The basic structure of private hospitality identified by Bruckner was: 'Welcome, Suppertime, Bedtime, and Departure'.[55] However, this basic structure could be augmented. An example, with relevance to this study, is the idea of a guest who required special care such as an injured knight. This was noted as a 'sojourn with special care' where the traditional overnight stay was replaced with a length of stay which was directly in line with the needs of the guest, i.e. until the individual had made a full recovery.[56] In another example, an agreement was made whereby the guest was to receive hospitality for three years – a scenario in which Bruckner compared the host/guest relationship to a lord and vassal which ultimately resulted in private hospitality which started to 'function as a court in miniature'.[57] Here, then, it is evident that hospitality could be offered on a temporary or long-term basis.

These observations correlate to both the lengths of stay by the guests of hospitals in this study and to the services offered – hospitals provided hospitality for varying periods of time dependent

[53] *Historiae Dunelmensis Scriptores Tres: Gaufridus de Coldingham, Robertus de Graystanes, et Willielmus de Chambre*, ed. J. Raine (London, 1839), p. cvi; Davis, *The Medieval Economy of Salvation*, p. 169.
[54] See Sweetinburgh, *The Role of the Hospital in Medieval England*; Davis, *The Medieval Economy of Salvation*.
[55] Bruckner, *Narrative Invention*, p. 29.
[56] Ibid., pp. 31-2.
[57] Ibid., p. 124.

upon the needs of the guest. For example, a hospital could accommodate a traveller who sojourned overnight or a retired priest for the remainder of his earthly life. In a similar way to servants who on retirement were assisted within great households, some were sent to hospitals.[58] Woolgar noted that some of the households had close connections with hospitals such as the bishops of Winchester with the hospital of St Cross which provided 'a dignified environment for aged servants'.[59] This was also the case in small towns and villages where, for example, individuals in the service of an aristocratic household were sent to a hospital in the gift of their patron. For instance, in 1360, at the request of Edward III, Richard Crowe the king's serjeant was sent to the master of the hospital at Ospringe in the place of John Wayte, deceased. Crowe was to receive the same maintenance for life.[60]

The hospital at Brackley is a prime example of the aristocratic duty to provide hospitality on display in the twelfth century. Founded in *c.* 1150 by Robert de Beaumont, second earl of Leicester, the hospital was immediately part of a transnational network – the earl's foundation charter boldly announcing his decision to *omnibus hominibus suis F[ra]ncis et Angl[icis]*.[61] The earl (d. 1168), a close ally over many years of Henry II, became justiciar in 1155, having already regained his Norman possessions in the previous decade. His son Robert, and future legal patron of the hospital, also had close connections with France through his marriage to the heiress of the Norman honour of Grandmesnil. There is no doubt that this was a well-connected man who has been described as 'perhaps the most distinguished aristocrat of his day, educated to a high standard and a consummate politician...The *curia regis* seems to have been the place where he was happiest'.[62] The extent to which his education extended to French romances cannot, of course, be categorically confirmed, but there can be little doubt that this pious individual, founder of two abbeys, holder of lands on both sides of the Channel, was aware of his Christian and courtly

[58] Woolgar, *The Great Household*, p. 39.
[59] Ibid.
[60] *CCR*: *1360-1364*, *Edward III*, vol. 11, (London, 1909), p. 133.
[61] MCA, Brackley 39.
[62] D. Crouch, 'Robert [Robert de Beaumont], Second Earl of Leicester (1104-1168)', Magnate and Justiciar', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/1882 (29 Jan. 2020).

duties. As were his heirs – his son Robert, who had developed a close attachment to Richard I, died on his way back from the Holy Lands in 1190.[63] As for Brackley and its hinterlands, it became internationally renowned as a host of tournaments in the twelfth and thirteenth centuries – in fact, it was so famous that Richard I granted the area permission to host these events as one of only six official sites in England.[64]

In the case of the earl of Leicester, hospitality, the extension of his aristocratic and Christian duties, and display of lordship are evident in his foundation charter. Not only did the earl specify that the poor should be taken in and offered hospitality (*pauperes recipiantur et hospitent[ur]*) but also that a chapel should be built there as his *demesne* chapel (*mea dominica capella*).[65] For this highly itinerant earl and his household, this was to be an important chapel; of such importance, in fact, that his heart was embalmed and interred within it.[66] In addition, the earl clearly expected to receive other visitors to his chapel. In a rare but thought-provoking use of the word *hospes*, the earl stated that he expected the masters of the hospital to celebrate divine offices for the poor and arriving guests for the salvation of his soul and that of his ancestors (*ut Salomon p[re]dictus et successores sui paup[er]ibus et hospitib[u]s sup[er]uenientib[u]s pro salute anime mee et antecessor[rum] meo[rum] et h[er]edum meo[rum] divina in ip[s]a cap[e]lla celebre[n]t officia*).[67] *Hospes/Hospitis* had several meanings at this time encompassing both a host and a guest. Furthermore, it could also imply that guests were strangers, even soldiers billeted to a location.[68]

[63] D. Crouch, 'Breteuil, Robert de, Fourth Earl of Leicester (d. 1204), Magnate', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/47202 (29 Jan. 2020).
[64] Raphael Holinshed, *Holinshed's Chronicles of England, Scotland, and Ireland: Vol. II, England* (London, 1807), pp. 253 and 418; *PR: 1216-1225*, vol. 1 (London: 1901), pp. 295, 388*; PR:1232-1247*, vol. 3 (London, 1891), pp. 69, 238; *CPR: 1313-1317, Edward II*, vol. 2 (London, 1898), p. 18.
[65] MCA, Brackley 39.
[66] Knighton, *Chronicon*, Lumby, p. 64.
[67] MCA, Brackley 39.
[68] 'Hospes', *DMLBS* (21 June 2019).

But what of other hospitals within this sample? As stated in Section I of Chapter One, there was a wave of hospital foundations in the twelfth and thirteenth century and yet we know not why – one might say it was fashionable to found hospitals at this time, following perhaps the lead of a famous earl of Leicester. Some consideration has already been undertaken in respect of the hospital at Aynho; in this case, the *hospitium* and feudal overlord, William Mandeville, earl of Essex, were of vital importance. Like the earl of Leicester, the earl of Essex was also an international player and connected to Henry II and the Angevin court.[69] But connections are also apparent between non-comital founders. Aynho was founded in 1189 by the constable of Newcastle, Roger Fitzrichard, lord Warkworth; and in *c.* 1190 the hospital at Castle Donington was founded by the constable of Chester, John Fitzrichard (d. 1190), lord Halton. John was the stepbrother of Roger, and it could be said that the two lords were imitating both their comital peers and each other in their desire to found their own hospital. Should there be any doubt as to the strength of these ties and influences, John's son and heir, Roger (d. 1211), witnessed the foundation at Aynho being described as 'son of John, constable of Chester'.[70] Thus, there is a small amount of evidence of downward cultural diffusion with lesser magnates aping their superiors during the period of hospital expansion.

Of course, it was not only earls and lords who founded the hospitals within this sample. Some, such as Ospringe, Kent, were founded by monarchs – in this instance, Henry III.[71] At least, it is thought to have been founded by Henry: it was not unknown for subsequent legal patrons to refound hospitals and be referred to as the founder. In many cases, these events were not precisely recorded; or if they were, this evidence has not survived the passage of time. That hospitals, perhaps with dubious claims, sought to associate themselves with current or deceased monarchs only adds weight to the idea that these institutions and their patrons were influenced by the practices of powerful individuals. For example, it was not until 1390 that the Holy Trinity hospital

[69] Thomas K. Keefe, 'Mandeville, William de, Third Earl of Essex (d. 1189), Magnate and Courtier', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/17929 (19 Feb. 2020).
[70] MCA, Aynho 1.
[71] Appendix I.

in Walsoken, Norfolk, appears to have claimed its founding links to Richard I.[72] In addition, archbishops and bishops also founded hospitals within this study. Examples here include the hospital at Kepier founded by Bishop Flambard in *c.* 1100 ranging to Bishop Bronescombe and the hospital in Clyst Gabriel as late as 1270.[73]

The preceding discussions within this chapter have demonstrated that there was an expectation within society in the twelfth and thirteenth centuries that hospitality should be provided to those in need. Founders had the freedom to design their households and hospitals as they chose – they were bespoke institutions. However, within this broad remit, it seems that a unifying feature was the bestowal of hospitality by high-status individuals on those in need. This was an integral part of medieval society for laymen, and secular and religious clergy. Hospitals were one of the options available to the wealthy to fulfil this duty of care. The question which now needs to be answered is whether the recipients of that hospitality were as wide ranging as the early Christian teachings recommended.

III: The Importance of Location

This section is concerned with a hospital's ability to attract guests and who they might have been. In the first instance, the significance of the location of these houses will be considered. Great households were peripatetic, and so lordly displays of 'generosity and magnificence' and the provision of entertainment needed to take place regardless of the location of the lord's caput.[74] If hospitals were designed to host the patron and important guests, as well as travellers and the local poor, and thus potentially tenants and workers of the patron, they needed to be accessible. In addition, they would require accommodation befitting of a great household – or at least facilities to cater for the lord and lady and their closest attendants. This section then proceeds to analyse whether hospitality was indeed offered to these high-status guests.

[72] *CEPR: 1362-1404*, vol. 4, eds W. H. Bliss and J. A. Twemlow (London, 1902), p. 376.
[73] Appendix I.
[74] Woolgar, *The Great Household*, p. 8, quote at p. 21.

Hospitals were often located on busy routes and were, thus, perfectly placed to welcome a variety of guests.[75] In this study those locations range from bridges such as at Longbridge, Lechlade, and Brompton Bridge; castles as at Castle Donington, Brackley, and Castleton; pilgrimage routes in the cases of Kepier, Ospringe, and Beck; and 32 hospitals were located in the same area as a market.[76] It can be reasonably assumed that those sited in the same locations as markets, fairs, pilgrimage routes, and castles were able to benefit from the highways and paths which provided access for these travellers. This is not unexpected. Hospitals were also often located near rivers, lakes, and the coast of England. Although a degree of caution should be exercised as the extent to which rivers were navigable is beyond the reach of this study, all the hospitals within this study which were identified as having good levels of primary source material, 18 in total, were sited in the vicinity of rivers, lakes, or the coast of England.[77] The importance of siting hospitals in the vicinity of water can be seen when the hospital at Kepier was relocated. It was originally located on the top of a hill by the junction of three roads on the outskirts of Durham. When it was destroyed by Scottish rebels in the twelfth century, it was rebuilt next to the river at Kepier.[78] This facilitated access directly to Durham, but it also permitted pilgrims access from the road while at the same time providing a degree of shelter from danger.

How these varying individuals navigated the country is an interesting point to consider. The document entitled *Mappa Mundi* (*c*. 1200), which was ascribed to the English chronicler Gervase of Canterbury, suggested that hospitals were important landmarks. It is a topographical survey by county which comprises four main categories: religious houses, hospitals, castles, and waterways, and on occasion additional types such as islands. The fact that it is known to have

[75] Orme and Webster, *The English Hospital, 1070-1570*, pp. 41-8.
[76] https://digimap.edina.ac.uk/historic These are nineteenth century maps, but they often clearly mark the site of a spital. Also see Historic England, https://historicengland.org.uk; 'Gazetteer of Markets and Fairs in England and Wales to 1516', http://www.history.ac.uk/cmh/gaz/gazweb2.html (29 June 2018).
[77] https://digimap.edina.ac.uk/historic These are nineteenth century maps, but they often clearly mark the site of a spital or the location is so small that it is a reasonable judgement to make that the hospital was in the vicinity of a watercourse, river, etc. Also see Historic England https://historicengland.org.uk.
[78] J. Barmby, *Memorials of St. Giles's, Durham: Being Grassmen's Accounts and Other Parish Records, Together with Documents Relating to the Hospitals of Kepier and St. Mary Magdalene* (Durham, 1896), p. xviii; D. Meade, *Kepier Hospital* (Durham, 1995), p. 1.

been copied from the fourteenth century onwards is testament to its contemporary value. In fact, it was still used in the Early Modern period as evidenced by its incorporation within the work of the renowned cartographer, John Speed (d. 1629).[79] It is true to say that much of the information was not compiled and added to each county listing; but the intention and expectation that these categories could be completed is noteworthy evidence that hospitals were perceived as discrete and important institutions. In fact, they were such fundamentally important landmarks in contemporary eyes that they were classified in their own right, whereas towns and roads are not even mentioned.[80] For a study which seeks to highlight the importance of these abundant institutions to medieval society and challenge the preoccupation in the historiography of English hospitals within larger urban locations, this is compelling evidence of their ubiquity.

The relevance of location and bustling transport routes with respect to the provision of hospitality can be seen in the following contemporary account written by the chronicler Gerald of Wales (d. *c.* 1223). Gerald was in possession of a letter which contained advice from John of St Paul, Cardinal of St Prisca, Rome, to Philip de Barri. Philip had become concerned that owing to his residence being sited on the busy land route between Milford Haven and Devon, he had given hospitality to the rich and, thus, could not give as much as he would have liked to the poor. He received a reply from the cardinal which quoted the bishop of Constantinople, St John Chrysostom (d. 407), 'If the rich seek hospitality, no inquiry should be made concerning them. For if Abraham had made anxious inquiry concerning those who sought hospitality, assuredly he would not have received the angels in his dwelling but would have driven them away...Therefore, you should bestow the works of hospitality and charity on rich and poor alike'.[81] The realities of balancing limited resources and differentiating as to who should receive hospitality was clearly a problem. Moreover, the act of balancing the needs of the poor with those of the rich was a responsibility

[79] *The Historical Works of Gervase of Canterbury,* ed. W. Stubbs, vol. 2 (London, 1880), p. xlii.
[80] Ibid., pp. 414-49.
[81] Wales, Gerald of, *The Autobiography of Gerald of Wales*, ed. H. E. Butler (Woodbridge, 2005), pp. 201-2.

which individuals or institutions took seriously in order to comply with their Christian duty to offer hospitality to strangers.

This problem of balancing of resources was addressed in the Statute of Westminster I (1275) which sought to provide a degree of protection to religious houses by stipulating that only the patron could demand hospitality: 'it is for this reason provided that no one come to eat, lodge or lie in a house of religion of anyone's patronage other than their own at the cost of the house, if he is not specially invited beforehand by the ruler of the house'.[82] Nevertheless, these individuals were still permitted to stay at the discretion of the house and at their own cost – a point which Bruckner raised in her model of hospitality. For those who were deemed to be in need, hospitality was still to be dispensed without charge.[83] The burden of hospitality can be seen in a hospital which does not form part of this study but is nonetheless revealing of the types of problems incurred with respect to this issue. In 1316, the bishop of Bath and Wells recorded the problems experienced at the house of St Mark, Bristol. The master and brethren of the hospital had complained that they did not have adequate resources to be able to support themselves and the visiting poor as 'in addition to the twice-daily distribution of alms which from the time of their foundation they have been bound to disperse, they are charged with other expenses arising from their hospitality to those who come there'.[84] There is also evidence that hospitals in this study were expected to offer hospitality of this nature through their requests for support. For example, in 1246 Henry III ordered that with reference to the hospital at Ospringe 'no forester, sheriff or bailiff shall take lodging at the house of the said hospital or their men, or take aught from them against their will'.[85]

It was also not unusual for officials to take goods; whether they deemed this to be an extension of hospitality is difficult to deduce, but they certainly believed they had a right to provisions. For

[82] *English Historical Documents 1189-1327*, vol. 3, ed. H. Rothwell (London, 1975), p. 393.
[83] Ibid.
[84] *Cartulary of St Marks Hospital, Bristol*, ed. C. D. Ross (Bristol, 1959), p. 137.
[85] *CChR*: *1226-1257*, vol. 1 (London, 1903), p. 295.

example, in 1313 Edward II issued an order from Woodstock that the purveyors of his own household and other offices should not take goods from the master and brethren at Brackley against their will.[86] This problem was identified by the Crown and protection could be issued with a clause *nolumus.* This clause was designed to protect religious houses from the burden of hospitality and later to prevent unwanted guests from seeking accommodation.[87] There is one such example that was issued to a master of a hospital in this study. This occurred in 1333 at Gateshead and was issued for one year as the master of the hospital was constantly attendant on the king's business. It is not clear whether the protection would be for the hospital in the absence of the master. It is clear, though, that as late as 1447, these types of services were still in demand in Yorkshire. In a case at Flixton, the brethren warned that unless the hospital remained open the 'divers lieges of the king' travelling in the winter would be in danger from the harsh local terrain unless 'entertained there'.[88] Unfortunately, it is not known whether a charge was made for either the overnight accommodation or the provision of subsistence.

In other cases, the bearer of the cost was clearly stated. This can be seen in the visitation of Bishop Montacute to the hospital in Lechlade in 1336. He received procuration there for a day with his whole *familia* (i.e. household) at the cost of the house.[89] Procuration has several meanings, but in the context of episcopal travel it related to the provision of entertainment or the action of looking after someone – in other words, hospitality.[90] It was evidently important to specify the exact length of time that hospitality could be provided for. This was perhaps in response to the Statute of Westminster I and the acknowledged need not to exploit religious houses. This can also be seen at Cricklade whose episcopal ordinances stated that its purpose was to care for poor priests, but hospitality was 'to be extended as much as possible to poor travellers,

[86] Macray, Northamptonshire I, No. 478.
[87] J. Hu, 'Messengers in Later Medieval England' (MPhil University of St Andrews, 2017), p. 55.
[88] *CPR*: *1446-1452, Henry VI*, vol. 6 (London, 1909), p. 69.
[89] *Calendar of the Register of Simon Montacute, Bishop of Worcester,* 1334-1337, ed. R. M. Haines (Worcester, 1996), p. 340.
[90] 'Procuration', *OED* (Oxford, 2020), http://www.oed.com/view/Entry/151901 (7 Mar. 2020).

who are to have a night's lodging and refreshment'.[91] Again, a clear limit on the length of stay but in this case relating to lower-status individuals. In both cases, the hospitals were not founded by bishops, yet they seemingly took an interest in the affairs of these houses – thus providing further evidence of the influences to which these hospitals were accustomed to receiving.

In some cases, it is the archaeological evidence which reveals the likely recipients of hospital services. One of the earliest buildings at the hospital precinct in Ospringe was the common hall at *c.* 1240. The hall was divided into two aisles by a central colonnade of pillars.[92] Documentary evidence indicates that in *c.* 1238 infirmaries (*infirmarias*) at Ospringe and Oxford were erected as indicated by a joint grant of money to their keepers by Henry III – this terminology being synonymous with monastic models.[93] This implies that the original hall did not accommodate the sick. An additional room with decorated floor tiles was possibly an entertaining room for wealthier visitors or a staff refectory.[94] An entertaining room would fit with the erection of a *camera regis* for Henry III which might have been built after the common hall and comprised four annexes.[95] In 1299, Edward ordered bailiffs of the manor of Ospringe to give eight oaks to the master of the hospital for the purpose of making a chapel and for other unspecified work.[96] The archaeological evidence from the thirteenth century, in what is described as the second phase of building, identified glazing of a high standard which was not thought to be completed by local artisans. It is, therefore, possible that this work can be associated with the chapel. In addition, it is thought that Edward stayed at the hospital on several occasions as a number of Close Roll entries were dated there.[97] Thus throughout his reign, Edward might have resided in Ospringe for a total of eighteen days with no single visit exceeding two days.[98]

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[91] *The Register of Robert Hallum, Bishop of Salisbury, 1407-17*, ed. J. M. Horn (Torquay, 1982), p. 153.
[92] G. H. Smith, 'The Excavation of the Hospital at Ospringe Commonly Called *Maison Dieu*', *Archaeologia Cantiana*, 95 (1979), pp. 81-184, at pp. 92, 106.
[93] *CLR: 1226-1240*, vol. 1 (London, 1916), p. 347.
[94] Smith, 'The Excavation of the Hospital at Ospringe', p. 102.
[95] Ibid, p. 109.
[96] *CCR*: *1296-1302, Edward I*, vol. 4 (London, 1906), p. 269.
[97] *CCR: 1296-1302*, pp. 296, 333, 559; Smith, 'The Excavation of the Hospital at Ospringe', pp. 105-6.
[98] *Itinerary of Edward I: Part 1 1272-1290*, ed. E. W. Safford (London, 1974); *Itinerary of Edward I: Part 2 1291-1307*, ed. E. W. Safford (London, 1976).

It is perhaps not surprising that monarchs in their capacity as patrons visited these houses; but they also visited houses of aristocratic patronage. At Brackley, a chamber was built in the hospital to host Henry III when he travelled through the town as recorded in the Close Roll of 1229 (*ad unam cameram faciendam in qua transitum faciens per Brackel' rex possit hospitari*).[99] It is likely that the king visited the hospital as there was no other suitable accommodation or resting point, the castle having been disbanded by 1173. It is also possible that Edward I spent time at the hospital as his itinerary placed him in the town or the nearby village of Halse on three occasions for between two and four days.[100] This compares to ten visits to Ospringe, which was a royal foundation, of one or two days.[101] Several monarchs had connections to other hospitals within this sample, and it is possible that they visited these houses too. In 1267, the hospital at Portsmouth was referred to as 'the king's poor hospital'.[102] Earlier in 1233, Henry had assisted the bishop of Winchester in building the hospital by granting the issues of the manor of Melbourne.[103] And the hospital continued to receive support in subsequent years. For instance, in 1307 Edward II granted the warden free warren in local lands, and in 1346 Edward III issued protection for two years following alien attacks by enemies of the king.[104]

Hosting an important guest brought great honour to a house, it enhanced the status of a hospital and consequently its ability to attract other high-status guests and their gifts.[105] The hospital at Ospringe might have hosted high-status individuals who were not its legal patrons – an entirely feasible proposition given its royal connections and prominent position on Watling Street en route to both Canterbury and Calais. For example, when in 1360 King John II was returning to France via Dover following his captivity in England, he decided to visit Thomas Becket's shrine in Canterbury before leaving the country. On his way to Canterbury, the king spent one night at

[99] *CR: 1227-1231, Henry III*, vol. 1 (London, 1902), p. 269.
[100] *The Itinerary of Edward I: Parts 1 and 2*, Safford.
[101] Ibid.
[102] *PR: 1266-1272, Henry III*, vol. 6 (London, 1913), p. 105.
[103] *PR: 1232-1247*, vol. 3 (London, 1891), p. 14.
[104] *CChR: 1300-1326, Edward I, Edward II*, vol. 3 (London, 1908), p. 100; *CPR: 1345-1348, Edward III*, vol. 7 (London, 1903), p. 209.
[105] Kerr, 'The Open Door: Hospitality and Honour', p. 326.

Ospringe recorded as '*sopper et giste à* Hospringe'.[106] The king's final destination in England was the hospital at Dover (a hospital which does not form part of this study) which was described as a place 'where travellers and pilgrims were constantly entertained'.[107]

It is also feasible that the wife of Edward II, Queen Isabella, had connections with hospitals within this study. In 1316, for example, the queen stayed in Kepier on 21 April and remitted £18 17s and 9d to cover her expenses (*In solucione facta pro expensis Reginae apud Kepier*). The source is unclear, but it seems that these were paid to Hugh the monk who was the master of the hospital.[108] An additional connection is also evident in 1343 when one of the queen's servants was sent to the hospital at Ospringe to receive maintenance for life.[109] She is known to have visited the town in 1358 following her release from Castle Rising in Norfolk. The hospital was not specifically mentioned but expenses for the *aula and camera* and *elemosina* were recorded and paid to the *Abbas sancti Augustini ad prandium* (for a meal): the payment to the abbot probably refers to the abbot of St Augustine's in Canterbury – the abbey had a direct interest as rector of the mother church at nearby Faversham and a thirteenth-century agreement with the then abbot protected the interests of that church and, thus, the abbey.[110]

Guests were often entertained in separate accommodation, possibly to segregate them from the sick. The archaeological remains at Brompton Bridge, Yorkshire, suggest that a building which was sited adjacent to the road near the river crossing and separate chapel was a guesthouse or hostel.[111] This hospital, however, does not appear to have catered for high-status guests as no evidence has emerged regarding food or bones which would indicate the presence of such visitors.[112] The existence of separate buildings, though, seems to have been of some importance.

[106] A. P. Stanley, *Historical Memorials of Canterbury* (London, 1906), p. 277-9.
[107] Ibid.
[108] *Historiae Dunelmensis Scriptores Tres*, p. cvi.
[109] *CCR: 1343-1346, Edward III*, vol. 7 (London, 1904), p. 220.
[110] *Historiæ Anglicanæ Scriptores X*, ed. R. Twysden (London, 1652), p. 1893-4.
[111] P. Cardwell, *et al*., 'The Excavation of the Hospital of St Giles by Brompton Bridge, North Yorkshire', *Archaeological Journal*, 152 (1995), pp. 102-225, at p. 145.
[112] Ibid., p. 223.

When Archbishop Chichele, for instance, refounded the hospital at Brackley in 1425, he specified that a decent house should be allocated for the reception of the itinerant poor or pilgrims (*vna domus honesta pro egenis paup[er]ib[u]s iten[er]antib[u]s siue p[er]egrinantib[u]s recipiendis*).[113] And again the contractual expectations were specified: they were to receive one night's accommodation or longer if this was permitted by the master or his deputy (*unum noctem...si neccesitas hoc requirat, se[cun]d[u]m discrecionem magistri vel eius deputati*). Moreover, only services which could be provided for free were to be given (*a d[ic]ta domo nichil exigentes nisi quod gratis eis oblatum fuerit*).[114]

Location was not unsurprisingly an important consideration for hospitals within this study. They were located on bridges, near fairs and markets, rivers, and waterways. They might have formed part of a system of landmarks prior to the use of maps which facilitated travel across the country. This would be an inherently sensible system for houses of hospitality to be integral to. They were designed to attract a variety of guests, but at times they could struggle to meet that demand. This is a point which Chapter Six will develop. As a result, some visitors were charged for the privilege. Bespoke guest accommodation is evident, and this included accommodation befitting of royalty. Not all hospitals have extant evidence of high-status visitors, so the next section turns its attention to who their guests were and the types of hospitality on offer.

IV: Sojourn with or Without Special Care

The definition of hospitality discussed at the outset of this chapter consisted of the entertainment of guests or the provision thereof. Inherent within the medieval Christian duty of the provision of hospitality to the poor was food, drink, and accommodation. And finally, Bruckner's definition of aristocratic hospitality comprised welcome, suppertime, bed, and departure. This section will consider the nature of the services provided by hospitals in small towns and villages. What is

[113] MCA, Brackley C62.
[114] Ibid.

immediately apparent within that evidence, whether a guest visited a hospital for the shortest of stays or for the rest of their life, is the importance of food. It has already been noted how the poor in the vicinity of Kepier hospital flocked to it on a daily basis.[115] The reason why the poor were visiting the hospital in 1312 was *pro victualium* (sic).[116] The *DMLBS* defines this as 'of or pertaining to bodily nourishment' or 'sustenance, (provision of) food (and drink)'.[117] The service was so important that in 1315 funds were made available to cater for an additional ten poor each evening (*et recipiant decem pauperes diebus singulis in hospitali predicto ultra solitum numerum in distributionibus vespertinis*).[118]

In other examples, the patron guaranteed that the poor would receive food by making it a condition of a gift. For instance, in 1351 Maurice Berkeley (d. 1368) stipulated that his grant of a holding to the hospital at Longbridge by Berkeley was given on the understanding that bread to the value of 2s should be distributed to the poor each year on the anniversaries of the current tenants.[119] One of the reasons that these distributions were so important to patrons was that they believed it would assist their soul through Purgatory. Thus, when the grandson of the founder, also named Maurice, granted land to the hospital for the purpose of funding a chaplain to sing in the hospital for his soul and that of his wife Isabel, he specified that if this did not take place six loaves of white bread should be distributed to the poor instead for the good of the aforesaid souls.[120]

Sometimes, the link between the provision of food, the patronal household, and accommodation for the poor is evident. At Sprotborough, for example, in 1404 it was recorded not only as being obliged to provide chaplains to say masses for the souls of the Fitzwilliam family and to directly

[115] *Registrum Palatinum Dunelmense: The Register of Richard de Kellawe, Lord Palatine and Bishop of Durham, 1311-1316*, vol. 1, ed. T. D. Hardy (London, 1873), p. 376.
[116] Ibid.
[117] '*Victuale*', Latham, *Medieval Latin Word-List*, p. 512.
[118] *Registrum Palatinum Dunelmense: The Register of Richard de Kellawe, Lord Palatine and Bishop of Durham, 1311-1316*, vol. 2, ed. T. D. Hardy (London, 1874), p. 1276.
[119] *A Catalogue of the Medieval Muniments at Berkeley Castle, Volume 1*, ed. B. Wells-Furby (Bristol, 2004), p. 125.
[120] J. Smyth, *The Berkeley Muniments: Lives of the Berkeleys, Lords of the Honour, Castle and Manor of Berkeley in the County of Gloucester from 1066 to 1618, with a Description of the Hundred of Berkeley and of its Inhabitants*, ed. J. Maclean, vol. 1 (Gloucester, 1883), p. 70.

attend to them for six months of the year, but also to provide hospitality to a poor man in the form of a house in their precinct and a cartload of wood. That individual would also receive additional hospitality in the form of food on a daily basis but notably from the Fitzwilliam family kitchen, not the hospital.[121] This example links back to the original ideas of entertainment at this time comprising fuel – in other words, a desire to make an inmate feel comfortable and at ease. The level of knowledge of the four humours, temperaments, and ideas concerning the healing benefits of the *regimen sanitatis* will remain unknown in this instance, but Christopher Bonfield has argued that the latter was widely understood in England at this time.[122]

An early example at Brackley recorded an instance of specific care. In 1260, a grant was made to the hospital at Brackley by Philip Whitfield which in part was to fund a *corrediu[m]* as for one of the brethren for the poor.[123] Corrodies (*corredia*) had the potential to lead to financial burdens being placed upon hospitals if inmates lived too long – an unfortunate drawback for a place of care. This point was made by Carole Rawcliffe who emphasised the link between excessive privatisation and the undermining of the *raison d'être* of these houses which in her view was to assist the poor and pray for the salvation of the founder's soul.[124] There is also evidence concerning hospitals outside of this sample which reveals the potential problem of the payment of large sums of money to secure these services and the issue of corruption. In Lincoln, for example, the non-resident master sold two corrodies for £17 6s 8d in 1316 and pocketed the money.[125] To put that into perspective, TNA's currency converter for the years 1310 and 1320 equates this to wages for a skilled tradesmen of 1,733 days, or the purchase of twenty horses. Or to put it another way, the equivalent of the princely sum of £10,602.65 in 2017 based on the 1310

[121] Sheffield City Archives, CD/399, reproduced in English on TNA website, http://discovery.nationalarchives.gov.uk/details/r/ca32875c-b4d4-4a45-a16f-e00711419bee (24 Sept. 2017).
[122] C. Bonfield, 'The Regimen Sanitatis and its Dissemination in England, *c*. 1348-1550' (PhD Thesis, University of East Anglia, 2006).
[123] MCA, Whitfield 69.
[124] Rawcliffe, *Medicine for the Soul*, p. 172.
[125] Orme and Webster, *The English Hospital, 1070-1570*, p. 132.

figures, or £7,974.84 based on the 1320 figures.[126] The risk of offering this type of service is clearly evident.

Yet the idea of a corrody fits perfectly within the hospital model as described thus far. The *OED* definition, based upon medieval source material, defines the noun as 'originally the right of free quarters due from the vassal to lord on his circuit'.[127] Again, as with the definition of hospitality it is not difficult to see how this could be extended to include a patron travelling across England and requesting hospitality in a hospital. The second part of the *OED* definition demonstrates the association with religious houses and in this case another potential influence in the operation of hospitals: 'but later applied to esp. certain contributions of food, provisions, etc. paid annually by religious houses'.[128] Turning now to the definitions in the *DMLBS*, the connections are brought into sharper focus. *Corredium, corredum, corredia* can be defined as 'allowance (or board etc.), maintenance, livery a (provided by lord or employer to workmen) b (provided by feudal tenant to his lord or his servants, or rent paid in lieu)'.[129] This was, thus, often a two-way process with customary rights of a lord, presumably acting in the capacity of patron, to place individuals in their institutions.

With reference to the evidence appertaining to this study, the first point to note is that it is likely that the evidence represents only a fraction of the original agreements to provide services. Several manuscripts refer to evidence which no longer exists. In one example at Brackley in 1320, the hospital made an agreement with William Koc which exonerated the hospital for the corrody of Hugh Hunter (*ab corrodio hugonis venatoris...exonerauit*).[130] The project database has no record of Hugh's corrody arrangements. In another case at Brackley in 1396, Helen Hardel's agreement referred to the chamber in which John Kyng lived (*vna[m] cam[er]am in qua fr[atrem]*

[126] TNA, https://www.nationalarchives.gov.uk/currency-converter/ (13 March 2020).
[127] 'Corrody', *OED* (Oxford, 2019), http://www.oed.com/view/Entry/42005 (24 June 2019).
[128] Ibid.
[129] 'Corredium/Corredii', *DMLBS* (11 March 2020).
[130] MCA, Brackley B242.

Joh[annis] Kyng inh[ab]itauit) which would now be allocated to Helen.[131] In addition, it was certainly not unusual for a patron to send another inmate when the previous incumbent died. Thus, when in 1335 Edward III sent Gilbert Sheffeld to Ospringe, it was noted that he was to receive maintenance in that house for life as John Toght, deceased, had.[132] Until this point, the fact that John Toght was maintained in the hospital was unknown in the historical record.

The agreements can reveal rare evidence concerning the internal workings of these houses and the services they provided. Hence, when Edward II sent one of his soldiers whose hand had been cut off by Scottish rebels to Brackley in 1314, it was stipulated that he should receive food, clothing, and other necessities as the soldier was unable to work.[133] Other manuscripts provide further information as to the exact terms of these negotiated settlements which could be surprisingly detailed. In 1308, Walter and Juliana Whitfield were permitted to take their allocation to their house in Brackley. If Walter should outlive Juliana, he could live in the hospital with an allowance of candles for his bedchamber. Walter and Juliana had their own servants who were permitted to collect firewood in the grove. They were, perhaps, related to the aforementioned Philip and able to benefit from his grant – or payment in kind for services – to the hospital.

Their provision of food in comparison to that for Sarra Macekyn, who also made an agreement in 1308, was evidently of a higher standard – the detailed description suggestive of the importance of food within these agreements. Sarra was only entitled to half and half ale, whereas the Whitfields also claimed a flagon of the better beer. And although Sarra's food was compared to that of the free servants, being pottage and meat, the Whitfield's was comparable to the brethren and included vegetables, flesh or fish, and a third dish if served. Sarra, in a comparable way to the soldier, was also entitled to a clothing allowance and this was specified as one garment of the

[131] MCA, Brackley 67; Macray, Northamptonshire II, No. 751.
[132] *CCR: 1333-1337, Edward III*, vol. 3 (London, 1898), p. 506.
[133] *CCR*: *1313-1318, Edward II*, vol. 2 (London, 1893), p. 192.

charity cloth (*vnu[m] garnementu[m]*[134] *de panno elemosine*). These were clearly negotiated settlements, and Sarra was of some status in her own right. She was able to demand that she would not serve any sister of the house but would assist with jobs which she could complete sitting down such as sewing and helping a maidservant to tend to the sick poor lying in the hospital. Her superior status is in evidence as the final part of the agreement specified that if her father fell into poverty, he would be received like any other sick or poor person – thus implying that Sarra had received special treatment.[135]

Sarra's corrody also revealed that even though grants appear to have ceased to be made specifically to the sick in 1286, the sick were still present in the hospital. This is evident in William Koc's agreement which provided for the possibility of his own sickness: and in this case, he could have his allocation of food in his room. For this privilege and another example of a payment in kind, William transacted legal business for the hospital and promised to leave his goods to them on death.[136] This arrangement indicates that some individuals were treated within their chambers and may perhaps relate to changes within society which were leaning towards a degree of privacy. The aforementioned Whitfield example provided for Walter and Juliana to take their allowance to their own home.[137] At Ospringe in 1397, Sir Philip Wem was allocated a chamber by the gate of the garden of the hospital on the west side and a corrody. That corrody comprised bread, ale, flesh, fish, pottage, a pittance at the kitchen, and a livery of woollen cloth as good as that of the best brother. The precise financial arrangements for this corrody were not specified, but the agreement does state that if he died within the time that the obligation of a certain sum of money was payable, this should be excluded from any other arrears payable on his death.[138]

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[134] This noun does not appear in the *DMLBS*; it does, however, appear in Latham, *Medieval Latin Word-List*, p. 208 and is defined as garment/livery.
[135] MCA, Brackley D71; Macray, Northamptonshire I, No. 438; MCA, Brackley 128; Macray, Northamptonshire I, No. 446.
[136] MCA, Brackley B242; Macray, Northamptonshire II, No. 531.
[137] MCA, Brackley 128.
[138] *CPR: 1401-1405, Henry IV*, vol. 2 (London, 1905), pp. 6-7.

The example of Philip Wem's agreement provides a rare insight into the layout of the hospital precinct and specifically noted the garden. This raises the possibility of the non-spiritual treatment of guests. It is often the case that there were passing references such as this, but it is difficult to make definitive links to herbal remedies on offer. At Brackley, for example, a tantalising fourteenth-century manuscript which comprises an extensive list of plants in Latin is contained within the hospital's archives. Unfortunately, there is no evidence as to how these plants were used or why the hospital held the list.[139] On the other hand, at Castle Donington, Leicestershire, there is a fascinating account of local practices but no hard evidence. A miracle is contained within The Book of St Gilbert (d. 1189) which was compiled in the early thirteenth century by a canon of Sempringham Priory as part of Gilbert's canonisation process. In this case, a local doctor fell ill with the tertian fever and sought a cure in the garden of the hospital which contained powerful herbs and roots for restoring health. However, Elias, the master of the hospital, knew of a superior cure: he possessed a fragment of the staff of St Gilbert which he washed and used the water to cure the doctor of his fever. Not only, then, did the doctor anticipate that the hospital's garden would contain a cure, there was also an expectation by the master that a relic could provide the answer.[140] In addition, the presence of a doctor in a hospital in England at this time is also rare in the fragmentary evidence which has survived the passage of time: doctors are not thought to have been attached to hospitals, and those institutions run by parishes were, *a fortiori*, not thought to offer medical care.[141] Hospitals were primarily houses of God complete with priest as physician of the soul and dispenser of refreshment through the medium of the host, but there is also reason to believe that they offered a variety of services to aid those in need.

Relics were also thought to be able cure sick inmates. For example, the aforementioned fragment of St Gilbert's staff was originally in the possession of the twelfth-century patron of the hospital,

[139] MCA, Brackley 194; Macray, Northampton I, No. 484.
[140] *The Book of St Gilbert*, eds R. Foreville and G. Keir (Oxford, 1987), pp. 304-7.
[141] Horden, 'Small Beer?', p. 359.

John de Lacy (d. 1240), constable of Chester, who held Gilbert (canonised 1202) in high regard and requested his staff which Gilbert happily gave to him. Subsequently, in a moment of anger, John struck a servant with the staff which broke into three pieces. The guilt and reverence for Gilbert meant that John placed one piece of the broken staff in his castle chapel, one in his hospital at Castle Donington, and one in his baggage. The healing properties of the said staff came to the fore when the warden of the hospital, Elias, fell ill and was close to death. Elias faced with his last moments recalled his earlier actions and payments of respect when Gilbert had died. Elias had fasted as was a traditional sign of respect and, consequently, requested St Gilbert's assistance in his own last moments. In this instance, Elias who had previously, owing to his illness, lost the ability to speak, had his speech restored through the intercession of the saint and immediately called for the piece of staff. The wood was placed on the part of his body which was most in need and suddenly his health was completely restored.[142] This account reveals several important points for this study. In the first instance, the patron gave the hospital a relic – something more than money or land. Secondly, that there was a belief, held by the master at least, that the relic could heal a sick person in conjunction with a saint's intercession. And finally, that hospitals contained relics – a further reason for a pilgrim to visit the house.

The provision of hospitality was, thus, wide-ranging: food lay at its heart, but accommodation and fuel also featured. Visits, as in the case of the provision of hospitality by aristocrats, could comprise a few hours, days, or even for the remainder of a guest's earthly life. It is unusual to find any direct association with the healing properties of herbs or the presence of physicians or relics within lesser-known hospitals, but here at least there are fleeting glimpses of a wider definition of hospitality whose ultimate aim was to care for the body. For some, these services were free of charge, for others indirect charges were made through grants of land. The level of special care varied, and this was evident in the negotiation of food provisions. What is clear is that these services were not limited to the poor.

[142] *The Book of St Gilbert*, Foreville and Keir, pp. 304-7.

Conclusion

This chapter has demonstrated that the provision of hospitality was an integral aspect of medieval life and a vital element in the creation of hospitals within this study. *Hospitalia* were founded in England throughout the twelfth and thirteenth centuries by both members of the laity and the clergy. These institutions assisted their patrons to fulfil their Christian obligation to provide hospitality. That hospitality was open to a wide variety of individuals both rich and poor. The service often comprised accommodation and entertainment, although that was not a prerequisite. The unifying feature was the sustenance of individuals through the provision of food to those in need because of sickness, poverty, or travel. Hospitals in small towns and villages were, therefore, carefully sited to be accessible to a wide variety of people hailing from near or far. Hospitality was a pivotal service offered by these institutions and, as such, was implicit within their most commonly-used name. It was not, however, the only method of sustaining their guests – as the following chapter will show, they were also houses of God which catered for the spiritual requirements of their visitors too.

Chapter Three: Care of Souls

The significance of the care of souls in the medieval period is beyond doubt. Carole Rawcliffe's seminal work concerning the hospital of St Giles in Norwich was clear that to cure the body, the soul must first be cleansed:

> 'The priest, aptly described in this decree [fourth Lateran Council, 1215, (cap. xxii)] as a physician of the soul, had at his disposal a pharmacopeia of potential cures, the best and most powerful was the medicine of Christ's body and blood as revealed in the sacrament of the Mass. Innocent III had described how the Eucharist washed away sin, bestowing eternal life and health through its redeeming grace. Such was the potency of this *medicina sacramentalis*, that the mere sight of the Host at the moment of elevation was deemed to ease the torment endured by sinners, and also relieve the more immediate earthly symptoms of disease'.[1]

In the Middle Ages, though, hospitals were not only concerned with cleansing the souls of the sick but also with saving the souls of their benefactors, temporary visitors, and residents – which comprised both the living and the dead. The administration of Extreme Unction to the sick and the need to remember the dead through prayers and intercessory masses were, thus, important components of hospital services.[2] However, the extent to which these services were offered and who the recipients were in the lesser-known hospitals remains not fully explored. One simple example should elucidate the problem. It cannot be categorically stated that all hospitals housed chapels within their precincts. The same applies to burial facilities, be they within a chapel or a piece of consecrated ground. Gaining an appreciation of how the buildings and land within a precinct were used has the potential to provide an insight into the amenities a hospital offered.

In this period, it is thought that many hospitals became 'collegiate churches or glorified chantry chapels', and, as a result, endowments intended to assist the poor were wasted on ostentatious displays of wealth.[3] This chapter will review the evidence to ascertain whether this could apply to hospitals within this sample. When reviewing that evidence, it was not assumed – perhaps

[1] Rawcliffe, *Medicine for the Soul*, p. 103.
[2] Ibid., pp. 103-32.
[3] Ibid., p. 107.

surprisingly given the importance of *medicina sacramentalis* and Christ the Physician – that all hospital precincts housed chapels.[4] The prayers of inmates could have been deemed sufficient. Adam Davis recently noted contemporaries saw the merit in giving alms to 'deserving recipients who could actually intercede spiritually on behalf of the almsgiver'.[5] On the other hand, the chapter also considers the notion that chapels might have always contained ostentatious displays of wealth, and that masses and elaborate services for the benefit of a variety of visitors were performed from the date of foundation. Within this review, attention is given to the wishes of the legal patrons and their vision of what comprised a hospital. If it was, therefore, the case that a hospital's spiritual work was equal to its work of hospitality – and Rawcliffe would place a higher value on the former services – it could be argued that if either service ceased the hospital remained a functioning establishment, a point to which Chapter Six returns.

This chapter, in a similar format to the previous chapter, considers which spiritual services the hospitals in this study provided, and to whom. It commences with an assessment of the existence of hospital chapels within the precinct but also considers extramural locations. In addition, it seeks to establish the extent to which a patron envisaged the provision of these services on foundation. It then moves to reflect upon the precise nature of these services and the reasons for the provision thereof. Again, as in the previous chapter, it is not concerned with the demand for these services and changes over time. It merely seeks to establish the *raison d'être* of hospitals in small towns and villages, which, as has already been shown, catered for a variety of visitors.

I: Chapels

When is a chapel a hospital and when is it not? At first sight, this may seem an unusual question, but contemporaries appear to have used the term 'chapel' interchangeably with the word 'hospital'. This is significant when trying to evaluate the primary source material herein in order

[4] Ibid., pp. 103-7.
[5] Davis, *The Medieval Economy of Salvation*, p. 67.

to assess the significance of spiritual services and the content of those services. It is well known that royal hospitals were often described as chapels.[6] There is an illuminating example contained within the Inquisitions Miscellaneous which demonstrates this point concerning a hospital outside of this study. In 1392, Richard II issued a writ to the bailiffs of St Oswalds, Nostell, concerning the friars preacher of Bamburgh. The friars had received the king's 'free chapel' in the said location as a gift to enlarge their dwellings. However, the friars had complained to the king that they were being hindered in their ability to use it. When in 1393 the bailiffs of the prior of Nostell replied to the king's enquiries, they stated that 'this supposed free chapel has from time immemorial been a hospital'.[7] The bailiffs then proceeded to describe how monarchs had paid for the maintenance of the hospital during voidances and the relationship between the hospital and its tenants. It is not known why royal hospitals were referred to in this way, but one suggestion could be that it emphasised the importance of their spiritual services.

The evidence concerning the two hospitals at Gateshead (both part of this study) was initially perplexing. The *VCH* provided a succinct summary of the 'hospital' of St Edmund the Bishop and Confessor, and the 'hospital' of the Holy Trinity.[8] Both are listed as hospitals in the work of Clay and K&H.[9] Yet some of the early primary source material does not use the term *hospitale* only *capella*. To add to the confusion, the recent published transcripts of the founding documents for the hospital of St Edmund have English summaries which also described the chapel as a hospital.[10] The Holy Trinity hospital was the earlier foundation known to be in existence by 1200, although the precise founding details are unclear.[11] The second hospital, St Edmund the Bishop, was founded by Bishop Farnham in 1248. The bishop donated lands to God, Edmund the Confessor, and four chaplains in the chapel which he had built (*in Capella quam construximus apud Gatesheved*).[12] The 'chapel' was then united with the then ailing Holy Trinity 'chapel'

[6] Denton, *English Royal Free Chapels*, p. 5.
[7] *CIM*: *1392-1399*, vol. 6 (London, 1963), p. 13.
[8] *VCH: Durham*, vol. 2, ed. W. Page (London, 1907), pp. 117-9.
[9] Clay, *The Mediaeval Hospitals of England*, p. 289; K&H, *Medieval Religious Houses* (1971), p. 321.
[10] *EEA 29: Durham, 1241-1283*, ed. P. Hoskin (Oxford, 2005), pp. 13-18.
[11] *VCH: Durham*, vol. 2, p. 117.
[12] *EEA 29: Durham*, p. 17.

(*capellam predictam cum suis pertinentiis capellae praenominate quam fundaverimus, praefata auctoritate consolidavimus*).[13]

In both cases, the brethren resided in the chapel. It is not known when this came to pass at Holy Trinity, but at St Edmund's the priest (who can be identified as the master in this case) and his men were described as residing in the aforesaid location (*presbiteri tamen et suo perpetuo in loco predicto residentes*).[14] In addition, three priests were subject to the master of house (*Predicto vero tres sacerdotes predicto Gilberto magistro domus et suis successoribus erunt obedientes*).[15] In this sentence the word *domus* (house) was used, and it is the view of this study that this signified that the foundation was a hospital. It seems the bishop, perhaps in the same way that monarchs used *capella* to describe a hospital, used the words *capella* and *domus* when referring to a hospital. What seems to differentiate a chapel from a 'chapel' is that individuals were resident in the *domus*. In addition, the bishop's ordinances for St Edmund referred to the Holy Trinity 'chapel' (*quoniam capelle sancte Trinitatis*) when uniting the two institutions and noted that the brothers had been accustomed to living there (*qui ibidem habitare consueverant*).[16] It is possible, then, in the case of Holy Trinity that this obscure house developed into a hospital as opposed to being founded as such. The inclusion of a master within the founding arrangements at St Edmund the Bishop also suggests that a hospital was in the process of being founded, as does the grant of land in 1249 to the four chaplains (*quatour capellanis in capella quam construximus*).[17] By 1340 the situation was clear: when the new master was collated to the office by Bishop Bury, the word *hospitale* was used: '*curam et custodiam hospitalis nostri Sancti Edmundi Episcopi et Confessoris in Gateheved*'.[18] Hence, the answer to the question at the start of the section is: a 'chapel' is a hospital when the site includes a house and master.

[13] Ibid., p. 14.
[14] Ibid.
[15] Ibid.
[16] Ibid.
[17] Ibid., p. 15.
[18] *Registrum Palatinum Dunelmense: The Register of Richard de Kellawe, Lord Palatine and Bishop of Durham, 1311-1316*, vol. 3, ed. T. D. Hardy (London, 1875) p. 380.

These steps in the foundation process are easier to see in the lay foundation at Brackley; and, thus, it is possible to describe the founder's vision of a hospital with more certainty. The first point to note is that the word *hospitale* was again not used in the foundation charter. Rather like the description of the foundation process at Aynho in Chapter Two which focused upon the word *hospitium* in the first instance, it is the concurrent documentation which confirms the intent of the founder to construct a hospital.[19] In the example at Brackley in *c.* 1160, the word *elemosina* was used to describe the land on which a series of buildings would be built to not only provide hospitality to the poor (*ad domu[m] [con]struendam et ad edificia paranda in quibus pro amore dei et salute animaru[m] n[ost]rarum pauperes recipiantur et hospitent[ur]*) but to house the earl of Leicester's *demesne* chapel (*Volo autem ut in predicta elemosina, in honore Sancti Johannis Ap[osto]li et Evang[e]liste edificet[ur] capella cum cimiterio libera ut mea dominica capella*).[20] But when the founder granted land to his clerk, Saloman, being first the master of the hospital in the same year, the word *elemosina* had been replaced with *hospitale* (*Capellano iconomo hospital[is] de Bracchele*).[21] Thus at Aynho the provision of hospitality appears to be the dominant service, whereas at Brackley the provision of hospitality and spiritual services are both given due prominence.

It is rare to find evidence such as this for hospitals located in small towns and villages in England which shows the dual core functions of hospitals. The inclusion of the chapel in the charter signified its importance to the earl. The significance of chapels to the aristocracy, in general, was a point noted by Christopher Woolgar. As late as 1473, a Burgundian court confirmed their centrality to daily life stating that the service of God and of the Duke's chapel must be the beginning and end of all things.[22] Thus, when a member of the aristocracy was on the move, it raises the question of where the requisite spiritual services were held. In the case of Brackley, for example, it is known that individuals other than the itinerant poor visited the demesne chapel of

[19] Chapter Two, pp. 36-8.
[20] MCA, Brackley 39.
[21] MCA, Brackley 5, B184; for *Iconomus* see 'Oeconomus', *DMLBS* (31 March 2020).
[22] Woolgar, *The Great Household*, p. 8.

the earl. For example, in 1271 the knight, John de la Haye, granted land, rents, and tenements to the hospital on the condition that whenever it came to pass that he or his heirs heard mass in the church of the master and brethren, and wanted to offer there, they were to be given 12d for that purpose (*q[uo]tiens [con]tig[er]i[n]t nos et h[er]edes n[ost]ros in eccl[e]sia[m] p[re]d[ic]t[orum] mag[ist]ri et frat[ru]m missam audire et ibid[em] offere volu[er]im[us]*).[23] And, as seen in Chapter Two, it is highly probable that reigning monarchs visited too.[24] This is in line with the earl's foundation charter which specifically mentioned the poor and arriving guests and the provision of spiritual services (*ut Saloman p[re]dictus et successores sui paup[er]ibus et hospitib[us] sup[er]uenientib[u]s pro salute anime mee et antecessor[um] meo[rum] et h[er]edum meo[rum] divina in ip[s]a cap[e]lla celebre[n]t officia*).[25] Thus, for the earl of Leicester the chapel was an integral part of the hospital precinct from the hospital's inception.

By the mid-fifteenth century, it seems that this process was normal. The following extract is taken from the Patent Rolls and, to be clear, does not relate to one of the hospitals within this study. It does, however, provide a clear view of the foundation process; and in this case, the significance of the chapel within that process is brought to the fore. So, rather than emphasising the importance of purchasing land for the *hospitium*, this process commences with the attainment of a chapel. In 1446, a chapel was built in New Braynford (Brentford) in Middlesex at the behest of the chancellor of the exchequer. The founding stone was laid by the king in honour of God, the Virgin Mary, and all the holy angels. This was the first step in the foundation process of the *hospital* which was to be 'contiguous to the said chapel' and provide services for 'nine poor men and a gild in honour of the nine orders of holy angels'. The king issued a licence for the master, brethren and sisters, and others in both the *hospital* and *chapel* to be called the 'gild of the nine orders of holy angels by Syon', and it was to be governed by one of their number.[26]

[23] MCA, Brackley 48.
[24] Chapter Two, p. 54.
[25] MCA, Brackley 39.
[26] *CPR*: *1446-1452*, p. 29.

In addition, the king issued a licence for the hospital to obtain lands to fund a chaplain to celebrate divine services in the chapel, and a clerk to care for the nine men and serve the chaplain. Finally, two sober and industrious servants were to be hired to care for the nine men who themselves were 'weak or impotent, to wit, blind, lame and withered'.[27] The evidence neatly encapsulates the variety of functions which were to be officially provided within the two buildings. The hospital's spiritual services were clearly as important as caring for the sick and poor men. In this case, then, the attainment of the chapel represented the first step in the foundation process. The two buildings were clearly designed to complement each other in the provision of services and the housing of those tasked with providing that care – they were both part of what Rawcliffe would term, the hospital precinct.[28]

At Aynho, on the other hand, the foundation process did not refer to a chapel at all. And in the same way that the founding documentation at Gateshead was initially perplexing, the subsequent use of a chapel by the hospital at Aynho was equally confusing. The foundation charter of *c.* 1180 did not refer to a chapel.[29] However, given that the bishop of Lincoln in *c.* 1190 gave consent to the hospital's creation there can be little doubt that the performance of services and works of piety which fell within the jurisdiction of his diocese would take place.[30] It is surprisingly difficult to ascertain the extent to which the hospital at Aynho possessed or had access to a chapel prior to 1210 when an extramural chapel was appropriated to the house. In this instance, Baldwin de Boulogne, with the assent of both his wife and son, gave the hospital his chapel following the death of Thomas the clerk, but the name of the chapel was not specified.[31] In a move to ensure clarity of title, another grant was made at a date between 1210 and 1215 by Walter the Chamberlain and his wife who appear to have had a shared interest in the unidentified chapel ('so far as it belongs to them'), and this time it was named as the chapel of St Michael.[32] This was

[27] Ibid.
[28] Rawcliffe, *Medicine for the Soul*, p. 45-6.
[29] MCA, Aynho 71.
[30] MCA, Aynho 22.
[31] MCA, Aynho 85; Macray, Northamptonshire III, No. 19.
[32] Macray, Northamptonshire III, No. 20.

confirmed by the bishop of Lincoln in February 1215 and the patron of the hospital, Guy de la Haye.[33] In the same year, the location of the chapel was recorded when its patron gave consent to its appropriation to the hospital. It was named as the *capelle de Crouleton* (a chapel in the neighbouring village of Croughton).[34]

It is unclear whether this was the only chapel associated with the hospital. In *c*. 1250-60 a grant was made by William de la Haye of Croughton to the hospital for the maintenance of a lamp before the altar of St Mary.[35] Another grant from William in *c*. 1260 revealed that he was the son of Guy and that Guy had specified in his will that two lights should burn daily at the Mass of St Mary.[36] The Mass of St Mary is associated with intercessory prayer and is, therefore, of particular relevance to hospital chapels.[37] In *c*. 1260 William made a further grant of land in return for which the brethren were to maintain a lamp before the altar of St Mary 'in the church of the hospital' (*vnu[m] lampade[m] in ecclesia dicti hospitali cora[m] altari beate marie inp[er]petuu[m]*).[38] A further link is that the *Taxatio* of 1291/2 recorded that a pension was payable by the parish church in Croughton to the master of the hospital in Aynho.[39] It cannot be categorically stated whether this referred to a chapel within the parish church at Croughton or the aforementioned chapel of St Michael which might have been a separate building in the same location and was described as such in the nineteenth century.[40] In this case, therefore, it cannot be proven that the hospital precinct housed a chapel in the twelfth century. Furthermore, the parish church at Aynho was in the gift of Walden Abbey and there is no evidence to suggest any links with the hospital – in fact,

[33] MCA, Aynho 82; Macray, Northamptonshire III, No. 21.
[34] *Liber Antiquus de Ordinationibus Vicariarum Tempore Hugonis Wells, Lincolniensis Episcopi, 1209-1235* (Lincoln, 1888), pp. 73-4.
[35] MCA, Aynho 66; Macray, Northamptonshire III, No. 32.
[36] MCA, Aynho 53; Macray, Northamptonshire III, No. 40.
[37] S. Roffey, *Chantry Chapels and Medieval Strategies for the Afterlife* (Stroud, 2008), p. 123.
[38] MCA, Aynho 27; Macray, Northamptonshire III, No. 35.
[39] 'Taxatio: Benefice of Croughton', https://www.dhi.ac.uk/taxatio/benkey?benkey=LI.NO.BR.20 (28 June 2020).
[40] G. Baker, *The History and Antiquities of the County of Northampton* (London, 1822), p. 602.

as the following section will show, the founder specifically prohibited the rector from interfering in the governance of the hospital.[41]

In addition to the detailed examples already discussed, there are also passing references in the lesser-documented houses which reveal the same fluidity in the language. For example, this was the case in 1393 at East Tilbury when it was recorded as 'the free chapel otherwise called the hospital or chantry of Estilbury'.[42] The site at East Tilbury was known as a poor hospital locally and the advowson was recorded as such in two inquisitions post mortem.[43] This trait was also noted by Norman Hidden in his study of the hospital at Hungerford: 'the hospital was variously referred to as hospital, priory or free chapel'.[44] Yet, there still remains at least the possibility that some hospitals did not house or were not associated with a chapel. At Armston, for example, the house was described as with chapel (*hospitale cum capella*), thus implying that there were hospitals without a chapel.[45] In addition, it must be acknowledged that the evidence does not exist to definitively state that all the hospitals in this study were able to access chapels – those for which there is only one piece of extant evidence being a prime example.

What this section has categorically demonstrated is that hospitals could be founded in a variety of ways. There is a small amount of evidence that suggests that monarchs and bishops might have placed an emphasis on the chapel over the residential accommodation in comparison to other founders – but the sample of hospitals under assessment would need to be increased to conclude one way or the other. Nevertheless, there is enough evidence to conclude that for the three hospitals assessed in detail, chapels were important elements in their early years and, thus, not an

[41] 'Taxatio: Benefice of Aynho', https://www.dhi.ac.uk/taxatio/benkey?benkey=LI.NO.BR.21 (28 June 2020).
[42] *CPR: 1391-1396, Richard II*, vol. 5 (London, 1905), p. 265.
[43] I. H. Jeayes, *Descriptive Catalogue of the Charters and Muniments in the Possession of Lord Fitzhardinge at Berkeley Castle* (Bristol, 1892); *CIPM:1361-1365, Edward III*, vol. 3 (London, 1912), p. 376; *CPR: 1391-1396*, p. 265.
[44] N. Hidden, 'The Hospital or Priory or Free Chapel of St John the Baptist in Hungerford', *The Wiltshire Archaeological and Natural History Magazine*, 83 (1989), p. 96.
[45] *The Rolls and Register of Bishop Oliver Sutton, 1280-1299*, vol. 2, ed. R. M. T. Hill (Hereford, 1950), p. 149.

adjunct to the care of the poor which were only developed in the later Middle Ages. How those chapels were used forms the subject of the next section; the answer to which may shed light on the value of spiritual services to these institutions in comparison to the wider range of services on offer.

II: The Provision of Intercessory Services

In 2013, Rawcliffe emphasised the need to understand contemporary concern for the spiritual health of an individual and 'even more of a wider community of the past, present and future patrons'.[46] In her view, the intercessory role of charitable institutions merited further attention – their contribution to this social need being regarded by historians as 'an unfortunate departure from their proper charitable functions'.[47] However, this is often difficult to achieve owing to either a lack of surviving evidence or the records are silent – the intent of a donor being one such example.[48] Nevertheless, for Rawcliffe it was still important to consider manifestations of popular piety and the intercessory role of hospitals.[49] With these points in mind, this section seeks to ascertain the extent to which the care of an individual's soul and the performance of chantry masses and other works of piety formed a pivotal role in these houses of hospitality.

Given the transient nature of the visits made by guests, it might have been the case that these services were solely intended to benefit the founders of these houses and their heirs. On the other hand, visitors were sick pilgrims or resident ageing servants, retired priests, and paying corrodians; these individuals are likely to have both participated in intercessory services and benefitted from these services. In addition, it is possible that these hospitals were highly regarded by the local population in small towns and villages, and that residents sought to benefit from their spiritual services. In a comparable way to the varying duration of services of hospitality offered

[46] Rawcliffe, 'Communities of the Living and the Dead', p. 134.
[47] Ibid., p. 133.
[48] Ibid., pp. 139-40.
[49] Ibid. p. 130.

in life, assistance to care for the spiritual diseases of the souls of the living and the dead might have varied in length too. There are, therefore, an array of potential outcomes of this research, and within the ensuing analysis a key question to explore was the nature of those pious services.

Turning in the first instance to the question of aristocratic chantries, the work of David Crouch has identified the baronial origins of the idea of employing priests to perform masses for the soul of an individual and its inception in the reign of Henry I. This idea developed during the twelfth century, leading to an understanding of a chantry as 'a priest or priests maintained and salaried for the purpose of saying numerous masses for the soul of a particular man, his family and friends (and in later days 'all faithful departed)'.[50] Initially, the use of the word *cantaria* was not connected with death and the souls of the deceased: it merely referred to any chapel in which mass was sung. By the thirteenth century, it signified an association between the daily sung offices, tombs, and at least a nominated altar if not a chapel – hence, a clear connection with the dead. With reference to monastic houses, the practice became associated with a patron's right to nominate a priest within the community to guarantee that their prayers were targeted to the correct individuals.[51] The two services merged to become a commemorative mass with interspersed prayers for the named dead. As a result of increasing demand, the way in which the services were funded changed, as did where they took place. Ecclesiastical benefices were created, and secular priests instituted and inducted into the living by the diocesan bishop.[52] In turn, private manorial chapels were converted by knights and other members of the gentry to accommodate chantry services; and finally in the fourteenth century, fraternities brought the services of a chantry priest to a greater array of individuals often connected to the local parish church – thus resulting in what Crouch has labelled a 'perfect example of downward cultural diffusion'.[53] But the extent to which these services and diffusion of ideas permeated their way through hospitals was not considered.

[50] D. Crouch, *The Image of Aristocracy in Britain, 1100-1300* (London, 1992), p. 316.
[51] Ibid., p. 319.
[52] J. McNeil, 'A Prehistory of the Chantry', *Journal of the British Archaeological Association*, 164/1 (2011), pp. 1-38, at p. 2.
[53] Crouch, *Aristocracy*, p. 321.

The hospital at Aynho, as noted in Section I, possessed an extramural chapel in the nearby village of Croughton. This chapel was annexed to the hospital approximately 30 years after foundation. There is no evidence of a chapel within the hospital precinct, overnight accommodation, or cemetery; and, in addition, a thirteenth-century episcopal inquisition noted that the hospital was not responsible for cure of souls.[54] Chapter Two has shown that it was undoubtedly founded to provide the service of hospitality to poor brethren. By 1282, this remit had either extended to include the poor, weak, and infirm (*ad hospitandum pauperes et debiles ac infirmos illuc accedentes*); or Bishop Sutton was providing clarification as to who the poor (lay) brethren were as part of a routine investigation upon the presentation of the patron's candidate for institution.[55] On foundation, the patron went to great lengths to obtain a declaration from the rector of the church of Aynho that he had no right in the charge or governance of the hospital (*nich[il] juris h[abe]re ut unq[uam] h[ab]uisse in custodia et gubernat[io]n[n]e hospitali*).[56] Therefore, this hospital's main work of piety was the provision of hospitality to the poor, weak, and infirm operating independently of the parish or mother church but within the remit of the diocesan bishop.

The extramural chapel does, however, signify the performance of a secondary work of piety – the performance of chantry masses as part of an aristocratic familial duty.[57] The chapel was originally gifted to the hospital by Baldwin de Boulogne for the souls of himself, his wife, his sons William and Walter, Geoffrey de Waffre, Beatrice, and all his ancestors.[58] Geoffrey was the father of his wife Alice, and it is assumed that Beatrice was the wife of Geoffrey.[59] Subsequently in *c.* 1250, an unknown person but presumably local individual, Thomas de Crewelton, granted two acres and a rood of land if the brethren celebrated annually on St Machute's day for the anniversary

[54] *The Rolls and Register of Bishop Oliver Sutton, 1280-1299*, vol. 2, p. 17.
[55] Ibid.
[56] MCA, Aynho 68.
[57] *OED* definition of piety includes 'Faithfulness to the duties naturally owed to one's relative, superiors, etc.', 'Piety', *OED* (Oxford, 2006), http://www.oed.com/view/Entry/14364 (31 Mar. 2019).
[58] MCA, Aynho 85.
[59] MCA, Aynho 83.

(*anni[ver]sarius*) of Margaret, countess of Kent.[60] Given the dates, the intended recipient must have been the third wife of the justiciar, Hugh de Burgh (d. 1243), the eldest daughter of William the Lion, king of the Scots, (d. 1214). The countess died in 1259.[61] Later, in *c.* 1270, a specific grant was made by the then patron, Robert Fitzroger, knight, to maintain a chaplain (*sustinere unu[m] cap[e]ll[anu]m*) to celebrate divine office for the souls of his grandmother the countess of Dunbar (*ad celeb[ra]ndum diuina p[ro] anima Eu...dam* [damaged] *comitisse de Dunbar avie mee*).[62] In this case, the countess in question is most likely to have been Countess Euphemia the wife of Patrick Dunbar (d. 1248), the fifth earl of Dunbar.[63] Here, then, are a series of examples of downward cultural diffusion manifested in lordly duties of gentry piety for family or feudal overlords.

The precise nature of these services for the souls of the living and the dead, which even at an early stage were sometimes lavish in nature, can be seen in the hospitals at Ospringe and Kepier. This is not in itself wholly surprising given the former was a royal foundation and the latter an episcopal one. Nevertheless, in the context of trend-setting founders, the wider provision of intercessory services, and the perhaps surprising role that hospitals in small towns and villages played within society, it is worthy of a succinct discussion. There is a memorandum in the Close Rolls as early as 1235 of a *cantaria* permitted by the abbot of St Augustine, Canterbury, at Ospringe to which the king's seal was appended.[64] The king appears to be giving his approval to an agreement that permitted mass to be sung in the chapel as opposed to *cantaria's* later association with the saying of office for a departed soul. [65] Subsequently, however, the

[60] MCA, Aynho 36.
[61] F. J. West, 'Burgh, Hubert de, Earl of Kent (*c.* 1170-1243)', *ODNB* (Oxford, Sept. 2004), https://ezproxy-prd.bodleian.ox.ac.uk:2095/10.1093/ref:odnb/3991 (29 Jan. 2020).
[62] MCA, Aynho 51; *The Rolls and Register of Bishop Oliver Sutton, 1280-1299*, vol. 2, p. 107.
[63] Fiona Watson, 'Dunbar, Patrick, Eighth Earl of Dunbar or of March, and Earl of Moray (1285-1369)', *ODNB* (Oxford, Sept. 2004), https://ezproxy-prd.bodleian.ox.ac.uk:2095/10.1093/ref:odnb/8206 (28 Mar. 2020).
[64] *CR: 1234-1237*, vol. 3 (London, 1908), p. 164, '*Memorandum quod sigullum domini regis appensum est instrumento facto inter Robertum abbatem Sancti Augustini Cantuarie et ejusdem loci conventum ex parte una, et fratres Hospitali Sancte Marie de Osspring' ex altera, de cantaria habenda in prefato hospitali*'.
[65] Crouch, *Aristocracy*, p. 318.

unequivocal association with death, and the death of an individual of the highest status, is apparent. In 1240, Henry III ordered Walter de Burgo, keeper of the king's estate (*demesne*), to search for a chaplain to celebrate divine office in the chapel for one year for the soul of his late uncle, William de Valence, who should be funded from the manor of Ospringe with a stipend of 50s.[66] In 1256, the funding was augmented by the king in order to fund a chaplain to celebrate the Mass of Edward the Confessor on a daily basis in the hospital.[67] By 1299, either a new chapel was ordered or provision made to refurbish the existing one, as evidenced by the gift of eight oaks for timber by Edward I.[68] Thus, if hospital intercessory services were an unfortunate departure from caring for the poor, the decline was evident in the thirteenth century.

The range of liturgical services offered by hospitals can be gleaned from the inventories of goods, bequests, or problems identified in visitation reports – the hospital of St Edmund the Bishop at Gateshead being a particularly informative example in the context of hospitals located in small towns and villages. An inventory taken in 1325, of which the following is a translation of the original Latin text, provides a rare insight into just how sumptuous its vestments were and the nature of its services which could be conducive to both spiritual and somatic health:[69]

> 'First, in the chapel, two gilded chalices, four robes, of which one is good, with a tunic and dalmatica of the gift of John de Denton, and of the other three robes, one vestment is very frail. Item, one alb *per se*, with a stole (*stola*) and banner (*fanula*),[70] of the gift of the same master John, four [blank in manuscript] and dalmatica, two cloaks of silk. In the choir, two missals, of which the best is of the gift of master John, one priest's book (*manuale*), three antiphonaries, two average, and the third, good, of the gift of the same master John, one martyrology (*legenda*), two collectars (*collectaria*), one ordinal, two psalters, a third the gift of the same master John, six blessed altar cloths (*tuealia*), of which the best two are of the gift of the same master John, one frontal and blankets, four surplices, greatly frail, one incense burner (*thuribulem*) of silver and lead alloy, two candelabras of metal, four phials (*phioli*).'[71]

[66] *CLR: 1226-1240*, pp. 240, 266.
[67] *CChR*: *1226-1257*, p. 391.
[68] *CCR*: *1296-1302*, p. 269.
[69] See Horden, 'Small Beer?', p. 360 for a summary of key texts concerning contemporary theology and medical theory.
[70] Latham, *Medieval Latin Word-List*.
[71] *The Register of Richard de Kellawe*, vol. 1, p. 84.

The antiphonaries, also known as chant books, indicate that parts of the services were sung and contained the notation to assist the singers during the performance of divine office. In the later medieval period, a breviary was often used as it was not possible for priests and monks to perform the full office. In this example, the inclusion of the psalters and collectars indicate that a full round of services was provided with the antiphonary providing the music for the chants. The *manuale*, also known as the *rituale*, provided priests with non-eucharistic liturgical texts to assist them to perform other liturgical rites as part of their ministry.[72] Two relevant examples for this study would be Extreme Unction and funerals. This could include the provision of candles which were thought to assist the soul through Purgatory.

The importance of these services appears to have continued into the fifteenth century in these locations: Archbishop Chichele's ordinances (1425) for the hospital at Brackley reveal the standards expected of these houses. The hospital was to have two chaplains who were to understand reading and singing; and in addition, the archbishop specified the following practices:

> 'three choristers, who on ordinary days shall say matins and vespers and the other hours together in the same chapel in a low voice, and shall also every day at fitting times chant by note and with due modulation and devotion high Mass at the altar, or at any rate Mass of the blessed Virgin in some convenient place within the same...also that the same chaplains [and] clerks shall be bound, on Sundays and on each principal and double feast, to sing matins, vespers and Mass by note in the quire of the chapel aforesaid.'[73]

The reference to chanting by note and singing are obvious indicators of the musical nature of the liturgical practices. Beds were to be provided for one night for those in need who were travelling or on a pilgrimage, and longer at the discretion of the master. The poor were enticed into the chapel every Friday by the distribution of bread or money, but only on the condition that they offered prayers at the Requiem Mass which was said for the souls of the founders and benefactors in the chapel.[74] So here, then, the provision of hospitality to the poor was an integral part of the intercessory services on offer to donors.

[72] J. M. Pierce, 'Medieval Christian Liturgy', *Oxford Research Encyclopedia* (2016), pp. 1-19, at p. 8.
[73] *Visitations of Religious Houses in the Diocese of Lincoln*, vol. 1, ed. A. H. Thompson (Horncastle, 1914), p. 18.
[74] Ibid., p. 19.

Unusually rich source material exists which sheds light on who these previous benefactors were and their precise requirements. Earlier in the history of this hospital, in 1256, the then patron Roger de Quincy, earl of Winchester, endowed two chaplains to celebrate in perpetuity in the hospital chapel: one for the soul of his brother, Robert, and one for the soul of his late wife, Elena.[75] By 1270, the services had lapsed and the new patron, Elena la Zouche, not only reinstated the ceremonies, she expanded the number of recipients and requisite chaplains to eleven. It is a rare example within this sample of hospitals and the wider historiography as it specified the role of each chaplain. Therefore, a summary of the provision is included below with their names listed in the original spelling:

Table 5: Chaplains at Brackley Hospital, 1279[76]

Chaplain	**Beneficiary**
John de Chynnore – Magister Frater Nicholas de Kinebautone Frater Thomas Swet	Roger de Quincy, earl of Winchester
Frater John de Kent	Robert de Quincy, brother of the said earl
Frater Richard de Wappenham	Joan, the late countess of Eu
Frater Geoffrey de Haush [Halse]	Ellen, the late countess of Winchester
Frater William de Dorsete	Richard de Yvetot
Brother Richard de Undele Sir Maurice the chaplain	Matilda Marshall, late countess of Winchester
Brother Alan and another chaplain	Lora, sister of the earl

This evidence demonstrates an association between the aristocratic family and nominated members of a community – a point also noted as being significant by Crouch with reference to monastic houses.[77] Many of the chaplains were tasked with caring for the souls of the earl's relatives. A further and unequivocal connection can be seen when Elena released the hospital from the obligation to provide a chaplain at her private chapel in nearby Halse; instead, the hospital was ordered to ensure that celebrations took place in the hospital chapel for her soul and that of her late husband, Alan.[78] And these actions all took place prior to the official commendation of Purgatory at the Second Council of Lyons in 1274 and the subsequent profusion

[75] MCA, Brackley 4A; Macray, Northamptonshire I, No. 187.
[76] MCA, Brackley B67; Macray, Northamptonshire I, No. 339.
[77] Crouch, *Aristocracy*, p. 317.
[78] MCA, Brackley B67.

of chantry endowments, obits, and purchase of indulgences which were so closely linked to the salvation of a soul.[79]

Within Table 5, there is one entry which unmistakably sheds light on the importance of these hospitals to aristocratic families, and, again, provides an invaluable insight into the minds of the individuals concerned. Frater Richard de Wappenham was tasked with celebrating divine office in perpetuity for the soul of Joan, late countess of Eu.[80] The original request occurred in *c.* 1250 when Roger de Quincy, earl of Winchester and patron of the house, created the endowment to fund the chaplain following the bequest of several items to the hospital in the countess's will. In this deed, she is described as Joan of Eu, lady of Criel, countess of Brittany.[81] The countess is not known to have had a direct connection with the hospital. However, further investigations revealed that she is thought to have died in the hospital on 3 October 1252.[82] This seems likely as there is evidence of the countess's grant of rent to fund a chaplain in the church of Eu which was dated at Halse in 1252, Halse being the hamlet next to Brackley.[83] This grant was witnessed by the earl. The countess, a stranger in need and seemingly close to death, who appears to have repaid the hospital's hospitality by donating several items in her will to it, including 140 *Livre Tournois* (*septie[s] vig[in]ti libris turoij*), a gold girdle, and a gold comb to buy a chalice, was evidently grateful for the care afforded to her as she began her journey into the afterlife. The dutiful earl replaced the gifts with the donation of 5 marks annually from the mill at Brackley to directly fund a chaplain to commemorate the countess for evermore.[84]

Gifts were made by a variety of people for a variety of people. In an early example of *c*. 1170, 23 acres of land were granted to the hospital at Brackley by Gilbert de Monte with the consent of

[79] J. Le Goff, *The Birth of Purgatory* (London, 1985), p. 237.
[80] MCA, Brackley B67.
[81] MCA, Brackley C108.
[82] G. W. Watson, 'The Marriages of Pierre Mauclerc, Sometime Duke of Brittany and Earl of Richmond', *The Genealogist*, 36 (1920), pp. 1-8, at pp. 4-6.
[83] Ibid., Bibliothèque Nationale de France, Cartulaire du Comté d'Eu, MS Latin No. 13904 f. 68 r and v, https://gallica.bnf.fr/ark:/12148/btv1b10033276z/f70.image and f71 image (20 Feb. 2020).
[84] MCA, Brackley, C108.

his wife and heirs. The gift was for the poor and the donor's mother and father.[85] In return, Gilbert was to be received into the brotherhood of the house and to participate in two weekly masses – one for the living and one for the dead.[86] Another grant shows a concern with immediate family as opposed to the poor. In *c*. 1170, Philip Sorel granted land to the hospital which his father bequeathed to him on death. In return, Philip requested that his deceased father, mother, himself, wife, brothers, and sisters all be entitled to the benefits of the house.[87] A slightly later grant by Aeliz de Rumeili gave four acres of land for the souls of her father, mother, son, mother-in-law, and all her forefathers.[88] Participation in the benefits of the house was unfortunately not specified; thus, it is not known whether this was an early fraternity or whether the individuals concerned sought to benefit from the general pious works of the house such as prayers and masses. What is clear is that these individuals were fulfilling their duty to their ancestors and that attempts were made to ensure that these services persisted. For example, in the sixteenth century the chantry commissioners specifically noted the importance of hospitality and stated: 'The Hospitall of Mary Magdalen *juxta* Bawtrie, founded by one Robert Morton for a Priest, there to be resident, and to keepe Hospitalitie for poore People, to pray for the Founder's Soule and all Christian Soules'.[89]

An additional role of the priest within these houses was to offer spiritual services to the sick, including pilgrims. If an individual died while on such a venture, they received total remission for their sins.[90] At Brompton Bridge, there is evidence that individuals were buried with their pilgrimage badges. In these cases, the individuals concerned appear to have travelled across Europe but many pilgrimages were local.[91] It is possible that some of the visitors to Brackley, for example, were attending the holy well dedicated to the local saint, Rumwold, who was said to be

[85] His father, Richard, worked with the sheriff of Oxfordshire in 1110 as stated in J. A. Green, *The Government of England under Henry I* (Cambridge, 1986), pp. 147-8.
[86] MCA, Brackley D24; Macray, Northamptonshire I, No. 6.
[87] MCA, Brackley 8A; Macray, Northamptonshire I, No. 10.
[88] MCA, Brackley B98; Macray, Northamptonshire I, No. 12.
[89] Thomas Hearne, *The Works of Thomas Hearne, M. A.: Vol. IV, Containing the Second Volume of Peter Langtoft's Chronicle* (London, 1810), p. 400.
[90] Roffey, *Chantry Chapels*, p. 124.
[91] E. Duffy, 'The Dynamics of Pilgrimage in Late Medieval England' in *Pilgrimage: The English Experience from Becket to Bunyan*, ed. C. Morris and P. Roberts (Cambridge, 2002), pp. 164-77, at pp. 165-6.

buried in Kings Sutton, Brackley, and Buckingham.[92] In 1695, John Philipot wrote of St Rumbals' (sic) well in Brackley that it was 'Much frequented in the misty Times of Popery for the Cure of sore Eyes, and Maladies'.[93] Perhaps a pilgrim visited the hospital in order to observe the consecrated elevated host before proceeding to the local shrine.

It is also open to debate to what extent the sick could have taken part in the liturgy as is widely thought to have normally been the case. It has already been shown that the chapel at Catterick was not thought to be an infirmary hall style: that is, a hall containing rows of beds with a chapel at its east end.[94] This may be due to the number of visitors passing through the precinct on a daily basis – either to maintain the tranquillity of the hospital or the chapel. It might have been the case that many of the sick were able to take the short walk to the chapel. This is known to have occurred at Clyst Gabriel where offices and masses were said in the chapel on a daily basis by two chantry priests, but they were assisted by elderly infirm priests if they were able to do so, the chapel being open to the public and located in a separate building. These inmates were relatively independent, receiving an allowance and being expected to feed themselves, but they lived as a community. Ordinances issued after a visitation in 1329 provide a further insight into their communal activities and the importance of their chapel. Bishop Grandisson stipulated that the chapel should receive the offerings of wax, books, vestments and church goods, and two-thirds of the money, rings, broaches, and donated animals. When an infirm priest died, two-thirds of their money and their service books were to pass to the chapel too.[95]

One final example, which draws together both this and the previous section, concerns the lesser-known hospital at Sprotborough. An inventory of the hospital's possessions during the reign of Henry VI was transcribed and published by a nineteenth-century antiquarian. It is partially

[92] D. H. Farmer, *The Oxford Dictionary of Saints* (Oxford, 1992), p. 424.
[93] J. Philipot, *Villare Cantianum, or Kent Surveyed and Illustrated* (London, 1659), p. 54.
[94] Godfrey, *The English Almshouse*, pp. 20-32.
[95] N. Orme, 'A Medieval Almshouse for the Clergy: Clyst Gabriel Hospital Near Exeter', *The Journal of Ecclesiastical History*, 39/1 (1988), pp. 1-15, especially pp. 4 and 6.

damaged, hence the lack of precise dating, but it paints a picture of a much-loved hospital church and chantry (chapel), and it sheds light on the importance of its spiritual services. The *cantaria* and its contents were listed before the *corpore ecclesia*, both of which appear to have been recently refurbished. The chantry was located on the bridge complete with a stone window and new tabernacle. There were painted tables, a new altar (auter), two new cloths with two frontals with fringes of silk for hanging them, as well as a new vestment, canopy, and desks. In the body of the church there were two new altars with board coverings, four new images (Catherine, Matthew, Thomas, and William), and a new window at the Thomas altar. In addition, the hospital church possessed a new lamp, window, and door into the garden, and a table painted with a crucifix, Mary, and John.[96] This document presents a rare insight into the ongoing care and maintenance which this house at least continued to receive in the fifteenth century – despite, as will be seen in Chapter Six, calls for reform and the loss of assets at other hospitals. This close attention to detail and care is something which was also in evidence in the provision of hospitality to the dead.

Some hospitals, such as Aynho, focused upon hospitality; others, such as Gateshead and Ospringe, emphasized the chapel; and the hospital at Brackley did both. But at Aynho if the chapel was not given due prominence at the outset, as appears to be the case, later grants of land and an association with the nearby village of Croughton appear to have extended the functions of this house, albeit outside of its precinct. This was, however, still in the thirteenth century. Patrons were not averse to interfering in ensuring chaplains were in place in accordance with the stipulation of gifts to hospitals to provide intercessory services – again in the thirteenth century. There was no substantial evidence of a shift in focus in the later period to the provision of spiritual services. Gifts were received from a variety of individuals throughout the period in question, and in general as far as can be seen, these continued to be essential services. Even the lesser-known

[96] P. Edward, 'A Mutilated Roll of Instruments Relating to the Hospital of St. Edmund, at Sprotborough, near Doncaster; with Prefatory Remarks by Edward Peacock, Esq. F.S.A. Local Secretary for Lincolnshire in a Letter Addressed to Charles Spencer Perceval, Esq. LL.D. Director', *Archaeologia*, 42/2 (1870), pp. 398-404, at pp. 403-4.

hospital at Sprotborough was able to reinvest in the religious paraphernalia as late as the fifteenth century in both its *cantaria* and *ecclesia.*

III: Hosting the Dead

As the seventh work of corporal mercy, the burial of the dead was an important service offered by medieval hospitals. It is acknowledged in the historiography of medieval death and burial that the performance of this work was difficult for an individual to execute for another person. Christopher Daniell has discovered one rare example of a will which made provision for the burial of another human being: in 1495, James Lounedale provided for 'poor maid's dowries and those without the means that they might be buried'.[97] What appears to have been overlooked is the role of the hospital in fulfilling this need. Some individuals might have wished to benefit from the prayers and masses performed by the chaplains and inmates of these houses in both life and death; but others wished to lay their earthly bodies to rest within the confines of the precinct for eternity. Thus, by endowing a hospital a donor assisted in the performance of this work. These were points considered by Carole Rawcliffe in a 2004 paper which noted the emphasis placed upon the community of the dead as well as the living, and the spiritual welfare of patients. Rawcliffe highlighted the importance of a good death and the role which hospitals played, often adapting their buildings in the post-Black Death period to accommodate the growing fear of Purgatory: intercessory prayers and masses, as well as elaborate rituals and services, were in demand.[98]

Within Rawcliffe's analysis, brief consideration was given to the role of small hospitals on pilgrimage routes and the benefit of locating hospitals on the edge of towns with vacant land suitable for new cemeteries. There is, however, room to explore these quasi-urban locations and their role more fully within society. Thus far, this chapter has suggested that the spiritual services

[97] C. Daniell, *Death and Burial in Medieval England 1066-1550* (Abingdon, 1997), p. 20.
[98] C. Rawcliffe, 'The Seventh Comfortable Work: Charity and Mortality in the Medieval Hospital', *Medicina & Storia*, 3/6 (2003), pp. 11-35.

of a hospital were of equal value to their services of hospitality. This could be viewed as a package of care in which a hospital extended its provision of hospitality in life into death. To put it another way, it is likely that individuals did not differentiate between services for the living and the dead to the extent that people do today: the boundaries were permeable. Section II has considered the concurrent care of souls in life and death; this section seeks to ascertain the extent to which hospitals in small towns and villages catered for the dead. It explores to whom these services were provided and whether they catered for a wide range of individuals in death as in life.

There are striking similarities at Brackley where a variety of guests were catered for in death as in life. As early as 1160, the hospital obtained a licence for a church with burial rights in their cemetery from the abbot of the Abbey of St Mary de Pratis (or St Mary of the Meadows), Leicester, whose deceased guests could include the poor, their family, their servants, and strangers (*Sepulcuram etiam paup[er]um et familie sue et seruientiu[m] suorum et p[er]eg[ri]no[rum] in predicto hospitali decedentium in cimeterio suo*).[99] These individuals were permitted burial in the hospital cemetery; furthermore, the master and brethren, if in priests' orders, were authorised to hear the confession of the poor and sick within their precinct, to administer the last rites to wayfarers (*et in artic[u]lo mortis viaticu[m] ministret*), and in Lent and on Easter Day administer the Eucharist.[100] Therefore, the intention of the founder was that the hospital should cater for both the poor and strangers alike. As well as the poor and strangers, though, there is no doubt that this hospital precinct was designed to house legal patrons and their ancestors. The interment of the heart of the earl of Leicester within the chapel has already been noted.[101] In addition, there is a detailed grant from Roger de Quincy, earl of Winchester, in *c.* 1240 describing a candle which was to burn day and night over the hearts of his mother Margaret (*pendere sup[er] tumulos cordium margar[ete] bone memorie Commi[ti]sse Win[n]on' m[at]r[i]s n[os]tre*) and his brother, Robert. Their hearts were buried before the high altar of the church (*ante magn[um]*

[99] MCA, Brackley 5; Macray, Northamptonshire I, No. 4.
[100] Ibid.
[101] Chapter Two, p. 47.

altare). Moreover, Roger bequeathed his own body to the hospital over which the said candle was also to be hung (*et sup[er] corp[us] n[ost]r[u]m quod ego delego concedo et confino*).[102] This is unequivocal evidence of an aristocratic duty to care for the dead, a desire to be accommodated together in death, and to rest near to the high altar in order to partake in the intercessory services performed in the hospital chapel.

There were other high-profile elective burials in the hospital which were described by the king's antiquary, John Leland, in the sixteenth century:

> 'There is in the Midle of the Towne a Churche of Seint James and S. John, somtime a College and an Almose House or Hospitale. This was suppressyd and gyven to S. Magdalenes College with Lands. There ly buryed in Tumbes dyvers Noble Men and Women in the Presibitery of this Churche: first 2. Noble Men in on Tombe havynge in theyr Shelds a Lyon Rampant and Flures de Luce.
>
> There lyeth on the South Syde in the Wall a Noble Man havynge in a Feld of Gules 10. Besants of Gold. And at his Feete lyethe a nother havynge in his Sheld a Lion Rampant. Ther lyethe also Robert Holand that dyed in Anno D[omi]ni 1373. Mawd his Wyfe lyethe there also.
>
> Ther lyeth a Noble Man and his Wyfe. He berithe in his Shild Varre Gold and Gules. One told me that of late Dayes one of the Lordes Lovells was taken for Foundar there, and that by his Graunt it cam in Gyft to Magadalen Coledge.'[103]

This description is interesting as it reveals that the hospital was in the middle of the town not at the entrance or next to a bridge. It was intended to be a central part of the local life of people, not just those passing through. The Robert de Holland identified by Leland as dying in 1373 was buried at Brackley, but his wife was not named Maud. Maud was his mother, wife of Robert de Holland who died in 1328. Robert de Holland (d. 1373) left instructions in his will that he desired to be buried at the church of St James and St John at Brackley and left eleven marks for a marble stone for his tomb.[104] There are other known notable patronal burials at the hospital described in

[102] MCA, Brackley B229.
[103] *The Itinerary of John Leland the Antiquary*, vol. 7, ed. J. Leland (Oxford, 1744), pp. 5-6.
[104] J. Clarke, *The Book of Brackley: The First Thousand Years* (Buckingham, 1987); A. Gibbons, *Early Lincoln Wills...Comprising the Counties of Lincoln, Rutland, Northampton, Huntingdon, Bedford, Buckingham, Oxford, Leicester, and Hertford, 1280-1547* (Lincoln, 1888), pp. 52-3.

the manuscript evidence. These comprised Lord Alan la Zouche (d. 1314) in the choir of the hospital and Lord John Lovell (d. 1408).[105] This is an impressive array of patronal support for this institution: there can be no doubt that these men and women held the hospital in high regard in both life and evidently in death too.

But this popularity was not restricted to the wealthy or higher-status individuals; it included ordinary parishioners too. In 1219, an agreement was reached with the mother church that if a member of the parish wished to be buried in the hospital, the body should be taken to the mother church in the first instance where mass should be celebrated and due offerings made (*pri[mum] deferetur corp[us] ad m[atr]icem eccl[es]iam et missa ibi celeb[ra]ta et oblat[i]o[n]e debita f[act]a*).[106] This was also the case, as noted above, at Portsmouth. In this instance, however, it was also specified that their first legacy be made to that church and, adopting an extra-cautious approach, that the parish priest was to be present at the making of their wills – such was their obvious popularity and threat to the local church. For this privilege, the hospital paid an annual fee in five instalments.[107]

For other hospitals in this study, archaeological evidence provides vital information which complements the manuscript sources. The burial findings at Brompton Bridge are essential to this study – put simply, without this evidence our understanding of the individuals associated with this house would be significantly reduced. In the first instance, there were three graves located within the hospital chapel, as opposed to the cemetery, thus signifying the social standing of the deceased individuals. The report suggests that the central grave was most likely to be that of a

[105] *Testamenta Vetusta: Illustrations from Wills, of Manners, Customs etc. from the Reign of Henry the Second to Queen Elizabeth*, ed. N. H. Nicholas, vol. 1 (London, 1826), p. 173; MCA, Brackley D250 (6); Macray, Northamptonshire I, No. 520; Macray, Northamptonshire I, No. 518. An indulgence of 40 days was issued by the bishop of Hereford in 1318 to persons in his diocese who shall say the Lord's Prayer and Ave for the soul of Sir Alan la Zouche, knight who lies buried in the choir of the church of the hospital (*qui pro anima d[omi]ni Alani la Souche mil[i]tas cui[um] corpus in choro eccl[es]ie hospitalis b[on]or[um] Joh[ann]is & Jacobi de Brakkel Lincoln[iensis] dioc[esis] requiestit humatum*).
[106] MCA, Brackley 187.
[107] H. P. Wright, *The Story of the 'Domus Dei' of Portsmouth, Commonly Called the Royal Garrison Church* (London, 1873), pp. 5-6.

benefactor which would concur with the documentary findings at Brackley. What is highly unusual in respect of this study is the identification of the two other bodies – both were juveniles. It is rare to find children associated with hospitals other than in the *pro anima* clauses of grants, and in these cases no mention is made of their age – in other words they could be adults. Whether they were the children of the unidentified benefactor remains a mystery. But what is certain is that these transient places were of great significance to certain individuals. Their centrally located burial designed to commemorate their lives which united the living and the dead through the services which were performed and witnessed by the congregation in the expanded chapel.[108] The burial in the cemetery of a priest with his mortuary chalice and paten, and another in the west end of the building, stand as further testament to the value placed upon their services within the spiritual sanctity of the chapel.[109]

There are other interesting aspects concerning the burial of individuals at this site which indicate the wide-ranging types of visitor. One of the bodies was buried outside the boundary of the cemetery, and this is thought to indicate that the deceased was either a criminal or had committed suicide. One grave within the cemetery contained a skull resting upon a stone pillow which could imply a type of punishment as the head would feel cold.[110] Several others were buried with the head to the west most probably in preparation for the day of judgement when the bodies would rise and face Jerusalem in the East.[111] Nails are usually indicative of the burial of a corpse within a coffin and an individual of some status. One body, arranged with praying hands, appears to have been interred in this manner.[112] The care with which these bodies were buried signifies the importance of this act and hence a vital service which hospitals provided. It also reveals belief

[108] Roffey, *Chantry Chapels*, p. 134.
[109] Cardwell, *et al*., 'The Excavation of the Hospital of St Giles by Brompton Bridge, North Yorkshire', pp. 134-5, p. 214.
[110] Daniell, *Death and Burial in Medieval England 1066-1550*, p. 160.
[111] Roffey, *Chantry Chapels*, p. 53.
[112] Cardwell, *et al*., 'The Excavation of the Hospital of St Giles by Brompton Bridge, North Yorkshire', pp. 127-41.

systems at this time of the permeable boundaries between life and death, and the expectation that the dead could rise and roam the earth at the day of judgement.

The location of the hospital at Brompton by a bridge over the river Swale, which is thought to have been the only crossing point in the area, is unlikely to have happened by chance and was no doubt intended to attract a range of guests. There are two valuable pieces of archaeological evidence which indicate the presence of pilgrims: one of the individuals buried within the precinct was interred with two metal (lead or tin) pilgrimage badges which are thought to date from the middle of the thirteenth century.[113] The first badge depicted Christ with a nail through each hand dressed in a long robe. With him are the Saints Peter and Paul. Peter holds the keys to the kingdom of heaven and a long cross symbolising his martyrdom by crucifixion. St Paul holds a sword over his right shoulder, a reference to his beheading. The badge was from Rome. The second badge was from Lucca and is a miniature replica of the town's *Volto Sancto* – a larger-than-life figure of the crucified Christ. Again, these careful burials of individuals with their passports to paradise demonstrate the pivotal role a hospital played in hosting the dead as they made the journey through Purgatory into Heaven. Moreover, it is also possible that additional items are yet to be found as only a quarter to a third of the site has been excavated.[114]

In addition to what could be classified as high-profile burials, the archaeological digs also yielded further relevant information concerning other deceased guests. Some of the skeletal remains indicate a diet low in carbohydrates with a deficiency of iron in childhood. There were eight trauma cases, with several examples indicating circulatory disorders and osteoarthritis. The study noted that there was a high rate of disease within the sample. It therefore appears that these were either long-term sick inmates or individuals undertaking pilgrimages to seek cures during the final stages of their life – or both. An infirmary hall was not located, but a building adjacent to the

[113] Ibid., p. 201.
[114] Ibid., pp. 201 and 214; J. T. Rosenthal, *The Purchase of Paradise: Gift Giving and the Aristocracy, 1307-1485* (London, 1972), p. 215.

road, river crossing, and chapel is thought to have been either the master's residence or, as is more likely given its precise location within the precinct, a guesthouse. It is also a possibility that infirm brothers were likewise housed on site as the earliest known document (*c.* 1182) refers to '*infirmis fratribus ibidem Deo servientibus*'.[115]

Turning now to compare the hospital at Brompton Bridge with others in this study, a more recent archaeological dig, this time for the hospital at Bawtry in Nottinghamshire, again produced evidence which supports the idea that hospitals were accessible to a variety of individuals.[116] The report noted that in the Middle Ages, Bawtry was probably an important inland port. However, a point of significance is that the residents of Bawtry were not permitted burial rights at their parish chapel until the middle of the fourteenth century. Radiocarbon dating tests conducted on a sample of bone from the vicinity of the hospital chapel firmly dated the burials to the thirteenth century.[117] In total, this small excavation identified a minimum of 53 individuals, but unlike Brompton Bridge these skeletons did not reveal significant signs of stress.[118] Consequently, it is possible that these were not infirm or elderly guests, and it is unlikely that they were local residents too.

On the other hand, Ian Forrest's work concerning burial practice in Hereford has demonstrated that the burial of the poor was often permitted locally when burial rights were held by a non-local body such as a cathedral church. By reviewing local disputes, Forrest was able to show that on occasion the definition of who constituted the poor could be open to interpretation, and in other instances the rights of the mother church were simply ignored. In the post-Black death period, although not necessarily as a direct result of it, Forrest noted that ecclesiastical views softened, and parish churches were eventually permitted to bury parishioners so long as the mortuary dues

[115] *Early Yorkshire Charters Volume 5: The Honour of Richmond, Part 2*, ed. C. T. Clay (Cambridge, 1936), p. 47.
[116] L. McIntyre and D. M. Hadley, *Archaeological Excavations at Bawtry Masonic Hall, South Yorkshire, July 2010: The Cemetery of the Medieval Hospital of St Mary Magdalene* (2010).
[117] Ibid., pp. 21-2.
[118] Ibid., p. 26.

and burial fees were still paid to the superior church.[119] These points of conflict are remarkably similar to the numerous agreements between hospitals, local churches, and the patrons of those churches – two such examples, at Brackley and Portsmouth, have been discussed above. These agreements have been identified by historians of hospitals for some time, but the importance of the burial of those individuals who died, for example, on a pilgrimage (local or otherwise) or who were sent to a hospital in old age, is rarely emphasised. Instead, historians focus upon lost revenues or the value of being able to negotiate with parish officials.[120]

Nonetheless, negotiated agreements were still an unfortunate necessity for these houses. In 1229, the master of the poor hospital at Hockliffe secured burial rights for religious within their chapel and permission for a chantry with the consent of the dean and chapter of Lincoln cathedral and the rector of the local church.[121] From 1236, this hospital had links to the parish church as evidenced by the presentation of a clerk for institution to the benefice by the master of the hospital. The patronage of the church had been transferred by the patron of both the hospital and the church, John Malherbe, to the warden of the hospital.[122] In 1304/5, the master and brethren received a licence to impropriate the church.[123] The site of the hospital, which subsequently became the Red Lion public house and then Hockliffe House, is less than a mile from the parish church of St Nicholas in Church Lane. The association between church and hospital can clearly be seen, and this relationship would have assisted the rector to fulfil his parochial duties. This practice is known to have continued until 1401.[124]

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[119] I. Forrest, 'The Politics of Burial in Late Medieval Hereford', *The English Historical Review*, 125/516 (2010), pp. 1110-38.
[120] Watson, 'Fundatio, Ordinatio and Statuta', pp. 145-53.
[121] *The Acta of Hugh of Wells, Bishop of Lincoln, 1209-1235*, ed. D. M. Smith (Woodbridge, 2000), no. 304, '*quod in capella sua infra septa ipsius hospitalis erecta cantariam habeant et apud eam sibi tantum qui habitum ibi religionis gestaverint sepulturam: salvo iure tam vicinarum ecclesiarum quam dicte matricis ecclesie de Hoclive in servientibus et aliis a premissis apud ipsum hospitale decedentibus et generaliter in omnibus et per omnia'.*
[122] *Rotuli Hugonis de Welles, Episcopi Lincolniensis A.D. MCCIX-MCCXXXV*, vol. 1, part 2, ed. W. P. W. Phillimore (London, 1905), p. 97.
[123] *List of Inquisitions ad Quod Damnum Preserved in the Public Record Office, part 1* (London, 1904), p. 75.
[124] *VCH: Bedfordshire*, vol. 1, ed. H. A. Doubleday and W. Page (London, 1904), p. 401.

A second example dated at 1245 concerning Ospringe in Kent was preserved by the chronicler William Thorne, an Augustinian canon writing in the late fourteenth century.[125] The grant recorded that Robert, the abbot of St Augustine, Canterbury, permitted burial at the hospital to the brothers who wore the habit as well as the infirm who happened to die in the hospital by chance.[126] So, this time the sick residents were permitted to be buried in the hospital if they should happen to die there. The priests in the hospital were not allowed to hear confession and administer Extreme Unction unless one of the brethren or poor were sick – except in the case of travellers.[127] If any of the parishioners of Faversham made offerings to the hospital these were to be given to the mother church.[128] This stands in contrast to the aforementioned example at Hockliffe and was intended to cater for the many pilgrims who used this house on their journey to visit the shrine of St Thomas at Canterbury. The hospital, thus, provided hospitality for those who were sick and unable to reach their intended destination – it assisted individuals as they crossed from life into death.

It is clear, then, that hospitals in small towns and villages hosted a wide variety of people in death as well as life. The examples cited herein include the rich and poor, lay brethren and priests, the elderly and the young, locals and strangers, and of course the sick. The careful burials and official permission sought to accommodate the dead reveal the significant role of the hospital in providing these services. It is a seemingly obvious point to emphasise the importance of burying the dead, but for some hospitals at least within this study it was a key component of their provision of care.

[125] *Historiæ Anglicanæ Scriptores X*, pp. 1893-4.
[126] Ibid. '*fratribus hospitalis de hospringe sepulturam fratrum habitum ipsorum gestantium ibidem & infirmorum tantummodo quos in dicto hospitali in fata decedere contingerit*'.
[127] Ibid., *Sacerdotes qui pro tempore ministrabunt in hospitali memorato nullam audient confessionem nisi tantum fratrum & pauperum ibidem aegrotantium & eisdem personis viaticum & extremam unctionem & omnia divina impendent*, E. A. Gooder, *Latin for Local Historians: An Introduction* (Harlow, 1978), p. 174 translates *viaticus* as wayfarer or tramp.
[128] Ibid., *Et si aliquis parochianus de Faversham oblationes aliquas in dicto hospitali fecerit, ecclesiae matrici sine deminuntione reddentur.*

Conclusion

These hospitals, dotted across the English landscape, represented a permanent display of material and spiritual alms. Those spiritual services could be elaborate during the high Middle Ages as well as in the fourteenth and fifteenth centuries – a point which is rarely acknowledged in the historiography of these houses. As in the case of the provision of hospitality in life, services in death were of varying length and offered to a variety of individuals. Each hospital tailored these services to meet the founding specifications and evolving needs within society – these were not static entities. Their independent nature permitted a degree of autonomy within the Church which many founders were at great pains to emphasise and document. The evidence suggests that hospitals had regard for both the physical and spiritual wellbeing of individuals in life and death. However, owing to the fragmentary nature of the evidence for some hospitals within this study, this cannot be claimed for the total sample. In general, though, guests were physically accommodated and spiritually nourished as they travelled from this life to the next. These intercessory establishments provided the vehicle through which individuals could seek salvation both as providers and recipients of hospitality in life and death. The beneficiaries were both young and old, rich and poor, parishioners and strangers, the laity and religious alike.

Chapter Four: Longevity, Legal Patrons, and the Ultimate Patron

The second research question which this project seeks to address is why did some hospitals survive and not others? This question arises from the findings of several historians, as noted in Chapter One, that many hospitals did not survive for long periods of time. Therefore, the present chapter starts to assess the factors which could have affected the longevity of a house. In the first instance, it considers the database evidence regarding the length of time the hospitals within this study endured. It then seeks to ascertain whether there was a correlation between the type of founding patron and the life of a house which could indicate why some of these houses are thought to be ephemeral. The chapter then moves to consider whether founding or subsequent legal patrons actively sought to relinquish their patronal ties by alienating their patronage rights or consenting to the appropriation of the house to another institution.

Benjamin Thompson's work regarding patronal status and monastic houses in Norfolk suggested that higher-status patrons lost interest in monasteries during the later Middle Ages.[1] Thus, as part of a developing theory concerning longevity it is possible that this, too, might have been a contributing factor to the life of a hospital. In the main, this chapter does not seek to ascertain why events might have taken place, as this is addressed in Chapter Six. However, in order to demonstrate the potential negative intent of a patron it is necessary to give some attention to the circumstances of individual patrons here. Nor does the current chapter assess the effectiveness of royal intervention. Consideration is given to the incidences of a monarch offering forms of support to hospitals – be they royal obligations or voluntary acts. This could comprise, for example, appointments to office or grants of land. This differs from the discussions in the ensuing chapters which assess the value to the institution of the said actions and the efficacy of other forms of direct intervention which stemmed from a monarch's temporary legal obligations. Here the

[1] Thompson, 'Monasteries and their Patrons at Foundation and Dissolution', pp. 103-25.

main aim is to establish the type of individuals who possessed the legal right to influence the operations of hospitals in small towns and villages in England, and whether there is a correlation between those houses which received the attention of the king and the longevity of a house. This work has the potential to provide vital evidence for hospitals within this project for which only fragmentary evidence has survived the passage of time – if indeed it ever existed in manuscript form at all.

I: Definitions, Rights, Lifespan, and Founder Types

For the purposes of this study, a legal patron is deemed to be the holder of the advowson (the right to present a candidate to the bishop for institution to their office) or the right to issue a licence to the brethren of the hospital to elect a candidate and to consent to their choice. Patronal rights in this area were varied and variable. The precise nature of those rights for hospitals can often be found in royal charters, bishops' registers, and inquisitions post-mortem. For example, in 1314 the mayor and burgesses of Devizes presented their candidate to the bishop on the 8 May, and the bishop instituted the said candidate to the office of warden on the 8 June.[2] At Brackley, on the other hand, rights more akin to those of a monastery were in place, and the patron possessed the right to issue a licence to the brethren to elect a master. This can be seen in the register of Bishop Oliver Sutton in 1289 when the bishop confirmed the election having satisfied himself that following the resignation of the previous master the brethren had elected the new master with licence from the patron (*patrona*) Elena la Zouche.[3]

In one instance, the right to present a candidate for institution or collation to a post was renegotiated and then shared between the lay patron and the bishop. In 1269, the patron of Longbridge, Maurice Berkeley, reached an agreement with Bishop Godfrey Giffard to present to

[2] *Registrum Simonis de Gandavo, Diocesis Saresbiriensis, A. D. 1297-1315*, vol. 2, eds C. T. Flower and M. C. B. Dawes (Oxford, 1934), p. 824.
[3] *The Rolls and Register of Bishop Oliver Sutton, 1280-1299*, vol. 2, p. 76.

the hospital on alternate vacancies.[4] And in another instance, this time at the royal hospital at Ospringe, the king as patron appointed the masters in his own right as it was deemed to be a free chapel exempt from ordinary jurisdiction.[5] These examples are important as they not only indicate that standard practices did not exist, they also shed light on who appointed whom and, thus, who was able to exercise further patronal rights. One such example of these rights has already been discussed in Chapter Two with reference to corrodians placed in houses at the behest of patrons.

In addition to their direct patronal rights, monarchs could assert both their feudal and regalian rights with respect to hospitals and their legal lay or ecclesiastical patrons. Lay landholders held their estates of the king who in turn had feudal rights of wardship (custody of the estate if the heir was a minor) and escheat (i.e. the estate reverted to the king in the absence of a legal heir or if the tenant was convicted of a felony which later became known as forfeiture).[6] In the case of a patronal bishop who held the right to collate to a benefice, the king had regalian right to the custody of the temporalities of the bishopric during a vacancy in England. From the point of view of a layman, patronage was in origin lay patronage regardless of whether it fell into ecclesiastical hands or not: the bishop's right of collation was in the king's view identical to the layman's right of advowson.[7] These rights passed to lay heirs or successors in office in the case of bishops acting in their capacity as patrons: advowsons were intangible assets and a form of real property.[8] When a tenant in chief was the patron of a hospital, it is likely that on occasion the patronage of the house passed into the king's hands. Thus, when a king suggested an appointment to a hospital office, it often signalled the status of a patron. This is valuable evidence when trying to understand the types of individuals who were associated with these hospitals. In cases of wardship, escheat, and forfeiture, the evidence has the potential to highlight vulnerable moments in the history of a house and, thus, their ability to endure.

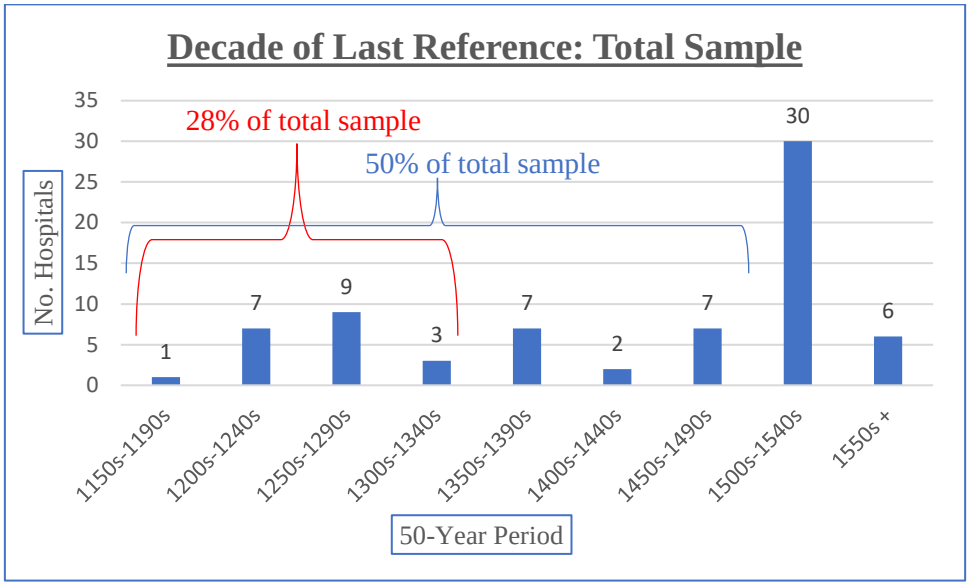
[4] *Register of Bishop Godfrey Giffard*, vol. 1, p. 31.
[5] *CCR*: *1313-1318*, pp. 434-5.
[6] J. H. Baker, *An Introduction to English Legal History* (Oxford, 2007), p. 239.
[7] M. Howell, *Regalian Right in Medieval England* (London, 1962), pp. 171-93.
[8] Baker, *An Introduction to Legal* History, p. 380.

The idea that the role of the patron was potentially central to the longevity of a hospital is perhaps unexpected as by the thirteenth century the official rights of patrons in both churches and religious houses had become significantly eroded. Elizabeth Gemmill's work in this area has demonstrated that the holder of an advowson of a parish church was now only permitted to present a candidate to the bishop for institution. And, except for Cistercian houses, the patron might have a right to issue a licence to elect a head of house. In addition, patrons were permitted to have custody of the house during vacancies, but in theory they were not able to intervene in their spiritual operations.[9] However, theory and practice are often two different things. It may also be possible, for example, that what could be termed the customary rights and duties of patrons – in other words the non-documented privileges and responsibilities which must be inferred from actions which have left a trail in the historical record – are of relevance to hospitals and their ability to endure, or not. Hospitals were not considered in Gemmill's work and, thus, merit attention in their own right.

Clearly, any discussion concerning the longevity of a sample of hospitals cannot proceed without an appreciation of the lifespan of the said establishments. In addition, a comparison to similar sets of results ought to enhance that understanding. The following chart, therefore, depicts the lifespan of the 72 hospitals within this study:

[9] Gemmill, *The Nobility and Ecclesiastical Patronage*, pp. 17-25.

Figure 1: Hospital Closures: Decade of Last Reference (72 Hospitals)[10]



The chart shows that the peak closure period for the hospitals within this sample was the sixteenth century; and Appendix I reveals that this was overwhelmingly due to the concurrent Reformation legislation in the 1530s and 1540s. This, arguably, is not surprising; but it is noteworthy that 72% of houses – which are often overlooked within the historiography of hospitals – were able to endure in the post-Black Death period. This is a slightly higher percentage than the results produced by Marjorie McIntosh's general study comprising 704 hospitals, which were pre-1350 foundations, of which two thirds survived post 1350.[11] Yet, the chart also indicates that 50% of these houses had a date of last reference prior to the sixteenth century, which in turn suggests that there were varying factors at play concerning the life of these houses.

There were 30 hospitals which had a date of last reference in the main period of this study being 1150-1450. Of those 30, three were united with another hospital, seven were associated with a monastery, and one with the parish church/rector. That they are not heard of again strongly suggests that their endowments were taken over by the new institutions, and that they were no

[10] Database extract from Founder Longevity Query (based on Final End Date table and Hospital Main table). See Chapter One for details of the primary source material and database construction method which underpin the compilation of the charts in this chapter.
[11] McIntosh, *Poor Relief in England, 1350-1600*, p. 69.

longer recognised as hospitals according to the definition of this study. Ten houses received letters of protection from the king, thus also demonstrating that they required additional support. The hospitals at Flixton and Stagshaw, as will be discussed, experienced difficulties with patrons. The hospital at Cannock was last heard of owing money to the sheriff.[12] And a potentially similar problem is evident at West Tarring which is last heard of taking legal action to recover assets.[13] The evidence is so fragmentary for the remaining five (Blean, Ivychurch, Morpeth, Portsmouth II, and Werhale) that a plausible explanation cannot be offered. To summarise, eleven hospitals were probably consumed into another institution, ten received letters of royal protection, four had either patronal or financial difficulties, and five remain unaccounted for. This equates to 83% of the hospitals within the main period of this study potentially ceasing to exist as independent houses as a result of the actions of their patrons, or lack of action. Naturally, this is a point which this chapter will continue to explore.

Reviewing hospital dates of last reference provides a useful starting point from which to explore the longevity of houses: reviewing their average lifespan by founding patrons commences the process of looking for trends in the data. Of the 72 hospitals within this study, 34 had unknown founders and their minimum average lifespan was 151 years. On the other hand, those for which the founder is known had a far greater minimum lifespan totalling 316 years on average and represent 53% of the total sample.[14] When Thompson undertook a similar exercise with reference to 34 monastic houses in Norfolk, he was blessed with clear founding data.[15] His work demonstrated the importance of understanding the status of patrons, their ability or desire to support their monasteries, and the fact that monasteries founded by lesser-status patrons were often more poorly endowed. In addition, Thompson noted how smaller houses drifted into 'lacklustre obscurity' in the later Middle Ages.[16] Thus, the performance of a similar exercise for

[12] Appendix I.
[13] *46th Annual Report of the Deputy Keeper of the Public Records*, ed. W. Hardy (London, 1886), p. 272.
[14] Based on Database Founder Longevity Query (based on Founder and Final End Data tables).
[15] Thompson, 'Monasteries and their Patrons at Foundation and Dissolution', pp. 124-5.
[16] Ibid., quote at p. 116. See also p. 106 with reference to founders of lesser status.

hospitals has the potential to provide a greater insight into the reasons why hospitals were unable to endure.

Despite attempting to follow in his footsteps, initially adopting the same methodology, adjusting it to compensate for the inadequacies in the data, alas the results were deemed to be so vague as to render them worthless. Many hospital founders and subsequent patrons remain unknown, and even if their identity is known it is often difficult to assess their status. For example, in two cases it is known that a vicar was the founding patron and in another case a royal chaplain; but to try to allocate a status to their office in comparison to a burgess, for example, especially as hospitals were religious houses, proved to be a task beyond the boundaries of this project. This study, therefore, considered the longevity of houses with known and unknown patrons. It then further explored the results for those hospitals with known patrons whose status was identifiable through their title which indicated that they were members of the nobility.

The idea of how to determine patronal status with reference to a religious house also applies to patrons of last reference such as earls in comparison to nuns, and so the list could go on incorporating the vagaries of gentry status over the ensuing centuries.[17] For hospitals, this was thrown into stark relief when the last-known patron data was compared to Thompson's work. The only meaningful comparable evidence regarding the status of patrons found that the average longevity results for hospitals founded by monarchs, earls, and archbishops and bishops were 320, 395, and 308 years, respectively.[18] This represented twelve hospitals in total which is 17% of the total sample. Tentative results for individuals styled lords revealed an average of 353 years for thirteen hospitals. The combined results for the two categories just discussed produce an average figure of 346 years at 35% of the total sample. This combined result of higher-status members of the aristocracy produced a greater average than the total known-founders category which had a

[17] B. M. S. Campbell and K. Bartley, *England on the Eve of the Black Death: An Atlas of Lay Lordship, Land, and Wealth, 1300-49* (Manchester, 2006), p. 69.
[18] Based on Database Founder Longevity Query (based on Founder and Final End Data tables).

minimum average lifespan of 316 years. In addition, further analysis of the 21 hospitals within this study which also formed part of Watson's foundation-charter work yielded an average longevity figure of 303 years. Watson's work was based upon foundation charters, and therefore known founders, which equates to 55% of the 38 known founders within this study. These results reveal that some hospitals within this study had remarkably long lifespans and certainly cannot be deemed to have quickly appeared and disappeared from the historical record. These findings in comparison to the unknown-patron average of 151 years, representing 47% of the total number of houses, suggests that the type of founding patron might have been a factor which contributed to the longevity of these houses, but that these results in isolation are inconclusive.

A further problem which needs to be taken into consideration concerns those hospitals founded closer to the cut-off date of 1279 in the sample selection criteria. These houses may be disadvantaged when calculating longevity figures in comparison to those founded, for example, in 1160. One way to address this issue is to consider whether a house was extant in the later Middle Ages. Figure 1 showed that 50% of the sample in this study survived into the sixteenth century. Further analysis revealed that of those 36 hospitals, 26 had known founders and 10 fell into the unknown category. 62% of houses with known founders survived, whereas only 33% of hospitals with unknown founders were able to join them. Thus, it is an irrefutable fact that hospitals with unknown founders were less able to endure and to survive into the peak closure period. It may be tempting to think, in the light of Watson's aforementioned work, that these houses were unable to rely upon repeated acts of almsgiving by their patrons to augment their slender founding endowments; or, perhaps, that they were smaller in size or that their subsequent patrons were less powerful or wealthy. The unknown category of founder, therefore, merits further review as it represents 47% of the houses in this study and a high failure rate.

Remembering, then, that it is not the aim of this chapter to establish why a hospital ceased to function, but to consider the types of patrons associated with these houses and their longevity, the

following chart provides an overview of the lifespan of the 30 hospitals with unknown founders. The ensuing discussion then provides additional information as to why a founder is unknown.

Figure 2: Unknown Patrons and Hospital Longevity (34 Hospitals)[19]

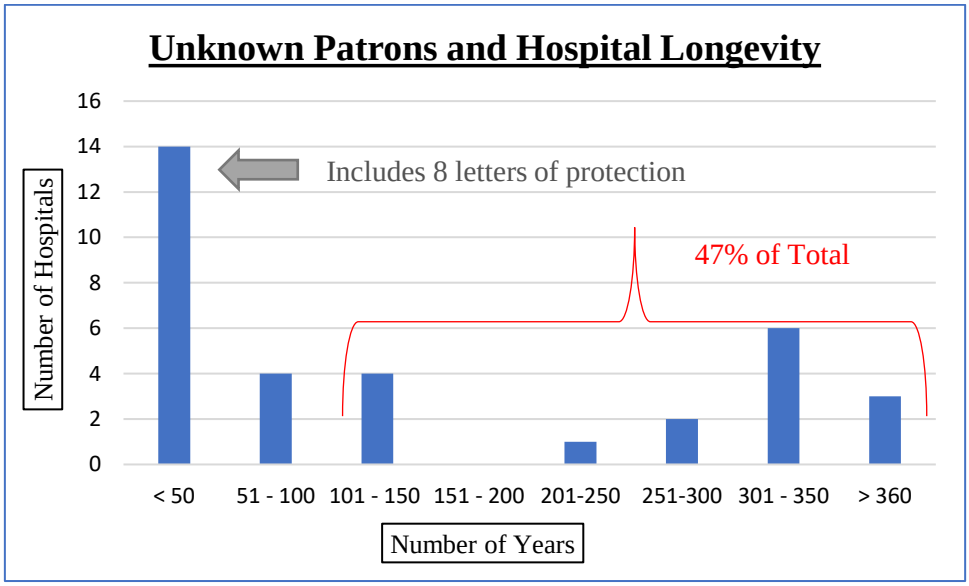


Figure 2 clearly highlights a blip in the data, as shown in column one, which reduces the overall minimum average lifespan of these houses to 151 years. This arises when only one or two pieces of evidence survive for a house, and, therefore, the rules of the database entry procedure dictate that a hospital has a minimum lifespan of twenty years. Eight of these entries relate to hospitals for which nothing is known except that they sought the support of the king as evidenced by the issue of letters of protection for a specified period of usually one or three years. Of the thirteen hospitals which are known to have received a letter of protection, nine had unknown founders. The underlying data produced a mode figure for unknown patrons of 20 years which is significantly lower than the bimodal figures of 330 and 340 years for those with known founders.

Yet, Figure 2 also clearly shows that 47% of hospitals in the unknown-founder category survived more than 100 years, and nine even survived more than 300 years. In seven of these cases, there

[19] Derived from Database Longevity Query and Founder table.

is simply no extant record of who the founder might have been. For example, in the case of Burford its earliest known date of existence was 1226 when Henry III granted it firewood from the nearby forest at Wychwood; there is no suggestion, however, that the king did so as a legal patron, and the nature of the grant indicates that the hospital was already operating at this point.[20] Burford had a longevity calculation of 320 years, and the idea of beneficial intervention by a monarch affecting the longevity of a house is a point which this chapter will develop. In other examples, such as at Tonge, the patronage of the hospital fell into the king's gift on two occasions, thus suggesting that at that point the patron was a tenant in chief. But the earliest known reference to the house which recorded a dispute concerning the master and the tenants of the hospital does not shed further light on the matter.[21] There are two houses, Elleshaugh and Hungerford, for which it is possible that their founders were a lord and an earl, respectively, which produced longevity results of 310 and 390 years. When comparing hospitals with known and unknown founders, those with known founders survived for an average of 316 years compared to 151 years for those with unknown founders. However, it is a distinct possibility that the early unknown patrons of those hospitals with longer lifespans were higher-status individuals.

This section has demonstrated that the legal patrons of hospitals in small towns and villages in England had varied and variable patronal rights, and that these rights could extend to the reigning monarch in certain circumstances. Nothing is known of the founding patrons for 34 houses within this study, and little can be concluded with reference to the status of the 38 patrons who are known. What can be stated is that those hospitals with known founders were more likely to endure, and that a significant proportion of those founders (66% of known founders or 35% of the total sample) were monarchs, earls, archbishops, bishops, and lords. The overwhelming majority of hospitals with unknown founders (88%) are deemed to be obscure houses based on extant primary source material. However, it should be noted that there are examples of obscure houses with

[20] *Rotuli Litterarum Clausarum in Turri Londinensi Asservati*, vol. 2, ed. T. D. Hardy (London, 1844), p. 135.
[21] H. Summerson, 'Repercussions from the Barons' Wars: a Kentish Inquest of 1264*', *Historical Research*, 91 (2018), pp. 573-8, at p. 575.

unknown founders, nine in total, which survived more than 300 years. In saying that, some clearly did at least on occasion receive support from high-status individuals. Overall, 72% of hospitals within this study survived after the Black Death of 1348/9 which is better than McIntosh's general study comprising 704 hospitals, of which two thirds survived post 1350. In addition, 50% were still extant in the sixteenth century. Within the limited classification types which this research was able to adopt, there is a clear correlation between known founders and the ability of a hospital to endure. The following section considers if there is evidence of strategies adopted by patrons to provide additional support to their hospitals and whether this affected the lifespan of a hospital.

II: Alienations and Appropriations

One strategy to support an ailing hospital which could be adopted by legal patrons was to alienate their rights of patronage (the advowson) to a bishop; an alternative strategy was to give consent to the formal process of appropriation to another institution. In the latter case, this could be regarded as a pooling of assets in challenging times. Martin Heale's work demonstrated just how concerned the patrons of small priories were in finding a suitable and preferably local institution to appropriate their houses to. In addition, there was a desire to ensure that the spiritual services continued to be performed despite economic and political difficulties whenever it was practical to do so.[22] These considerations are also evident for the hospitals in this study. This section seeks to establish which option a patron selected and whether this resulted in the effective closure of the hospital – it being subjugated to another house, losing its autonomy, and disappearing from the historical record.

Another option available to a patron to cure an ailing hospital was to alienate it to a stronger house in their gift. The following example concerns a hospital with an unknown founder which survived for an estimated 290 years. It is a particularly interesting example as it demonstrates that a

[22] M. Heale, 'Dependent Priories and the Closure of Monasteries in Late Medieval England, 1400-1535', *The English Historical Review*, 119/480 (2004), pp. 1-26.

subsequent patron actively intervened in an attempt to ensure the survival of their hospital, but it also shows the wider network of support which could be deployed to the benefit of these houses. In 1329 the hospital at Perio was reordained by the diocesan bishop, and in 1338 it was annexed to nearby Cotterstock College. Crucially, the hospital remained a separate entity. Within this scenario, both the bishop and patron played pivotal roles. Following the collation of a master in 1329 by Bishop Burghersh owing to too few brethren being resident in the hospital to elect a master of their own accord, the bishop appears to have made further enquiries. The hospital ordinances were subsequently, but in the same year, added to his registers. As part of this process, the patron was noted as John Giffard. [23]

Giffard was a man of ambition, a former rector of the church of Cotterstock, favourite of Queen Isabella, steward, and surveyor of lands beyond the Trent for the Crown. In 1331, he was made deputy justice of South Wales and received appointments until his death in 1349 from the plague. In 1339, Giffard received episcopal sanction to found a college in Cotterstock of a grand scale in honour of the king and queen, and the dowager queen. During the foundation process, the patron received a licence to 'annex and unite' the hospital at Perio to the college.[24] Prior to this point, the hospital had clearly fallen into difficulty: it lacked the requisite thirteen chaplains and was subsequently reconstituted to have a prior and two chaplains.[25] A problem had undoubtedly arisen within the hospital, perhaps owing to Giffard's ambition and myriad of posts. However, once the bishop had identified the issue, the patron acted and secured the hospital's survival into the sixteenth century through its annexation to his new foundation.

Not all such transfers can be deemed to be definitively successful as hospitals were consumed within new organisations and their founding objectives curtailed or eradicated. In some examples this is clear and is evidenced by the hospital endowments being amalgamated with the new

[23] *The Registers of Bishop Henry Burghersh, 1320-1342*, vol. 2, ed. N. H. Bennett (Woodbridge, 2011), p. 26.
[24] *CChR: 1327-1341, Edward III*, vol. 4 (London, 1912), p. 449.
[25] *The Registers of Bishop Henry Burghersh*, vol. 2, p. 26.

institution's assets and its buildings rented out or put to an alternative use. This is usually signalled by the implementation of the process of appropriation. In these cases, it is often difficult to ascertain the extent to which the decision made by the patron influenced the continued operation of a hospital in its intended form. This is because in many cases there is no evidence of the intent behind the founder's action, the agreement, and the actual outcome. Nor is there evidence that a patron was aware, or not, of the imminent fate of a house. In the cases of Aynho and Brackley hospitals whose lands and spiritual duties were transferred to Magdalen College, Oxford, the surviving documentation is, however, detailed and informative. The following assessment looks at Aynho in the first instance and then Brackley.

In 1483, the patron of the hospital at Aynho, William, earl of Arundel and lord of the manor of Aynho, granted the advowson of the hospital to Bishop Waynflete, founder of Magdalen College, Thomas Danvers, treasurer of Wolvesey at the episcopal exchequer, and Thomas Troys esquire.[26] At the same time a separate indenture was issued in which the patron specified that in return for the annexation of the hospital to Magdalen College, the fellows must pray for the soul of himself and his son perpetually at the Arundel altar in the college and on their death perform an annual obit, dirge, and mass forever.[27] In addition, every fellow and master should pray for them in their sermons at the university and at Paul's Cross.[28] These documents were raised before the formal appropriation process commenced in April 1485.[29] There is no doubt that the earl transferred the assets of the hospital to the college and not only the advowson, as in *c.* 1490 the president of Magdalen College received a request from the earl's heir to permit his servant to have the spital farm at Aynho.[30] In this case, the patron sought to protect the hospital's spiritual obligations, and the appropriation of the hospital to a college which housed poor scholars represents a reasonable

[26] V. Davis, *William Waynflete, Bishop and Educationalist* (Woodbridge, 1993), pp. 119 and 144; Macray, Northamptonshire III, No. 82.
[27] MCA, Aynho 4.
[28] Ibid.
[29] Macray, Northamptonshire I, No. 84.
[30] MCA, Aynho 6 (the document states J. Arundel, but this appears to be a scribal error and is most likely T. Arundel, earl William's son and heir, who, as Lord Maltravers, was specifically noted on the indenture Aynho 4).

solution in the quest to appropriately utilise the hospital's endowments. Nevertheless, the patron clearly knew that it would cease to function as originally intended. Moreover, only the patron could approve such a terminal decision.

The case of Brackley hospital represents a similar example.[31] Initially, the patron, Viscount Lovell, drafted a deed of sale on 26 February 1484 which specified that a solemn obit should be celebrated for the souls of himself and his ancestors, thereby fulfilling his duty to ensure that spiritual services were provided for the dead.[32] However, the final deed of sale dated 27 February 1484 appears to have been a negotiated arrangement between Viscount Lovell and Bishop William Waynflete: the souls of the viscount's heirs no longer formed part of the agreement, but the bishop did agree that the college should keep an annual obit for him and permit both himself and his heirs to share in prayers and alms deeds.[33] The agreement offered some protection in that the fellows of the college were sworn on their admission to honour the terms of the agreement, but it seems the parties realised that the hospital was liable to fall into decline following the annexation as the document also contained a penalty clause which stipulated that the bishop would pay an additional 100 marks to the viscount if the hospital became void of an incumbent.[34] In this example, despite the patron's apparent attempts to protect the hospital, it ceased to function and in 1494 the site was leased out to a gentleman for twelve years.[35]

The examples at Aynho and Brackley suggest that patrons were losing interest in their houses as the Middle Ages drew to a close, but that there was a desire to protect their spiritual services. These examples, therefore, concur with both Thompson and Heale's findings. The hospitals at Aynho and Brackley were founded by a lord and an earl, respectively. In general, this category of founding patron was remarkably successful with reference to the lifespan of a hospital. There

[31] Macray, Northamptonshire II, No. 871.
[32] Macray, Northamptonshire II, No. 872.
[33] MCA, Brackley B207: Macray, Northamptonshire II, No. 873.
[34] Ibid.
[35] MCA, Brackley B132.

were nineteen entries in the database Founder table of this type in total; when combined with the End Date table data in the form of a query, the result shows that fourteen hospitals were extant in the sixteenth century. The remaining five were all associated with new institutions and not heard of again, and in three cases this was with the patron's consent:

Table 6: Comital and Baronial Foundations: Pre-Sixteenth-Century Closures[36]

Hospital Location	Last-Known Date	Patron Request	Reason for Last Reference
Lorwing	1225	✓	Alienated to the prior of Stanley St Leonard
Flixton	1447	x	Plea for assistance. Refounded as Carmanspitell
Mitford	1464	?	Possibly appropriated to Newminster Abbey
Brackley	1484	✓	Appropriated to Magdalen College, Oxford
Aynho	1485	✓	Appropriated to Magdalen College, Oxford

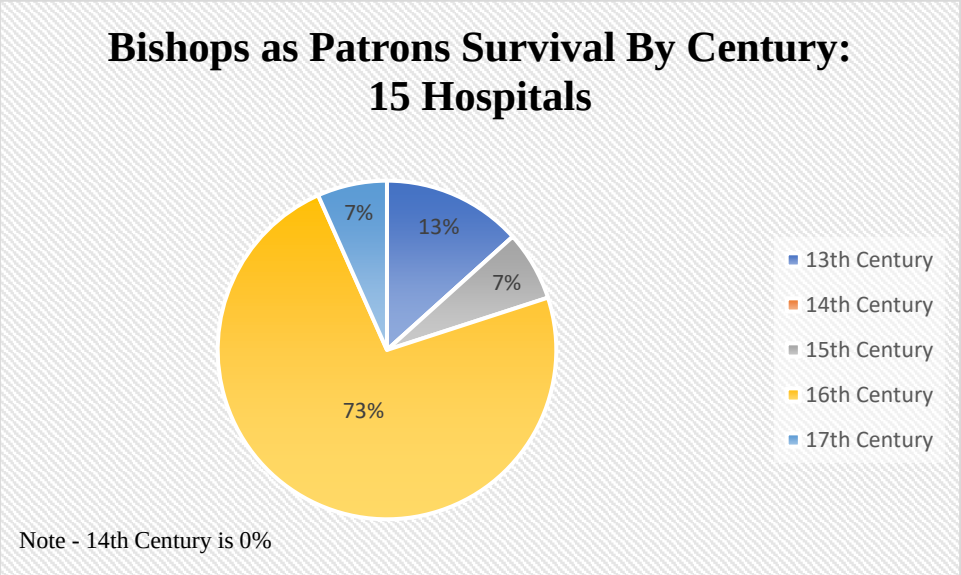
Even in the case of Mitford where the association with Newminster Abbey is questionable, the direct patronal line had ceased to exist upon the death of the heir of the last-known patron, Margaret Percy (d. 1464) and her son Henry Fourth Baron Gray (d. 1496).[37] What is starting to emerge from the data is the importance of the decisions made by patrons and a hospital's ability to endure – not forgetting the obvious point that many ceased to exist as the result of the Reformation and the actions of the ultimate patron, the king.

Patrons on occasion transferred the advowson to a third party shortly after the hospital's foundation. It is unlikely that at the start of the founding process that a patron would be an uninterested patron – therefore, this was a tacit recognition that a founding patron knew that he or she would be unable to protect their house. Furthermore, it is an interesting divergence from the concept that the institution was tied to the founding patron through repetitive acts of almsgiving and a purposefully limited founding endowment.[38] This, and the findings noted above,

[36] Appendix I.
[37] *A History of Northumberland in Three Parts*, part 2, ed. J. Hodgson (Newcastle, 1832), p. 77.
[38] See footnote 41.

raise the question of whether these active patronal interventions to protect their houses were successful survival strategies. The ensuing paragraphs consider this point across the total sample. Taking in the first instance the transfer of a house to an episcopal patron, the following chart demonstrates this was a successful strategy in terms of a hospital continuing to function and maintaining its independent nature. The table includes archbishops and represents both founding and subsequent patrons. It excludes occasional episcopal acts when, for example, there were not enough brethren to elect a master. It includes the case at Longbridge when the bishop and lay patron presented or collated a candidate on alternate vacancies.

Figure 3: Longevity and Episcopal Patrons (15 Hospitals)[39]



The project database reveals that there were fifteen hospitals which were associated with archbishops or bishops: in six cases they were the founding patrons and five of these survived into the sixteenth century. In the remaining nine their roles varied and seven were extant in the sixteenth century. In three instances, it can be clearly seen that the bishop worked closely with the founding patron (Beck, Cricklade, and Portsmouth). For example, the hospital at Beck was founded by a local vicar who served parishioners at Wood Dalling in Norfolk, being less than ten

[39] Database Final End table.

miles from Beck (also known as Beck near Billingford). The hospital was dedicated to St Thomas the Martyr and founded to host thirteen poor travellers for one night. Given the hospital's location en route to the Shrine of Our Lady at Walsingham, these travellers were most probably pilgrims.

The patronage was transferred on foundation to the bishop of Norwich with a lavish endowment from over 30 parishes in Norfolk.[40] In this case, it seems that the founder envisaged a financially independent house under the protection of the diocesan bishop.[41] As shown in Chapter Two, members of the Church were encouraged to extend hospitality in the first instance to the local poor and then if resources permitted to strangers. Clearly, a bishop and vicar working together to found and then sustain a hospital on a prestigious pilgrimage route must have been regarded as a positive step in the fulfilment of these duties and a contributory factor in the longevity of the hospital. One subsequent bishop, Walter Suffield (d. 1257), even bequeathed 2 marks to the hospital in his will.[42] Suffield made lavish provision in his last testament for the hospital he founded in Norwich, the hospital of St Giles. But apart from two small grants to hospitals in Oxford and Norwich of 20s, and a grant of land to yet another hospital in Norwich, Beck was his only other chosen hospital.[43] It had a last-known date of 1540 and an impressive lifespan of 330 years.

The remaining six of the nine cases vary in nature, but what is evident is that the bishop provided support at key moments. Thus, for example, at Pelawe the bishop of Durham appears to have acted as a short-term patron before conveying the advowson to the Elmedon family in the mid-fifteenth century. Crucially, the bishop signalled his ongoing direct interest by adding a caveat

[40] *Index Monasticus, or the Abbeys and Other Monasteries, Alien Priories, Friaries, Colleges, Collegiate Churches, and Hospitals*, ed. R. C. Taylor (London, 1821), p. 52, Appendix 1.
[41] Watson, 'The Origins of the English Hospital', pp. 75-94, at p. 85. Watson identified founding endowments prior to thirteenth century were purposely small. Beck was founded in 1224.
[42] *Index Monasticus*, Taylor, p. 52.
[43] www.thegreathospital.co.uk contains a copy of the will in Latin and a translation into English (17 Nov. 2017).

which protected his rights to intervene in the future.[44] This house survived until 1460 and was one of two in the subcategory which succumbed prior to 1500. The other hospital which failed to reach the sixteenth century, at Gateshead, was amalgamated with another hospital in this study in the same location. In a different case, this time at Martin-by-Bawtry, Nottinghamshire, several archbishops of York collated candidates to the office of master before the hospital was further endowed by the sheriff of Nottingham in 1390 under the protection of the archbishop.[45] Subsequently, the advowson was forfeited to the Crown in 1405 and was regranted to John Peryent, the king's esquire.[46] This example demonstrates that, unlike the monasteries in Thompson's study, hospitals were able to attract new patrons and were supported at both a regional and national level. Bawtry survived until the early seventeenth century and, thus, evaded suppression during the sixteenth century reforms – unfortunately, it is not known how it managed to achieve this. This, again, potentially differs to Thompson's findings which concluded that powerful individuals who held the patronage of monastic houses were not minded to offer a great deal of resistance in the run up to the Reformation. When the legislation to suppress these houses was drafted, the government, aware of potential legal action, comprehensively excluded the rights of the 'founders', but it seems objections to this were not forthcoming.[47]

Patrons of hospitals also made the active decision to appropriate their houses to monasteries or to appoint monastic custodians. Thus, it could be expected that these houses would fall foul of the aforementioned attitudes within society potentially being seen as no longer relevant to the living owing to their close association, over time, with the specified monastic house. In the case of hospitals located in small towns and villages, the picture is hazy. There are sixteen hospitals which were transferred to the custody of another institution, four of which were hospitals. In ten

[44] 'Calendar of Durham Cathedral Archive: Register IV', http://reed.dur.ac.uk/xtf/view?docId=ark/32150_s15999n339g.xml (8 June 2018).
[45] *VCH: Nottingham*, vol. 2, ed. W. Page (London, 1910), pp. 162-4; *CPR: 1388-1392, Richard III*, vol. 4, ed. H. M. C. Lyte (London, 1902), p. 336.
[46] *CPR: 1405-1408, Henry IV*, vol. 3 (London, 1907), p. 57.
[47] Thompson, 'Monasteries and their Patrons at Foundation and Dissolution', pp. 103-25, especially p. 118.

cases the contact with the new institution in the historical record represented the last-known reference to the hospital. For example, at Glanford Bridge the patron requested in 1236 that Bishop Grosseteste publish a bull of Pope Gregory IX which contained details of an accusation against the abbot and convent of Selby. It was alleged that the abbot had caused the hospital considerable damage and injury by converting its endowment for their own use. The bishop also published the abbot's reply in which he agreed to abide by the founder's wishes.[48] Nothing more is known of this hospital, and it is a distinct possibility that the abbot continued to abuse his position and subsequently took control of the house. In a similar example this time at Gedney, the patron sought to protect her house, but on this occasion direct legal action was undertaken. In 1341, Margaret Roos brought an action of *cessavit* against the abbot of Creake Abbey for failing to find a chaplain to sing divine services and feed certain poor persons. Earlier in 1256, an agreement had been reached that the abbey would staff the hospital.[49] The hospital was also not heard of again, and it is possible that it too succumbed to the might of an abbot, but what is certain is that in both cases their patrons tried to protect them. Of the twelve hospitals which had a close association with a monastic house only 33% were extant in the sixteenth century.

Finally, there are examples where patrons adopted neither strategy and attempted to rectify the problems themselves through financial assistance. Earlier in the history of the hospital at Brackley, the earl of Winchester, Roger de Quincy (d. 1264), made several grants of land to the hospital, either directly or indirectly, to fund its expansion. For example, in *c.* 1250 he granted three virgates of land, its tenants, and their descendants (*sequela*) in Brockhampton to his wife in order that she might regrant them to the hospital for the purposes of funding a chaplain to celebrate for both of their souls.[50] At Kepier, as has been already noted in Chapter Two, additional grants of land were made by its episcopal patron to cater for those individuals who flocked to the hospital

[48] *Rotuli Roberti Grosseteste Episcopi Lincolniensis, A.D. MCCXXXV-MCCLIII*, ed. F. N. Davis (London, 1914), pp. 9-10.
[49] Appendix I.
[50] MCA, Brackley 183.

on a daily basis.[51] And at Ospringe, a royal foundation, gifts of land, inquisitions when wrongdoing occurred, and privileges abounded throughout the life of the house. Three particularly noteworthy examples comprise a grant of twelve oaks to provide timber for the hospital, presumably to assist with building work (*ad opus hospitali*), in 1241 by Henry III.[52] And in recognition of the 'great charge of the maintenance of the hospital', exemption from a variety of taxes and aids was granted by Edward III in 1347, including fifteenths, ninths, taxes on wool, and aids payable on his first daughter's marriage and knighting of his first-born son.[53] These were not repeated acts of almsgiving, but they were certainly well-timed acts of support.

To summarise, patrons often tried to assist their houses by forming associations with another institution which sometimes resulted in their formal appropriation or transferring the advowson to a bishop. The latter strategy was the most successful in terms of maintaining independence and surviving in the historical record: 80% did so post 1500. With reference to monastic houses, this percentage falls to only 33%. There is evidence that hospitals which were founded by definitively higher-status patrons witnessed a small amount of subsequent disinterest but largely this was not the case. It was not possible to comment in detail on the closing-patron status across the sample for the reasons cited earlier in this chapter. Finally, there were examples of beneficial interventions in other forms such as additional grants of land, exemption from taxation, and operational reviews. These emerging themes will, therefore, be explored in greater detail in the final two chapters of this thesis. In the main, then, the examples in this section have highlighted the positive attempts made by patrons to assist their hospitals. Unfortunately, though, as Section III discovers, not all patrons had the best interests of their hospitals at heart.

[51] *The Register of Richard de Kellawe*, vol. 1, p. 376.
[52] *CR: 1237-1242*, vol. 4 (London, 1911), p. 305.
[53] *CPR: 1345-1348*, p. 351.

III: The Problem with Patrons...

This section analyses what happened when a patron was purposefully obstructive or was unavailable to help. One example, which plainly highlights the importance of patrons and what happened when problems arose, refers to the hospital at Flixton. This house has scant extant evidence, but a vital piece concerning a mortmain application, which is more fully discussed in the ensuing chapter, sets the scene for the discussions here and the concluding section of this chapter. When in 1447 the alderman, brethren, and sisters sought the king's assistance, it was specifically noted that this occurred as they 'cannot now call upon their founder'.[54] This single document demonstrates that there was an expectation that a patron should be in a position to provide assistance, and that if he or she could not, the king could be called upon to do so. However, even if a patron was able to oblige, this did not necessarily guarantee their active support. In fact, patrons were in the position to do precisely the opposite – and on occasion they did.

The actions of Thomas Berkeley (d. 1243), patron of two hospitals within this sample, Longbridge and Lorwing, demonstrate how patrons could treat hospitals within their gift in diverse ways. Lorwing is believed to have been located between Berkeley and Dursley, Dursley being about seven miles away. Longbridge was also known as Longbridge by Berkeley. Therefore, these were both local hospitals in the vicinity of their founding patron's castle at Berkeley.[55] Longbridge endured until 1561, but for unknown reasons Thomas disposed of Lorwing to the prior of Stanley St Leonard in 1225, and nothing more is known of the house.[56] It was a strange decision as it was founded by Maurice Berkeley (d. 1190) for his two young sons, Thomas being one of the said sons.[57] The most obvious explanation is that Thomas was not able to support it. When the elder brother, Robert, died in 1220 without issue, Thomas inherited the family estate.

[54] *CPR*: *1446-1452*, p. 89.
[55] Smyth, *The Berkeley Muniments*, p. 63.
[56] Appendix I; *CPR: 1560-1563, Elizabeth*, vol. 2 (London, 1948), p. 329.
[57] Smyth, *The Berkeley Muniments*, p. 63.

In 1211 the family lands and castle had been seized by the Crown, subsequently restored, and seized again when Robert joined the baronial revolt against King John. Before he died, Robert was able to secure the return of his lands but not the castle. Thomas was successful in this endeavour and secured the return of the castle in 1224. The problem for Thomas was that he also had inherited large debts – a problem which was further exacerbated by the lands held in dower by Robert's wife. Given the timing of the alienation of the hospital, 1225, it is possible that Thomas needed to reorganise his asset base to repay his debts. Nevertheless, it is still an odd decision as generally at this time, as can be glimpsed in these brief examples, this family were very protective of their landed interests and rights.[58] Therefore, this suggests that Thomas was very well aware of the impending fate of this house.

It could be assumed, given its long lifespan, that the hospital at Longbridge was fully supported by its baronial patrons, but it was not. It seems the patronal heirs of the founder relied heavily on educated masters and the diocesan bishops to perform their duties, but in this case the bishop was also a co-patron. For example, Arnald Berkeley was the master of the hospital in 1269. Arnald had worked in the Exchequer with Nicholas of Ely, and H. Barkly surmised that he secured the mastership of the house as a result of this relationship: Nicholas was made bishop of Worcester in 1266, and since 1269 the Berkeley family and the bishops had presented/collated candidates to the office on alternate occasions.[59] Arnald was an experienced administrator and was immediately despatched by Prince Edward to Ireland. Before he left, Arnald placed the custody of the hospital in the hands of his friend, the bishop of Worcester, and appointed the local vicar as his bailiff to look after the property. When Arnald was absent, Robert de Kingston and Roger de Grevel came into possession of a messuage in Slimbridge belonging to the hospital. It seems that the bishop had transferred the custody of the hospital to the vicar, and the vicar, perhaps in a bid to assert his

[58] TNA, 'Berkeley Castle Muniments', https://discovery.nationalarchives.gov.uk/details/r/700bf6df-8013-45e2-8de7-5e97db25eeea (24 Feb. 2016).
[59] *Register of Bishop Godfrey Giffard*, vol. 1, p. 31.

own local power, granted the messuage to the aforesaid Robert and Roger.[60] A legal case ensued, and the jury found that the bishop was not the custodian of the hospital as Arnald had not resigned and, therefore, could not grant the messuage to Robert and Roger.[61] The final verdict of the jury unequivocally demonstrated the responsibility and power of the master for the hospital's temporal possessions: Arnald could recover the messuage on behalf of the hospital.[62]

Clearly, then, in this case the master fulfilled his duty and assisted the hospital. The bishop as joint patron and friend of the master probably entrusted the parish priest with the custody of the hospital in good faith. Further discussion of the role of the master will be undertaken in Chapter Six. Here, though, the question which this case really raises is where was the other patron, Maurice Berkeley II (d. 1281)? The antiquarian John Smyth of Nibley (d. 1640) translated and summarised the deeds of the hospital which were subsequently published in the late nineteenth century. Within this collection is a record of a grant of thirty acres of wood by the earl of Warwick (William Maudit, d. 1268) and his wife to the hospital. The same patron sought to prevent this grant, and the case was subsequently tried by a jury. Maurice won on the basis that the land was held of him, and the hospital lost the land.[63] On both this and the previous occasion at least, it seems this patron was not supportive of the hospital. It was the commitment, experience, and local ties of the master which protected the hospital in the short term. It is likely that if the uninterested attitude of hospital patrons persisted, this hospital would have encountered the same fate as others. Notably not all its subsequent patrons took the same view.

In a later example, the importance of the bishop as joint patron can again be seen for this hospital, but by the fourteenth century, and a point which is discussed in detail in Chapter Six, the ability

[60] H. Barkly, 'Arnald De Berkeley, Baron of the Exchequer', *The Transactions of the Bristol and Gloucestershire Archaeological Society*, 16 (1891), pp. 167-182, p. 179, '*et motu Episcopi loco suo constituit p[re]d[ictu]m Nicholaum ballivum suum ad custodiendum pred[ict]um Hospitalem'.*
[61] Ibid., p. 179, '*et dicunt quod predictus Ernaldus numquam resignavit custod[em] p[re]d[ict]i Hosp[itali]'.*
[62] Ibid., p. 179, '*quod predictus Ernaldus recuperet jus suum de predicto Messuaguo ut de jure Hospitalis ipsius est'*.
[63] Smyth, *The Berkeley Muniments*, pp. 127-8.

of a patron and bishops to intervene in the operational affairs of a hospital had grown. The lords of Berkeley Castle were tenants in chief of the king, and an illuminating series of events concerning their house took place in the early fourteenth century. During the Despenser wars, Maurice Berkeley rebelled against Edward II and was subsequently imprisoned at Wallingford Castle in 1322.[64] Thus as a felon, the king confiscated Maurice's lands. Perhaps not surprisingly given its patron's disloyalty to the king, the hospital came under attack in 1322 and books, ornaments, and revenues were stolen.[65] These acts were recorded by the bishop who appears to have acted in his capacity as joint patron and intervened to support the hospital. In the previous year, during the wars, Bishop Cobham had ordered a commission to take place as the hospital had been ruinous for some time. Interestingly, the same documents specified that the approval of Maurice was required in order to restore it to its former condition.[66] In this case, it was the action of the bishop which assisted the hospital, but crucially the king did not seek to prevent this intervention despite the prevailing circumstances.

By 1492, one legal patron and founding heir, the marquis of Berkeley, at last made a definitively beneficial intervention by making a substantial investment in this house which quite probably ensured its post-Reformation survival. William bequeathed 22 marks for land to be purchased to fund two chaplains, one for the chapel at Longbridge and the other at the parish church. In addition, 100 marks was allocated for a house to be built for the two chaplains in Longbridge, and 40 marks for the purchase of ornaments and vestments for the chapel.[67] The hospital evaded suppression, and it was claimed in the sixteenth century that its lands had been concealed from assessors.[68] There is no direct evidence to say that the patron lay behind its successful evasion, but its close proximity to the castle, longevity in comparison to Lorwing, and the many timely

[64] Ibid., p. 230.
[65] *The Register of Thomas de Cobham, Bishop of Worcester, 1317-1327*, ed. E. H. Pearce (London, 1930), p. 108.
[66] Ibid. p. 132.
[67] PROB-11-9-104, 'Will of William Berkeley', 1492.
[68] *CPR: 1560-1563*, pp. 329, 357.

interventions of bishops and monarchs as temporary patrons suggest that this is the most plausible conclusion.

In other cases, bishops who were not patrons appear less able to influence proceedings. The house at Lechlade is a good example of a hospital which had a series of patrons and fell into decline on a regular basis. Bishops, as will be seen, did intervene, but in comparison to the other hospitals in this study, this house experienced an unusually high level of corruption. What appears to have taken place is that the patrons failed to support the hospital and ensure that the bishop's recommendations were implemented. The problems date back to the death of Isabella Mortimer in 1252 when the manor of Lechlade reverted to the Crown and was then granted to Henry III's brother, Richard, earl of Cornwall. [69] In 1255, the earl granted the site of the hospital to the master and brethren as well as the advowson of the parish church of Lechlade, an oven, and two burgages in the vill of Lechlade.[70] The earl had attempted to grant a certain amount of independence to the hospital. Roger Mortimer pursued a claim that the manor should not have reverted to the Crown but dropped the case in 1263 when he received a grant of alternative property.[71]

It was from this point that the hospital lost its familial ties with its patron, and a string of local problems ensued. In 1290, the bishop of Worcester, Godfrey Giffard, intervened and issued a series of corrections.[72] The corrections suggest a complete breakdown of control, citing: a lack of discipline, misappropriation of funds given to the almonry and infirmary, gluttony including eating and drinking outside the precinct, and a lack of uniform dress.[73] The situation further deteriorated, and by 1300 the bishop's registers detailed yet more abuses including: priests, brothers and sisters who had been expelled from the house, lands alienated, the hermitage released, and the hospital library and ornaments removed.[74] In 1300, the earl of Cornwall,

[69] *VCH: Gloucester*, vol. 7, ed. N. M. Herbert (Oxford, 1981), pp. 106-21.
[70] *CChR*: *1226-1257*, p. 440; Dugdale, *Monasticon Anglicanum*, vol. 6, part 2, p. 684.
[71] *VCH: Gloucester*, vol. 7, pp. 106-21.
[72] *Register of Bishop Godfrey Giffard*, vol. 1, p. 391.
[73] Ibid.
[74] Ibid., p. 537.

Edmund son of Richard, granted both the manor and the hospital to Hailes Abbey.[75] Whether this was designed to assist the house cannot be categorically stated; it certainly does not appear that the earl wished to personally intervene in the affairs of the house as other patrons have been known to do.

The hospital, remarkably given the fate of many hospitals in the same situation within this study, maintained its independence and was soon back in the gift of lay patrons. In 1330, the Mortimers (in this case Geoffrey) briefly held the manor of Lechlade, probably as a result of the execution of Edmund, earl of Kent. Then in 1330, Edward III intervened and gave royal assent to the appointment of a chaplain and prior before restoring the temporalities of the hospital to the new master.[76] The manor then passed to a variety of individuals throughout the fourteenth century including Queen Isabella, Thomas de Bradeston (on the minority of the earl of Kent's sons), before being settled in dower on several occasions, then passing to Edmund Mortimer, and finally his nephew, Richard, duke of York, in the fifteenth century. [77]

The hospital struggled to survive during this period; bishops also intervened, but their instructions often went unheeded. For example, in 1352 Bishop Thoresby ordered an inquiry into excesses and defects of the hospital believing that the priests were celebrating masses as chaplains and being paid to do so.[78] However, a further attempt to reform the hospital was again required in 1374, and by 1375 during a vacancy of the see of Worcester orders were executed to excommunicate the prior of the hospital. Finally, in November 1472, following the success of the Battle of Tewkesbury in the previous year and the restoration of her son, Edward IV to the throne, the duchess of York converted the hospital into a perpetual chantry of three chaplains. In this case, it seems there were so many parties trying to help the hospital, but ultimately nobody

[75] *Register of Bishop William Ginsborough, 1303 to 1307*, ed. J. W. Willis Bund and R. A. Wilson (Oxford, 1907); *VCH: Gloucester*, vol. 7, pp. 106-21.
[76] *CPR: 1327-1330, Edward III*, vol. 1 (London, 1891), pp. 503, 508, 513.
[77] *VCH: Gloucester*, vol. 7, pp. 13-21.
[78] Ibid., p. 125.

was willing or able to assert their control over the house and prevent the constant stream of abuses and failings. Thus, while monarchs and bishops could provide a level of assistance, only the legal patron could ultimately ensure that their houses operated successfully. This was not something the duchess of York as patron evidently wanted to countenance: a licence was granted by the king for the conversion of the hospital to the said perpetual chantry of three chaplains who were to perform their work in the parish church. At the same time, a mortmain licence was granted to the master of the hospital to grant its site and possessions to the chaplains.[79]

By contrast, the hospital at Castle Donington, which also formed part of the estate of the earl of Kent in the mid-fourteenth century, appears not to have encountered as many operational difficulties. It received the support of subsequent patrons, and it survived into the sixteenth century. Between 1343 and 1348, the king granted the wardenship of the hospital to four individuals (three clerks, two of whom were described as the king's clerk, the fourth individual's position is unknown) citing the reason as the custody of the earl's lands and heir being in his gift.[80] In 1353, the king ordered the escheator in the county of York to deliver several advowsons to Elizabeth, the late wife of John, earl of Kent.[81] These included both the hospital at Castle Donington valued at £10 per annum and the priory (presumably within the hospital precinct) at Lechlade valued at £30 per annum.[82] When comparing the two hospitals, it is noteworthy that the patrons appear to have taken less interest in the more highly valued advowson. This suggests that the value of hospitals to their patrons cannot be assessed in terms of wealth alone. That Elizabeth was granted the advowson is also interesting as the earl's heir was his sister Joan (d. 1385) who married Edward, prince of Wales and Aquitaine, in 1361 following the death of her first husband, Thomas Holland, in 1360.[83]

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[79] *CPR: 1467-1477, Edward IV & Henry VI* (London, 1900), p. 361.
[80] *CPR: 1343-1345, Edward III*, vol. 6 (London, 1902), p. 33; *CPR: 1345-1348*, p. 266; *CPR: 1348-1350, Edward III*, vol. 8 (London, 1905), pp. 87, 101.
[81] *CCR: 1349-1354, Edward III*, vol. 9, ed. H. C. Maxwell Lyte (London, 1906), p. 554.
[82] Ibid.
[83] Richard Barber, 'Joan, suo jure countess of Kent, and princess of Wales and of Aquitaine [called the Fair Maid of Kent] (*c.* 1328-1385)', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/14823 (7 Nov. 2017); Scott L. Waugh, 'Edmund [Edmund of

It is possible that the advowson did eventually pass to Joan as in 1363, in a clear example of patronal concern, Prince Edward sent a yeoman to inquire into why the warden had not provided a chaplain and dwellings for six poor persons.[84] In 1411, the advowson passed to the king's niece Margaret Holland (d. 1439), widow of John, earl of Somerset (d. 1410), and daughter of Thomas Holland, fifth earl of Kent.[85] It was known to still be functioning as a hospital in 1462 when the master was noted on a duchy of Lancaster rental as owing suit of court every three weeks.[86] Very little is known about the hospital after this point, but it survived until it was dissolved under the 1547 Chantry Act.[87]

It is, perhaps, not surprising to find unsupportive patrons, and on occasion this appears to have had a terminal consequence as in the case of Lorwing. This could also happen when a hospital struggled for years, despite episcopal attempts to assist it, and the legal patron alienated his or her rights. Notably, subsequent legal patrons could be uninterested from an early point in a hospital's history. On the other hand, there are examples of subsequent support for hospitals when patronal heirs intervened to remedy the situation when their predecessors had failed to perform their duty. What is continuing to emerge is that only a legal patron could actively prevent a hospital from enduring. As is well-known, one patron attempted to do just that in the sixteenth century – the ultimate patron or advowee paramount.

Woodstock], First Earl of Kent (1301-1330), Magnate', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/8506 (7 Nov. 2017).

[84] *Register of Edward the Black Prince: Preserved in the Public Record Office*, vol. 4, eds A. E. Stamp and M. C. B. Dawes (London, 1933), p. 520.

[85] *CCR: 1409-1413, Henry IV*, vol. 4 (London, 1932), p. 251; R. L. J. Shaw, 'Holland [Married Name Beaufort], Margaret, Duchess of Clarence (b. in or Before 1388, d. 1439) Wealthy Widow and Monastic Patron', *ODNB* (Oxford, Oct. 2008), http://www.oxforddnb.com/view/article/98133 (7 Nov. 2017).

[86] G. F. Farnham and A. Hamilton Thompson, 'The Castle and Manor of Castle Donington', *Leicestershire Archaeological and History Society: Transactions*, 14 (1925), p. 56.

[87] *VCH: Leicester*, vol. 2, ed. W. G. Hoskins and R. A. McKinley (London, 1954), p. 39.

IV: The Advowee Paramount

In addition to the rights held as titular patrons, the king held rights as the ultimate patron or advowee paramount. As noted at the outset of this chapter, monarchs could assert their feudal or regalian rights with reference to the advowson of hospitals – in effect the king became a temporary legal patron. The notion of the king as the ultimate patron was highlighted in 1962 by Margaret Howell with respect to Henry III presenting candidates to churches in the gift of bishops during *sede vacante*. The justification for this intervention was that the bishop's barony was in his hands. In the case of cathedral prebends, however, the picture was not as clear as the bishop's right of collation stemmed from his role as prelate as opposed to his baronial rights. The king, nonetheless, argued that advowsons of prebends were 'annexed to the temporalities' and thus within his remit. The final answer to this problem, in Howell's summary, was given in the Statute of Provisors (1351) which argued that patronage, regardless to whom it had been granted, pertained to the king as 'Advowee Paramount'.[88]

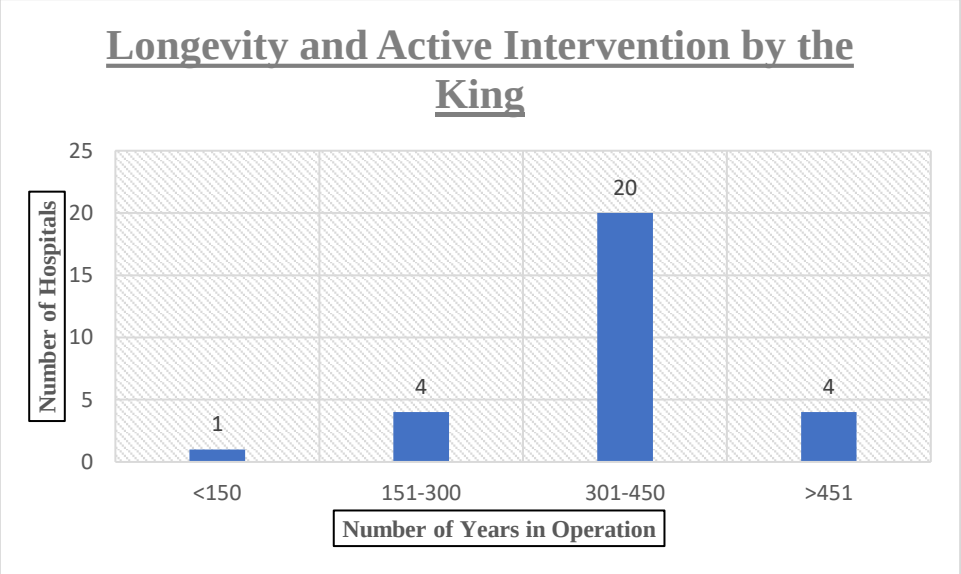
Just prior to this in 1348, a court ruling concerning a dispute between Edward III and the archbishop of York was clear: 'The King is Patron Paramount of the whole Bishopric'.[89] Given that bishops were patrons of hospitals, this meant that the king could claim the right of collation when the bishopric was vacant. In addition, when a tenant in chief of the king was the patron of a hospital, it is likely that on occasion the patronage of the house passed into the king's hands. Thus, the king had the potential to act as a temporary patron for hospitals regardless of their type of founder. And, what is more, the precise moment when those opportunities arose could be of pivotal importance to a hospital's ability to endure – a minor heir, no heir, or a patron whose lands had been seised might have resulted in the house becoming more vulnerable to external threats

[88] Howell, *Regalian Right in Medieval England*, pp. 192-3.
[89] *Statutes of the Realm*, vol. 1, pp. 316-8; *Year Books of the Reign of King Edward the Third: Year XVIII*, ed. L. O. Pike (London, 1901), pp. 524-540, quote at p. 538 '*Le Roi est Souverein Patroun'*. The case concerned a presentation by the king to the deanery of York.

such as theft of its assets, famine, disputes, or war. The previous section highlighted one such case concerning the hospital at Longbridge.

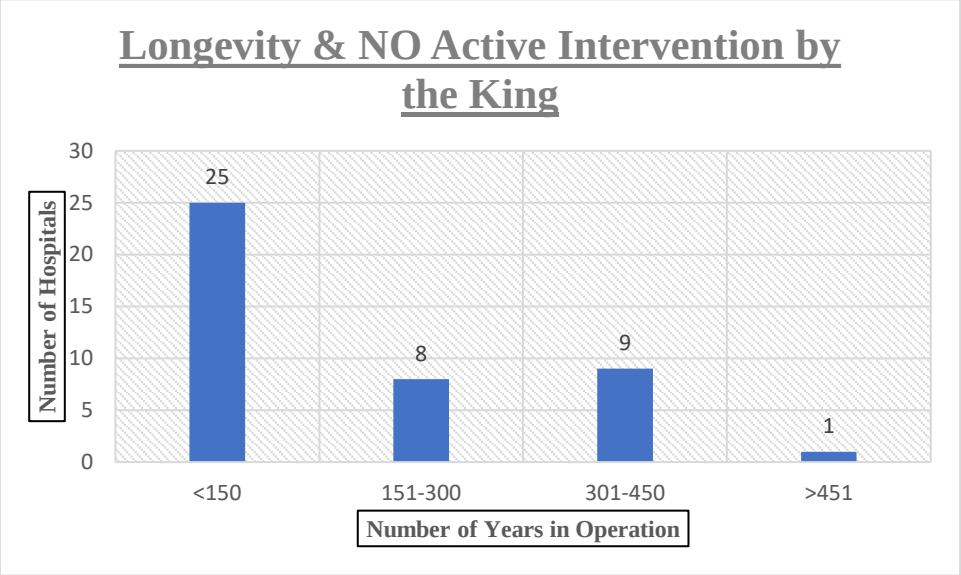
The following charts demonstrate that hospitals with an association with the Advowee Paramount endured for more years than those that did not. The chart does not include points of contact concerning letters of protection or mortmain licences. This assistance was of some value, but these acts did not directly affect the internal operations of a house. It does, however, include grants of wardenship made by the king. Arguably, this is not an active intervention; however, Chapter Six will contend that it was. For the purpose of this chapter, all that needs to be established is that there was an association between the king and the hospital which, arguably, had the potential to influence the operations of the house – to its benefit or otherwise.

Figure 4: Hospital Longevity in Cases of Royal Intervention (29 Hospitals)[90]



[90] Taken from Database Longevity Groups Query which is based upon the Founder Longevity table and the K[ing] B[ishop] M[onastic House] Query.

Figure 5: Hospital Longevity Without Royal Intervention (43 Hospitals)[91]



In the view of this study, these charts demonstrate that a hospital was more likely to endure if it had a direct royal association. Only one such hospital was unable to endure for more than 100 years as opposed to 25 without an association. In addition, 24 were able to last for more than 300 years versus 10 in the alternative category – and the latter category contained a higher proportion of the sample.

It is acknowledged that it could be argued that the results indicate that the longer a house operated for, the more likely it was to come to the attention of the king. This argument would tally with the legislative change created by the imposition of *Quia Emptores* in 1290 which replaced subinfeudation with substitution. Ultimately, this should have resulted in a situation where more lands were held directly of the king and, thus, more associations over time – especially if landholdings decreased in size.[92] But in order to definitively prove that theory, it would need to be demonstrated that 100% of the associations in the charts above did not occur before 1290; and, what is more, the underlying detailed data reveals that this was not the case. In the first instance, there are at least two hospitals founded by monarchs within this sample (Ospringe and Walsoken).

[91] Ibid.
[92] *Statutes of the Realm*, vol. 1, p. 108.

Given that the sample selection method was based on foundations prior to 1279, this clearly occurred prior to the introduction of the 1290 legislation – and, thus, it is safe to conclude that the hospital came to the attention of the king on day one. There are also other examples for non-royal houses such as the building of the *camera regis* at Brackley in 1229 funded by Henry III.[93] In addition, land, of course, escheated to the king throughout the Middle Ages, and bishoprics are known to have become void prior to 1290. One example of the latter occurred at Portsmouth in 1267 when the king appointed one of his serjeants and an unknown individual to support the hospital until the brethren had elected a master.[94] And monarchs could be generous in their gifts of building materials to hospitals as occurred in 1232 at Devizes.[95] These two examples relate to hospitals that survived for in excess of 300 years. Suffice it to say, then, the charts do not show that the longer a hospital endured the more likely a hospital was to encounter the attention of a king. The examples just discussed demonstrate the benefit a monarch could bring to a house.

There are later examples, too, of beneficial royal connections of this nature with hospitals in this study. The hospital at Cricklade, for instance, was founded by a chaplain of Henry III and subsequently received royal permission of free transit through the forest of Braden in order to transport firewood, charcoal, and timber – notably these were key components in the deliverance of hospitality.[96] The ordinances of this hospital bear a close resemblance to those of a monastery. A copy of the 1237 statutes survive in the register of Bishop Hallam and permitted the brethren the right to select their own prior with the permission of the bishop, to be instituted by the bishop.[97] In 1322, the registers provide confirmation that the procedure was adopted when Adam Kynny was nominated as prior by the brethren.[98] However, in the late fourteenth century the king twice granted the wardenship to individuals, perhaps indicating an internal management problem among

[93] *CR: 1227-1231*, p. 269.
[94] *PR: 1266-1272*, p. 105.
[95] *CR: 1231-1234, Henry III*, vol. 2 (London, 1905), p. 43.
[96] *CChR: 1226-1257*, p. 130; *CR: 1227-1231*, p. 487.
[97] *The Register of Robert Hallum*, p. 153.
[98] Ibid., p. 272, '*in quem omnes alii ipsius hospitalis fratres unanimiter consenserunt et suum ejusdem hospitalis priorem concorditer nominarunt'.*

the brethren.[99] Certainly, there was a high turnover of wardens between 1389 and 1391: four in total.[100] The penultimate appointment, by an unknown patron, was quashed for procedural faults alone.[101] The capacity in which the king intervened is not known – the bishopric, for example, was not void at this time, and there is no evidence as to why the brethren had failed to make an election. The actions do, however, suggest a degree of concern for the welfare of the hospital by the king.

An early example concerning the intervention by the king in 1267 at the hospital at Portsmouth has already been noted above.[102] The king also made a grant to one of his clerks of the mastership of this hospital in 1386, but this was challenged by the bishop of Winchester in 1388.[103] This is not surprising given that in 1284 the bishop had paid £2,000 and the manor of Swainstone in return for a confirmation from the king of the manor of Menes, the advowson of Menestoke, and the advowson of the hospital at Portsmouth.[104] Part of the problem appears to be the historic relationship between the king and the hospital owing to its vulnerable position in times of war. As early as 1230, letters of protection exist from the king to the prior and brothers of the hospital, but the frequency of these letters increased in the fourteenth century.[105] In 1340, the warden of the hospital was also exempted from fulfilling his obligation to find men at arms for the custody of the Isle of Wight as the hospital's manors and possessions had been burned by alien enemies.[106] And in the same year, the hospital received a one-year grant of protection which specified that alms could be collected in churches – this is of particular note as it is the only specific example of this nature encountered by this study.[107] In 1343, the king issued protection with a clause

[99] *CPR: 1388-1392*, pp. 152, 330.
[100] *VCH: Wiltshire*, vol. 3, eds R. B. Pugh and E. Crittall (London, 1956), p. 336.
[101] *The Register of John Waltham, Bishop of Salisbury, 1388-1395*, ed. T. C. B. Timmins (Woodbridge, 1994), p. 80.
[102] *PR: 1266-1272*, p. 105.
[103] *CPR: 1385-1389, Richard III*, vol. 3, ed. H. C. M. Maxwell Lyte (London, 1900), p. 226; *CCR: 1385-1389, Richard III*, vol. 3 (London, 1921), p. 480.
[104] Wright, *The Story of the 'Domus Dei' of Portsmouth*, p. 8.
[105] *PR: 1232-1247*, p. 344.
[106] *CCR: 1339-1341*, p. 637.
[107] *CPR: 1340-1343, Edward III*, vol. 5 (London, 1900), p. 29.

rogamus presumably to continue to assist the beleaguered hospital to raise funds.[108] By 1346, the hospital was so impoverished by the attacks from the king's enemies that the king again issued protection to the master and brethren.[109] This hospital survived until 1540.

A further example of the king assisting a troubled hospital concerns the hospital of St Leonard at Stoke-by-Newark. In 1317, the patron, Edmund Deyncourt, enfeoffed his estate comprising several manors and advowsons including that of the hospital to Oliver and John Deyncourt.[110] Earlier, Edmund 'fearing that his name and arms may become extinct in the person of Isabella his daughter and heir apparent' had received a licence to 'enfeoff whomsoever he will': thus, in a move to block his daughter's inheritance and to protect his estate, including his hospital, he disinherited his daughter.[111] Edmund's fears were justified as, despite his effort to protect the hospital, it lapsed into decline. In 1368, the responsibility for supporting the hospital fell to Edward III who sought to rectify the hospital's failings by ordering a commission to enquire into the hospital's possessions and the behaviour of the brethren.[112] In 1370, the king despatched another party to investigate the affairs of the hospital, and again emphasising the ties to the original founders, issued instructions to remove those individuals concerned, and to restore the hospital according to the ordinances and statutes of its first foundation.[113] In this example, the king clearly did not approve of the changes to the running of the hospital and the original founding vision which he described as 'defects and incontinencies (sic) and wicked doings'.[114]

Ongoing royal interest persisted and was again evident when in 1398 Richard II ratified the estate (status) of Hugh Hanworth as warden and master of the hospital.[115] Then in 1477, Edward IV

[108] Ibid., p. 575.
[109] *CPR: 1345-1348*, p. 209.
[110] *CPR: 1313-1317*, p. 651.
[111] Ibid.
[112] *CPR: 1367-1370, Edward III*, vol. 14 (London, 1913), p. 126.
[113] Ibid., p. 472.
[114] Ibid.
[115] *CPR: 1391-1396*, p. 161.

granted the hospital to Laurence Duckworth during the minority of Francis lord Lovell.[116] The links to the Crown continued into the sixteenth century when Queen Mary sought to restore the hospital in 1558.[117] This document is noteworthy as it stated that the founder was one of the queen's progenitors; given that the founder is unknown this seems unlikely, but it would explain royal interest and a statement in the 1368 commission which claimed that the king was founder and visitor.[118] The patron of this hospital went to great lengths to support and protect his house, and this was further assisted by the intervention of the king.

Even in cases where the identity of the founder is uncertain, such as the hospital near Castleton, royal ties are, nevertheless, sometimes evident. The only known reference to this founder's identity was made by William of Worcester who stated in the fifteenth century that 'Peak hospital is founded by the wife of Peverel' (*domus hospitale de Peke fundatur per uxorem de Peverelle*).[119] Whoever the founder was, their importance was recognised by Henry VII in 1488 when he granted the hospital and its lands, tenements and profits to George Salvage, clerk, specifying that mass and divine service should be celebrated four times a year for the good of the king's estate and for the souls of the dead founders of the hospital.[120] Earlier in the hospital's history, its master, Richard de Creyk, received letters of protection from King Edward III when he accompanied Queen Isabella overseas.[121] Scholarship to date has surmised that it was owing to Richard's influence that the queen made a grant of rent in 1343 to the hospital.[122] A now badly damaged petition by Richard the queen's chaplain in 1343 contains details of that grant and its intended use to fund the sustenance of the chaplain singing in the chapel of the hospital.[123]

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[116] *CPR: 1476-1485, Edward IV, Edward V, Richard III* (London, 1901), p. 14.
[117] *CPR: 1557-1558, Philip and Mary*, vol. 4 (London, 1939), p. 466.
[118] Ibid., *CIM*: 1348-1377, vol. 3 (London, 1937), p. 265.
[119] *Itineraria Symonis Simeonis et Willelmi de Worcestre: Quibus Accedit Tractatus de Metro, in Quo Traduntur Regulæ a Scriptoribus Medii Aevi in Versibus Leoninis Observatæ*, ed. J. Nasmith (Canterbury, 1778), p. 358.
[120] *Materials for a History of the Reign of Henry VII: From Original Documents Preserved in the Public Record Office*, vol. 2, ed. W. Campbell (London, 1877), p. 236.
[121] *Fœdera, Conventiones, Litteræ, et Cujuscunque Generis Acta Publica Inter Reges Angliæ*, eds T. Rymer, T. Rymer, G. Holmes, and R. Sanderson (1727), p. 57.
[122] *VCH: Derby*, vol. 2, ed. W. Page (London, 1907), pp. 86-7.
[123] *CPR: 1343-1345*, p. 58; 'Petitioners: Richard de Ore…chaplain of the queen and warden of the hospital of St…' SC 8/342/16133, http://discovery.nationalarchives.gov.uk/details/r/C9736614 (07 Nov.

Finally, there is evidence that the monarchy was prepared to closely guard these rights. For instance, the patronage of the hospital of St Edmund the Bishop in Gateshead, not to be confused with the hospital of St Edmund the King in the same location, was in the gift of the bishops of Durham. In 1383, a dispute arose when Richard II attempted to grant the custody of the hospital to Richard Leuesham claiming the hospital was still in his gift owing to the lately void bishopric of Durham.[124] The key phrase being 'lately void' – Richard was attempting to extend his rights by arguing that time did not run against the king: in other words, the king presented a candidate after the vacancy of the see had ceased.[125] A legal battle ensued as the king sought to test the power of the bishop in the palatinate. The bishop had already collated Laurence de Allerthorp, or so Allerthorp claimed.[126] Richard, suspecting foul play, accused ecclesiastical personnel of attempting to prejudice his rights and to eject his master of the hospital.[127] The king endeavoured to shield his candidate by instructing Leuesham's cousin, Thomas de Claxton, and William Elmeden to protect him and prevent anyone from forcibly expelling him.[128] However, in October 1383 the king began to accept Allerthorp's contention and issued a writ to prevent Claxton and Elmedon from protecting Leuesham.[129] In November 1383, he ordered an inquiry into the matter.[130] The case was not resolved until 1388 when Richard finally acquiesced and acknowledged Allerthorp as warden of the chapel of Gateshead known as the hospital of St Edmund, Gateshead.[131] This protracted dispute demonstrates how important these rights were to the king.

2017). The National Archives summary suggests that the surname commences 'Ore', but while it is difficult to decipher it is more likely that it reads 'Cre' and does indeed refer to the aforementioned Richard.

[124] *CPR: 1381-1385, Richard II*, vol. 2, ed. H. C. M. Lyte (London, 1897), p. 242.

[125] Howell, *Regalian Right in Medieval England*, pp. 183-4.

[126] 'Petitioners: Laurence de Allerthorp, master of St Edmund's Hospital, Gateshead', http://discovery.nationalarchives.gov.uk/details/r/C9334648 (23 Nov. 2017).

[127] *CCR: 1381-1385, Richard II*, vol. 2, ed. H. C. Maxwell Lyte (London, 1920), p. 278.

[128] *CPR: 1381-1385*, Lyte, p. 351; 'Petitioners: Laurence de Allerthorp, master of St Edmund's Hospital, Gateshead', TNA.

[129] *CCR: 1381-1385*, Lyte, pp. 383-4.

[130] Ibid., pp. 345-6.

[131] *CPR: 1381-1385*, Lyte, p. 526.

It can, therefore, be seen that an intervention by a reigning monarch often assisted a legal patron in their endeavours to ensure the survival of their house. When the patronage came into the king's hands, as the ultimate patron, the king usually took such matters seriously. In fact, this occurred to such an extent that the monarch was on occasion reticent to relinquish that control when, for instance, a void see was filled. It was in the king's power to appoint high-calibre individuals to these posts: this and direct operational matters will be further considered in Chapter Six. The results here demonstrate that a hospital was more likely to endure when it is known that a king was associated with a hospital.

Conclusion

This chapter has demonstrated that hospitals located in small towns and villages were remarkably resilient having a minimum average lifespan, depending on the classification of their patrons, of between 151 and 316 years. In addition, it has highlighted the pivotal role of the legal patron in their ability to endure, and that their role went above and beyond issuing consent for licences to elect or presenting masters for institution. It also seems that the more that is known about the founding patron, the more likely the house was to survive. The study was unable to make direct comparisons to the work of Thompson and assess whether the interest of legal patrons in these houses might have waned over time. What this study did find, however, was that a hospital was more likely to endure if its founder is known, and within that category 66% of those hospitals were founded by the Crown and higher nobility.

Patrons were often aware of their own limitations and devised survival strategies to protect hospitals. The most successful strategy was to grant the advowson of the house to the diocesan bishop as opposed to a monastic house. However, not all patrons were supportive of their houses, and it was in their remit to actively seal their fate. When the advowee paramount had an association with a house, it was more likely to endure; and this may explain why earls, lords, or

bishops, that is persons whose estates were more likely to fall into royal custody, were often the patrons of hospitals which endured for longer periods of time. Yet there are also examples, such as Sprotborough, where this was not the case, and the hospital survived into the sixteenth century. What is emerging is a direct causal link between active interventions by a patron and the survival of hospitals. Patrons undeniably played a pivotal role in the longevity of these houses. Discussions now turn to the possibility that external factors played an equally prominent role in the ability of these institutions to survive or not.

Chapter Five: *Statutum de Terris et Tenementis ad Manum Mortuam*, 1279[1]

> 'No one at all, whether religious or anyone else, may presume to buy or sell any lands or tenements, or to receive them from anyone under the colour of gift or lease or any other title whatsoever, or to appropriate them to himself in any other way or by any device, or subterfuge, so that they pass into mortmain in any way, under pain of forfeiture'.[2]

The Statute of Mortmain (1279) had the potential to make a significant difference to the life of medieval hospitals in England – and yet its effects on hospitals have received little scholarly attention to date. The implication of the statute – that lands could no longer be granted to religious institutions – may be particularly relevant to hospitals in this study. Sethina Watson's work on the early hospital in England considered them to be dependent upon their legal patron because of their slender founding endowments until at least the middle of the thirteenth century.[3] Occasionally other benefactors did make substantial grants, but Watson found that this was not the norm. Most subsequent grants in their formative years were 'small annual rents or regular payments by lesser local lords or townsfolk'.[4] This raises the possibility that if a subsequent hospital patron was unable or unwilling to support their house, any restriction upon a hospital's ability to attract further gifts of land might have limited its chances of survival if it experienced difficulties. Alternatively, a successful hospital might have sought to expand its activities during times of need and, thus, attract additional grants of land to support that growth. Regardless of the

[1] The licences consulted during this project, such as Brackley 2 in 1282, adopt the phrase '*statuto de terris et tenementis ad manum mortuam non ponendis edito non obstante*'.
[2] Raban, *Mortmain Legislation*, p. 1 representing a translated extract of the legislation. The complete Latin text was reproduced on pp. 193-4.
[3] Watson, 'The Origins of the English Hospital', pp. 75-94 – Watson's dates vary sometimes stopping at 1200, but on pp. 84-5 the foundation charters used to make the statement that a hospital's 'endowment was not meant to ensure independence' included those founded in the period to 1250. Her earlier doctoral thesis, considered the period to 1300. Both pieces of work are based on the premise that the foundation process continued over several years.
[4] Ibid., p. 93.

reason behind the need to attract further gifts, the statute clearly had the potential to affect these houses.

The hospitals initially selected in this project were thought to have been founded prior to 1279, although subsequent work has shown that one may be up to 20 years later.[5] They, therefore, should fit Watson's model and, thus, have the potential to have been significantly affected by the statute. As a group, they denote an interesting unit of study representing early foundations which have received significantly less attention than their counterparts in the later Middle Ages; yet many survived into this period. By giving consideration to their ability to adapt their operations in response to the mortmain legislation, this study has the opportunity to gain a greater understanding of these institutions.[6] It first sets the scene by reviewing the scholarship in this area both in terms of the need to implement the statute and how a process evolved which watered down the initial draconian royal stance. Subsequent sections explore the pre- and post-mortmain landholding position for the hospitals within this study and provide an assessment of the effect of the legislation on these houses. The evidence deployed is based upon both the results of the database work and detailed primary source analysis. This method facilitates the study of the lesser-documented houses which is an important goal of this project.

I: Context

The *Statutum de Viris Religiosis*, known as the Statute of Mortmain but in the texts consulted as part of this study referred to as *Statutum de Terris et Tenementis*, was promulgated in November 1279.[7] It pronounced that alienations of lands and tenements to ecclesiastical institutions which

[5] Ivychurch, see Appendix 1. The database entry method produced a date of 1280 as Clay appears to have mistyped 1299 for 1229. The decision was made not to remove the house from the sample – given the nature of the evidence concerning these hospitals in general and the overall aim of the study it was felt that this would not be detrimental to the results of the study. In addition, K&H recorded the date as 1229.
[6] Watson, 'The Origins of the English Hospital', p. 77; Chapter One of this study.
[7] Raban, *Mortmain Legislation*, p. 1. The licences consulted, such as Brackley 2 in 1282, adopt the phrase '*statuto de terris et tenementis ad manum mortuam non ponendis edito non obstante*'.

would fall into mortmain were without exception now prohibited. Moreover, the king foresaw the potential manipulation of the legislation through the creation of, for example, leases as a mechanism to disguise the now illegal grants. As seen at the start of this chapter, an appropriate clause to counter this scenario was incorporated into the order which was issued in the form of a writ to the justices of Common Pleas.[8] The penalty of disobeying the statute would be forfeiture of those lands.[9] In reality, the statute merely provided a precursor to the implementation of a licensing system which gave the king and lay landholders authority to approve or prevent this type of grant, or not as the case may be.[10] In circumstances such as these, it is not difficult to envisage outcomes which gave preferential treatment to the king's favourites or houses within his gift – two scenarios which the ensuing sections of this chapter will consider.

Paul Brand has suggested that the legislation was designed to protect the loss of a lord's feudal incidents and the king's ability to defend the realm through military service: both parties were concerned to control the levels of land passing into the hands of the Church.[11] The feudal incidents in question arose on the death of a tenant when land could escheat to the lord if the tenant died without heirs. If the heir was not of age, the lord could enforce his rights of wardship and take temporary possession of the estate. In addition, rights existed concerning the estates of a convicted felon. If an estate was transferred to an institution, such as a hospital, these events could not take place as the institution was theoretically eternal and therefore could not die, nor could it be convicted of criminal activities. Furthermore, grants to ecclesiastical institutions were often made in frankalmoign, or free alms, which absolved the institution from secular services due to the lord including those of military service. The king suffered a direct loss of income when the donor in question was a tenant in chief, but of at least equal concern was that the donor would

[8] *Councils and Synods: With Other Documents Relating to the English Church, A.D. 1205-1313, part II: 1265-1313*, ed. F. M. Powicke and C. R. Cheney (Oxford, 1964), pp. 864-5.
[9] *Statutes of the Realm*, vol. 1, p. 5.
[10] P. Brand, 'The Mortmain Licensing System, 1280–1307', in A. Jobson (ed.), *English Government in the Thirteenth Century* (Woodbridge, 2004), pp. 87-96.
[11] P. Brand, 'The Control of Mortmain Alienation in England, 1200-1300', in J. H. Baker (ed.) *Legal Records and the Historian: Papers Presented to the Cambridge Legal History Conference, 7-10 July 1975, and in Lincoln's Inn Old Hall on 3 July 1974* (London, 1978), pp. 29-40, especially p. 40.

still be able to meet their military obligations to the king either by providing the appropriate number of knights in relation to their land holding or by offering financial recompense instead. The implication of these concerns was that established religious houses were growing in both wealth and power, or that available resources were limited – it was not until the fifteenth century that licences were issued as a fiscal device.[12]

The scholarship in this area indicates that there is little doubt that the king wished to control the alienation of lands through the licensing system, and that any changes to this system, despite pleas from the church, would only be made at his behest.[13] It is, therefore, feasible that a hospital's ability to secure access to, in the first instance, legal guidance to gain an understanding of the said process and, in the second, the ear of the king played a significant role in its ability to operate. In addition, it poses the question as to whether the king as instigator of the licensing system and advowee paramount provided additional support to these houses. However, before proceeding to examine the hospitals in this study in detail, it is first necessary to briefly explain the process of obtaining a licence. The process usually commenced with the submission of a written petition to the king, or the king and his council. This petition requested permission to make the alienation. A writ was then issued ordering an investigation into the potential losses that the king might suffer, but as time passed that was extended to include other lords and the donor's neighbours. This investigation was known as an inquisition *ad quod damnum* (to what damage?). These enquiries were obligatory for individuals seeking to grant land in mortmain. Attempts to match these inquisitions to licences have shown that they have not survived in all cases. Consent from the lord of whom the property in question was held was required from at least 1292. From 1299, a charge could be made for each licence issued and that fine recorded in the Patent Rolls.[14]

[12] See also Raban, *Mortmain Legislation*, especially p. 71.
[13] Raban, *Mortmain Legislation*, pp. 29-71; Brand, 'The Control of Mortmain Alienation in England, 1200-1300'; T. F. T. Plucknett, *Legislation of Edward I* (Oxford, 1949), pp. 99-100.
[14] Raban, *Mortmain Legislation*, see especially Chapter 2 and pp. 39, 60.

Even though this does not appear to be an overly complex process, it does suggest the need for a degree of administrative sophistication on the part of the hospital. Hospitals would have needed to demonstrate that the appropriate consent had been received; and in time, prove that previous grants fell outside the scope of this legislation – i.e. the land was acquired prior to its introduction. Furthermore, it has been noted that the process often required the assistance of a powerful patron who could steer the petition through the system until a licence was issued.[15] There is a small amount of existing scholarship in this area with reference to English hospitals *per se*. Carole Rawcliffe is one of the few historians who has considered the effect of the legislation through her study of the hospital of St Giles, Norwich. Adopting a pragmatic stance, Rawcliffe painted a picture of a financially astute approach to hospital management. In the early fourteenth century, the hospital appeared to conduct its business within the law. In 1318 it acquired a royal licence permitting alienation of 100 acres of arable and pastoral land, and in 1321 another licence from Edward II to purchase land to the value of £10 per annum.

However, the hospital accounts contain examples of land purchased for which approval was not obtained. Rawcliffe surmised that it is likely that the general licences were used as a safety net to provide some justification for alienations for which a specific licence had not been sought. Technically speaking, a specific licence was required regardless of whether a general licence had been granted on an earlier occasion or not.[16] Furthermore, Rawcliffe suggested that in order to avoid government suspicion the hospital petitioned Parliament in 1334 for its support to appropriate the church of Mundham St Peter. In a cunning move, the hospital feigned poverty claiming that it required assistance owing to the burden of its costs and its poor chaplains.[17] It is of little surprise that a hospital located in a large medieval city in the gift of powerful episcopal patrons could access the finest legal and financial advice in order to remain solvent.

[15] Ibid., p. 39.
[16] Ibid., p. 50.
[17] Rawcliffe, *Medicine for the Soul*, pp. 84-7.

Miri Rubin's work on St John's hospital in Cambridge revealed the implementation of an alternative strategy to bypass the statute. This hospital adopted the tool of enfeoffment to use (the holding of land by trusted individuals for the use of the hospital). A policy had been in place for several years whereby individuals held land until what Rubin termed the fiction was dissolved. In the case of St John's, a licence was obtained in 1347, and within three weeks the hospital had obtained the property it sought both in Cambridge and the surrounding villages along with the supporting documentation: the title deeds. In Rubin's view, prior to the attainment of a licence the hospital placed reliance on the emerging notion of *usus* (usage) as opposed to *dominium* (full ownership). These usages were evolving in relation to mendicant orders who were unable to hold land but could benefit from the use of a property without being seised of it. A defensible right emerged from the benefits of tenure, as opposed to seisin, which accrued from the feoffment. This had the result that an agent became the legal possessor, but the hospital enjoyed the benefits – clearly, then, a system based on trust and the idea of protecting a house.[18]

One further strategy which was employed by hospitals in medieval cities can be seen in the London hospital of Elsyngspital. Ann Bowtell's doctoral thesis provided an in-depth discussion of the way in which its founder, William Elsyng, accumulated lands prior to its foundation in 1331. William was a wealthy merchant, and it seems he took a different approach to the statute. William obtained licences for several of the properties used to endow the hospital but not all of them. It appears that he decided to use his will to ensure that the hospital received the property and thereby alleviated the necessity to obtain licences. Bowtell raised the question why William obtained licences for some properties and not others, and concluded that it is likely that this added credence to the venture which would be required to attract other donors in the future.[19]

[18] Rubin, *Charity and Community in Medieval Cambridge*, pp. 213-7.
[19] A. Bowtell, 'A Medieval London Hospital: Elsyngspital 1330-1536' (PhD Thesis, Royal Holloway, University of London 2010), pp. 86-94, 170, 290; *VCH: London*, vol. 1, ed. W. Page (London, 1909), pp. 535-7.

There were, therefore, a variety of options to mitigate any risk posed by the statute which were potentially available to hospitals within this study. A favourable relationship with the king might have secured a licence; a general licence and pleas of poverty could disguise illicit grants of land; trustees could be employed to circumnavigate the controls and achieve an identical outcome; and finally, the passing of a grant of land from one dead hand to another through the vehicle of a testamentary bequest could secure the desired outcome too. A comparison of the detailed post-mortmain results of this project to these findings will occur in due course. It is, however, necessary in the first instance to ascertain the landholdings of hospitals in small towns and villages from their date of foundation to the eve of the legislation, and the context in which they were operating.

II: The Pre-1279 Position

Before proceeding to gain an insight into hospital landholdings, a reminder of the foundation dates of the 72 hospitals within this sample is required. This is necessary in order to begin to establish whether these houses might not have needed, albeit surprisingly given the aforementioned discussions, to attract further grants of land, thus, nullifying the impact of the legislation.

Figure 6: Foundation/Date of First Reference by Half Century (72 hospitals)[20]

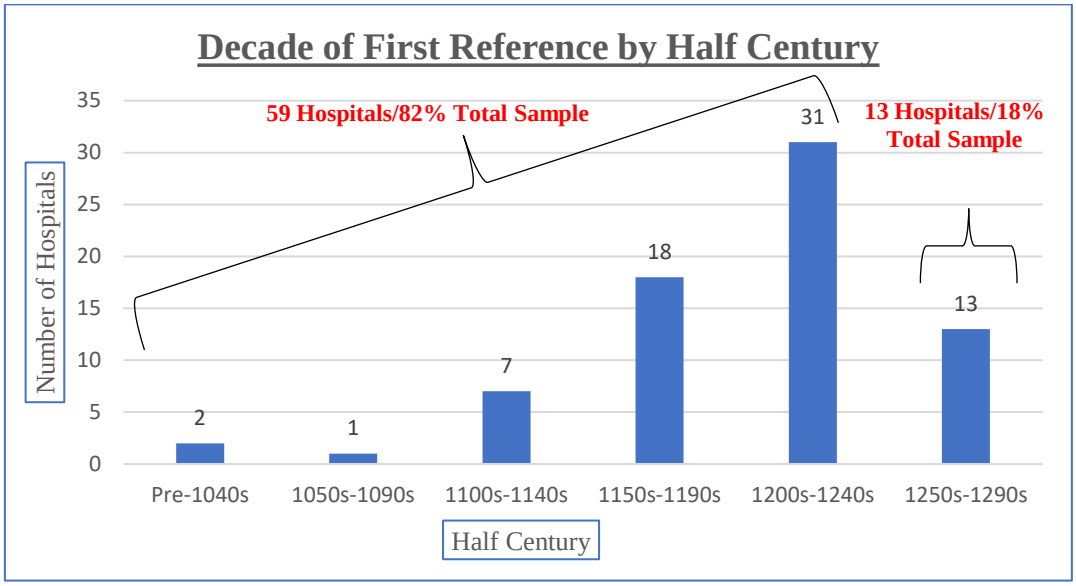


Figure 6 shows that of the total sample, at least 82% of hospitals in this study relate to the period covered in Watson's published article (to 1250) and 100% to her doctoral thesis (to 1300) – although only 21 of those noted in her thesis were directly covered by this work as the remaining 51 do not have extant foundation charters.[21] As stated at the start of this chapter, Watson's work has shown that those hospitals founded prior to 1250 are likely to have had slender founding endowments. They might, therefore, have required further gifts of land in the decades and centuries following the foundation process. There are two hospitals in this study, which were undoubtedly founded in the twelfth century, for which an abundance of relevant factual material has survived which to date is unexplored.[22] The two hospitals were both located in Northamptonshire: one at Aynho and one at Brackley. A detailed examination of their estate

[20] Created from the database Founder Longevity Query extract (taken from Hospital Main, Founder, and Final End tables), based upon Detailed Start Appendix, based upon the review of primary sources as listed in the bibliography for the total sample of 72 hospitals from *c.* 1100 to 1650. See also Appendix I for summary and Section II of Chapter One.

[21] Watson, 'The Origins of the English Hospital'; Watson, 'Fundatio, Ordinatio and Statuta'. See footnote 3 for clarification of date ranges used by Watson.

[22] The bibliography for Watson's thesis does not cite the original foundation charters and accompanying documentation, it instead relied upon the work of Dugdale. However, there is a passing reference to 87 charters concerning Aynho on p. 215, but it is not clear how the data was compiled. It is likely given the very brief nature of the analysis that the calculation was made using Macray's detailed calendars. It concluded that these grants were all local in nature.

documents has, therefore, the potential to further elucidate the understanding of the position of hospitals in small towns and villages. In addition, three further houses will also be discussed.

Aynho was founded in 1189 by Roger son of Richard, first baron Warkworth; and Brackley was founded in *c.* 1160 by Roger de Beaumont, second earl of Leicester. Neither of their founding endowments conform to type. Brackley was granted a meagre one acre of land, but this landholding was quickly augmented with two virgates of land in nearby Halse which was subject to a rental charge of 10s per annum.[23] Aynho, on the other hand, received one hide of land on foundation which is thought to equate to approximately 120 acres.[24] Turning in the first instance to discuss the position at Brackley, its initial grant by an influential earl, in turn, attracted several other small grants of local land but not necessarily from local people. For example, Ralph de Diva, the prior of the hospital of St John of Jerusalem, alienated twenty acres of land in nearby Boddington (Bottendum) to the hospital in Brackley in *c.* 1180.[25] The founding grants of the second earl of Leicester (d. 1168) were confirmed by the third earl of Leicester (d. 1190) in *c.* 1170.

The familial connections continued following the death of the fourth earl of Leicester who died without issue in 1204. His sister, Margaret, who took a personal interest in the hospital, granted lands to the house which were previously farmed by the hospital for a rent of 10s from her now deceased brother (presumably these were the second part of the founding endowment noted above). At the same time, Margaret also granted a croft formerly held at 2s rent and a mill at Halse with its appurtenances at an annual rent of 4 marks.[26] There is also a second accompanying deed by Saer de Quincy, Margaret's husband, prior to his admission to the earldom of Winchester (as evidenced by his seal), which granted the same assets as Margaret but which clearly stated

[23] MCA, Brackley 39; Macray, Northamptonshire I, No. 2; MCA, Brackley B184; Macray, Northamptonshire I, No. 3.
[24] MCA Brackley 39; MCA Aynho 71; C. Corèdon with A. Williams, *A Dictionary of Medieval Terms and Phrases* (Cambridge, 2004), p. 154.
[25] MCA, Brackley 53A; Macray, Northamptonshire I, No. 14.
[26] MCA, Brackley C132; Macray, Northamptonshire I, No. 33.

that this occurred with Margaret's consent.[27] Subsequently, Saer, now in his capacity as earl of Winchester, made a valuable grant to the house of his wood in Littlehey. This was again at the request of Margaret.[28] Concurrent evidence also exists which documented the start of the hospital's sheep farming activities; activities which would ultimately differentiate it from the smaller house at Aynho. In *c.* 1210, the hospital obtained a grant of pasture for 200 sheep in Evenley and Astwick and a grant of a virgate of land in nearby Whitfield including pasture for 60 sheep.[29]

Saer de Quincy, as patron of the hospital, used his new-found social and political standing to further endow and support the house. Initially, Saer had a close relationship with King John as shown by his attestation of John's surrender of his crown to Pope Innocent III in 1213 and his taking of the vow to go on crusade with the king in 1215.[30] However, he also appears to have become increasingly perturbed by the king and developed close connections with Scottish royalty and nobility from his castle in Leuchars – his mother was Orabile, daughter of Ness, son of William, lord of Leuchars in Fife. In 1215, he attended the court of Alexander II as events which led to civil war later in the year began to unfold.[31] It is these Scottish connections which Saer drew upon in furtherance of his duty to support the hospital. King Alexander confirmed Saer's grant in the capacity of lord of Gask, Perthshire, of the church of Gask to the hospital; and Roger de St Andrew, his nephew, granted rent from land in Colesyn, Scotland, to endow the hospital with sufficient funds to maintain a light in the church and to support the infirmary.[32] Subsequently, Saer was one of the 25 barons who rebelled against King John using Brackley as

[27] MCA, Brackley B179; Macray, Northamptonshire I, No. 34.
[28] MCA, Brackley D219; Macray, Northamptonshire I, No. 42.
[29] MCA, Evenley and Astwick 66; Macray, Northamptonshire III, No. 112; MCA, Whitfield 45; Macray, Northamptonshire IV, No. 6.
[30] Richard D. Oram, 'Quincy, Roger de, Earl of Winchester (*c.* 1195-1264), Constable of Scotland', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/22966 (25 June 2020).
[31] Ibid.
[32] Whitfield 13(1); Macray, Northamptonshire IV, No. 4; Macray, Northamptonshire I, No. 300.

his base.[33] In the first instance, then, this patron protected his house by confirming earlier grants and then proceeded to augment the endowment.

Following the death of Saer de Quincy on crusade in 1219, the close relationship between hospital and patron continued. Saer's son, Roger de Quincy, did not inherit the title of earl of Winchester until his mother's death in 1235, but he did receive his father's land in 1221 and became a generous patron of the hospital.[34] The earl made twenty grants to the hospital ranging from a bondman, to rents of 5 marks per annum, to 60 acres of land.[35] In addition, the earl granted two virgates of land to his wife to gift to the hospital in her own right.[36] Despite the hospital's expansion, Earl Roger took an interest in its activities and witnessed several of the deeds. For example, in *c.* 1250 he witnessed a release of rights in the aforementioned meadow on the site of the upper fishpond.[37] The earl also worked closely with the hospital to develop its sheep farming activities by both granting and securing further donations of land. In *c.* 1220 the earl having inherited his father's lands and titles, gave his demesne in Gask, as lord of Gask, to the hospital with pasture for 24 oxen, 15 cows, and 100 sheep.[38] This was later annulled in 1241, most probably due to its distant location, but a confirmation of grants in 1228 by Henry III provides a useful summary of the nature of local grants which the hospital had attracted in the intervening years.[39] In nearby Whitfield, for example, several grants emanated from Gilbert de Monte, lord of Whitfield.[40] Other grants confirm the hospital's farming practices, such as one in 1238 by Robert le Gras, knight, who described neighbouring Astwick as a village 'in which the brethren have their sheepfolds and other buildings'.[41]

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[33] Richard D. Oram, 'Quincy, Saer de, Earl of Winchester (d. 1204), Magnate', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/22967 (29 Jan. 2020).
[34] Ibid.
[35] Extracted from the database Grants table based on Macray see Primary Sources section i.
[36] MCA, Brackley 183.
[37] MCA, Brackley 15; Macray, Northamptonshire I, No. 145.
[38] MCA, Brackley C127; Macray, Northamptonshire I, No. 58.
[39] Macray, Northamptonshire I, No. 139.
[40] MCA, Whitfield 106; Macray, Northamptonshire IV, No. 27; MCA, Whitfield 28; Macray, Northamptonshire IV, No. 28.
[41] MCA, Astwick 54A; Macray, Northamptonshire III, No. 95.

The hospital, patron, benefactors, and sheep farming practices were inextricably linked. There is no doubt that many of the local knights and tenants who donated land wanted to be associated with the hospital and sought to identify themselves with its prestigious and wealthy patrons who held lands across England and Scotland.[42] As noted in Chapter Three, Roger de Quincy's mother's and brother's hearts were buried within the hospital before the high altar, and the earl bequeathed his own body to the hospital.[43] Several grants contained specific requests from donors that they and their spouses should be admitted to the brotherhood and be granted the right of burial within the hospital cemetery: for example, Robert the clerk of Whitfield and his wife Mabel in *c.* 1220.[44] It seems that there was an early form of confraternity or guild in existence at the hospital which accommodated both males and females. Many of the grants were specifically designated to fund chaplains to pray for the donor's soul and often those of their ancestors and heirs too. Earl Robert's grant of his demesne was given in order to finance three chaplains in the hospital, and the grant of 10 marks rent was given to finance one chaplain.[45] Grants which were more modest in nature were made in order to fund lights in the hospital, such as an annual rent of 6d granted in *c.* 1240, or for anniversary masses, such as that given by Philip de Whitfield in the same year.[46]

The hospital continued to obtain grants following the death of Earl Roger in 1264 until the issue of the statute in 1279.[47] This accumulation of land led to disputes within the town, but the hospital was now a powerful institution. On the eve of the legislation in August 1279, the hospital reached a compromise with the burgesses of the town regarding a dispute over the rights of pasture in common fields.[48] An agreement was made whereby the hospital was permitted to enclose lands for their sheep fold subject to the consent of Leicester Abbey.[49] The importance of the wool trade

[42] Oram, 'Quincy, Roger de, Earl of Winchester (*c.* 1195-1264)'.
[43] MCA, Brackley B229; Macray, Northamptonshire I, No. 110.
[44] MCA, Whitfield 17; Macray, Northamptonshire IV, No. 16.
[45] MCA, Brackley C127; Macray, Northamptonshire I, No. 58; MCA, Brackley 4A; Macray, Northamptonshire I, No. 187.
[46] MCA, Whitfield 69; Macray, Northamptonshire IV, No. 52.
[47] Oram, 'Quincy, Roger de, Earl of Winchester (*c.* 1195-1264)'.
[48] MCA, Brackley 239; Macray, Northamptonshire I, No. 338.
[49] Ibid.

to the area at this time can be seen by the arrival of several wool merchants to the town. Evidence survives which shows that by 1279 Roger de Luton exported 180 sacks of wool overseas and Thomas Terry nine sacks.[50] There is no doubt that the hospital at Brackley on the eve of the introduction of the statute was a well-endowed, well-maintained, and supported hospital operating in a successful sheep farming region of England. The findings also show that the hospital had benefitted over many years from donations made by a variety of people.

In a comparable way to the hospital at Brackley, the hospital of St James and St John at Aynho, Northamptonshire, does not appear to be tied to its early patrons. The founding grant was followed by a series of donations, predominantly of small parcels of land in nearby Croughton, from two landholding families – the La Hays and the Beaumonts. The development of the relationship between the families and the hospital commenced with the grant of a chapel by Aliz de Wavere, the mother of William de la Hay, son of Baldwin de Boulogne in *c.* 1200.[51] At the same time, Aliz's sister and husband, Milesent and Robert de Beaumont, sold the hospital a messuage for 20s and her husband granted it a virgate of land in Byfield.[52] The grants continued from members of the two families: for instance, a gift of two acres in Croughton from Guy de la Hay in *c.* 1220 and from William de la Hay half an acre in *c.* 1250.[53] In addition, individuals with local connections donated land, such as Thomas de Croughton who in *c.* 1250 granted two acres and one rood of land in Croughton for the soul of himself and his wife Margery.[54] That is not to say that patronal interest ceased. In *c.* 1270, a subsequent patron of Aynho, Robert Fitzroger, fifth lord Warkworth and Clavering, granted 40s of annual rent from his mill at Aynho for the

[50] *Rotuli Hundredorum Temp. Hen. III. Edw. I., in Turr' Lond' et in Curia Receptæ Scaccarij Westm. Asservati*, vol. 2 (London, 1818), p. 16.
[51] MCA, Aynho 83; Macray, Northamptonshire III, No. 9.
[52] MCA, Aynho 86; Macray, Northamptonshire III, No. 17; MCA, Aynho 43; Macray, Northamptonshire II, No. 14.
[53] MCA, Aynho 50; Macray, Northamptonshire III, No. 24, MCA, Aynho 26; Macray, Northamptonshire II, No. 28.
[54] MCA, Aynho 36; Macray, Northamptonshire III, No. 31.

maintenance of a chaplain to celebrate for the soul of his grandmother Euphemia, countess of Dunbar, in the said hospital.[55]

Furthermore, in a commercially astute move, Robert married Margaret de la Zouche, daughter of Alan de la Zouche (d. 1270), patron of the hospital of St James and St John at Brackley.[56] It is most likely that it is this close connection with the hospital at Brackley which ensured the survival of the much smaller and less well-endowed institution at Aynho. The hospital at Aynho appears to have started to acquire land in Croughton for sheep farming purposes which then possibly fed into the wool-trade network centred on Brackley. A series of grants of land ensued; for instance, in *c.* 1270 Thomas le Neweman alienated two acres of land to the hospital.[57] Then, in *c.* 1279, a release of rights in a piece of ground in Brackley to the hospital at Aynho reveals a link between the two hospitals and the wool trade: the witnesses included the master of the hospital at Brackley, John de Chinnore, and several wool merchants.[58] This represents another example of a patron ensuring the survival of a hospital, which coincidentally occurred on the eve of the introduction of the 1279 legislation, by developing powerful local networks through marriage and possibly trading links too. The patron was influential in the hospital's expansion, but the hospital was not tied through repetitive acts of almsgiving to its patron.

Not all the hospitals in this study gradually enhanced their endowments, some were granted ample lands on foundation and in one case immediately transferred the patronage to a bishop. The hospital of Beck, near Billingford in Norfolk, was founded by William de Bec prior to 1224 and was endowed with the manors of Beck, Billingford, and Howe, as well as lands and rents in several Norfolk parishes.[59] The patronage rights were transferred to the bishop of Norwich in

[55] MCA, Aynho 51; Macray, Northamptonshire III, No. 39.
[56] J. Burke, *A Genealogical and Heraldic History of the Commoners of Great Britain and Ireland, Enjoying Territorial Possessions or High Official Rank, but Uninvested with Heritable Honours* (London, 1834), p. 283.
[57] MCA, Aynho 46; Macray, Northamptonshire III, No. 47.
[58] MCA, Aynho 14; Macray, Northamptonshire III, No. 51.
[59] *VCH: Norfolk*, vol. 2, ed. W. Page (London, 1906), p. 438.

1224.[60] There is also evidence of minor grants of service owed by individuals, rents and a mill (Kirkemille), and a pool and acres [of land] and fisheries (*et cum stagnis et ac[r]is et piscariis*).[61] Another well-endowed hospital on foundation was Kepier near Durham.[62] The hospital, founded by Bishop Flambard in 1112, was granted the bishop's vill of Caldecotes with appurtenances in field and in pastures, in meadows and in woods, in water, with cultivated and uncultivated land, a mill in Milneburn, and two sheaves of corn from fifteen of his vills.[63] These demesne lands stretched from Wearmouth north of Sunderland down to Sedgefield, thus demonstrating the scale of farming practice and management, and the system which bound the hospital to its hinterlands. The hospital was further endowed by Bishop Hugh with the vill of Clifton and a lead mine to roof the church of St Mary (*minerum plumbi ad cooperiendam ecclesiam sancte Marie*).[64] These grants attracted donations from local nobility, such as Ralph de Eppleton who granted a carucate of land (*c.* 120 acres) in Eppleton in the early thirteenth century.[65] Therefore despite its large founding endowment, this hospital was also expanding on the eve of the mortmain legislation, a further example being the grant by Henry Lightfoot of his land in Dernecrok in the parish of Gateshead in *c.* 1274.[66]

The final hospital with a patron who attracted additional endowments is that of the hospital of St Mary, Ospringe, Kent. This house is said to have been founded by Henry III, but S. E. Rigold has questioned this as Henry was prone to appropriating foundations.[67] This appears to be a reasonable assumption especially as the foundation charter does not seem to have survived, when some of Henry III's grants were recorded in the royal Charter Rolls, such as in 1258.[68] Regardless of who founded the hospital, there is no doubt that its success in the thirteenth century was as a

[60] Ibid.
[61] Billingford 6 (Grant of a mill, pool and fisheries, *c.* 1260, Billingford 10 (Grant of lands in Dalling, *c.* 1260), Billingford 12 (Grant of land in Ho, *c.* 1270).
[62] Dugdale, *Monasticon Anglicanum*, vol. 6, part 2, p. 732.
[63] Ibid.
[64] *EEA 24: Durham*, pp. 48-50.
[65] Barmby, *Memorials of St. Giles's, Durham*, p. 197.
[66] Ibid., p. 205.
[67] S. E. Rigold, 'Two Kentish Hospitals Re-Examined: St. Mary, Ospringe and SS. Stephen and Thomas, New Romney', *Archaeologia Cantiana*, 79 (1964), pp. 31-69.
[68] *CChR: 1257-1300, Henry III, Edward I*, vol. 2 (London, 1906), p. 9.

direct result of Henry III's abundant gifts. It is, of course, of no surprise that such a pious king and patron of the hospital would want to ensure that it was a shining example, befitting of his status, and provide for it accordingly.

The king's grants were largely a mixture of land and liberties. The grants spanned several years and included: land in Waltham in 1235 and 1237, a house in London in 1239, in 1240 land in the parishes of Headcorn, Twitham, Staple, Adisham, Wingham, Hammewolde, and the advowson of the church at Headcorn, and in 1252 land in Romney Marsh.[69] These grants encouraged several smaller gifts which were recorded in the Charter Rolls. In 1247, a roll recorded a grant of 71 gifts to the hospital by 60 donors.[70] The gifts were predominantly of land and rent, although there was the occasional gift of produce, such as honey. Some gifts were sizeable, for instance, rent of 20s 6d per annum for 21 acres of land in Poltun or 26s 8d donated by the prioress and Convent of St Helens, London, payable by Adam le Dyer for his land in the parish of St Mildred, Canterbury.[71] In 1258 the donations continued, a grant was recorded in a roll containing twenty gifts from eighteen donors.[72] On this occasion the gifts were more substantial in nature, most notably 120 acres of land at Whitstable.[73] Thus, yet again, here is an example of a hospital expanding not only its land holdings but its donors in the thirteenth century.

To summarise, there is unequivocal evidence that five hospitals within this study were acquiring lands and privileges prior to the introduction of the statute. These detailed findings support Watson's overview in the sense that the grants were mostly local in nature – but not exclusively so. Of course, not all hospitals were growing in the thirteenth century – in fact, sixteen were never heard of again.[74] It is, therefore, possible that some weaker houses had already dissolved

[69] *CR: 1234-1237*, pp. 98 and 495; C. H. Drake, 'The Hospital of St. Mary at Ospringe Commonly Called Maison Dieu', *Archaeologia Cantiana*, 30 (1914), pp. 35-78; *CChR*: *1226-1257*, p. 391.
[70] Ibid., p. 315-8.
[71] Ibid., pp. 316, 318.
[72] *CChR: 1257-1300*, pp. 8-9.
[73] Ibid., p. 9.
[74] Database, Founder Longevity query.

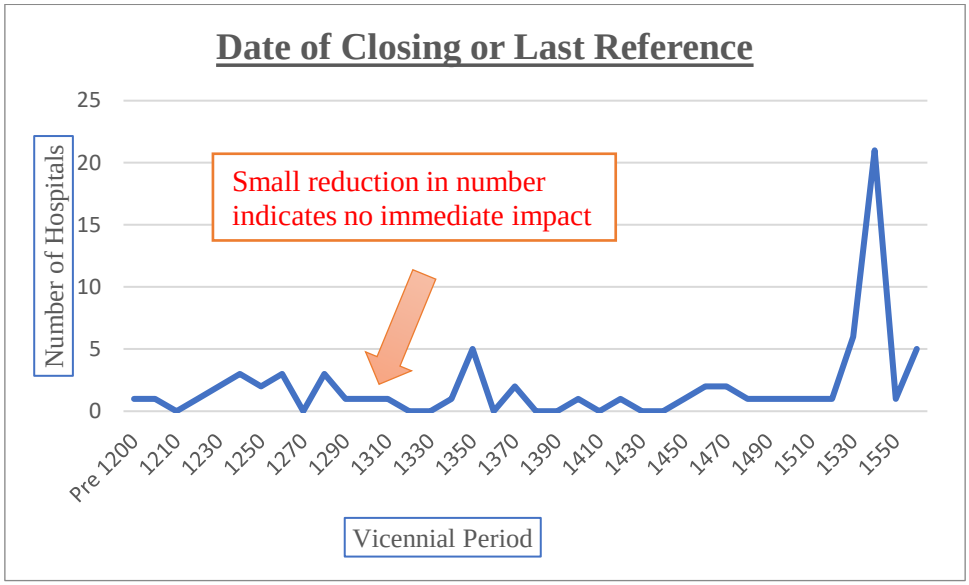
prior to the introduction of the statute. There is also a suggestion that the total holdings and commercial activities for some hospitals were quite significant by 1279 – thus, the stronger ones were so well-endowed that they would not subsequently require additional grants of land. In addition, the five houses discussed in this section reveal that some hospitals were not reliant on patrons in their early years for alms. However, they might have required general support to obtain additional land or commercial revenues prior to 1279.

III: The Database Results and the Impact of the Legislation

At first glance, the database outputs appear to indicate that these houses were largely unperturbed by the introduction of this seemingly harsh statute. The following chart provides evidence of their ability to endure throughout this period of change and uncertainty: no immediate increase in closures or date of last reference is apparent in the data – in fact, these cases declined in number in the ensuing years, albeit from a low starting point. There is a small spike in the following decade where three houses were last recorded. Two, Chesterfield and Seaton, had received protection from the king in 1276 and 1271, respectively.[75] This suggests that they were experiencing difficulties prior to the introduction of the statute. The third hospital at West Tarring is known to have been attempting to recover a tenement in 1277 through an action of *novel disseisin*. In this case, the master instigated the proceedings and nothing more is known of the hospital. The three hospitals were, therefore, experiencing difficulties on the eve of the legislation, but it is not known whether the legislation and prevailing attitudes to these houses at this time contributed to their ultimate demise.

[75] *PR: 1272-1281, Edward I*, vol. 1 (London, 1901), p. 187; *PR: 1266-1272*, p. 603.

Figure 7: Total Sample Hospital Closure Dates (72: Hospitals)[76]

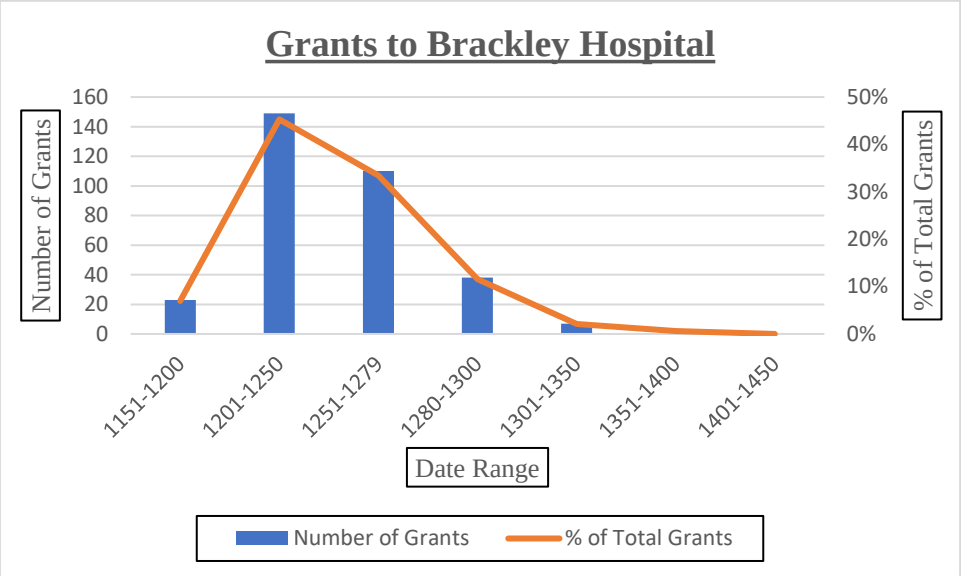


With reference to the results shown in Figure 7, scholarship to date, largely concerning hospitals outside of the remit of this study, indicates that all is not as it may first appear. Section I of this chapter has discussed the avoidance strategies employed by houses in Norwich, Cambridge, and London. These ranged from the appointment of trustees or bequests made in wills to disguise the ultimate use of the grant, to token applications for licences, and petitions of feigned poverty. The successful implementation of these schemes required knowledge and ability – including the ability to avoid the ever-watchful eye of the escheators who were 'expected to seek out and confiscate acquisitions made without royal licence'.[77] The aforementioned discussions concerning the increasing asset base of the hospitals at Aynho and Brackley in the thirteenth century suggest that they were able to access extremely influential patrons who, through their courtly and commercial connections, in turn had access to some of the finest legal minds in the country. Thus, the questions which merit consideration are – to what extent did these houses require additional grants of land to survive and who assisted them to obtain the said land should it have been required. These points are considered in both this and the following section.

[76] Created from the database Founder Longevity Query extract (taken from Hospital Main, Founder, and Final End tables), based upon Detailed End Appendix, based upon the review of primary sources as listed in the bibliography for the total sample of 72 hospitals from *c.* 1100 to 1650. See also Appendix I for summary and Section II of Chapter One.
[77] Raban, *Mortmain Legislation*, pp. 72-101, quote at p. 73.

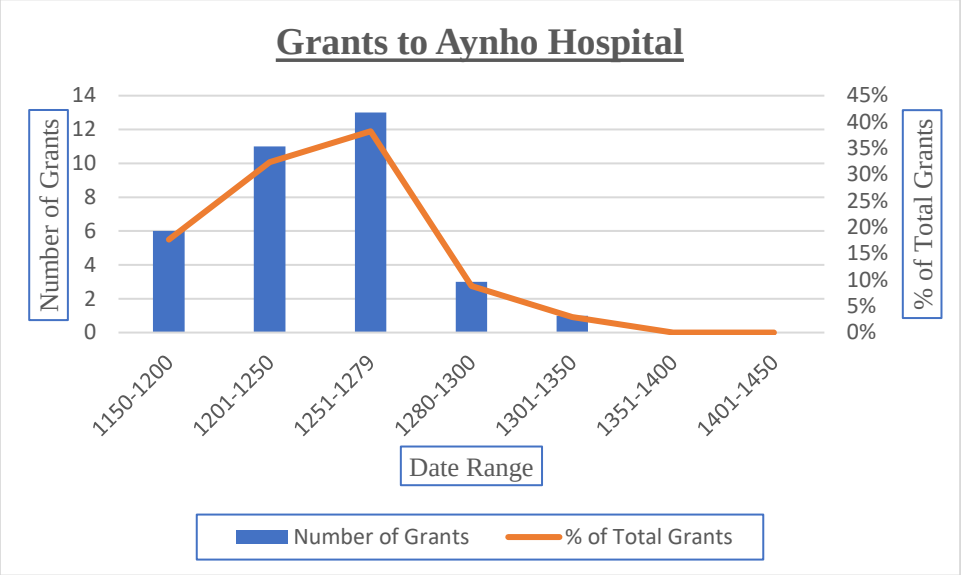
When looking at the data concerning grants of land to the hospitals at Aynho and Brackley across their operational years, it appears that they either did not require further grants of land or were unable to secure them. The following graphs analyse the said grants and support the detailed discussions in Section II that grants were increasing prior to the introduction of the statute. However, they also clearly show that these grants fell sharply at both houses in the post-mortmain period.

Figure 8: No. of Grants of Lands, Rents, and Tenements to the Hospital at Brackley (329 Entries)[78]



[78] Created from database Grants of Land Query filtered on Brackley and To Hospital checkbox (Tables: Hospital Main, Deeds, and Grants) based upon Macray's detailed calendars as given in the bibliography, Primary Sources, Section i.

Figure 9: No. of Grants of Lands, Rents, and Tenements to the Hospital at Aynho (34 Entries)[79]



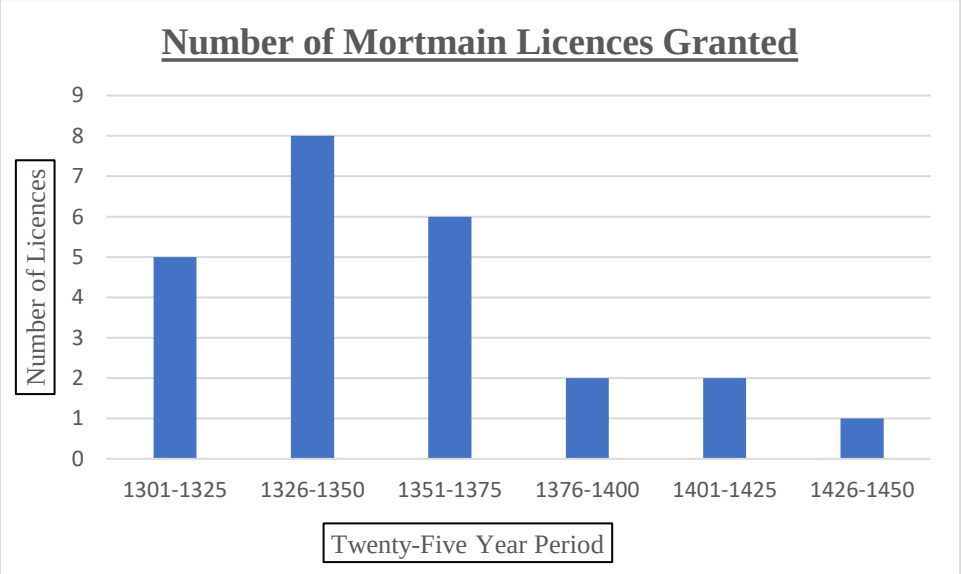
A review of mortmain applications may shed further light on the question as it could highlight refused requests or successful requests which may or may not have come to fruition. Raban's work on the impact of the legislation demonstrated that a shift occurred in the granting of licences from the enclosed clergy in the late thirteenth and early fourteenth centuries, to parochial clergy, secular colleges, guilds, and hospitals in the period between 1351 and the late fifteenth century.[80] This, however, is not wholly unexpected given the overwhelming predominance of licences issued to monastic houses in the fourteenth century and the expansion of the legislation to incorporate guilds and fraternities in 1391.[81] Thus, any apparent fashionable transfer in grants from monastic houses to hospitals does not necessarily indicate a shift in royal favour, land acquisition policy, or anti-monastic feeling. Therefore, Raban's findings require further consideration. In addition, the effect of the legislation on hospitals is not something which has been considered in other studies in this area, such as Paul Brand's discussion of the legislation

[79] Created from the database Grants of Land Query filtered on Aynho and To Hospital checkbox (Tables: Hospital Main, Deeds, and Grants) based upon Macray's detailed calendars as given in the bibliography, Primary Sources, Section i.
[80] Raban, *Mortmain Legislation*, pp. 169-70.
[81] Ibid.

and Elizabeth Gemmill's analysis of the effect of the statute on lay patrons' ecclesiastical benefices.[82]

The following chart represents grants of mortmain licences recorded on the Patent Rolls to hospitals in this study. It was created in order to make a comparison to Raban's general findings that 'at the latter date [1451-1455], more than twice as many licences were allocated to parochial clergy, secular colleges, gilds or hospitals as were granted to the religious'.[83] It finds that although this may well have been the case, the hospitals in question were clearly not those located in small towns and villages and founded prior to 1279. Figure 10 stops at the period 1426-1450 as there were no recorded grants of licences after this period for the hospitals in this study. What it clearly demonstrates is that these houses obtained more licences in the period 1326 to 1375.

Figure 10: Mortmain Licences Granted to Hospitals in CPR (24 Entries)[84]



The database also tracked other entries in the records of central government, such as the *ad quod damnum* inquisitions, to build a picture of centrally recorded mortmain events. These results were

[82] P. Brand, *Kings, Barons and Justices: The Making and Enforcement of Legislation in Thirteenth-Century England* (Cambridge, 2003); Gemmill, *The Nobility and Ecclesiastical Patronage*.
[83] Raban, *Mortmain Legislation*, p. 169.
[84] Created from the database Mortmain table filtered on Type, *CPR*.

extracted from the database and used to compile the following chart which assesses mortmain interventions and the longevity of houses. In other words, it seeks to establish whether there was a correlation between desired mortmain assistance and the ability of a house to endure. These results include the issue of a licence. In compiling the chart, hospitals which in all probability were not extant in the post-mortmain period (or their last-known date is so close to the date of the statute that it is unlikely to have had a significant impact on the house, i.e. those with a database entry date of 1280 or earlier) were removed from the sample. This produced a revised sample size of 56 houses in total.

Figure 11: Mortmain Intervention and Hospital Longevity (56 Entries)[85]

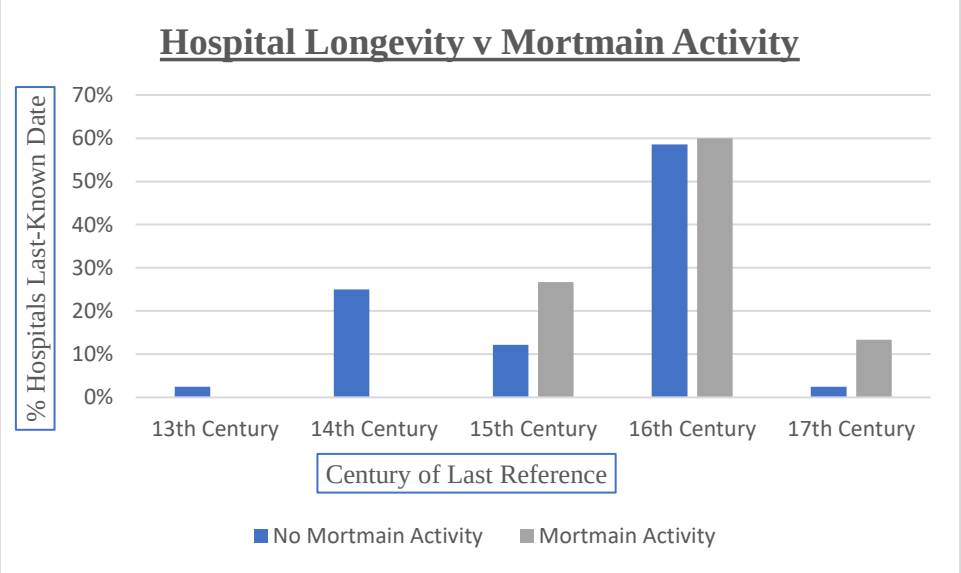


Figure 11 indicates that although hospitals which survived post mortmain had a high chance of surviving into the sixteenth century and beyond, those which did not pursue acquisitions in mortmain, whether the actual licence was granted or not, were more likely to terminate prior to the fifteenth century than those that did. To emphasise the results, not a single hospital which closed in the fourteenth century had a recorded event of mortmain activity: every single licence granted in the fourteenth century, as shown in Figure 10, related to hospitals which endured into

[85] Created from the database Mortmain Longevity query (Tables: Hospital Main, Mortmain, Final End, Founder) sorted by century, and Founder Longevity query (Tables: Hospital Main, Founder, Final End) sorted by century. The mortmain data represents records of central government not just *CPR* and excludes local records.

the fifteenth century. The issue of mortmain activity in the fourteenth century is important as it signals whether a hospital sought to expand its holdings – perhaps due to an increased demand for its services, an increase in the cost of living, or the previous mismanagement of its assets. These points will be considered in Chapter Six; here the motivation is to a certain extent irrelevant, it is the signal of intent which is important and the ability to garner support to fulfil those wishes.

In the fourteenth century, general licences were often applied for even though a specific licence was technically also required when a grant came to fruition. This raises the question of what purpose a general licence served? Raban concluded that it provided some reassurance that future approval for a specific licence would be granted.[86] Crucially for the hospitals in this study, this permitted hospitals to plan for future acquisitions of land. Thus, unless a hospital was planning to adopt one of the avoidance strategies with the associated risks, hospitals which did not apply for a licence, general or specific, were in all probability not seeking to expand their landholdings. Therefore, if a hospital closed and did not pursue a land acquisition strategy it suggests that it was not in a position to gain additional support or that its services were no longer in demand – in the first instance the legislation and its associated bureaucracy might have sealed the fate of a smaller or weaker hospital.

That there were hospitals with mortmain interventions which closed in the fifteenth century is not deemed to be of such significance to this study – it will argue in Chapter Six that other factors led to their closure which were not related to landholdings. In addition, Figure 10 demonstrates that the number of mortmain licences issued had dramatically fallen and a corresponding review of the mortmain database table in this study revealed that there were no other mortmain activities at this time. Moreover, the hospital closures of the fifteenth century which had an earlier mortmain intervention, ceased to operate post 1450. And two of those hospitals, Aynho and Brackley, form a substantial part of this thesis. It will be proven beyond doubt that their dissolution did not occur

[86] Raban, *Mortmain Legislation*, pp. 50-5.

because of the legislation. Again, this is considered in Chapter Six. So, the question which these results raise is what differentiated those hospitals which received fourteenth-century licences from those that closed at this time? The answer to this query could go some way to shedding light on the question as to why some hospitals survived and not others.

What is immediately striking concerning the hospitals which returned mortmain hits within the data in the fourteenth century or earlier (thirteen hospitals in total, although several recorded more than one event) is that ten also experienced other points of contact, excluding royal letters of protection, with the king. Moreover, of the ten hospitals which are thought to have closed in the fourteenth century only one, the second hospital in this study located in Portsmouth, received active regal support. This was in the form of assistance to release the hospital from its obligation to provide men at arms to help defend the Isle of Wight in 1340 as its estates had been burned by alien enemies.[87] Notably, though, no tangible assistance to replenish the endowments or repair the damage appears to have been forthcoming. One possible explanation, given the obscure nature of this house in the historical record, is that the patron was not a tenant in chief of the king, and he was, therefore, not liable or minded to make a further intervention. It may be a coincidence, but it is worthy of note.

In addition to highlighting the correlation between houses which had mortmain occurrences and previous associations with the king, the results also demonstrate that hospitals which were amassing lands prior to the implementation of the statute signalled their intent to continue to do so – and to do so at least in part through official channels. Two such hospitals were discussed in Section II of the present chapter: Brackley and Ospringe. The former is thought to have hosted visiting monarchs on several occasions as outlined in Chapter Two, and the latter's legal patrons were monarchs. Both houses appear more than once in the mortmain table: Brackley in the period to the Black Death and Ospringe throughout the fourteenth century. The following section will

[87] *CCR: 1339-1341*, p. 637.

return to consider the multiple events at these houses. Here, the key point to consider is the potentially early nature of these occurrences for hospitals. Unfortunately, Raban did not provide her complete results for the fourteenth century; instead, she drew attention to key short periods. Her first period of interest concerning hospitals has already been discussed and concerned the years 1451-55. The second notable result is the period 1351-55. In this category, grants to non-monastic houses such as hospitals are similar to those given to monastic houses which fall in the range of 150 to 200. This also, from the selected results given, appears to be the peak period of licence-granting for hospitals and similar institutions.

The results of this study show that licences were issued across the fourteenth century in small numbers, which is understandable given that there are only 72 hospitals in this sample. If they are analysed in the same timeframes given by Raban, as revealed in Figure 10, they too show that the period 1351-55 witnessed the largest number of grants, but these are small numbers indeed. Of the 24 licences issued, three were issued in that period representing the highest number and 12.5% of the total sample. Perhaps more importantly, a summary of the data contained in Figure 10 reveals that the fourteenth century witnessed the overwhelming majority of licence activity being 87.5% of the total – thus, in contrast to Raban's findings, the hospitals in this study did not benefit from the shift in focus to hospitals in 1451-55; they obtained licences throughout the fourteenth century.

Even though the numbers of licences issued in the peak period were small, they can still yield interesting information. As already noted, the peak mirrored the general apex observed by Raban, and it would be easy to dismiss this as not particularly significant – yet it is. The three grants of mortmain licences in 1351-55 relate to two different houses: Killingwoldgraves in Yorkshire which was run by sisters and has scant extant evidence, and Ospringe in Kent which was a royal foundation with an abundance of evidence. The two grants to the sisters represent a general

licence for 100s and a grant of messuages, lands, and rent in part satisfaction of it by two clerks.[88] The third grant to Ospringe was in part satisfaction of a yearly allowance of 100s of land and rent; however, it represented 9s 6d in rent and grants of land from ten individuals of varying sizes taking the total valuation to 20s. These grants ranged from 1 acre of pasture to 50 acres of wood.[89] This indicates that a variety of individuals wanted to assist the poor at this time and fund the hospital's activities.

Therefore, it can be concluded from the database overview that hospitals did not cease to try to obtain additional lands through official channels and that this continued throughout the fourteenth century. In fact, these additional fourteenth-century grants of land differentiated successful houses which were able to endure into the fifteenth century from those that disappeared from the historical records in the fourteenth century. The database outputs can yield yet more results: as noted above, many of the hospitals have more than one entry in the database table. In order to gain an in-depth understanding of the effect of the legislation on these houses, or not, the discussions will move to explore the detailed scenarios of these multiple occurrences which may further elucidate the matter.

IV: Detailed Examples of the Impact of the Legislation

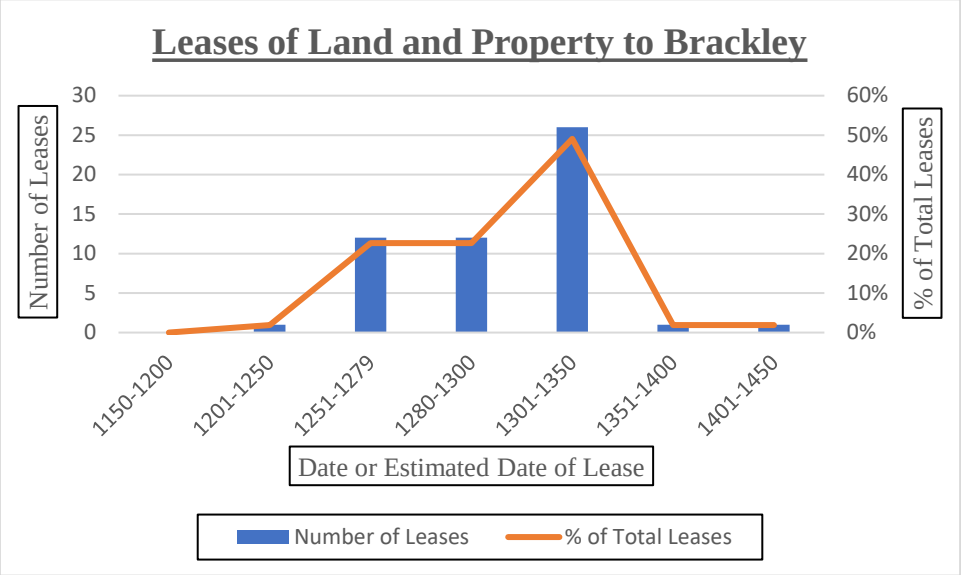
When reviewing the primary source material concerning the acquisition of lands, rent, and tenements prior to the legislative announcement and in the subsequent centuries, it is immediately apparent just how complicated the local administrative processes were. The results of attempts to unpick vague documentation in order to unearth the truth of the transaction are frequently perplexing. Then to decide whether – as in the cases noted in hospitals outside of this study in Section II – these were purposefully evasive acts, the norm, or the result of incompetent

[88] *CPR: 1350-1354, Edward III*, vol. 9 (London, 1907), p. 426; *CPR: 1354-1358, Edward III*, vol. 10 (London, 1909), p. 250.
[89] *CPR: 1354-1358*, p. 54.

individuals is equally difficult to establish. Nevertheless, by combining information contained in the database – in the Mortmain, Grants, and Leases tables – with specific primary source material of note, a picture emerges. This section pays particular attention to the hospitals at Aynho and Brackley for which copious source material has been logged and many original manuscripts consulted. In addition, though, it also includes fleeting insights into the other hospitals within the sample where the evidence permits.

Figures 8 and 9 in Section III suggest that the hospitals at Aynho and Brackley were adversely affected by the implementation of the statute experiencing a sharp and immediate decline in the number of grants of lands, rents, and tenements. Yet further analysis of the grants of licences which underpin the results shown in Figure 10 demonstrate that Brackley sought to continue to expand its land holdings. The following graph, which represents a summary of leases issued to the hospital at Brackley as opposed to grants received by the house, reveals a post-mortmain increase and, thus plausibly, a shift in behaviour as a direct result of the statute. In contrast to the grants of land, it shows an increase in lease transactions to the hospital in the early fourteenth century.

Figure 12: Leases of Property to the Hospital at Brackley (53 Entries)[90]



What is particularly interesting about this chart, however, is that the shift occurred prior to the introduction of the statute. And, what is more, the principal known transfer of land in the second half of the thirteenth century to the hospital, on a temporary basis or otherwise, which comprised 49 acres of land over 11 years and an upfront payment of 13 marks, occurred on 18 December 1278 – the carefully recorded date reinforcing the pre-mortmain transaction. This precisely dated lease might suggest an understanding and an acknowledgement of the situation which led to the desire to introduce the restrictions, or that the lessor required cash, or simply a commercial need for the acquisition of land on a short-term basis by the hospital. The parties to the lease were John le Poer, as lessor – and a name which will recurr in the ensuing analysis – and the master and brethren of the hospital as lessees. Additional research complicates the picture further. Not only did the said John lease land to the hospital in the pre- and post-mortmain years, he also granted land to the house in both periods. Moreover, the grants of land are not dated with the exception of the grant which took place in 1279; this is in stark contrast to the leases of land which were

[90] Database Leases table extract, filtered on Brackley, sorted by year. Based upon Macray's detailed calendars as given in the bibliography, Primary Sources, Section iii.

dated in full. The post-mortmain leases ranged from 8 sellions to 9.5 acres of land and the grants from 3 sellions to 35 acres.[91] A general licence was not in place at Brackley until 1316.[92]

Only one inquisition *ad quod damnum* took place during these years concerning the hospital at Brackley and the said John le Poer – or indeed, any other individual at this time. The inquisition was undertaken in 1301, and it appears to permit the grant of a messuage and land in Westbury, the location of John's land transfers, to the master and brethren.[93] Further information was recorded in the Patent Roll which described the land as 35 acres located in Westbury, as well as a messuage and a moiety in an acre of meadow, granted to provide maintenance for the infirm in the hospital.[94] A copy of this licence is also housed at Magdalen College, Oxford, although it was not consulted as it was subsequently mutilated by rats.[95] What was consulted, however, was a rare piece of evidence which demonstrates that the grant in mortmain actually took place. This undated manuscript, which duly noted King Edward's licence as well as the requisite consent of the lord of the fee, precisely recorded the boundaries of the 35 acres of land and revealed that the messuage was John le Poer's chief messuage.[96] A conclusion can be drawn that John le Poer only sought permission for those post-mortmain transactions, of either type, which were in excess of 10 acres of land.

This series of manuscripts coupled with the records held centrally provide evidence that the statute did not prevent the acquisition of land in the hinterlands of these houses in the decades or so immediately after its enactment; and, that in this case at least, it was possible to obtain the necessary consent of a variety of individuals. The Patent Roll noted that John le Poer's application was made at the instance of John de Segrave. A John de Segrave appears several times on the

[91] Data extracted from the database Grants and Leases tables, based on Macray's calendars see Section iii in the Primary Source section of the Bibliography.
[92] *CPR: 1313-1316, Edward II*, vol. 2 (London, 1898), p. 524.
[93] *List of Inquisitions ad Quod Damnum: Preserved in the Public Record Office, part 2* (London, 1906), p. 5.
[94] *CPR: 1292-1301, Edward I*, vol. 3 (London, 1895), p. 595.
[95] Macray, Buckinghamshire, No. 323.
[96] MCA, Westbury 89A.

Patent Rolls at this time and was noted as being in the king's service in Scotland before he is mentioned in 1305 as being the king's lieutenant in Scotland. [97] This was probably John Seagrave, second baron Seagrave, who was an extremely well-connected and important figure during the reigns of both Edward I and Edward II. It is likely that his support of John le Poer's application carried favour with Edward I and secured the requisite licence.[98] It appears, though, that very small grants or leases of land were not deemed to be sufficient to trigger the licensing process, nor subsequent enquiries, or as Raban noted the subsequent licence was an afterthought when in her example exchanges of land were made.[99] Finally, in the case of John le Poer, the manuscripts show the desire to continue to support a hospital to care for the infirm. However, it is doubtful whether a local man would have been able to steer this course unaided. The time, potential costs, and requisite knowledge and access, were most probably beyond his means.[100] The costs in this case are unknown, and it is possible that an additional benefit of obtaining the support of John Seagrave was that the licence was granted free of charge by the king which is known to have occured in other cases when the king wished to reward a loyal subject.[101]

However, not every application for a licence to alienate in mortmain received royal assent, yet the hospital at Brackley circumvented the legislation with ease. An agreement in 1308 exists between the hospital, Walter de Whitfield, and his wife Juliana to proceed with an assignment of certain lands and tenements to fund their maintenance (i.e. a corrody) – this appears to be despite their failure to obtain a licence from the king.[102] Initially, they tried to strengthen their case by obtaining the permission of the lord of the manor, Peter de Montibus. Peter issued a licence to Walter in January 1309 permitting him to grant certain lands and tenements to the hospital in return for the hospital providing maintenance for both himself and his wife.[103] However, the

[97] *CPR: 1292-1301*, pp. 217, 595; *CPR: 1301-1307, Edward I*, vol. 4 (London, 1898), p. 406.
[98] A. J. Musson, 'Seagrave [Segrave], John, Second Lord Seagrave (1256-1325), Soldier and Baron', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/25038 (30 Apr. 2020).
[99] Raban, *Mortmain Legislation*, p. 35.
[100] Ibid., pp. 60-4.
[101] Ibid., p. 62.
[102] MCA, Whitfield 90; Macray, Northamptonshire IV, No. 139.
[103] MCA, Whitfield 84; Macray, Northamptonshire IV, No. 140.

licence stated that the king's permission was required.[104] No licence appears to have been issued, but in the following month power of attorney was obtained by Walter to permit the hospital to have seisin of the land.[105] These measures appear to have been successful as in 1315 the hospital leased the same lands for a period of thirty years to a Robert Flekeman.[106] The importance of this corrody to the house is clear – the legislation was not going to prevent this hospital from achieving its desired outcome.

This type of approach, that is to say the adoption of differing land-transfer strategies, is similar to those noted in Section I at Norwich and London which sought to circumvent the legislation. A further similarity can be seen in their apparent adoption of a similar general-licence strategy. The aim of the general licence was to set a total value of permitted landholding which often specified whether land held directly of the king could be included in the acquisitions. This, as noted in Section I, was designed to protect the king's ability to maintain his military forces. Thus, many of the *ad quod damnum* inquisitions also stated whether the applicant retained land in the area if the licence were to be awarded.[107] In 1316/7, Edward II granted one such general licence to acquire land and rents to the value of £10 per annum to the hospital at Brackley. The licence was issued at Brackley by the king and duly noted in the Patent Roll in 1316 (by the king) and in 1317 (by privy seal).[108] At this time, the patron was Robert de Holland, first baron Holland (d. 1328) through his marriage to Maud la Zouche (d. 1349), the great-granddaughter of Sir Roger de Quincy. Robert de Holland played an important and active role in government being a close friend of Edward II's cousin, Thomas, earl of Lancaster. He received large grants of land from the earl and on occasion liaised between the earl and the king.[109] Shortly before the licence grant in 1312, it was the view of John Maddicott that Edward still trusted Holland despite his links to

[104] MCA, Whitfield 90; Macray, Northamptonshire IV, No. 139.
[105] MCA, Whitfield 149; Macray, Northamptonshire IV, No. 142.
[106] MCA, Whitfield 111; Macray, Northamptonshire IV, No. 144.
[107] *List of Inquisitions ad Quod Damnum: Preserved in the Public Record Office*, 2 parts (London, 1904, 1906).
[108] *CPR: 1313-1317*, pp. 525, 625.
[109] J. R. Maddicott, 'Holland, Sir Robert (*c*. 1283-1328), Baron', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/37562 (19 June 2019).

Lancaster who subsequently fought against the king.[110] From 1314 Robert was summoned to Parliament. In the year that the licence was granted, 1316, he witnessed a charter of the king's son at Langley which Maddicott ascribed to his growing political influence while attending Lancaster. By 1317, he was one of only nine men to be summoned to London by the king for a 'special *colloquium*'.[111]

However, it was not Holland who raised the petition but the widow of Roger Bigod, earl of Norfolk, Alice. Alice does not appear to have had any dower lands in this area and, thus, her interest is unknown.[112] Perhaps, given Holland's role at the heart of government, Alice was assisting Maud. Maud was the great-great-granddaughter of Maud Marshall, countess of Norfolk (d. 1248); and Alice was the widow of the earl of Norfolk. In addition, there are no extant grants of land in the Brackley muniments from Alice. Of course, it is possible that they were sold or retracted at a later date, but this study has not found a direct link. Subsequently, it has been suggested that Holland fell under the protection of Thomas Brotherton, earl of Norfolk, following his betrayal of his lord, Thomas of Lancaster, until his murder in 1328.[113] The Brackley evidences contain a copy of Edward's general licence which described Alice as 'our beloved' (*ad requisit[i]o[n]em dil[ec]te nobis Alicie*) and, thus, indicated that Alice was well placed to secure it on behalf of the hospital. The licence permitted lands, tenements, and rents to the value of £10 per annum, but, of that total, only 100s could relate to lands held of the king.[114] Going forward, it was expected that inquisitions would be undertaken and that those findings be returned to the chancery.[115]

[110] J. R. Maddicott, ''Thomas of Lancaster and Sir Robert Holland: A Study in Noble Patronage', *The English Historical Review*, 86/340 (1971), pp. 449-72, at p. 467.
[111] Ibid., p. 466.
[112] *CFR*: 1272-1307, p. 551-2; *CCR*: 1302-1307, pp. 508-9, 511-13.
[113] Maddicott, 'Thomas of Lancaster and Sir Robert Holland', p. 469.
[114] MCA, Brackley 17A; Macray, Northamptonshire I, No. 368, '*Dum tamen de feodo n[ost]ro ultra centu[m] solidatas terre et redditus non adquirant'.*
[115] Ibid., '*et p[er] legales inquisit[i]o[n]es inde faciendas et in cancellaria n[ost]ra rite retornandas compertum fuerit'.*

What is noteworthy, again, is the special relationship between this hospital, the monarchy, and individuals at the heart of government at the time the licence was issued – for despite the fact that Lancaster was the king's enemy and in 1322 Holland's lands were seized by the Crown, Maddicott emphasised the importance of his connections in this slightly earlier part of his career: 'His place in Parliament from 1314 onwards as well as his ties with Lancaster, (sic) allowed him to rub shoulders with those whose families and offices were far superior to his own, and gave him the kind of contacts which resulted, for instance, in his liveries from Audley and Badlesmere. We must keep in mind the expanding range of Holland's connections and ambitions when we consider the best-known part of his career: his desertion of his lord in 1322'.[116] Thus, the importance of the timing of the request and being in favour with the king in order to obtain a licence is clear.

The hospital at Aynho adopted similar strategies to those in Brackley. It, too, obtained a general licence but not until 1331.[117] Prior to this point, what appears to have occurred is that the hospital acquired lands before the introduction of the statute for which the patron, John Fitzrobert of Clavering (d. 1345 at Aynho), secured a confirmation from Edward II paying 20s for the privilege.[118] However, this study was unable to find the documentation for the pre-mortmain grant which included a mill named *Goldesboltesmilne* and an entire watercourse – grants which are usually relatively easy to spot in the local records. The grant came to light as part of an inquisition in 1319, and this raises the question as to what triggered that investigation by the escheator south of the Trent.[119] The only grant from this patron to the hospital (in this case to its master) in the local records is dated at *c*. 1290 and was for a *vivarium* (fishpond).[120] Therefore, it has to be assumed that the evidence has subsequently been mislaid, or that rather conveniently, the transaction was not documented at the time and this triggered the investigation. In addition, given

[116] Maddicott, 'Thomas of Lancaster and Sir Robert Holland', pp. 449-72, at p. 466.
[117] MCA Aynho 2; *CPR: 1330-1334, Edward* III, vol. 2 (London, 1893), p. 66.
[118] G. E. Cokayne, *The Complete Peerage of England, Scotland, Ireland, Great Britain, and the United Kingdom: Extant, Extinct, or Dormant, Vol. III, Canonteign to Cutts* (London, 1913), p. 275; *CPR: 1317-1321*, p. 885; *CIM: 1308-1348*, vol. 2 (London, 1916), p. 99.
[119] *CIM: 1308-1348*, p. 99.
[120] MCA, Aynho 16.

that John de Clavering was one of the barons who fought and was captured at the battle of Bannockburn in 1314, it is likely that he was in favour with Edward II in 1319 and could secure the confirmation; that is, he simply purchased retrospective permission for the grant.[121]

This patron continued to assist his house in subsequent years, too, with potentially yet another retrospective grant. The aforementioned general licence of 1331 was issued at his request to acquire land and rent in mortmain, not held of the king, to an annual value of 5 marks.[122] Prior to this it seems that 10.5 acres of land were possibly acquired on behalf of the hospital over several years and held in trust for the hospital by a feoffee. The hospital muniments contain leases for portions of this land and subsequent grants from 1306 to 1324. In the earlier years, Geoffrey Beaumont of Croughton leased and then granted the land in full to Richard le Bedel. There does not appear to be a valid reason for the hospital to hold the leases unless they had an interest in the transactions. Subsequently, in 1324, Richard granted the land to John le Bar who in turn granted it to the hospital in 1333 – that is to say, after the hospital had obtained the general licence.[123] Even if the only transaction which concerned the hospital was the final grant of land to it, the patron still provided assistance by securing the mortmain licence.

What is particularly striking about this patron is that he does not appear to have treated the hospitals within his gift in a like manner. John de Clavering was also the patron of the hospital at Stagshaw which is likewise a hospital in this study's sample. It is one of the hospitals contained within the findings of Figure 11 which did not receive mortmain assistance and did not survive past the fourteenth century. As such, it stands in stark contrast to the hospital at Aynho which, as has been demonstrated, did receive the patron's direct assistance. Stagshaw is believed to have been in the vicinity of Dere Street which is now the A68 – thus having the potential to be a major

[121] A. Beesley, *The History of Banbury: Including Copious Historical and Antiquarian Notices of the Neighbourhood* (London, 1841), p. 104.
[122] *CPR: 1330-1334*, p. 66.
[123] From the database Grants and Leases tables. Aynho 23, 2, and 87 consulted in manuscript form being the full description of the boundaries and tenants of the 10.5 acres, the local copy of the mortmain licence, and the final grant to the hospital.

thoroughfare. Stagshaw Bank was the home of a famous fair just north of Corbridge and was sometimes referred to as Corbridge Fair.[124] This fair is recorded as selling horseshoes, nails, and ironware in 1298 and 1299.[125] A fair of this nature in such a militarily strategic position is likely to have been extremely popular. The area was clearly associated with the provision of this type of product. By way of illustration, in 1314 Edward II ordered Walter le Ferour to travel to the Corbridge area to purchase horseshoes and nails for the war in Scotland.[126] The total cost was 50 marks which in today's terms equates to approximately £20,000. In 1310, that was the equivalent of 39 horses or 3,333 days of purchased skilled labour.[127] The patron, as already noted, fought at the Battle of Bannockburn, and this was clearly a strategically important area for both the king and the patron.

However, Corbridge and the surrounding areas felt the full force of many Scottish raids, and, for example, in 1296 the town came close to total destruction and subsequently received grants of wood from the king to assist in its rebuilding.[128] By 1316, John was still struggling to maintain control of his manors in this region, again receiving the king's support but this time in the form of protection for his chattels.[129] Earlier in 1311, John made an agreement with the king that if he died without a male heir, which indeed happened, his holdings in Northumberland, including Corbridge, would revert to the king. This did not apply to the manor at Aynho which it was agreed would fall to Ralph de Neville if the said situation came to pass.[130] Nothing is known of the hospital at Stagshaw after 1345. Given that John also died in 1345 at Aynho (being a further indication of his attachment to this village) and that the hospital at Stagshaw must have fallen into the gift of the king, it seems likely that the advowee paramount withdrew his support for Stagshaw

[124] Northumberland County Council, *Corbridge: Northumberland Extensive Urban Survey* (2008), p. 25.
[125] H. H. E. Craster, *A History of Northumberland: Volume X, the Parish of Corbridge* (London, 1912), p. 103.
[126] *CCR*: *1313-1318*, p. 42.
[127] http://www.nationalarchives.gov.uk/currency-converter/#currency-result (4 Sept. 2019).
[128] *CCR: 1288-1296* (London, 1904); *VCH: Northumberland*, vol. 10, p. 78.
[129] *CPR: 1313-1316*, p. 508.
[130] *CCR: 1330-1333, Edward III*, vol. 2 (London, 1898), p. 427; *CFR: 1307-1319*, vol. 2 (London, 1912), pp. 114-5.

for unknown reasons – although its vulnerable position is likely to have been a contributing factor. A further difference in the treatment of the two houses by John is that he also obtained the grant of a weekly market and a fair to assist Aynho.[131] No such direct assistance was recorded for Stagshaw (either in the form of a grant of a market or fair, or a mortmain licence) and it would be remarkable if the Patent Rolls, inquisitions *ad quod damnum*, miscellaneous, and post mortem failed to record such support both before and after his death at Aynho.[132] Nor is there any evidence of the king appointing a master to the hospital in the wake of John's death. Thus, it seems patronal lack of interest resulted in the demise of the hospital at Stagshaw, whereas at Aynho there was undoubted recurrent support from the legal patron.

Like Aynho, the hospital at Ospringe also fell under investigation. Its royal status did not shield it from such events; in fact, it arguably might have meant that it was held to a higher account. What it did benefit from, which undoubtedly ensured its success into the sixteenth century, was repeated acts of support from the king. When, for example, it was found to have acquired lands in 1314 in mortmain without a licence, the king issued a pardon.[133] And, in the same way that Brackley was able to acquire lands in the pre- and post-mortmain period, Ospringe, too, augmented its holdings. When these events occurred, the correct procedures were expected to be followed – there were no royal exemptions here. This can be seen in 1368 when John Barler, chaplain, and Robert Elys of Leysden obtained a licence to alienate in mortmain the following: a tenement comprising a messuage and 80 acres of land, a salt marsh, 3s rent, a rent of 3 hens and 50 eggs held of the king, and 11 acres of land not held of the king.[134] In this case, the inquisition *ad quod damnum* does not appear to have survived, although the licence itself had been granted at the request of William Wykeham, bishop of Winchester, in his capacity as chancellor, and this might have been regarded as sufficient authorisation. In 1392, the official procedures were plainly followed and the inquisition recorded that both Semannus de Tonge and Richard Saundre were

[131] *CChR: 1300-1326*, p. 463.
[132] See Chapter One Section II for the search methods employed by this study.
[133] *CPR: 1313-1317*, p. 88.
[134] *CPR: 1367-1370*, p. 98.

permitted to grant land to the hospital.[135] This can be matched against the patent-roll entry which also confirmed that the grants were made for the maintenance of the master and brethren as well as the poor who resorted thereto.[136] Both cases suggest that hospitals were happy to continue to acquire land and donors happy to provide it, albeit less frequently than in earlier years.

Lesser-known hospitals, from the perspective of the historiography of these houses, were also able to obtain licences after the Black Death. One of the benefits for a study such as this which relies on fragmentary evidence for many of its hospitals is that the mortmain licence process did not only apply to earls and lords. As such, it permits a rare glimpse into the operations of these houses. For example, at Killingwoldgraves a general licence was issued in 1350 for the sisters to acquire lands not held of the king to the value of 100s per annum at a cost of 5 marks. In this case it is, unfortunately, not clear who funded the purchase.[137] Subsequently, in 1353, grants by two clerks were made to the hospital which the escheator judged to equal 24s worth of the total allowance.[138] On its dissolution in 1547, it held land in several areas of Yorkshire, but it is unknown whether this was acquired before or after the licence was issued.[139] It is, thus, possible that as the years passed and the investigations ceased, lands were still acquired. The immediate post-Black Death period was also the time when this house received an indulgence from Pope Clement VI in 1353 which encouraged visitors to its church.[140] It is unknown as to who the backers were except that they must have been people of influence. In addition, the mortmain procedures – its application process, subsequent checks regarding the value of land, and ever-watchful eye of the escheator – provide rare and clear evidence that a hospital was supported and that it sought to expand its land holding. This may appear to be an obvious point, but it is a crucial one as it strongly suggests that where there is an absence from the historical record of any

[135] *List of Inquisitions ad Quod Damnum, part 2*, p. 679.
[136] *CPR: 1391-1396*, p. 289.
[137] *CPR: 1348-1350*, p. 543.
[138] *CPR: 1354-1358*, p. 250.
[139] *CPR: 1547-1548, Edward VI*, vol. 1 (London, 1921), p. 170.
[140] *CEPR: 1342-1362*, vol. 3, eds W. H. Bliss and C. Johnson (London, 1897), p. 467.

mortmain intent, a hospital was unable or unwilling to augment its endowment – unless, of course, it or its patron was ultimately prepared to break the law.

Nor should it be assumed that mortmain intent guaranteed the issue of a licence and subsequent alienation of land. The following example highlights this and a further key point: it was possible for a monarch to assist a house by refusing an application to grant a mortmain licence. The hospital in Buckingham has left very little evidence in the historical record with the exception of one key document – an inquisition *ad quod damnum* which took place in 1290.[141] The sheriff of Buckingham's reply to the king's writ recorded the fact that the hospital was founded by a local man to receive the infirm poor in the name of hospitality (*no[m]i[n]e hospitalitatis*), and it did this for many years (*p[er] m[u]ltos annos*). For unknown reasons, the hospital stopped providing hospitality (*deficiente hospitalitate*), and the steward of the lord of Buckingham took possession of the building on an unknown date before it was sold to a variety of individuals – the last one being the archdeacon of Buckingham who re-founded the hospital, again on an unspecified date. The hospital was given an endowment, being the messuage and ten acres of land which represented the topic of the inquisition, and the house recommenced its services.[142]

Afterwards (*postea*), the archdeacon then transferred the hospital to the master of St Thomas Acon in London, and the hospital's assets were stripped leaving only a chaplain in situ.[143] The master of St Thomas Acon, as patron, then petitioned the king for permission to alienate the lands and rents (comprising a carucate and 40 acres of land and 40s in rent) which funded the hospital chaplain to the hospital of St John of Jerusalem in England.[144] It seems, however, that the ultimate patron took this matter seriously. There is no evidence that the king granted a licence to the master to alienate the land. In a case of land passing from mortmain to mortmain this, it could be

[141] Poornan, *The Royal Latin School, Buckingham*, pp. 162-73 – contains photographs, transcripts, and translations of the instruction to the sheriff by Edward I and the subsequent *ad quod damnum* investigation.
[142] Ibid, p. 167.
[143] Ibid, p. 168.
[144] Ibid, p. 163.

assumed, was simply a matter of procedure. It is notable that the hospital was still in the gift of the hospital of St Thomas Acon at the Dissolution and that the chantry was still operational with attached lands and ornaments.[145] Without a licence, the patron would not have been able to legally alienate the hospital and risked forfeiting the lands to the king. It is, therefore, a possibility that the fact that a licence was not issued contributed to the hospital remaining in the possession of St Thomas Acon.

In contrast, the patrons of another house in Yorkshire within this study's remit, this time at Sprotborough, were undoubtedly supportive of their hospital. This hospital had a close relationship with its patrons, the Fitzwilliam family, and in the fifteenth century might have received the backing of Henry V as overlord. One of the ways in which the ongoing support of the family continued to manifest itself can be seen in the issue of a licence to alienate in mortmain in 1364 to the then patron John Fitzwilliam following the payment of 13s 4d to the king. The granted lands comprised ½ an acre of land in the manor of Sprotborough, four acres of a named wood (Le Londe) and ½ an acre which was not named, none of which was held in chief. In this instance, the licence was issued following an inquisition *ad quod damnum* by the escheator in York which took place in 1364. The inquisition also clearly followed the expected procedure at this time stating that the patron still held land in the manor of Sprotborough.[146] Unlike other examples, though, a general licence does not appear to have been put into place. This patron was clearly willing to support his house: not only by granting the land to the hospital but by funding the purchase of the licence too.

This section has demonstrated that there was a certain amount of leeway within the system and a sensible approach to smaller grants of land in some instances. Access to that system was not, however, easy and, in addition, it required a relatively sophisticated administrative system at a

[145] *L&P*, vol. 16, eds J. Gairdner and R. H. Brodie (London, 1898); *CPR: 1550-1553, Edward VI*, vol. 4 (London, 1926), p. 318.
[146] *CPR: 1364-1367, Edward III*, vol. 13 (London, 1912), p. 200; *List of Inquisitions ad Quod Damnum, part 2*, p. 540.

local level to be able to withstand any subsequent inspections. Nevertheless, some of the lesser-known houses were able to access the official system, despite its complex nature, and when they did, the king took the matter seriously. There is, of course, a natural bias in many of the records of central government which reveal a system through royal eyes. Yet, the local records provide a valuable insight into the ways in which hospitals attempted to circumnavigate the official restrictions – sometimes successfully, and sometimes not. That they wished to do so indicates that either their pre-mortmain landholdings were not sufficient, or just that they wanted to augment them – although this might have been less to do with the size of the grant than the support it denoted. The value of this study is that it shows mortmain interventions signified an intent – an intent to continue to expand land holdings and on that basis, there can be no doubt that the legislation did affect these houses. The extent to which it affected all the hospitals within this study is impossible to assess. What can be concluded, however, is that the significance of the legislation declined over time.

Conclusion

The simple answer to the question whether the mortmain legislation affected these houses' ability to endure is that it did. By contrast, the outcome of that impact was not simple: different hospitals were affected in different ways. In the first instance, the study found that the unifying feature for the hospitals whose last-known date of reference was the fourteenth century was that none had recorded mortmain occurrences or active interventions by the king. That is not to say that the houses which survived into the fifteenth century received mortmain assistance; hospitals in both categories did endure. But if mortmain assistance was at least contemplated, a hospital did not close in the fourteenth century – this is a significant indicator of intent to expand land holdings which is indicative of a positive attitude to endure. This suggests that it was a principal factor in their success but not the pivotal factor. Thus, the following chapter will seek to ascertain the factors which might have led to their demise in the fifteenth and sixteenth centuries. Secondly, the research has demonstrated that a favourable relationship with the king assisted a house to

obtain a licence. What this relationship did not do, however, was ensure that a hospital could bypass the system – in fact, those in royal patronage might have been held to a higher standard. In saying that, the king often looked favourably upon houses which erred and either issued a pardon or retrospective permission. There is little doubt that many of these houses wished to continue to grow. What seems to have taken place is that blind eyes were turned to smaller grants of land – a practical solution which would both assist a house but not to the detriment of the king's interests. Of unequivocal importance was a hospital's ability to compete and adapt in the face of this particular external threat – the ensuing chapter considers external threats in general. Whether the houses which dissolved in the fourteenth century would have done so anyway is of course an unanswerable question. But there is no doubt that this piece of legislation stifled a hospital's ability to attract further grants and, thus, might have sounded the death knell for some of these houses. This chapter, therefore, concludes that the mortmain legislation exacerbated the phenomenon of the weak falling by the wayside while the stronger houses endured.

Chapter Six: The Question of Demand and Supply in the Late Middle Ages

In 1988 when Peregrine Horden made his plea to place hospitals, large or small, into a wider context of welfare provision, he reflected upon the outstanding need to give consideration to the demand for their services, such as the causes and extent of poverty, and the links between poverty and disease. The request was for a nuanced understanding of individual houses and their contacts within 'the wider urban community'. However, a major concern was that it was far too tempting for historians to take a regional study or detailed assessment of an individual house and assume that the results represented a larger field. Indeed, he raised the point that historians might be tempted to 'look for reassuring parallels elsewhere, no matter how partial'.[1] This chapter will, thus, assess the question of demand for services in the post-Black Death period from the perspective of the 72 hospitals within its remit.

In addition to considering demand, the chapter contemplates the question of supply – this being the second point raised by Horden. It adopts, though, a slightly different approach and focuses upon a hospital's ability to provide their services rather than what those services were – that topic was addressed in Chapters Two and Three. It does, however, contemplate two specific points which were made by Horden: first, that hospitals, especially those deemed to be 'small', incorporated various functions; and second, that the definition of 'the poor' need not be drawn too tightly.[2] The chapter evaluates how these institutions adapted to changing circumstances and what it terms operational problems. This study adopts a broad definition of operational activities which incorporates non-core functions which contribute to the supply of services. Thus, for example, it considers administration, farming practices, and staffing as integral parts of a hospital's operations in addition to the provision of direct care to its guests.

[1] Horden, 'A Discipline of Relevance', quotes at pp. 365, 367.
[2] Ibid., pp. 368-9.

The intention is to discover why hospitals ceased to function. There is an array of potential answers to a broad question such as this. One possible scenario might be that their services were no longer required within society, another could be that they were poorly executed. Consideration will be given to competing or complementary providers of hospitality, chantries, and other works of piety. In doing this, attention will be given to all options regardless of whether they seem, *a priori*, unusual comparisons to make. For example, independent inns could easily cater for the needs of a weary traveller. There was an extensive programme of ecclesiastical construction projects at this time, and parish churches and wayside chapels abounded. Monasteries were not averse to offering similar services in extra-mural hospices or inns, and local support through extended family networks or almshouses might have contributed to the oversupply of welfare providers. On the other hand, the importance of the parish structure at this time is a point which has been questioned. It might have been the case that it survived into the post-Reformation period, but that does not necessarily imply that it was a useful or valuable institution in the later Middle Ages – it might have survived as a result of luck rather than judgement.[3]

Another factor to consider in the fourteenth century is the Statute of Cambridge (1388) which stipulated that beggars were to remain in the town or city where they dwelt at the time of the statute, or if the town was unable to care for them they were to return to their place of birth.[4] This might have resulted in an increase of poor relocating to the countryside of their birth. Conversely, these were competitive times which also witnessed an increasing role for guilds and fraternities, and a proliferation of almshouses to accommodate both short- and long-term welfare needs within local areas. An assessment of the 72 hospitals within this study has the potential to contribute to the understanding of the plight of the poor, or not, in the post-Black Death period and the role of the later medieval hospital in the mixed economy of care.

[3] Horden, 'Small Beer?'.
[4] *Statutes of the Realm*, vol. 2 (London, 1816), pp. 55-60, at p. 58.

However, there are caveats and problems which need to be noted: assessing issues concerning the demand and supply of services is notoriously difficult to gauge for these quasi-charitable institutions. There is simply no accurate way of knowing the extent to which these houses assisted the poor on a daily basis. Nor is there a straightforward way to assess need in general – a topic which the first section of this chapter considers. In addition, there are only glimpses of chargeable services such as corrodies, burial fees, and offerings which are available for inspection. When services were directly chargeable, income could provide an indication of demand. But where services were provided free of charge and income was raised on an ad hoc basis, for example, through offerings, it is likely that this revenue at least reflected a perceived demand. Thus, Section II turns its attention to the thorny problem of assessing demand. It does this by engaging with scholarly debates concerning the Black Death and the number of hospitals which were subsequently able to endure. It then looks at levels of poverty, competition, connections within the parish, and the use of indulgences as a tool to stimulate demand.

Section III reviews the ability of these institutions to offer their services to a high standard. This represents an appraisal of supply based on their core functions. Taking its lead from fourteenth-century conciliar legislation, it reviews the role of the master and the requirement to protect a hospital's assets. This is predominantly achieved by reviewing royal and episcopal visitations and appointments to office. Within this work, the study searches for clues as to whether the supply of chantry masses was given priority over services to the poor. It also contemplates how these houses were perceived nationally and whether this represented a fair reflection of the ways in which these institutions were attempting to mitigate the risks posed by a series of external threats. But first, the chapter surveys the scholarship to date with a focus upon the post-Black Death period, attitudes to the poor, and economic indicators.

I: Attitudes to Poverty in the Wake of the Black Death

A key question to consider in any debate concerning the demand for hospital services and their ability to meet that demand is the effect of the Black Death. Within the historiography of English hospitals, a topic of discussion concerns attitudes to the poor and in effect the desire to provide these services. Miri Rubin triggered this debate based on her research of charitable provision in Cambridgeshire. In Rubin's view, the attitudes of employers hardened in the wake of the Black Death, and as their wealth reduced, they felt less inclined to support the poor. Weaker members of society came to be seen as 'others' as opposed to 'brothers': recipients of charity were carefully considered with the result that charity 'began and often remained at home'.[5] Patricia Cullum has taken umbrage at Rubin's stance on several occasions. In her early work based on hospitals located in Yorkshire, Cullum argued the case that due to a thriving economy there was an increase in charitable activities as evidenced by a new wave of hospital foundations, an increase in the standards of living, and a clearer definition of those in society who were most in need of alms.[6] In effect, the commercialisation of society highlighted the gap between the haves and the have nots which created a moral obligation to assist those members of society who were not able to share in that success.

In 1994, Cullum continued the critique noting that the foundation of the majority of York's almshouses took place following a period of economic growth in the later fourteenth and early fifteenth centuries. For Cullum, Rubin had missed the point with reference to the poor who were seen as distinctly different to the peasant or wage-labourer and who merited additional assistance precisely because of increasing levels of wealth and a corresponding rise in what was deemed to be an acceptable standard of living.[7] In 2008, Cullum returned to the question of Rubin's claim that attitudes were hardening towards the poor. This time, Cullum called for distinctions not to

[5] Rubin, *Charity and Community in Medieval Cambridge*, pp. 31-3, 53, 299.
[6] Cullum, 'Hospitals and Charitable Provision in Medieval Yorkshire', pp. 439-47.
[7] Cullum, 'For Pore People Harberles', pp. 36-54.

be made between the providers of charity and that lines should not be drawn too tightly as the functions of hospitals, colleges, almshouses, and other religious institutions often overlapped: 'charity continued to be an important religious practice but was channelled through a greater range of outlets than just those narrowly labelled as hospitals'.[8] With specific reference to Rubin's work concerning the withdrawal of charity and the neglect of hospitals by the anxious elites, Cullum left the reader in no doubt of her opposing view based on her own research, pointedly disagreeing with the idea that charity was withdrawn and that there was more hostility to the poor in the post-Black Death period. Instead, she concluded that 'there was a greater interest in provision for the poor than there had been before' and that her evidence contradicted Rubin's: 'The evidence above, on the contrary, shows a rather different picture'.[9]

For other historians, poverty and the plight of peasants had its roots in the late thirteenth and early fourteenth centuries – the Black Death merely exacerbated an existing phenomenon. In 1998, Mark Bailey suggested the agrarian crisis of 1315-22 coupled with high levels of taxation imposed by the government to fund military campaigns laid the foundations for a decline in welfare standards. Those with smaller landholdings, i.e. not the elite peasants, might have been particularly susceptible to the rise in grain prices occasioned by the famine and were consequently forced to liquidate their assets to survive. The outlook was most definitely bleak: 'With diminishing assets and meagre reserves, most farmers were pulled into a spiral of chronic impoverishment which led ultimately to starvation'. This combined with a fall in the opportunity to augment cash income via wages and casual labour placed these families in a dire predicament. Thus, Bailey raised the question of the extent to which these individuals were able to access external support. He concluded that money markets were not a viable source of support, that is to say the ability to access credit, with the result that the only remaining option was charitable assistance – and that was 'insufficient to alleviate rural poverty in times of stress'. In the end,

[8] Cullum, 'Medieval Colleges and Charity', p. 153.
[9] Ibid., p. 148.

Bailey tentatively suggested that the commercial changes of the thirteenth century increased the vulnerability of smallholders to economic change.[10]

The more recent work of Broadberry *et al*. provides valuable economic data concerning the pre- and post-Black Death periods to enhance this picture and a framework against which to consider a hospital's social relevance (i.e. the need to assist the poor within society). This work drew an economic poverty line for seven benchmark years: 1290 and 1381 are the relevant dates for this project. The poverty line was designed to highlight those members of society who fell below the income levels required to purchase a 'respectability basket' of consumables for a family of four. That basket was defined as 'bread, quality ale or beer, eggs, cheese, with moderate quantities of meat, textiles and fuel, and an allocation of rent'. Below this level, the study identified a 'bare-bones basket' which provided 'coarser and less processed staple foods' which produced enough calories and protein to sustain a working adult.[11]

The study revealed a downward shift in the numbers of households unable to afford the 'respectability basket' from 42% in 1290 to 22% in 1381. Furthermore, it noted the smaller size of households in 1381 and suggested that the 1381 figure could be less than 20%, perhaps even 15%. It concluded that, largely as a result of the reduction in the post-Black Death population size and the corresponding increase in Gross Domestic Product per head and real wage rates, 'poverty had most certainly not gone away but it was massively reduced'.[12] The concern lay with individuals not supported by households who often fell into vagrancy and destitution. This specific problem increased when external threats such as famine and war prevailed.[13] Therefore,

[10] M. Bailey, 'Peasant Welfare in England, 1290-1348', *Economic History Review*, 2 (1998), pp. 223-51, quotes at pp. 241, 244. For additional summary information and debates concerning the Great Famine and the early fourteenth century see: B. Harvey, 'Introduction: The "Crisis" of the Early Fourteenth Century', in ed. B. M. Campbell, *Before the Black Death: Studies in the "Crisis" of the Early Fourteenth Century* (Manchester, 1991), pp. 1-24; W. M. Ormrod, 'The Crown and the English Economy, 1290-1348', in ed. B. M Campbell, *Before the Black Death: Studies in the "Crisis" of the Early Fourteenth Century* (Manchester, 1991), pp. 149-83; I. Kershaw, 'The Great Famine and Agrarian Crisis in England 1315-1322', *Past and Present*, 59 (1973), pp. 3-50.
[11] Broadberry, *et al*., *British Economic Growth*, p. 309.
[12] Ibid., pp. 319-321.
[13] Ibid., p. 313.

the increases in population size in the thirteenth century resulted in an increase in the number of families living on the poverty line, which conceivably would have increased the role of hospitals in society with respect to those individuals in greatest need. By the close of the thirteenth century, a wide variety of individuals would have lived a precarious existence, including 'most petty smallholders and cottagers provided with just an acre or two of land and/or common rights, many rural and urban artisans, most miners, fishermen and sailors, and all agricultural and non-agricultural and urban labourers, plus, of course, paupers and vagrants.'[14]

For Marjorie McIntosh writing in 2013, there was a relatively low level of poverty between 1350 and 1450.[15] In her view, medieval society placed the poor into two categories: the deserving poor who were genuinely needy, and the undeserving poor who threatened local order, were outsiders, and in all probability had no intention of finding work. After 1388, concerns about the mobile poor lessened until the later fifteenth century.[16] For McIntosh, increasing sizes of land holdings, higher wages, and lower prices meant that most people could be supported locally. This could be in the form of gifts, local begging, clerical assistance which was gradually replaced with lay assistance within the framework of the parish, monasteries, and fraternities. For those who were unable to live independently, hospitals and almshouses provided shelter. Based upon patchy evidence concerning the numbers of individuals housed in these institutions and the number of extant almshouses nationally, McIntosh estimated that 4,700 people were cared for in this way which represented one person for every two parishes.[17]

However, the primary focus of McIntosh's work was the poor, but, as has been demonstrated throughout this study, hospitals were not solely intended to serve the resident poor. In addition,

[14] Ibid., p. 319.
[15] McIntosh, *Poor Relief in England, 1350-1600*, pp. 39-43. McIntosh is referring to the Ordinance/Statute of Labourers 1349/1351.
[16] Ibid.
[17] M. K. McIntosh, 'Local Responses to the Poor in Late Medieval and Tudor England', *Continuity and Change*, 3/2 (1988), pp. 209-245, especially pp. 210-7. For the method of calculating the number of people cared for and extant houses see p. 216.

the qualitative primary source material employed by McIntosh was overwhelmingly weighted towards the Early Modern period, although her argument commenced in 1350.[18] This work placed equal weight on hospitals and almshouses – almshouses being especially popular with late-medieval founders who wished to assist those in need and could do so by offering a room in a private home on a temporary basis.[19] McIntosh recorded 462 hospitals founded pre-1350 and continuing after 1350, with another 333 founded post-1350 to 1539. However, 60% of the latter category were described as almshouses. There are, therefore, a variety of opinions concerning the extent of poverty, exactly who was deemed to be in need in the pre- and post-Black Death periods, and when change occurred. For some, poverty was not a significant problem in the wake of the Black Death, attitudes to the poor did not harden, and almshouses provided a flexible short-term approach to local issues. On the other hand, the imposition of the Statute of Cambridge suggests there was a concern within society and changing attitudes to the poor which is the view adopted by Rubin.

These points largely concern the potential demand for hospital services. The second issue to be addressed in this chapter will be a hospital's operational ability to supply those services – a supply-side perspective. McIntosh identified a trend which linked foundations in the post-Black Death period to market centres and a shift from self-governance to the appointment of secular external governors run by lay people, such as 'a town, parish, fraternity, urban guild or school'.[20] Watson has suggested that towns were important during periods of economic boom and that determined the supply of hospitals'.[21] And Dyer has pointed out that 'Hospitals were mostly sited in towns, to which the rural poor had limited access'.[22] These points beg the question, what was the role of medieval hospitals in small towns and villages in this mixed economy of welfare?

[18] McIntosh, *Poor Relief in England, 1350-1600*, pp. 312-24.
[19] Ibid., p. 64.
[20] Ibid., pp. 69, 90.
[21] Watson, 'City as Charter', at 238.
[22] C. Dyer, 'Poverty and its Relief in Late Medieval England', *Past & Present*, 216 (2012), p. 48.

McIntosh, for example, did not consider the parish and churchwardens to play a significant role in assisting the poor in this period. Acknowledging the problem of recording this type of assistance in the historical record, McIntosh concluded that 'with the possible exception of a handful of churches in larger communities, there is thus little sign that late medieval parishes defined themselves as institutional centres for the provision of aid to needy people.'[23] This was also the view of Christopher Dyer in 1988: 'for all the fuss that the clergy made about charity, the charitable institutions were pathetically inadequate...the clergy's idea that the poor and rich were bound together by a social contract of charity had always been a myth'.[24]

On the other hand, there are historians who have argued the case that the parish formed part of the mixed economy of welfare in the Middle Ages. For Horden, the definition of what constituted parish aid was an important consideration. He raised the question of whether institutions needed to be involved in the process or did, for example, informal relief via doorstep begging form part of parish aid? In addition, the role of both institutions and individuals often overlapped. For instance, burgesses also served as church wardens. The key point of emphasis was that medieval society did not differentiate between individual/collective, private/public, or informal/institutional forms of relief.[25] The work of Beat Kümin also emphasised the complementary nature of what he termed sub parochial institutions (fraternities, gilds, chantries, and chapels) which, although they might have appeared to be a threat to the parish priest, are best thought of as supplementing the parish and catering for differing and changing tastes and needs.[26] In addition, Kümin noted the shift from aristocratic philanthropic dominance to an increase in bequests further down the social scale through wills and a shift from monasteries to the parish which for him 'had now emerged as the undisputed centre of local ecclesiastical life'.[27]

[23] Ibid., pp. 95-112, quotation at p. 112.
[24] C. Dyer, 'Reviews' in *Social History*, 13/2 (1988), pp. 233-5, quotation at p. 235.
[25] Horden, 'Small Beer?', pp. 339-64.
[26] Kümin, *The Shaping of a Community*, pp. 148-182, especially p. 179.
[27] Ibid., pp. 185-6.

By the fifteenth century, the mismanagement of hospital resources, or at least the claim that this had occurred, resulted in a petition to Parliament. Carole Rawcliffe has considered the wide-ranging accusations against hospitals at this time which included embezzlement, corruption, poor stewardship, neglect, idolatrous and doctrinally suspect practices, poor administrative standards, and extravagant lifestyles.[28] The petition requested a national inquiry which was granted but came to nothing: by 'declining to impose any form of timetable or sanctions for non-compliance, Henry [V] effectively rendered it toothless'.[29] For Rawcliffe, there were examples of well-managed hospitals such as the hospital of St Giles in Norwich. Nevertheless, many hospitals became enslaved to the evils of the corrody and the corresponding burden of debt, the confidence trick of the free chapels, and fraudulent claims of proctors who 'offered no discernible form of spiritual or physical care to others'.[30] Rawcliffe acknowledged that these accusations did inspire some patrons to reform their houses, but concluded that the older houses disappeared at a steady rate. A further supply-side problem for these older hospitals – or as this study will consider an opportunity – was the proliferation of almshouses in the later Middle Ages. These establishments were associated with the provision of care in urban communities which included temporary single-room accommodation in private houses to a community of residents who were vetted as to their upstanding character and worthiness as recipients of charity.[31] There was, thus, the potential for sections of society, which it could be argued were the most vulnerable individuals, to be ignored.

The third section of this chapter considers whether hospitals struggled to provide their services in the fourteenth and fifteenth centuries, and if so why. It draws upon the recommendations of the papal decree entitled *Quia contingit* (canon 17 of the Council of Vienne) in the early fourteenth century, which can be summarised as guidance to control the protection of assets and ensure staff

[28] C. Rawcliffe, 'A Crisis of Confidence? Parliament and the Demand for Hospital Reform in Early-15th- and Early-16th-Century England', *Parliamentary History*, 35/2 (2016), pp. 85-110.
[29] Ibid., p. 94.
[30] Ibid., p. 103.
[31] For more information see: McIntosh, 'Local Responses to the Poor'; McIntosh, *Poor Relief in England, 1350-1600,* pp. 61-94; Dyer, 'Poverty and its Relief', pp. 45-8; Godfrey, *The English Almshouse*.

competency which were deemed to be significant factors in the demise of hospitals. The analysis, therefore, reviews the role of masters and whether assets were protected to ensure that hospitals were able to continue to function. And it considers the case, as outlined in the fifteenth-century petition to Parliament, that these houses were no longer institutionally or financially viable.

In the view of Orme and Webster, the decree did not have a short-term influence in England, although it is acknowledged that it might have been reconsidered in the fifteenth century, and that is a possibility which will be considered later in this chapter.[32] Miri Rubin has suggested that the problems discussed in the decree arose as a result of the inadequacy of hospital rules regarding their internal administration. Rubin also acknowledged that there was some attempt by bishops to rectify other abuses noted within the decree, most notably misuse of hospital funds.[33] And Watson has acknowledged that the decree represented the first piece of legislation which directed the regulation of hospitals.[34] Koen Goudriaan's work concerning the provinces of Holland, Zealand, and Utrecht considered the decree to represent mere theory, and argued that the local evidence did not point to an actual advancement of church control over hospitals.[35] And although Sally Mayall Brasher's study of hospitals located in Northern Italy did not consider this particular decree, it did note the overarching concern of the Council of Vienne to rectify lax managerial practices.[36] Scholarship to date, thus, presents a mixed picture as to the impact and importance of this legislation. In addition, the extent of the operational problems discussed herein is unclear, as is the consequential need for reform.

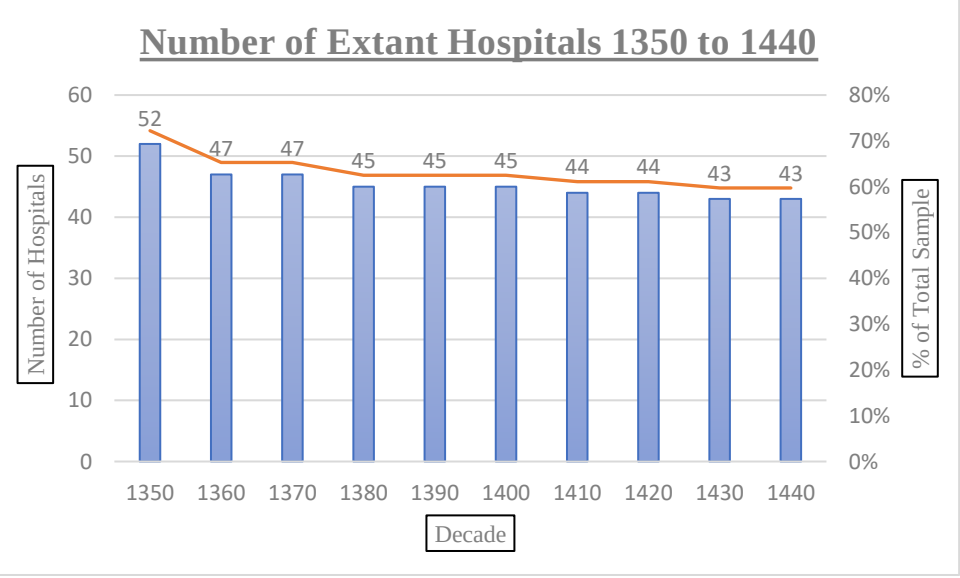
[32] Orme and Webster, *The English Hospital, 1070-1570*, pp. 131-2.
[33] Rubin, *Charity and Community in Medieval Cambridge*.
[34] Watson, 'The Origins of the English Hospital', pp. 75-94, at p. 83.
[35] K. Goudriaan, 'Early Hospital Development in the Provinces of Holland, Zealand and Utrecht', in K. Goudriaan, *Piety in Practice and in Print: Essays on the Late Medieval Religious Landscape* (Hilversum, 2016), pp. 31-62.
[36] Brasher, *Hospitals and Charity*, p. 121-2.

II: Demand and the Generation Thereof

There are several factors which could be deemed to influence the demand for hospital services. The most prominent concern to date, as indicated in Section I, has centred on demand driven by levels of poverty within society. This is not surprising as hospitals were strongly associated with the poor, but, as this study has argued, the poor were not the only recipients of care. In the first instance, this section will provide an analysis of the relationship between hospital longevity and changing levels of poverty within society. The chapter will then turn its attention to alternative factors which could affect levels of demand such as competition and institutional specialisation. Finally, consideration will be given to attempts to generate demand through the issue of indulgences.

Longevity, Poverty, and Disease

Figure 13: Number of Extant Hospitals, 1350-1440 (72 Hospitals)[37]



Taking in the first instance the debates concerning demand, pestilence, and poverty, the results displayed in Figure 13 demonstrate that 72% of hospitals in this study were able to survive the

[37] Extracted from the Founder Longevity Query (based on Founder and Final End Date tables).

immediate effects of the Black Death. It is difficult to say whether the five that disappeared from the historical record in the 1350s did so as a direct result of the events of 1348/9. Cookham is a potential candidate as the advowson was granted to Hardham Priory in 1351, and it is possible that Croxton became consumed within the *domus dei* at Thetford by 1355. The last-known date concerning the hospital at Gedney was a writ of *cessavit* brought by the patron against the abbot of Creake Abbey in 1341. It was alleged that the abbot had failed to provide the requisite services in the chapel and to feed certain poor persons.[38] The patron, Margaret Roos, won the case. Operational problems were evident, but it cannot be categorically stated whether the patron was able to ensure that the services were reinstated. What can be concluded, though, is that the patron demanded that the services be performed – that is to say both the divine services as stipulated in the original agreement of 1256 between John d'Ory and the then abbot, and the feeding of five poor persons each day. The reason why, in this case at least, the poor did not lose out was that both services were required to save the souls of the named individuals in the original grant.[39] Nothing can be concluded with reference to Stagshaw and Werhale, although the point was made in Chapter Four that Stagshaw might have been deemed untenable due to a lack of patronal interest and war.[40]

In addition, the chart shows that institutions were still viable in the post-Black Death period, but this does not necessarily equate to the existence of a fully functioning institution. This is why the qualitative aspect of this study is so important in conjunction with the data overviews. There are a few general indicators which would suggest that these houses were providing services when the records are silent: patronal duty, the provision of the Statute of Westminster II, and royal and episcopal obligations. The extent to which patrons, monarchs, and bishops took these duties seriously can never be truly known in all cases, but previous chapters have demonstrated that many tried to assist these houses in times of need. They have also shown that donors were

[38] *Year Books of the Reign of King Edward the Third: Year XV*, pp. 448-51.
[39] *Final Concords of the Country of Lincoln from the Feet of Fines Preserved in the Public Record Office, A. D. 1244-1272*, vol. 2, ed. C. W. Foster (Horncastle, 1920), pp. 145-6.
[40] Appendix I.

prepared to seek redress if their grants were not being used as intended, as indeed the example at Gedney has just demonstrated.

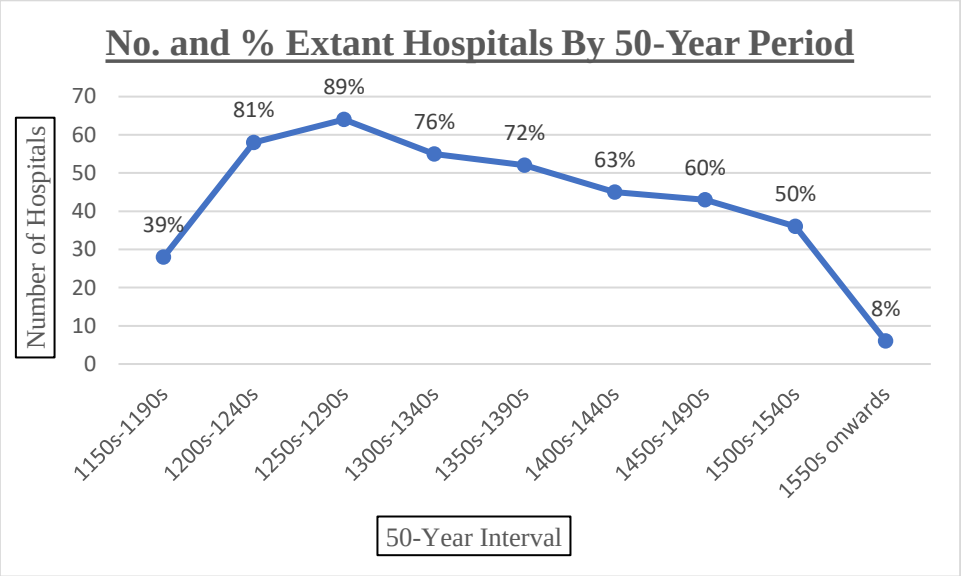
There are also indicators of compliance such as the lists of masters contained in the *VCH* publications. It should, however, be noted that a master might have been a non-resident pluralist and shown no interest in the running of the hospital. There are studies of appointments to benefices for other institutions which have demonstrated that patrons were not averse to appointing members of their family, their household, or even their friends to benefices as a form of remuneration or reward.[41] Nevertheless, the *VCH* lists were entered into the project database to gain an overview of the situation in the counties for which data has been published. If a Master Longevity query is raised based on this data, it shows that 30 of the hospitals in this study had masters, and they all relate to hospitals which survived in the post-Black Death period. The problem is that the query also reveals gaps in the appointments for those hospitals, and it remains unknown as to whether the appointments were simply not recorded, the hospital operated without a master, or the hospital temporarily ceased to function. The absence of evidence for the remaining hospitals raises the possibility that there were lay masters who were not required to be instituted to their office by a bishop. Nevertheless, an appraisal of the role of the master is addressed in Section III.

What would be beneficial, in the light of the matters just discussed, is an assessment of the relationship between poverty levels and hospital longevity as this may reflect a decline in the numbers of poor (a reduction in demand); or changing attitudes in society towards the poor when hospitals ceased to function either as a result of a reduction in income from voluntary donations; or an active decision by the patron (a reduction in supply). In addition, given the broader debates concerning the effects of the commercialisation of society in the thirteenth century and the effects of the Great Famine discussed in Section I, it may also suggest that any change had its roots in

[41] E. Gemmill, 'Jobs for the Boys', in Gemmill, *The Nobility and Ecclesiastical Patronage*, pp. 68-97.

the pre-Black Death period. The following chart, therefore, provides a summary of the number of hospitals which were extant in the twelfth to sixteenth centuries in this study and the percentage of the total sample within each fifty-year period.

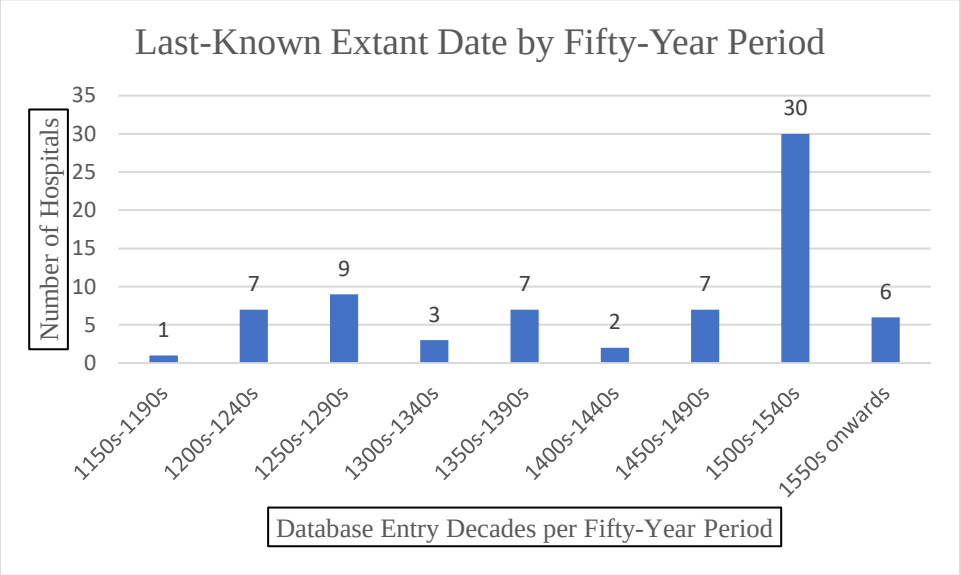
Figure 14: Number and Percentage Extant Hospitals, 1150-1550 Onwards (72 Hospitals)[42]



The percentage figure provides an immediate indication of the peak period of existence of hospitals within this study and reveals that at no point within the given timeframe were the 72 hospitals operating at the same time. In addition, the chart indicates that there was not one single shock factor which caused hospitals to cease to operate prior to the sixteenth century. Instead, hospital numbers were rising in the thirteenth century despite weaker new foundations falling by the wayside in the first half of the century (seven in total). This was followed by a slow gradual decline in the fourteenth and fifteenth centuries with ten and nine houses respectively succumbing to closure as shown in the following chart:

[42] Extracted from the Founder Longevity Query (based on Founder and Final End Date tables). For respectability basket information see Broadberry, *et al*., *British Economic Growth*, p. 309 and discussion below.

Figure 15: Last-Known Extant Date by Fifty-Year Period (Total Sample: 72 Hospitals)[43]



The number of dates of last reference in the decades following the Black Death are not unusual. The first half of the thirteenth century and later part of the fifteenth century produced the same results, and the second half of the thirteenth century yielded even more potential closures. It is, of course, technically possible that the houses noted in the first four categories, twenty in total, all ceased to operate because of the Black Death. The qualitative evidence reveals, for certain hospitals at least, the types of issues which could be faced by these houses and how they sought to address them. For example, the Great Famine temporarily changed the working practices at Brackley. The following section, Section III, is concerned with operational practices, but this particular example is pertinent here as it provides a broader indication of local problems and food supply issues which could drive up demand through an increase in poverty and starvation. In 1317, the master and brethren petitioned the king to grant them the tithes of the church at nearby Finedon, Northamptonshire. The petition stated that they were unable to provide for their own sustenance from their temporalities, thus implying limited spiritual income – certainly, this study is not aware that they held a church in their gift at this time.[44]

[43] Extracted from the Founder Longevity Query (based on Founder and Final End Date tables).
[44] TNA SC 8/240/11991.

The hospital, however, undoubtedly held an abundance of land. Although it is difficult to calculate its holdings at any one time, there are several grants of land of at least a virgate which would place the hospital as at least a middling landowner.[45] However, the records, as has been suggested throughout this thesis, indicate that they were sheep farmers. The request for tithes, therefore, suggests either a need for staple foodstuffs or money. In 1316-17, the master and brethren entered into five agreements for the purchase of crops in Westbury, Buckinghamshire. These are interesting as they are leases but not for a fixed period of time: they were dependent upon the number of successful harvests.[46] These were small grants ranging from half an acre to one acre of land by villagers. Each was leased for an unspecified amount of money until between 6 and 50 crops of corn had been gathered. Therefore, despite the difficulties which arose in the early fourteenth century, Brackley was able to devise short-term solutions to mitigate the risk.

The economic findings discussed in Section I may shed further light on the matter. To briefly recap, more individuals were able to afford the respectability basket of goods in 1391 than in 1290 (78 to 85%, versus 58%), and the individuals who were most at risk were those who could not draw upon the support of a wider household. As a result, this study posed the question that increased poverty levels in the thirteenth century might have driven the demand for hospital services. Returning, then, to Figure 14, the peak period for hospital numbers within this study was indeed the second half of the thirteenth century at 89%. But the greatest number of 'closures' prior to the Reformation took place in the thirteenth century too as shown in Figure 15. Taken together, these two facts indicate that some hospitals were founded and closed rapidly in the thirteenth century – a point which this study has now made on several occasions. There were 13 hospitals which fell into this category. This is not surprising in a situation where attempts were made to meet an increasing demand for this type of service with the result that some new ventures failed. Moreover, as the level of poverty fell within society at some point between the benchmark

[45] Bailey, 'Peasant welfare in England, 1290-1348', p. 234.
[46] Extracted from the database Leases table being Westbury A111, 105, A120, A100, and A6 from Macray, Buckinghamshire, No's 349, 350, 351, 352, and 353.

years of 1290 and 1381, the total number of hospitals also fell but not as quickly as during the thirteenth century as a whole. This suggests that hospitals might have targeted their efforts to provide the most relevant services to society. It could be suggested that hospitals were storing resources to survive rather than supply their services, but this does not seem likely. In the first instance, studies have shown that money might have been regarded as a store of wealth, but it was not thought of as something to be accumulated: its value lay in the ability to spend it.[47] Secondly, land (which can be held as a long-term asset) is not a liquid asset; and finally, grain cannot be stored indefinitely. Nevertheless, it is an option which must remain on the table.

One way of assessing the general concern for the poor and sick is through named grants for their benefit. If a donor felt the need to specifically mention that a grant was for the poor or sick this is likely to indicate their desire to at least be seen to help this type of individual – whether that occurred through social pressure, or a genuine desire to assist those in need, or both will never be known. However, what is particularly striking about the data for the hospital at Brackley is that grants of this nature were rare. There are nineteen which make a direct reference to the sick and twenty-one to the poor, and except for one which is dated *c*. 1170 they took place in the thirteenth century. Clearly, the evidence does not categorically show that donors in the fourteenth and fifteenth centuries were not concerned with assisting the poor and sick. Nevertheless, it is a point to consider as part of an overall assessment of the provision of demand-led services and in the light of the aforementioned debates concerning attitudes to the poor. As such, it must be noted that grants which were specifically made to assist the poor and the sick at Brackley took place in the thirteenth century when levels of poverty and the number of hospitals within this study approached their peak.

The charts and qualitative evidence demonstrate a concern for the poor in the thirteenth century, but they also show that many hospitals, 63% to be precise, operated at some point in the early

[47] Diana Wood argued the change took place in Italy in the fifteenth century. See D. Wood, *Medieval Economic Thought* (Cambridge, 2002), especially p. 81-4.

fifteenth century. If demand for services to the poor declined, as indicated by the economic data, it begs the question as to what purpose these institutions served in the late Middle Ages. The historiography of these houses suggests that the poor suffered because hospitals placed a growing emphasis on the provision of chantry services.[48] Yet, it is now evident that this might not have been the case. Firstly, if there were less poor it would be an eminently sensible course of action to rein in those services – thus indicating that the poor did not lose out. Secondly, hospitals were suffering and closing or adapting their working practices prior to the Black Death. And finally, an institutionally viable establishment does not necessarily provide its services to anyone – spiritual or temporal. Therefore, a closer examination of the evidence is required.

Reorganisation and Specialisation

Subsequently as the population fell, one possibility is that they reorganised their activities to assist corrodians: in other words, the individuals identified in the discussed economic survey as requiring assistance. Historians often regard corrodians with a sceptical eye and consider that their primary purpose was to generate short-term funding for a hospital during periods of economic difficulties – that is to say, periods during which hospitals were struggling to generate revenues.[49] Yet the desire to raise money does not negate their role as providers of care to those in need – this study has now consistently argued that their services were not limited to 'the poor'. A closer examination of the types of individuals who received this care closely aligns them with the smaller household in which an ageing or sick relative would be unable to rely on care within their home. The postings by monarchs to hospitals of former servants, both within this sample and in general, substantiate this view. For example, a servant of the king was sent to the hospital at Brackley in 1314 to receive 'maintenance for life in food, clothing, and other necessaries' as his hand had been chopped off by Scottish rebels, and he was unable to earn a living. At the same

[48] Orme and Webster, *The English Hospital, 1070-1570*, p. 129; Phillips, 'Charitable Institutions in Norfolk and Suffolk *c.* 1350-1600', p. 28.
[49] Rawcliffe, *Medicine for the Soul*, p. 172; Rubin, *Charity and Community in Medieval Cambridge*, p. 182; Clay, *The Mediaeval Hospitals of England*, pp. 213-4, 223.

time and the implication being that a similar scenario was the reason, John de Sheperton was sent to Ospringe.[50] There were also examples of locally based recipients of hospital care. At Brackley in 1308, Sarra Macekyn's corrody was granted as she was weak or infirm (*infirme*). But as noted in Chapter Two, it also stated that if her father became in need (*inopia*), he would be received in the same way as any other poor or infirm person – in other words, care was given to a variety of individuals, although the level of service provided differed.[51] Sarra was clearly unable to turn to her father or wider household, if it existed, for assistance. It is not known why Sarra received preferential treatment, but the wording of the agreement concerning her father suggests that at this time there was competition for these services.

Competition was rife among the providers of care too. For example, there was a variety of service providers catering for the needs of weary travellers. Some establishments, such as inns, may not appear to be a direct competitor to hospitals at first glance; but they were, and as will be seen, two hospitals in this study were even described as such. Robert Palmer's work in this area has argued that these establishments suffered from a decline in travelling visitors in the post-Black Death period.[52] Innkeepers were held to high standards, too, being forced to swear an oath to guarantee standards as early as 1318 in London. Nevertheless, there were problems with theft of their guests' possessions who were advised to lock their rooms or face a charge or accept the consequences.[53] In addition, monasteries provided hospitality to travellers. There is no doubt that individuals used these varying types of guesthouses on their travels in the fifteenth century as an autobiography of Margery Kempe shows. Margery resided in monastic houses, at least one hospital, albeit overseas, an inn, and private houses. At the hospital of St Thomas in Rome, known as the English Hospital, Margery located her former servant who was now living in 'much wealth

[50] *CCR*: *1313-1318*, p. 192.
[51] MCA, D71; Macray Northamptonshire I, No. 438.
[52] R. C. Palmer, *English Law in the Age of the Black Death, 1348-1381: A Transformation of Governance and Law* (London, 1993), p. 253.
[53] Ibid., pp. 252-67.

and prosperity' in the hospital.[54] Therefore, it seems that accommodation could serve a variety of purposes.

There are examples of different types of guest accommodation within the 72 hospitals in small towns and villages. For instance, one of the buildings within the hospital complex at Brompton Bridge has been identified by archaeologists as either a guesthouse or master's residence – in all probability it was not necessary to differentiate between the two at the time with the master undertaking the provision of hospitality to certain guests.[55] In another example, the late hospital at Brackley was operating as a guesthouse for the president and members (*sociis collegi*) of Magdalen College when they performed their annual progress offering accommodation and food for two days and nights.[56] Throughout the document the former hospital was described as *manerium mansum sive hospitale* meaning a dwelling house within the manorial property. What is clear is that the hospital, just prior to its annexation to the college, had accommodation which was suitable for a variety of individuals. This can also be seen in the aforementioned hospital at Gedney. The agreement between the abbot and founder stipulated that although the hospital was not to be subordinated to the abbey (*subiectione*), the abbot and his successors were permitted a *hospitium* throughout the year or half a mark.[57]

By 1547, the hospital at Armston was described as a hospital or inn of St John the Baptist which indicates specialisation.[58] It is, in general, not unusual to find these buildings being used as public houses in the centuries following their closure – thus, they maintained their services of hospitality but ceased their intercessory services. Examples include Hockliffe, Lechlade, and Milton – and in the case of Lechlade it, too, was recorded as an inn in 1472/3 'Ye Sygne [inn] of St John Baptist

[54] A. Bale, *The Book of Margery Kempe* (Oxford, 2015), pp. 28-30, 87, 101; W. R. Childs, 'Moving Around', in *A Social History of England, 1200-1500*, eds R. Horrox and W. M. Ormrod (Cambridge, 2006), pp. 260-75, at p. 263.
[55] Cardwell, *et al.*, 'The Excavation of the Hospital of St Giles by Brompton Bridge, North Yorkshire', pp. 102-225, at p. 145.
[56] MCA, Brackley B132 – the agreement was reached in 1494.
[57] *Final Concords of the Country of Lincoln*, vol. 2, p. 145.
[58] *CPR: 1547-1548*, p. 176.

Head'.[59] The point is that a degree of specialisation might have been undertaken prior to their dissolution which was resurrected in subsequent years, sometimes using the same endowments and buildings. It is a distinct possibility that the Reformation functioned as a catalyst to hastening a process which was already underway. Thus, in the same way that Cullum has noted the overlap between charitable services and institutions as discussed in Section I, this study suggests hospitals really did provide a multitude of caring services for a myriad of people. Furthermore, it proposes that hospitals started to specialise and delineate their services in order to protect their income in the face of stiff competition and calls for reform. In this respect, these hospitals did not experience the problems which Thompson found with monastic houses in Norfolk which 'were often not seen to be performing a useful contemporary function to the living'.[60]

Another specialised function which three hospitals are known to have turned their hand to is the provision of education. The evidence here is not as strong as in other areas, but it nevertheless merits consideration as a conceivable way that hospitals avoided closure and remained relevant to society. At Calne, for example, the master of the hospital prior to its dissolution, not being in priest's orders, was permitted to use the endowment to 'fynde [fund] hym to scole'.[61] And at Kepier in the early fifteenth century there was a school under (*infra*) the hospital hall.[62] It seems subsequently, after dissolution, hospital buildings in this sample were used for educational purposes. Whether this continued an existing practice is unknown, but there was clearly a desire to find a close match for the hospital endowments, and it suggests that there was an affinity between the town and the hospital. Taking the example of what is now High Wycombe, there is a clear link between the old hospital, the subsequent grammar school, and its patrons – despite

[59] 'The Hospital of Saint John Hockliffe', http://bedsarchives.bedford.gov.uk/CommunityArchives/Hockliffe/TheHospitalOfSaintJohnHockliffe.aspx (9 May 2017); 'Hockliffe House', https://historicengland.org.uk/listing/the-list/list-entry/1158688 (6 June 2020); 'The Trout Inn', https://www.historicengland.org.uk/listing/the-list/list-entry/1155618 (4 May 2017); 'Milton Chantry', https://historicengland.org.uk/listing/the-list/list-entry/1089047 (28 Feb. 2019).
[60] Thompson, 'Monasteries and their Patrons at Foundation and Dissolution', p. 121.
[61] E 301/58/30 as detailed in Pugh and Crittall (eds), *A History of the County of Wiltshire*, vol. 3, pp. 334-5.
[62] *Wills and Inventories Illustrative of the History of Manners*, Language, *Statistics &c. of the Northern Counties of England from the Eleventh Century Downwards*, part 1, ed. J. Raine (London, 1835), p. 67.

the fact that it was dissolved during the Reformation and fell into private hands. In 1562 the mayor, bailiffs, and burgesses of the town were granted a licence to found a grammar school with a master. As part of this process, the Crown specifically recognised their role as patrons of the late hospital and regranted its lands 'for the better support of the school and four poor of the town'.[63] Calne and Wycombe, discussed herein, held out until the mid-fifteenth century. As did Buckingham which may also have functioned as a school in 1423.[64]

Of course, not all hospitals were able to adapt. There are, for example, easily identifiable reasons for the hospital's decline at Brompton Bridge near Catterick. This hospital experienced difficulties following the construction of a new bridge at Catterick in 1422.[65] Earlier in the fifteenth century the church of St Anne in Catterick was rebuilt on the instruction of Dame Catherine of Burgh and her son William.[66] Subsequently, this church became the focal point of the lord of the manor as indicated by the burials of several members of the family within the porch of the church and monumental brasses of William Burgh and his son housed within it.[67] Archaeological evidence suggests that the hospital was abandoned between 1420 and 1460.[68] It seems likely, therefore, that the hospital suffered from a loss of passing visitors after the construction of the new bridge and a concerted effort to promote the nearby town of Catterick. It is not known what happened to the hospital, but it is last heard of in 1468 when its patron Henry lord Fitzhugh, knight, received a licence to found a perpetual chantry at Ravensworth Castle.[69] What is particularly striking about this licence is that it specified that the chaplains must pray for

[63] *CPR: 1560-1563*, p. 254.
[64] 'The Chantry Chapel, Buckingham', http://www.nationaltrust.org.uk/features/the-chantry-chapel-buckingham (14 Jan 2016).
[65] 'Original Documents Contemporary Copy on Parchment of the Contract for Building Catterick Bridge, 9 Henry V. (1421-22)', *Archaeological Journal*, 7, ed. W. L. Bart (1850), pp. 56-62.
[66] *Catterick Church in the County of York: A Correct Copy of the Contract for its Building Dated in 1412, Illustrated with Remarks and Notes*, ed. J. Raine (London, 1834), p. 7.
[67] Ibid., pp. 12, 20.
[68] Cardwell, *et al.*, 'The Excavation of the Hospital of St Giles by Brompton Bridge, North Yorkshire', p. 154.
[69] *CPR: 1467-1477*, p. 90.

the founder and benefactors of the hospital of St Giles by Brompton Bridge – in other words the patron made a pragmatic decision to ensure that one service was guaranteed in this instance.[70]

The local competition and increasing importance of the parish church was undoubtedly the reason for the closure of the hospital at Brompton Bridge near Catterick. In this competitive environment with a proliferation of suppliers, hospitals were forced to tailor their services to meet demand – acknowledging, of course, that the provision of perpetual chantry masses was a fixed service once undertaken for which demand could only increase: this may account for the reputation of hospitals as intercessors par excellence and accusations of neglect of their duties to the poor. Two ways in which hospitals tried to differentiate their services was through the provision of hospitality in inns or educational services to assist poor scholars. Indeed, three hospitals within this study, Aynho, Brackley, and Ospringe, were ultimately appropriated to newly founded university colleges.[71] A third available option for a patron to instigate was a close relationship with the parish church, or at least try to negotiate with their rectors, patrons, and diocesan bishops.

In the first section of this chapter it was noted that medieval society did not differentiate between public and private welfare assistance in its mixed economy of care. This view can also be applied to the provision of liturgical services. Certain hospitals within this sample were clearly not averse to straddling what would now be deemed the boundaries of public and private care of souls. At Flixton in 1447, for instance, it was noted that the vicar of Folketon and his predecessors came to the hospital chapel on the feast of St Andrew each year in order to celebrate mass 'with the benediction of the chalice and after mass to bless the bread and water and to divide it among the people and sprinkle them'.[72] This is a rare insight into the internal spiritual life of a hospital within this study. Other examples of parish connections provide mere glimpses into this type of arrangement and the existence of local networks. For example, the masters at Hockliffe were

[70] Ibid.
[71] Appendix I.
[72] *CPR*: *1446-1452*, p. 69.

responsible for presenting the candidate to the living at the parish church from the early thirteenth century and, thus, held wider parochial responsibilities for the cure of parish souls.[73]

In one case at Portsmouth in 1229, a deed containing an agreement between the hospital and the Prior and Convent of Southwick (in their capacity as appropriator) regarding the rights of the parish church recorded that the hospital was not permitted to have a heavier bell than the church and was restricted as to when its two permitted bells could be rung – in other words, a bid to prevent the hospital from attracting members of the public to its services. The arrangement prevented the brothers from hearing the confession of parishioners or celebrating mass unless an individual was sick, and, even then, the consent of the parish priest was required in advance. Evidently all concerned realised that it was going to be difficult to stop parishioners visiting the hospital; a further restriction specified that if they did attend the hospital on chief feast days, the offerings were to be given to the mother church. Parishioners also wanted to be buried within the hospital precinct, and another part of the agreement stipulated that before the burial of the body it was to be taken to the parish church where mass was to be celebrated. But it was not only parishioners who were attracted to this hospital: priests on their way overseas were authorised to celebrate in the chapel. The brethren actively spread their message on the ships that came in and out of this bustling area.[74]

In another example, at Devizes, the bishop of Lincoln was clear in 1326 that the hospital was subject to the parish church following a dispute concerning its independence.[75] And as late as 1436, a papal letter recorded that the warden and inmates at Lutterworth were parishioners of the parish church and received the sacrament of the Eucharist and other sacraments from its rector.[76] Occasionally, though, a hospital was successful when attempting to battle with parish churches and bishops. By now it is perhaps of no surprise that the example which this study found concerns

[73] *Rotuli Hugonis de Welles*, vol. 1, part 2, p. 97.
[74] Wright, *The Story of the 'Domus Dei' of Portsmouth*, pp. 5-6 (being a translation of the deed).
[75] *The Registers of Roger Martival, Bishop of Salisbury, 1315-1330*, vol. 2, part 2, ed. K. Edwards, p. 514.
[76] *CEPR: 1427-1447*, vol. 8, ed. J. M. Twemlow (London, 1909), p. 558.

the hospital at Brackley. In an act of defiance in 1320, the hospital stood accused of withholding parish tithes from the mother church and receiving offerings on feast days and at funerals – on this occasion, the archbishop of Canterbury ruled in the hospital's favour.[77]

What is evident here is that there was an oversupply of providers or a paucity of resources for which they were competing – such as offerings and fees. These institutions fought to protect their interests and to continue to provide their services. In order to differentiate themselves in this competitive welfare market, hospitals did not diversify their activities: instead they tailored their activities to meet demand. This may account for the accusation that they became glorified chantry chapels. If that were indeed the case, it does not necessarily follow that the poor suffered as a direct result.

Indulgences

The final part of this section considers the role of the indulgence in assisting hospitals to generate demand and to present themselves as worthy causes. The subject of indulgences is a complex one as shown in Robert Swanson's seminal work on the subject. Swanson often made the point that it is difficult to separate the various intentions, motivations, and components of the indulgence seeker, creator, and recipient. Of particular relevance here is the idea that although some indulgences issued by bishops were paid for in the form of prayers, a corresponding 'voluntary' donation to a good cause (a charitable act) might have been an intended consequence of the grant. Swanson has further noted just how unusual evidence outside official ecclesiastical records is. The following evidence is hitherto unexplored and as such is highly valuable. Being local evidence, it can provide an insight into motivations which were difficult for Swanson to probe as well as shedding light on demand *per se*.[78]

[77] MCA, Brackley C60; Macray, Northamptonshire II, No. 532.
[78] R. N. Swanson, *Indulgences in Late Medieval England: Passports to Paradise* (Cambridge, 2007), especially Chapters 3 and 6, pp. 77-112 and pp. 224-77.

As noted earlier in this section, the hospital at Brackley experienced a temporary crisis during the Great Famine. As well as extra grants of lands and attempts to augment resources through the acquisition or withholding of tithes, the hospital sought assistance from some of the most powerful individuals within society through the issue of indulgences.[79] In 1314 the patron of the hospital, Alan la Zouche, died. Little is known about his life, but there are a handful of facts which are relevant to the present project. In 1306 Alan was noted as present at the Trinity Parliament.[80] On his death, he held land in several counties across England.[81] In the same year an order was issued by the king that Alan's daughter and her spouse, Matilda and Robert first baron Holland, were to be given the advowson of the hospital which had a yearly value of 100s.[82] Alan's death is recorded in detail among the hospital muniments held in MCA. This is unusual and of value to this study as there are a series of indulgences issued after his death – issued that is, during the early fourteenth-century crisis.

In 1318, some four years after Alan's death, five bishops (Norwich, Hereford, Worcester, Salisbury, and Lincoln) issued indulgences, three on the same day being 13 April and two of those were noted as being issued at Leicester, and one at Braunceston near Leicester.[83] On 12 April a Parliament was held at Leicester, and two of these bishops are known to have been in attendance (Norwich and Hereford).[84] The then patron of the hospital, Robert Holland, had been summoned to sit in 1317, and it is feasible that he would have been summoned in 1318 too.[85] Robert was a chief agent of one of the most powerful earls at this time, Thomas, earl of Lancaster, cousin of Edward II. Earlier, in January 1318, Robert was in Scotland serving his lord.[86] Parliament was postponed on several occasions throughout the year at the behest of the prelates who cited the

[79] For the example of withholding of tithes see MCA, C60; Macray, Northamptonshire II, No. 532.
[80] 'Introduction Trinity 1306', in *Parliament Rolls of Mediaeval England, 1275-1504*, ed. C. Given-Wilson, *et al*. (Leicester, 2005), http://ezproxy-prd.bodleian.ox.ac.uk:6378/PROME (28 June 2020).
[81] *Calendar of Inquisitions Post Mortem and Other Analogous Documents Preserved in the Public Record Office: Edward II*, vol. 5 (London, 1908), pp. 255-9.
[82] *CCR: 1318-1323, Edward II*, vol. 3 (London, 1895), p. 117.
[83] Macray, Northamptonshire II, Nos. 518-20.
[84] *Chronicles in the Reigns of Edward I and Edward II*, vol. 2, ed. W. Stubbs (Cambridge, 2013), p. 54.
[85] *Parliament Rolls of Mediaeval England, 1275-1504 (SDE)*, 'Introduction January 1318' Ed. II.
[86] Maddicott, 'Holland, Sir Robert (*c*. 1283-1328), Baron'; Maddicott, 'Thomas of Lancaster and Sir Robert Holland', pp. 449-72.

need to repel the Scots. It is a possibility that if the bishops met at Leicester, the earl of Lancaster was also present at the parliament and that Holland was in attendance too: Lancaster and Holland both held significant land in that area.[87]

Whatever the reason, it cannot be a coincidence that five bishops – Hereford, Lincoln, Norwich, Salisbury, and Worcester – all issued indulgences in the same year.[88] In addition, just two years later the bishop of Glasgow also issued an indulgence – perhaps again emphasising the hospital's Scottish connections.[89] Robert at this time, being so closely associated with Lancaster, was an extremely powerful man. There is no doubt that this hospital could draw on support from those individuals in the top echelons of society and, as has been noted on several occasions now, the advowee paramount himself. In fact, Edward II might have stayed in the hospital, or at least visited it during these years, as in 1317 he spent three nights in Brackley and one night in 1318.[90] The delay in issuing the indulgences to support the former patron's soul to navigate its way through Purgatory strongly suggests that the issue of this particular indulgence was designed to generate income during one of its greatest times of need.

The content of these indulgences also merits further exploration in a quest to understand the intent behind their issue. Each grant offered a remission of penance of between 20 and 40 days (40 days being the maximum that could be offered by a bishop at this time) for individuals within each diocese who said the Lord's Prayer and Ave for Alan's soul.[91] There are several points to note here. The first is that these requirements made the grant available to a wide range of parishioners as the laity were expected to know both the *Pater Noster* and *Ave Maria*.[92] The second is that the grants did not require parishioners to visit the hospital. It seems that an intangible spiritual force of prayers was intended to unite people in thought – this is what Swanson labelled devotional

[87] Ibid., p. 459.
[88] MCA, Brackley D250, (6), (9), and (10); Macray, Northamptonshire II, Nos. 521, 522, and 527.
[89] Macray, Northamptonshire II, No. 527.
[90] C. H. Hartshorne, *The Itinerary of King Edward the Second* (1861), pp. 18-20.
[91] R. N. Swanson, *Church and Society in Late Medieval England* (Oxford, 1989), p. 283.
[92] Ibid., p. 276.

indulgences paid for in the form of prayers.[93] The third point is that there were also persons at the upper echelons of the ecclesiastical hierarchy who were saying prayers for this individual. Thus, a range of people were being called upon to assist this soul. Nevertheless, it is a possibility that the intent behind the offer was that individuals would be motivated to visit the hospital to both give alms to the poor and to offer prayers at Alan's final resting place being in the choir of the hospital's church (*in choro eccl[es]ie hospitalis*).[94] Whether individuals were expected to visit the hospital or not, this was certainly an attempt to focus attention upon this house in a bid to assist it.

Once this format had been adopted it continued to be used, and, thus, it can be reasonably assumed that it was a successful strategy. In addition, it was not just patrons for whom indulgences were issued, nor simply by bishops holding English dioceses. In 1327, the bishop of Salisbury, Roger Martival, issued a grant to the people in his diocese who prayed for the soul of the deceased master at Brackley, William Dorset. Interestingly, Dorset was also buried in a prime position in the hospital chapel in front of the altar of St Mary.[95] By 1340, the indulgences were specific in their requirements, and the benefactors were of international repute. In this example, the grant was issued from Avignon by Archbishop Manasgarden and the bishops of Polignano, Ulcinj, Cyme, Cervia, and Callincium.[96] It stated that 40 days of remission of penance would be granted to individuals who attended the church and its services, but most specifically, and of relevance to an important service provided by the hospital, to those individuals who would follow when the body of Christ or holy oil was carried to the infirm – in other words when the sacrament of Extreme Unction was administered to assist the dying. Presumably those concerned would seek to assist

[93] Swanson, *Indulgences*, p. 228.
[94] MCA, D250 (6).
[95] MCA, Brackley D250 (13); Macray, Northamptonshire, I, No. 563.
[96] The exact names as quoted in the document which may represent sees in Turkey and Italy are Pollen, Dulcinen, Cimen, Cervicen and Callien based on http://www.gcatholic.org/ (6 Oct. 2019). It is possible that these were members of the papal curia who were permitted to issue indulgences – Swanson, *Indulgences*, p. 40.

this soul through Purgatory and in return receive salvation for their own soul.[97] The intent behind the issuing of the indulgence in this case was clearly to support a critical service offered by the hospital. In addition, the text provides an indication of the type of gifts which a hospital such as this might expect to receive in return for their remission of penance: contributions to the building, lights, or other necessaries, or gifts of gold, silver, clothes, beds, linens, and beasts.[98] Therefore, over time the terms of the indulgence were clearly specified and tailored to the precise needs of the hospital in order to support it. Brackley was, again, obtaining support from the highest echelons of society, this time from the papal curia at Avignon.

The list of suggested gifts to the hospitals also raises the issue of income generation *per se*. By the late thirteenth century, many hospital income streams were severely curtailed or blocked. The mortmain legislation has been discussed in Chapter Five, the restriction of services which hospitals could provide and the requirement to forward offerings to the mother church in Chapter Three, but there was a further problem: The Statute of Westminster of 1285. Clause 41 is the clause which related to hospitals, and it ordained that if keepers of hospitals alienated lands granted to their houses by the king or his progenitors, the king could take back the said land and the purchaser would lose both the land and the purchase price. This remedy appears to have been designed to serve as a deterrent to both the masters of hospitals and the purchasers from disposing of assets. In addition to this, a writ was available for individuals who had endowed chantries or contributed towards the cost of providing candles in chapels through the gift of land: they too could seek to recover those lands. Finally, if the intended services were simply not performed in the hospital for a period of two years, an action of *novel disseisin* was available whereby the donor could demand the said lands or seek redress to at least 25% of the land value.[99]

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[97] MCA Brackley D250 (3), '*seu Corpus C[hrist]i vel oleum sacrum cum infirmis portentur secuti fuerint'.*

[98] Ibid., '*necnon ad qui ad fabricam luminaria ornam[en]ta q[ue]uis alia d[ic]to hospitali n[e]cc[es]ia manus porrex[er]int adiutrices. Vel qui in eor[um] testamentis aut ex[tra] aurum argentum uestim[en]tum lectos*'.

[99] *Statutes of the Realm*, vol. 1, pp. 91-2; Gemmill, *The Nobility and Ecclesiastical Patronage*, p. 159.

There are several points to note concerning this statute. The king wanted to address the issue of services which were not being performed in accordance with the terms of the grant of land. The remedy, crucially, applied not only to the donor but also their heirs. The king was clearly signalling his intent that the generosity of these donors should not be exploited. It seems the ability to raise revenues was tightly controlled. Hospitals and their inmates are also associated with begging for alms, but even this cannot be assumed when so many short-term licences were issued in the thirteenth century as seen in Chapter Four. Indulgences can be viewed, therefore, as part of a strategy designed to increase demand and generate income when alternative options were unavailable. In the case of Brackley, they were marketing campaigns of international repute. This was not necessarily so for all the hospitals, but the goal of raising funds for one-off projects or at times of uncertainty prior to the fifteenth century appears to be a recurrent theme. The following table represents a summary of indulgences issued to hospitals in this study. The reasons why indulgences were issued vary from repairing buildings to encouraging visitors to the precinct and especially the chapel. In later years, the process appears to have returned to the original format being general in nature. Of specific note is the indulgence identified in 1355 for Kepier. This was arranged by its patron, the bishop of Durham, and it left the purchaser in no doubt that they would be assisting a hospital struggling with the effects of the Black Death on its estates, both in terms of its flocks of sheep and its ability to produce crops. Again, with the correct support a hospital could overcome a period of difficulty: Kepier became the richest hospital in this diocese by 1535 with an annual income of more than £186.[100]

[100] *Valor Ecclesiasticus: 1509-1547,* vol. 5 (1825), pp. 307-8.

Table 7: Hospital Indulgences in the Later Middle Ages

Year	Hospital Location	Length of Remission	Reason for Indulgence	Issuer
1290	Hockliffe	20 days	Repair burnt buildings	Bishop of Lincoln[101]
1291	Lechlade	40 days	Visit the church of the hospital	Pope Nicolas IV[102]
13th century	Lechlade	13 days	Contribution to the *paupertatem attendentes et inopiae pie compatientes*	Archbishop of York[103]
1352	Killingwoldgraves	100 days	Visiting the church of the hospital p.a.	Pope Clement VI[104]
1355	Kepier	40 days	Plague, dead sheep & infertile land	Bishop of Durham[105]
1368	Seaford	40 days	Assistance as hospital ruined by the incursions of the sea	Archbishop of Canterbury[106]
1399	Hungerford	40 days	The poor & chapel repair	Bishop of Salisbury[107]
Late 14th century to 1481	Walsoken	3 years, 100 days	To all benefactors	Popes[108]
1411	Helston	40 days	General support	Bishop of Exeter[109]
1487	Walsoken	40 days	General support	Bishop of Ely[110]
1503	Devizes	40 days	General	Bishop of Salisbury[111]

The final example to note, this time at Lechlade, binds this and the following section together. In 1290/1, at what is thought to be the height of demand for hospitals with respect to the poor, two indulgences were issued designed to raise one-off income for repairs and to encourage visitors to the hospital church. This is not, however, the full story. The indulgences are likely to have arisen at the behest of the bishop of Worcester's intervention. In 1291, his concern for the hospital was

[101] *The Rolls and Register of Bishop Oliver Sutton, 1280-1299*, vol. 3, ed. R. M. T. Hill (Woodbridge, 1948), p. 4.
[102] *CEPR: 1198-1304*, vol. 1, ed. W. H. Bliss (London, 1893), p. 541.
[103] *The Register, or Rolls, of Walter Gray, Lord Archbishop of York: With Appendices of Illustrative Documents*, ed. J. Raine (Durham, 1872), p. 44.
[104] *CEPR: 1342-1362*, p. 467.
[105] Barmby, *Memorials of St. Giles's*, p. 223-4.
[106] *Registrum Simonis Langham, Cantuariensis Archiepiscopi*, ed. A. C. Wood (Oxford, 1956), p. 193.
[107] Hidden, 'The Hospital or Priory or Free Chapel of St John the Baptist in Hungerford', p. 97.
[108] *VCH: Norfolk*, vol. 2, pp. 452-3.
[109] Orme and Webster, *The English Hospital, 1070-1570*, p. 197.
[110] W. Miller, *An Essay Towards a Topographical History of the County of Norfolk: Volume 6* (London, 1807), p. 131.
[111] *VCH: Wiltshire*, vol. 3, p. 337.

clear when he issued corrective ordinances which reprimanded the brothers and sisters for a lack of discipline, and suggested that they had permitted the misuse of hospital assets, and had left the house without consent.[112] In addition, the bishop's support to attract visitors to the hospital and potentially away from the parish church is noteworthy in this competitive charitable environment – or mixed economy of welfare. Therefore, consideration will be given to a hospital's ability to provide its services and assessment of the types of operational issues identified in the bishop's ordinances in Section III. To summarise the results of Section II: in the early fourteenth century, at the time of both the Great Famine and war with Scotland, the hospital at Brackley clearly experienced difficulties. But with the support of its patrons – it could be said be they living or dead – they were able to overcome these external threats. This also occurred at Kepier, although this was in the post-Black Death period. Indulgences played a part in generating income for ten of these houses and raised their profile at times when they were most in need. This was a form of emergency funding, in part necessary as other fundraising avenues had been curtailed.

III: Operations, Legislation, and the Role of the Master

This section will shed light on the role of the master in ensuring that a hospital was in the position to be able to provide its services. A hospital might have accumulated many endowments and benefitted from highly influential and supportive patrons, but if its assets were mismanaged it could fall into decline. Thus, within a short period of time it could find itself in a vulnerable position and ultimately cease to operate. Therefore, the present project sought to question the extent to which hospital assets were protected and used for their intended purpose, and the importance of the master in that process. Within this analysis, the question of what happened if a master did not perform his duties is probed as it is a crucial point to consider when seeking to understand the ability of these houses to endure.

[112] *Register of Bishop Godfrey Giffard,* vol. 1, p. 391.

This extract from the Parliamentary Rolls encapsulates several key points of relevance to this section.

> **Petitioners:**
>
> 'Let it be shown to our lord the king and to his council that whereas the poor hospitals of the realm are impoverished and ruined in many ways by people who are appointed wardens of the said hospital during vacancies, both on behalf of our lord the king and by others, as regards waste and destruction committed in the meantime for which hardships and damage the brethren and the sisters cannot have recovery without a master and the masters appointed to the said hospitals by the patrons cannot have recovery through common law for damage done before their time. Because of which the masters pray, for God's sake, that specific remedy be ordained in that case.'
>
> **The king:**
>
> 'It is answered: on the matter of waste and destruction committed in the hospitals by wardens appointed by the king during vacancies there, they are to sue against these wardens at the exchequer. On the matter of waste and destruction committed by wardens appointed by lords other than the king, they are to sue against them at common law etc.'[113]
>
> **January 1315**

At first sight, it appears that when keepers were appointed during the vacancies, they did not always serve the best interests of the hospital. In fact, it could be argued that the king, as patron and indeed in the case of non-royal patrons too, was merely exercising his patronal right without due regard for these houses. Yet the petition was given respectful consideration and the response appears to be an eminently sensible and reasonable one. The king acknowledged the problem – he was not forced to do so – but obliged the hospitals to justify their case at the Exchequer. In other cases, his judicial arm would stretch into the localities if requested. The petition demonstrates just how important the role of keeper or permanent master was, and the ability of an individual to negatively affect the operations of a house. What, however, is also apparent from the extract is that subsequent masters who sought to resolve these issues were now lobbying as a group, and there were now shared concerns on a countrywide basis.

[113] 'On behalf of hospitals laid waste during vacancies etc., Jan. 1315, Text and Translation', in *Parliament Rolls of Mediaeval England, 1275-1504*, ed. C. Given-Wilson *et al*., item 73.

At a European-wide level legislation was in the process of being considered by successive popes in Avignon at this time which sought to rectify these problems. The papal decretal *Quia contingit*, (because it happens) being canon 17 arising from the Council of Vienne in 1311 but not published until 1327 under the papacy of John XXII following the death of Pope Clement V in 1314, was clear in its intent.[114] The decree left its readers in no doubt as to the types of maladministration which these houses stood accused of perpetrating. The recent work of Adam Davis made a passing reference to the legislation and provided an excellent succinct summary of that intent:

> 'The overriding concern of this decretal centered (sic) not on the religious life and discipline of hospital brethren but on protecting hospital assets and ensuring that donations made to the hospital were being used for the poor and sick, not the personnel. *Quia contingit* was meant to serve as a reminder of the need for competent personnel to carry out the caritative function for which hospitals were founded and enforced'.[115]

When Davis reviewed the effect of this legislation on houses in France, he noted bishops carried out inspections, and that they seem to have influenced appointments too.[116] Of course, the law in England, as noted in Section II, was already taking these types of problems into account through the Statute of Westminster II (1285) – the penalty to be imposed was the return of hospital assets to donors if they were not used for their intended purpose. Nevertheless, the decretal should have provided welcome support for those tasked with ensuring that these houses were able to supply their services. Therefore, the two key issues identified by Davis in his brief perusal of *Quia contingit* were the competency of masters and the protection of assets. These two pivotal points merit further exploration which now follows with respect to hospitals located in small towns and villages in England.

[114] *Decrees of the Ecumenical Councils: Volume I (Nicaea I to Lateran V)*, ed. N. P. Tanner (London, 1990), pp. 333-5.
[115] Davis, *The Medieval Economy of Salvation*, pp. 238-9.
[116] Ibid.

Competency

Taking, then, in the first instance the issue of competency, the decretal was explicit in specifying the qualities expected of masters: they were to be prudent men (*viris providis*) and individuals who would have the 'ability to rule the institutions...defend their rights...and who are not likely to divert the property to other uses'.[117] In other words, masters should ensure that hospitals were in a position to supply their services. Unlike the hospitals considered by Davis in France, there is rarely a direct reference to the decretal in the extant fourteenth-century evidence concerning hospitals in small towns and villages. There is one reference in 1354 by Bishop Bateman, but this was in his capacity as patron of the hospital of Beck not as a bishop *per se*. When Robert Markant was collated to the mastership, he swore an oath to render an annual account of the goods of the hospital in accordance with the new constitution which begins *Quia contingit*.[118] Promising to account for the hospital's assets is one thing, having the ability to complete the task is something different.

Vetting candidates was not a new procedure in England, and as stated before the decretal might have added weight to existing best practice. Prior to an institution, an inquisition was often undertaken to establish the character or experience of a master. For example, at Aynho the registers of Bishop Hugh of Wells in the early thirteenth century recorded the presentation of a canon of Bliburgh, Staffordshire, to the position of rector at the hospital by Roger de Creissy. The rector was appointed for the governance of the hospital (*ad regimen de hospitalis*) following an inquisition by the official of Northampton (*per Magistrum S., Officialem Northamptonie*).[119] Another example in the same register can be seen with reference to the house at Armston. In this case, a chaplain was presented by Alice de Trubleville, *ad regimen hospitalis de Armistone*,

[117] *The Decrees of the Ecumenical Councils: Volume I (Nicaea I to Lateran V)*, ed. Tanner, p. 375.
[118] *The Register of William Bateman, Bishop of Norwich, 1344-1355, Volume II*, ed. P. E. Pobst (Woodbridge, 2000), pp. 383-4.
[119] *Rotuli Hugonis de Welles, Episcopi Lincolniensis A.D. MCCIX-MCCXXXV*, vol. 2, ed. F. N. Davis (London, 1908), p. 171. The printed register does not provide the name of the *magister*.

following an inquisition by the archdeacon of Northampton.[120] By the late thirteenth century, the remit of the inquisitions had grown to enquire into not only the *fama* of the proposed candidate but also the legitimacy of the patron making the presentation and the precise nature of the devolved accountability. For instance, the presentation of a chaplain by Roger Fitzroger, knight, to the hospital at Aynho was permitted following an investigation by the archdeacon of Northampton in 1282. The inquiry confirmed that Roger was indeed the lawful patron, that there was no responsibility for the cure of souls only temporal possessions, and that the presentee was a man of good repute.[121]

The character of the master was of such importance to bishops and monarchs that it was often mentioned in their own records. At Cricklade in 1237, the master who was responsible for both the spiritual and temporal administration of the house was expected to be discreet.[122] In another example, this time slightly later and in Aynho in 1294, the new master was noted as a praiseworthy man in life and of honest behaviour (*vir laudibilis vite et conversationis honeste*).[123] And in 1295 when Edward I granted the custody of the hospital at Ospringe to the master, the agreement specified that he should 'faithfully perform what belongs to the custody of the same and to the hospitality thereof'.[124] Part of the role of the master was to ensure that these houses functioned efficiently, and in order to achieve that they were expected to be able to manage the inmates in their respective roles. It was, therefore, important that their authority was respected. Bishops and monarchs also on occasion reinforced this message, such as at Cricklade in 1322 when the bishop of Salisbury enjoined the brothers and sisters of the hospital that they should obey (*obedient*) the newly appointed prior.[125] In the following year, the bishop of Lincoln mandated that the brethren

[120] Ibid., pp. 171-2, 256-8.
[121] *The Rolls and Register of Bishop Oliver Sutton, 1280-1299*, vol. 2, p. 17.
[122] *The Register of Robert Hallum*, pp. 153-4.
[123] *The Rolls and Register of Bishop Oliver Sutton, 1280-1299*, vol. 1, ed. R. M. T. Hill, (Woodbridge, 1948), p. 107.
[124] *CPR: 1292-1301*, p. 148.
[125] *The Registers of Roger Martival, Bishop of Salisbury, 1315-1330*, vol. 1, ed. K. Edwards (Oxford, 1959), p. 272.

of the hospital at Hockliffe should obey its master.[126] Given the caritative nature of these houses it is not surprising to find that the brethren, too, were expected to perform their duties in a certain manner. There is an endearing example in the corrections made for the hospital at Lechlade by Bishop Giffard in 1290 which stated that: 'the hospitality, according to the means of the place, be observed with charity and cheerfulness; that two kind and courteous brothers be chosen for this, and the same for the sick brothers and sisters and others received into the said hospital'.[127]

As indicated at the start of this section, abuses by masters holding office were taken seriously by the king. This can be seen in 1314 at Ospringe when the king gave a clear instruction regarding an ousted master who sought to be reinstated to the position.[128] If he were to govern to the advantage of the house and had not committed wrong to such an extent that he could no longer hold the position, he might be appointed at the king's will. However, if he had been at fault he could return to the status (estate) of a brother, this being his status prior to his appointment as master.[129] The master was not reappointed presumably as in April 1314 another brother of the house had been admitted keeper, promising to do all that 'appertains to the custody of the house and exercising its hospitality' – a clear affirmation of the importance of hospitality.[130]

Thus, if masters did not perform their duties royal patrons could intervene. In another example, this time in 1272, Henry III ordered an inquiry into the state of his hospital following the accusation that the master had permitted 'daily dispersals, dilapidations and destruction of goods'.[131] Again, the king took direct control by issuing an instruction that one of the brethren should be made responsible for the hospital's assets until he visited or at least gave further orders.

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[126] *The Registers of Bishop Henry Burghersh*, vol. 2, p. 104.
[127] *Register of Bishop Godfrey Giffard*, vol. 1, p. 391.
[128] 'The king is requested to grant to brother Nicholas de Staple the wardenship of the king's hospital of the Maison Dieu, Ospring, which he had before and from which he had been ousted' in *Calendar of Chancery Warrants Preserved in the Public Record Office, A.D. 1244-1326*, ed. H. C. M. Lyte (London, 1927), p. 408.
[129] Ibid.
[130] *CPR: 1313-1317*, p. 167.
[131] *PR: 1266-1272*, p. 707.

However, he also stipulated that the brother who was thus appointed could use the hospital assets to sustain the brethren and infirm so long as they were not damaged or dispersed – and thereby indicated his support for the purpose of the hospital. By the fifteenth century, there were repeated interventions by the king to protect the assets of the hospital when masters were accused of bad governance or negligence. These visitations were ordered in 1407, 1414, and 1424.[132] These were in addition to what might be deemed normal inspections when the instruction issued by the king did not cite a specific problem, such as in 1422.[133]

There can be no doubt that Henry V took his responsibilities as patron seriously. When, for example, in 1414 he issued a confirmation of earlier letters patent to the hospital, the reason for the grant was given 'for God because they are poor'.[134] Nor was the king a passive bystander following an inspection. For instance, in 1415 he placed the hospital in the care of the keeper of the privy seal and one of his justices, and he granted it protection. The reason for the additional support was to assist the hospital to manage its annuities, corrodies, pensions, and payments of debts.[135] The intent was to support divine worship, which was noted as being withdrawn, and the infirm – so in this example divine worship had suffered more than the care of the needy. The accusation that masters were negligent in their duties disguises the reality of the situation which the frequent interventions reveal. There is no logical reason why a monarch would repeatedly appoint wardens who were incapable of guarding the hospital's assets only to repeatedly issue instructions to inspect these houses. The appointment of senior officials in addition to the extant 'master or warden, and brethren, and the infirm there and their servants' is evidence of the complex underlying financial problems.[136]

[132] *CPR: 1405-1408*, p. 386; *CPR: 1413-1416: Henry V*, vol. 1 (London, 1910), p. 264; *CPR: 1422-1429: Henry VI*, vol. 1 (Norwich, 1901), p. 176.
[133] *CPR: 1422-1429*, p. 37.
[134] *CPR: 1413-1416*, p. 250.
[135] Ibid., p. 364.
[136] Ibid.

These problems were clearly of such magnitude that by 1424 the Crown was forced to intervene, issuing protection and placing the custody of the hospital's assets in the hands of the bishop of London, the abbot of Faversham, and one of his justices.[137] It should, therefore, be of no surprise that these senior guardians were not resident, and secondly, that masters had been forced to sell hospital assets – it was not negligence but a matter of survival. A further point to note is that those assets comprised not only grants of land which should have been allocated to the poor but also 'many relics, ecclesiastical ornaments, books and jewels of the hospital'; thus, again, suggesting the performance of divine service was not given preferential treatment over the poor. In this case, a deceased master and his executors stood accused of corruption.[138] This series of events raises the question of why would masters appointed by the king, often noted as chaplains and therefore servants of God, seek to harm this institution in the full knowledge that there would be a strong possibility of an investigation into their behaviour? It seems an unlikely proposition. A more feasible answer is that these institutions had become extremely difficult to protect and manage and, thus, ensure that they were in a position to provide their services. It is also, therefore, not at all surprising that this countrywide phenomenon was raised in Parliament in 1414, although, again, no further action was forthcoming.[139]

In the same way as monarchs, lay patrons were also not averse to intervening to ensure that the hospital was operating as intended. There is a highly unusual piece of evidence concerning a dispute between the patron of the hospital at Brackley, Elena la Zouche, and the master and brethren. It is rare, in Orme and Webster's view, to find a female exercising patronage rights of 'headship', and rare to find a lay patron actively intervening in spiritual matters.[140] The problem appears to have centred around the payment of the hospital chaplains. In 1256, Roger de Quincy granted ten marks of annual rent to the hospital to fund two chaplains.[141] It seems that these

[137] *CPR: 1422-1429*, p. 176.
[138] *CPR: 1416-1422, Henry V*, vol. 2 (London, 1911). p. 208.
[139] Rawcliffe, 'A Crisis of Confidence?', pp. 86-92.
[140] Orme and Webster, *The English Hospital, 1070-1570*, for a brief discussion of female patrons, see pp. 82-3. The term headship is assumed to mean the management of the hospital.
[141] MCA, Brackley 4A; Macray, Northamptonshire I, No. 187.

amounts had not reached the chaplains and they had withdrawn their services. In 1279 an agreement was reached, and Elena's desire to exert managerial control over the brethren is evident and notably over the provision of the hospital's spiritual services in spite of her lay status. Elena specified exactly which chaplains were to pray for which ancestor. For instance, the master and two named brothers were tasked with praying for the soul of Roger de Quincy, the now deceased earl of Winchester (d. 1264). The earl, as noted in Chapter Three, had specified that his body should be buried in the hospital.[142]

Protection

It can, therefore, be seen that prior to the publication of the legislation emanating from the Council of Vienne measures were underway to protect the assets of these houses and that this continued into the fifteenth century. That is not to say, however, that the decretal did not serve a useful purpose – it did, but its cited use was more prominent in the fifteenth century for the houses in this study which concurs with the aforementioned findings of Orme and Webster. A brief example can be found concerning the hospital at Hockliffe. In this case the decree was invoked in 1425 when the wardenship of the hospital which was in the king's gift owing to the temporalities of the bishopric of Lincoln being in the king's hands. The letter patent explicitly linked the wardenship with the decree: 'grant...of the wardenship...with all its rights and appurtenances in the form of the Clementine constitution beginning *quia contingit*...and according to the foundation of the said hospital'. The master was then 'charged on his conscience' with preserving the goods of the hospital and ensuring that they would be used for the appointed purpose.[143] The master was clearly tasked with protecting the hospital's assets and promising to provide the services in accordance with the foundation charter and law.

[142] MCA, Brackley B229; Macray, Northamptonshire I, No. 110.
[143] *CPR:1422-1429*, p. 233.

The next example is an in-depth assessment of the context of the application of the legislation, issues of maladministration, and the role and desired competency levels of the masters. The advowson of the hospital at Brackley came to John, lord Lovell and Holland (d. 1408), through his marriage to Matilda Holland (d. 1423). Lovell was a wealthy and prominent courtier during the reign of both Richard II and Henry IV, as well as a dominant and influential local figure in Oxfordshire and Wiltshire.[144] The master during this period was John Brokehampton (d. 1423).[145] Contrary to the view of the historian John Clarke, this study has not found Brokehampton guilty of the maladministration of the assets of the house.[146] Instead, it firmly locates Brokehampton as an integral member of Lovell's network of power who endeavoured to run the hospital according to his patron's vision. Following the death of Lord Lovell and Holland, Brokehampton hired public notaries to assist him with hospital matters – an action which in itself indicates the complexity of the issues which this hospital master was confronted with at this time.[147] Far from being a corrupt enemy of the hospital, Brokehampton held the hospital in such high regard that he was buried in its cemetery.[148] Lovell himself left the disposal of his goods for pious purposes to his wife Matilda and requested burial in the church of the hospital.[149] These matters, however, were not as straightforward as they may first appear. In *c.* 1381, Lord Lovell, perhaps in the wake of the Peasants' Revolt, considered closing the hospital; and in 1420 Maud Lovell requested a licence from the king to convert the hospital into a house of friars preacher.[150] Thus, both patrons appear to have been dissatisfied with the hospital's operations, and yet neither of the events came to pass during their lifetime.

[144] Simon Walker, 'Lovell [Lovel], John, Fifth Baron Lovell (*c.* 1342-1408), Courtier and Royal Councillor', *ODNB* (Oxford, Sept. 2004), http://www.oxforddnb.com/view/article/53092 (22 Apr. 2018).
[145] *VCH: Northampton*, vol. 2, eds W. R. D. Adkins and R. M. Serjeantson (London, 1906), p. 153.
[146] Clarke, *The Book of Brackley*, pp. 80-81.
[147] Macray, Northamptonshire II, No. 792.
[148] *The Register of Henry Chichele, Archbishop of Canterbury, 1414-1443*, vol. 1, ed. E. F. Jacob (Oxford, 1943), p. 13.
[149] Walker, 'John Lovell'.
[150] *CCR: 1419-1422, Henry V*, vol. 2 (London, 1932), pp. 125-6; MCA, Brackley D,114.

There were, nonetheless, problems which needed to be rectified. Attempts to address these issues seem to have occurred with the assistance of a reforming and legally astute archbishop of Canterbury – Henry Chichele. Chichele issued revised statutes for the hospital at Brackley in 1425 following the collation of a new master, Thomas Morton, in 1423.[151] Chichele had visited the hospital in his role as metropolitan during the voidance of the see of Lincoln.[152] The archbishop sought to resolve the recent problems which had beset the hospital. The rents and revenues were now so scant that the archbishop feared that it would not be able to continue to support a master, two chaplains, two clerks, and the other burdens. The cause was identified as the carelessness and neglect of the hospital masters, but blame was not apportioned to a specific individual.[153] Although there were a series of events prior to this point which suggest that the process began in 1423.

It seems that Chichele took advantage of the administrative system, arranging for a letter patent to be issued in the brief window between the death of the outgoing patron (7 May 1423) and the taking of fealty from the new patron to select his candidate for presentation (7 July 1423).[154] The instruction was issued on behalf of the infant king on 22 June 1423 in an opportunistic move which highlights the speed at which the machinery of local and central government could operate. The letter patent was not enrolled, but it was preserved in the bishop of Lincoln's register. The right to present the candidate in 1423 was given as 'by reason of the minority of William lord Lovelle and Holande, who is in our wardship'.[155] However, William was not a minor. His precise date of birth is unknown, but he succeeded his father aged 17 in 1414 and was given possession of the lands inherited from his mother in 1423.[156] What is more likely is that those individuals representing the king exercised his right of *premier seisin* which specifically stated that the king

[151] *Visitations of Religious Houses in the Diocese of Lincoln*, vol. 1, pp. 11-20.
[152] Ibid., p. 15.
[153] Ibid., p. 16.
[154] 'Maud widow of John Lovell, chevalier', 1423, TNA, E-CIPM 22-176; *CFR: 1422-1430, Henry VI*, vol. 15 (London, 1935), p. 42.
[155] *Visitations of Religious Houses in the Diocese of Lincoln*, vol. 1, p. 16.
[156] G. E. Cokayne, *Complete Peerage of England, Scotland, Ireland, Great Britain and the United Kingdom: Extant, Extinct, Or Dormant: Volume V, L to M* (London, 1893), p. 165.

had first seisin until the heir received the inheritance from the king. This is stated in the Statute of Marlborough of 1267.[157] Chichele then explicitly cited the papal decree of 1311, *Quia contingit*, as part of the presentation process binding the new master unequivocally into a wider ecclesiastical framework of control.

Chichele undoubtedly desired further hospital reform, but in order to achieve this he required the support of William the incoming patron. Prior to this point, it is likely that it was the former master Brokehampton's petition to the pope in 1411 which brought the problems of the hospital to the attention of the ecclesiastical authorities. When a solution was not forthcoming, the then patron, Maud, petitioned the king in 1420 to request a licence to convert the hospital into a house of friars preacher which brought the problems to the attention of the secular authorities. Chichele's ordinances were designed to assist patrons and masters by providing unambiguous guidance outlining rules regarding the governance of the hospital, the celebration of divine services in the chapel, and the support of future burdens. All that was required was the approval of the current patron. The order was wide ranging and detailed in nature. In the first instance, it addressed the issue of what it believed to be the cause of the current problem, the lax behaviour of previous masters, by stipulating that a master should be ordained into priesthood within one year of his appointment, and that he should be well-regarded in both temporal and spiritual matters. Here, then, a clear indication of his wide-ranging responsibilities and expected competency levels. The order then stipulated the skills required of the clerical staff: the chaplains should have 'an understanding of reading and singing…approved in life, manners, behaviour and apparel', and the clerk should be sufficiently lettered. In addition, the precise duties of the choristers were specified: for example, they should say matins, vespers, and other hours celebrating daily together in a low voice in the said chapel.[158]

[157] *Statutes of the Realm*, vol. 1, p. 24; *English Historical Documents, 1189-1327*, p. 386.
[158] *Visitations of Religious Houses in the Diocese of Lincoln*, vol. 1, pp. 17-18; MCA, C62.

The archbishop's ordinances were explicit: these individuals were accountable to the master who could dismiss them and in the case of the chaplains set their salaries. The order then proceeded to issue guidance with regards to the behaviour of the clerics. For instance, it specified that they should not 'keep chattering in the time of divine service or roaming about outside the quire', and it stipulated that they should be dressed in white surplices.[159] Measures were then put in place to prevent the unauthorised removal of goods by the master which permitted the bishop of Lincoln to canonically remove the master in these circumstances. Furthermore, the archbishop prescribed the exact charitable services which should be provided including the distribution of six loaves of bread worth three pence to six poor persons in the chapel every Friday, and six or four beds allocated for the use of poor pilgrims or travellers free of charge and usually for one day only. [160]

Subsequently the system of control and accountability continued to evolve. In 1428, the orders appear to have been inspected by Bishop Gray on behalf of the master, and with the consent of the patron, to confirm their legality with respect to the hospital's canons (*canonicis ipsius hospitalis*). The official decreed that the premises were just and reasonable, and proceeded to approve, ratify, and confirm them by issuing the said document. In 1432, the new bishop of Lincoln, William Gray, issued his approval.[161] In 1442, a further inspection took place in the chancel of the church hospital. On this occasion, the master and fellows of the hospital were brought before the bishop of Lincoln, William Alnwick, to prove their qualifications to serve in their positions. In the case of the master this comprised his certificates of institution and induction, for a member (*collegiatus*) his letter of orders, and for the chantry-priest (*stipendiarius celebrans in eodem hospitali*) his letter of orders. Furthermore, the bishop sought confirmation from the master that silver coins were being assigned to the poor as given in the ordinances (*et si denarios pauperibus dandos iuxta ordinacionem tribuisset*). That master was still Thomas Morton of York Cathedral (and this is stated in the visitation records): evidently, Chichele's vision

[159] Ibid.
[160] Ibid., p. 19.
[161] Ibid., p. 21.

and ability to execute it was initially successful as the non-resident master does not appear to have caused significant difficulties for the hospital at this time. [162]

The idea of a non-resident master may seem somewhat at odds with the desire of patrons to support hospitals. However, it is the thought behind the appointment which is the significant factor. Morton was appointed by Chichele on behalf of the acting patron – i.e. the infant king. It was of such importance to Chichele that it was not merely a line or two in his register, it was a carefully documented process resulting in – and this is worth emphasising – the archbishop of Canterbury issuing statutes for a hospital in a small town. Morton did not need to be resident: his role was to educate the secular chaplains – this was a key part of Chichele's reforming strategy.[163] Part of that process was to ensure that the individuals held sufficient qualifications to perform their duties, and in the case of the chaplains they were rewarded through their stipends. The post of master would be compatible with any benefice with or without cure of souls, the master need not be resident, and the master should ensure that the endowments of the hospital were used as intended.[164] These requirements clearly reflect the key components of the decree being the protection of assets and staff competency. In order to continue to survive in the short term, this hospital required a cohesive set of reformed procedures and the agreement of interested parties, however, the process could not have occurred without the approval and direct intervention of the patrons.

There are further examples of attempts to protect these hospitals. In a similar case at the hospital in Kepier, the patron, the bishop of Durham, instigated a visitation in 1437.[165] The instructions were standard requesting an inquiry into the 'the condition of the governance and administration of the aforesaid hospital and of the goods' following accusations of failings, crimes, and excesses

[162] *Visitations of Religious Houses in the Diocese of Lincoln*, vol. 2, ed. A. H. Thompson (Horncastle, 1918), p. 39.
[163] E. F. Jacob, *Henry Chichele* (London, 1967), p. 72.
[164] *The Register of Henry Chichele*, vol. 1, p. 14.
[165] *The Register of Thomas Langley, Bishop of Durham, 1406-1437*, vol. 1, ed. R. L. Storey (Durham, 1956), p. 37.

which the bishop ordered to be reformed and corrected.[166] In this instance, the bishop expressly stated that the hospital was not to be raised up or deemed an ecclesiastical benefice, that he did not wish the nature or foundation of the hospital to change, and it was to 'remain in the character and the form of the common law'.[167] The aim of the bishop was the 'increase of the divine worship of the poor spending time in the hospital, and all who flock to it daily for sustenance'.[168] The master was cleared of the charges and granted his office for life.[169] In an earlier case, when the bishop of Durham ordered an inquiry into the dereliction of duty by the master in 1311, it was stated that there were 30 brothers there, six of whom were chaplains, fifteen were laymen, and the remainder were the poor of Christ. The master had permitted a decline in the divine services and the sustenance of the poor – again, no preferential treatment of chantry services here – and the bishop was concerned that souls were now both being put in danger.[170] The master continued to serve.[171] The bishops were acting in their capacity as patrons of the hospital in order to ensure the supply of its services, but their somewhat lenient approach again suggests that the problems could not be laid at the feet of the said masters. Therefore, without such interventions, it is at least questionable whether this hospital would have been able to overcome the pressures which the masters had clearly encountered.

It is sometimes difficult to fully appreciate the pressures under which these houses operated and the lengths to which the masters had to go to try to ensure that they could endure. The following requests for exemption from taxation indicate the predicaments faced by the hospital at Ospringe. They also highlight the extent to which hospital revenues could be taxed in the mid-fourteenth

[166] Ibid. '*et super statu regimine et administracione hospitalis predicti et bonorum', 'defectus crimina et excessus eorumdem corrigenda et reformanda*'.
[167] Ibid., '*Nolumus...ipsum hospitale erigatur seu beneficium ecclesiasticum censeatur', 'volumus quod idem hospitale in natura et forma juris communis remaneat*'.
[168] Ibid., '*ad divini cultus augmentum pauperumque in ipso hospitali degencium et aliorum ad idem confluencium indies sustentacionem*'.
[169] Ibid., p. 43 '*Acquietancia facta ricardo Bukley custodi hospitalis de Kepier super compotum administracionis sue bonorum ejusdem ac commissio custodie ejusdem facta eidem domino Ricardo ad vitam*'.
[170] *The Register of Richard de Kellawe*, vol. 1, pp. 34-5.
[171] *Fasti Dunelmenses: A Record of the Beneficed Clergy of the Diocese of Durham Down to the Dissolution of the Monastic and Collegiate Churches*, ed. D. S. Boutflower (Durham, 1926), p. 129.

century by both lay and ecclesiastical authorities and, thus, the importance of obtaining an exemption of this nature – in other words its value lay in its protection of income to be used in full for its intended purpose.

> 'the said master and brethren and their successors shall be quit of all aids, contributions and tallages on account of the tenements, rents, goods and chattels of their hospital; so whenever the clergy of the realm or of the province of Canterbury grant to the king a tenth or other proportion of their spiritualities, or when the communities of counties of the realm or the citizens and burgesses of the cities and boroughs thereof grant a tenth or a fifteenth or other proportion of their temporalities, or when the king or his heirs tallage their demesne throughout England, or when the pope imposes a tax of a tenth or other proportion upon the clergy aforesaid, granting it, or a part of it, to the king or his heirs, neither they nor their lands, tenements, rents or goods shall be taxed, tallaged or in any way molested thereof.'[172] **1338**

The second example demonstrates that without such assistance from its patron this hospital at least would have been unable to function:

> 'Release to the master and brethren of the hospital of St Mary, Ospreng, of the king's progenitors, from fifteenths, the ninth of sheaves, lambs and fleeces and the wools lately granted to the king by the commonalty of the realm; as it has been testified to the king that without such relief the hospitality, chantries, and other works of piety incumbent on the hospital cannot be maintained.'[173] **1342**

This section has demonstrated the key role of the master in the successful operation of these houses. Masters were often responsible for both temporal and spiritual matters; they were tasked not only with protecting the assets of these houses but also delivering their services. As such their character and ability to perform their duties were scrutinised by patrons, bishops, and monarchs – and even discussed in Parliament. Patrons were not averse to requesting inspections if a dereliction of duty or bad governance was suspected. However, the masters concerned were often acquitted, and it seems that many of the problems which beset hospitals throughout their existence, but most especially in the fifteenth century, were of such magnitude that masters could not resolve them in isolation. Additional support was therefore garnered from the most talented officials of the day, but even their efforts brought limited results. Legislation, protection,

[172] *CChR: 1327-1341*, p. 444.
[173] *CPR: 1340-1343*, p. 516.

petitions, repeated interventions, inspections, and new regulations could not save these houses from closure. Therefore, the position of master was necessary but not sufficient to ensure the survival of these houses.

Conclusion

This chapter has demonstrated that the problems which these hospitals faced in the fourteenth and fifteenth centuries were complex and multi-faceted. What is most apparent is that the early fourteenth century was a challenging period for these houses which were tasked with providing sustenance for the needy at a time when that need temporarily grew, but their ability to meet that demand fell. Nevertheless, many were well-supported, rose to the challenge, and continued to function. The direct evidence for the effect of pestilence is limited, although there are some tentative glimpses into failing crop levels and non-resident poor requiring assistance. It would, however, be difficult to imagine that the Black Death did not wreak havoc on these houses which catered for the needy in life and death. Again, that many survived is a testament to their strong foundations – many of the weaker houses having already disappeared from the historical record in the thirteenth century.

During the period under review, this study did not find evidence that the provision of chantry masses took precedence over the provision of services to the needy in life. The poor, although often no longer resident (and perhaps many never were), still received assistance via distributions of food. During the fourteenth century, it is known that some hospitals at least were still caring for residential poor and sick even if they were rarely mentioned. That care extended to wealthier corrodians who it seems were unable to rely on a household to assist them. Thus, rich and poor faced the same issues. In the later Middle Ages, it is true to say that hospitals were tailoring their services to meet demand, but this study argues that this occurred within their founding remit. As part of this process, a natural degree of specialisation started to develop through a focus upon hospitality or educational services. In order to achieve this, many hospitals formed stronger bonds

within the parish structure and received indirect government support through tax exemptions – this, it could be argued, represented a degree of public funding to augment their private corrodarian or indulgence-based income in the mixed economy of care.

The problems which beset these hospitals in the early fifteenth century do not appear to be purely the results of bad governance by the masters. Masters were charged with protecting hospital assets, but it is evident that this was no longer always a viable objective. It seems that despite the efforts of at least two archbishops, several patrons, government officials, and local dignitaries the problems were of such immense proportions that not even a radical overhaul and new rules could save many of these houses. In the case of Brackley, Chichele's reforms ultimately failed and the hospital was appropriated to Magdalen College, Oxford, in the latter half of the century. The fault cannot be laid purely at the feet of the masters, unless, in the case of Ospringe, the monarch and his officials were so negligent that they repeatedly appointed wardens, resident or not, in the knowledge that they did not possess the requisite skills. This seems to be an unlikely scenario when there was clearly such a focus on their standing and qualifications and the ever-present impending threat of repeated visitations – it would serve no useful purpose to the patron or society in general.

Rather hospitals faced genuine difficulties which prompted the 1414 petition to Parliament. These problems had their roots in the early fourteenth century and despite national and international attempts to legislate against many causes, many houses simply could not continue to operate throughout such challenging times. These were nationwide problems from Brompton Bridge in North Yorkshire, via Brackley in Northamptonshire, to Ospringe in Kent. When hospitals were unable to tailor their services or control their assets, patrons went to great lengths to annex or appropriate these institutions to as similar a house as possible. The provision of hospitality, residential or otherwise, was of equal standing to the provision of chantry services – in fact, they were part of a unifying objective to care for those in need in life and death through acts of individual and collective piety. The research found that where evidence has survived, the decision

to operate or not rested ultimately with their legal patron. That said, there are many houses which disappeared from the historical record for reasons which are likely to remain unknown.

Conclusion

This research project was designed to shed a light on hospitals in small towns and villages in England in the later Middle Ages. It sought to gain a better understanding of the lesser-known houses in what has been termed the many small and obscure places at the base of the urban hierarchy. The specific aims of the present research were twofold. One objective was to establish whether early hospitals can be defined by the services they provided as opposed to their guests. The second goal was to ascertain why some were able to endure longer than others. The project adopted a quantitative and qualitative approach in order to combine the extant fragmentary evidence for some hospitals with the copious evidence for others. It achieved this through the project's bespoke database designed to address specific questions and an in-depth analysis of the hospitals at Aynho and Brackley. The research comprised a study of 72 hospitals in total and represents the first comprehensive examination of hospitals in smaller urban areas or villages across England in the later Middle Ages.

The study argues that the provision of hospitality, chantries, and other works of piety represented the unifying feature of these houses as opposed to classification by type of inmate. Hospitality was the pivotal service offered by these institutions and, as such, was implicit within their most commonly-used name. In addition, the evidence reveals that care of the souls of the living and the dead was an important service performed by several hospitals within the sample. In the cases explored herein, those functions formed part of the founding vision or were implemented in their formative years. However, it must be acknowledged that there is some doubt, albeit surprising, as to whether all hospitals performed this function. This is due to the fragmentary nature of the evidence for certain hospitals within this study. For those that did, though, the functions of hospitality and spiritual services were given due regard. When, for example, a hospital fell under investigation as its provision of hospitality, chantries, and other works of piety had fallen into decline, attempts were made to resurrect all functions.

There is no doubt that these houses were unified by their services as opposed to their type of guest. Their visitors were wide-ranging and not limited to the sick and the poor – nor were they ever intended to be limited in this way. Customary obligations to provide hospitality to patrons or their nominees arose on the creation of the endowment or subsequent gifts. This is also known to have applied to general benefactors who donated land in order to share in the benefits of the house. Over time, such was the burden of the provision of hospitality that legislative measures were put in place to protect these and other institutions. Some were able to reduce the financial pressures by tailoring their provision of hospitality to fee-paying guests, be that on a long- or short-term basis. This has been regarded by some scholars as an imposition on these houses or a distraction from their main purpose, but this study takes the view that the primary function of a hospital was to care for those in need – rich or poor.

A key finding to emerge from the research was that these houses were remarkably institutionally resilient. Hospitals for which founders are known had a minimum average lifespan of 316 years, and even those for which little is known the minimum average was 151 years. One of the reasons for the success of many houses was their ability to specialise their services in order to compete in the mixed economy of care. The provision of hospitality was a form of care which could be adapted to meet the needs of specific individuals. Thus, some hospitals tailored their functions to cater for passing travellers and were described as hospitals or inns. Others appear to have focused on their spiritual services and were termed hospitals or chapels. In the latter case, however, the study did not find that the poor lost out to the performance of chantry masses. Time and again, the poor figured prominently in reforming visions. At times it may appear that hospitals were chantries, but there is evidence to suggest that the poor flocked to these houses on a daily basis. It, therefore, cannot be assumed that the lack of beds within the precinct indicated a rejection of this category of guest. Their residential accommodation was adapted over time to serve the needs of a variety of individuals – be that a local pauper or a passing monarch.

Many hospitals were able to function over prolonged periods of time as a result of the systems within which they operated. This comprised a support network of temporary patrons. Bishops were permitted to issue corrections to hospitals within their diocese which were largely designed to ensure the competency of the masters and to protect the hospital's assets. The general system of presenting candidates for induction to their office, or collation if the bishop was the legal patron, was designed to ensure that individuals were vetted before taking up their post. It is true to say that the presentation of a candidate or the issuing of a licence to elect was part of a patron's role, but what an important part it was. Masters held responsible positions and it was essential that patrons selected them with care. This, unsurprisingly, did not always occur. Yet the system was designed to correct abuses. That could be through secular or ecclesiastical visitations or legal action to recover grants of land which had been misappropriated. What is most evident, however, is that without the patron's support, abuses persisted. A facet of this would be the need to select a competent master to govern the house and protect the hospital's assets.

This obligation was enshrined within canon law in the early fourteenth century in the decree known as *Quia contingit*. This decree highlighted a myriad of abuses perpetrated by those responsible for running these institutions. It obliged local ordinaries to hold patrons to account, and patrons to hold masters to account. It is perhaps slightly misleading though: it paints a picture of lax management, but it does not provide an explanation as to why these problems occurred. At a local level, where the evidence has survived the passage of time, it can be seen that the early fourteenth century was a difficult time for hospitals in small towns and villages. At Brackley in the early fourteenth century, episcopal and papal indulgences were issued to generate demand for their services and attract donations. At the same time, agreements were made based on the number of successful crops harvested and the allocation of tithes requested.

At the head of the system of protection was the ultimate patron, the king. The king held the right to act as a temporary patron at pivotal moments in a hospital's life. This occurred at times when the advowson was forfeited to the Crown and at times when the new patron was a minor. That

kings could argue that time did not run against them and sought to extend their rights of appointment to office demonstrates that monarchs wanted to assist these houses. Of course, it could be argued that kings were merely providing an income to their favoured servants, but it seems there was often something more behind these actions. The care of an injured soldier sent to a hospital, the gifts of fuel and timber to provide hospitality to the inmates, and the timely interventions when accusations of abuses were received add weight to this line of thought. These beneficial interventions were not only extended to royal hospitals in this study. The interventions might have been modest grants of land, exemptions from taxation, letters of protection, or grants of mortmain licences; nevertheless, they mattered and assisted these houses to function.

That assistance is more apparent when the patron was a tenant in chief of the king. There is evidence which requires further exploration over a wider sample base that suggests that when a house was associated with a beneficial intervention by the king, it survived for a longer period of time. In addition, when the identity of a founding patron or earliest patron is known, the minimum average lifespan of a house exceeded that of those with unknown equivalent patrons. Known patrons were unsurprisingly more likely to be higher-ranking nobility who have left a trace in the records. That is not to suggest that the king was directly responsible for a hospital's ability to endure throughout the period in question. Even when the axe fell during the Reformation, three houses within this sample managed to escape immediate suppression. Yet there is no doubt that the system could be used to rectify abuses and issue reforming statutes, albeit sometimes on behalf of the king. Within that system, the significance of archbishops and bishops, whose duties also comprised the facilitation of the provision of hospitality and obviously spiritual services to all in need, is plain to see. When a hospital was in the patronage of a bishop, 80% survived into the sixteenth century. This figure fell to 33% for monastic houses.

Several patrons looked to find alternative uses for hospital endowments when they decided to terminate their relationship with their house and agree to their inevitable closure. This could comprise their appropriation to another hospital, a monastery, or a university college. Some

hospitals sought to endure through the specialisation of their activities into either of the two core functions – hospitality or chantry masses. Yet, the evidence has shown that regardless of how many visitations took place, refoundations, corrections, and legislative measures put in place, a legal patron held the metaphorical keys to the house. Masters were invested with quotidian responsibilities, but the patron could prevent an institution from functioning by permitting the office of master to lapse, thereby taking direct responsibility for the hospital endowment. There is evidence that patrons contemplated these decisions and that they did not come to fruition at that time, but the fact remains it was their decision to offer a stay of execution. This thesis, therefore, concludes that hospitals in small towns and villages can be defined by their provision of hospitality, chantries, and other works of piety, and that their ability to ultimately endure rested upon their patron.

A discipline of relevance, it has been said, is knowing where to go next. The results of this research project suggest a return to the study of individual hospitals, which were much maligned by Guy in 1985, is now required. This time, however, these studies should avoid focusing upon star names and momentous dates. Instead, they should consider broader themes such as the role of patrons, masters, land-holding patterns, commercial ventures, disease in a local context, interactions with their immediate hinterlands, the specific services they offered, and who exactly they sought to serve. For there is still no predicted institutional response to the Black Death – this study would suggest the key period for houses in this study was the late thirteenth and early fourteenth centuries. Nor is there yet a widely discernible graph of foundation and decline. Thus, of the writing of hospital history, there should be no end.

Appendix I: Alphabetical Listing of Hospitals

Key:

- () = alternative name
- ✓ = agrees with the historiography
- × = differs from the historiography
- P = historiography inconsistent
- [] = denotes hospital classification for primary source purposes: Core, Semi-Core, and Ancillary

For information concerning the dates entered into the project database which are given below, please see Table 3 in Chapter One. *VCH* volumes are as listed in the bibliography.

1) Armston, Hospital of St John the Baptist, Northamptonshire [Semi]

A copy of the 1232 foundation agreement between Ralph de Trubleville, sheriff, and the parson of the parish church is contained within the registers of Bishop Hugh of Wells.[1]

The *VCH* stated the hospital was dissolved in 1535-6, but a master was appointed in 1540.[2] The advowson/title in the hospital was surrendered to the king in 1547 at which point it was noted as a hospital or inn.[3]

	Database Entry	Historiography
Year of Foundation or First Reference	1232 = 1230	✓
Year of Closure or Last Reference	1547 = 1540	×

2) Aynho, Hospital of St James and St John, (St Mary and St James), Northamptonshire [Core]

The hospital was founded in 1189 by Roger son of Richard, first baron Warkworth. Clay and K&H (1953) have later dates. The charter is in MCA.[4]

K&H (1953) stated the hospital existed post appropriation to Magdalen College, Oxford. The *VCH* noted 1483 as the key date, but the formal annexation did not occur until 1485.[5]

	Database Entry	Historiography
Year of Foundation or First Reference	1189 = 1180	P
Year of Closure or Last Reference	1485 = 1480	×

[1] *Rotuli Hugonis de Welles*, vol. 2, pp. 256-8.
[2] *VCH*: *Northampton*, vol. 2, pp. 149-50.
[3] *CPR: 1547-1548*, p. 176.
[4] MCA, Aynho 71; Macray, Northamptonshire III, Nos 1-2; *EEA 4: Lincoln, 1186-1206*, ed. D. M. Smith (London, 1986), p. 6.
[5] MCA, Aynho 80; Macray, Northamptonshire III, No. 84.

3) Bagby, Not Dedicated, Yorkshire [Ancillary]

In 1148, Pope Eugenius III confirmed a grant of land on which was built a poor hospital with four bovates of land (*et terram in qua edificatum est hospitale pauperum cum quator bovatis terre*) to the hospital of St Leonards, York.[6] Dugdale recorded a grant of land by Gundreda, wife of Nigel de Albini (d. 1129), with four bovates located in Bagby and stated that the hospital was extant in 1200 – a date which the *VCH* misprinted as 1290.[7] Nigel de Albini's first wife was the wife of Robert de Mowbray, earl of Northumberland: this may account for Clay's founding patron recorded as Mowbray.[8]

The printed bishops' registers and the hospital of St Leonard's cartulary did not yield further information.[9]

	Database Entry	Historiography
Year of Foundation or First Reference	-1148 = 1130	✓
Year of Closure or Last Reference	*c.* 1200 = 1200	×

4) Beck, Hospital of St Thomas the Martyr, Norfolk [Core]

Founded by William de Bec, the vicar of Wood-Dalling, by 1224. Francis Blomefield made reference to a deed by the founder in 1224, but this does not appear to have survived and Blomefield did not state where the deed was located.[10] The patronage was given to the bishop of Norwich on foundation.[11] The hospital had a large endowment of land in over 30 parishes.[12] K&H (1971) recorded the foundation date as +1216.

A chapel was recorded in 1535 with a master, William Rede, and an endowment.[13] In 1556, the lands formerly belonging to the late chapel were sold to Sir John Perrot, knight.[14]

	Database Entry	Historiography
Year of Foundation or First Reference	-1224 = 1210	P
Year of Closure or Last Reference	1535x1556 = 1540	P

[6] *Early Yorkshire Charters: Volume I*, ed. W. Farrer (Edinburgh, 1914), p. 150.
[7] *VCH: York*, vol. 3, ed. W. Page (London, 1974), p. 301.
[8] C. B. J. Stourton, *History of the Noble House of Stourton: Of Stourton, in the County of Wilts: Volume II* (London, 1899), p. 736.
[9] *The Cartulary of St Leonard's Hospital, York*, ed. D. Carpenter, vols 1-2 (Woodbridge, 2015).
[10] F. Blomefield and C. Parkin, *An Essay Towards a Topographical History of the County of Norfolk*, vol. 8 (London, 1808), p. 191.
[11] F. Blomefield and C. Parkin, *An Essay Towards a Topographical History of the County of Norfolk*, vol. 4 (London, 1775), p. 365; *Index Monasticus*, Taylor, p. 52.
[12] *VCH: Norfolk*, vol. 2, p. 438.
[13] *Valor Ecclesiasticus Temp. Henry VIII: Auctoritate Regia Institutus*, ed. J. Caley, vol. 3 (London, 1817), p. 361.
[14] *CPR: 1555-1557, Philip and Mary*, vol. 3 (London, 1938), p. 299.

5) Bedwyn/Bedwin, Hospital of St John the Baptist, Wiltshire [Ancillary]

The founder might have been Walter le Bret but upon his gift the brethren and sisters were noted as present.[15] In 1264, the master was granted protection with a clause *rogamus* for five years.[16]

In 1360, Peter of Upton died holding land of the warden of the hospital.[17]

	Database Entry	Historiography
Year of Foundation or First Reference	-1264 = 1250	✓
Year of Closure or Last Reference	+1360 = 1370	✓

6) Blean, Hospital of St John, Kent [Ancillary]

It was stated in 1187 that St Thomas consulted the convent at Canterbury to found a hospital at Blean, and it is specifically mentioned in 1188.[18] Additional entries occur in the Pipe Rolls: for example, in 1215/16.[19] A date prior to Thomas Becket's death marks the start of the foundation process.

There is a reference in the Fine Rolls noted by this study of 1220.[20]

	Database Entry	Historiography
Year of Foundation or First Reference	-1170 = 1160	P
Year of Closure or Last Reference	+1220 = 1230	×

7) Brackley, Hospital of Saint James and St John the Apostle and the Evangelist, Northamptonshire [Core]

Founded by Roger de Beaumont, second earl of Leicester, as indicated by reference to his wife Amice in the charter housed in MCA. [21]

The hospital site and advowson were transferred to Bishop Waynflete in 1484 to endow Magdalen College, Oxford.[22] By 1494, the fellows agreed to lease the 'mansion' (*man[s]io sive hospitali*) and its lands to a gentleman for twelve years, specifying only that board and lodging should be available for two days and nights for the use of college officers.[23]

	Database Entry	Historiography
Year of Foundation or First Reference	*c.* 1160 = 1160	x
Year of Closure or Last Reference	1484x1494 = 1490	P

[15] 'A Forgotten Bedwyn Experience' in *Wiltshire Archaeological and Natural History Magazine*, 39 (1915), pp. 380-1.
[16] *CPR: 1258-1266, Henry III*, vol. 6 (London, 1910), p. 306.
[17] *Abstracts of Wiltshire Inquisitiones Post Mortem: King Edward III, A.D. 1327-1377*, ed. E. Stokes (London, 1908), p. 264.
[18] *Chronicles and Memorials of the Reign of Richard I, Volume II*, pp. 45, 169.
[19] *Pipe Roll 17 John and Praestita Roll 14-18, Roll of Summonses 1214, Scutage Roll 16 John*, ed. P. A. Brown and J. C. Holt (London, 1964), p. 29.
[20] Henry III Fine Rolls Project, https://finerollshenry3.org.uk/content/search/do_text_search 1220 (15 April 2019).
[21] MCA, Brackley 39; Macray, Northamptonshire I, No. 2.
[22] MCA, Brackley B207; Macray, Northamptonshire II, No. 873.
[23] MCA, Brackley B132; Macray, Northamptonshire II, No. 884.

8) Braintree, Hospital of St James, Essex [Ancillary]

This hospital was granted protection with a clause *rogamus* by Henry III in 1229 (Branketre).[24]

	Database Entry	Historiography
Year of Foundation or First Reference	-1229 = 1210	✓
Year of Closure or Last Reference	+1229 = 1230	✓

9) Brompton Bridge (Catterick), Hospital of St Giles, Yorkshire [Core]

The earliest source is a grant by Hugh son of Jernegan in *c.* 1182-1203.[25] Clay recorded a date of 1231. It is not known why Clay cited H. Fitzrandolph as the founder, but it is most likely that she was referring to Henry Fitzrandolph of Ravensworth. This is feasible as a chantry founded by Henry, lord Fitzhugh, in 1468 in Ravensworth Castle included prayers for the dead of the hospital.[26] This is also the last-known reference to the hospital.

	Database Entry	Historiography
Year of Foundation or First Reference	1182x1203 = 1190	P
Year of Closure or Last Reference	1468 = 1460	×

10) Broughton near Malton, Hospital of St Mary Magdalene, Yorkshire [Ancillary]

Eustace Fitzjohn, lord of Alnwick, founded this hospital in *c.* 1154.[27] It is the view of this study that the hospital was not a dependency of Malton Priory as the advowson was in the king's gift in 1399.[28]

The Broughton parish entry in the *VCH* contains a reference to its dissolution in 1618/9 when it sheltered two men and three women.[29] The *Valor Ecclesiasticus* Volume 6 and Edward VI's Patent Rolls are silent. There is a chantry listed in the church of Broughton which might have been connected to the hospital.[30]

	Database Entry	Historiography
Year of Foundation or First Reference	*c.* 1154 = 1150	✓
Year of Closure or Last Reference	1618 = 1610	×

[24] *CPR: 1225-1232, Henry III*, vol. 3 (London, 1903), p. 270.
[25] *Early Yorkshire Charters: Volume 5: The Honour of Richmond, Part 2*, p. 47.
[26] *CPR: 1467-1477*, p. 90.
[27] Dugdale, *Monasticon Anglicanum*, vol. 6, part 2, p. 780.
[28] *CPR: 1396-1399, Richard II*, vol. 6 (London, 1903), p. 468.
[29] *VCH: York*, vol. 1, ed. W. Page (London, 1914), p. 531.
[30] *CPR: 1548-1549* (London, 1924), pp. 270, 272.

11) Buckingham, Hospital of St John the Baptist, Buckinghamshire [Ancillary]

P. K. Poornan surmised that the hospital was founded when the manor of Buckingham came into the hands of the Braose family in the late twelfth century.[31] This is based on an inquisition *ad quod damnum* which took place in 1289/90 which stated that the hospital was founded by William Frechet in the time of John de Braose.[32] It also revealed that the archdeacon of Northampton refounded the hospital and gave it to the hospital of St Thomas Acon.[33] Grants of land remained attached to the property, and a chantry priest was still in situ under the order of St Thomas Acon in London at the Reformation. In 1540/1, the lands formerly of the College of Acon were granted to a servant of Henry VIII.[34]

	Database Entry	Historiography
Year of Foundation or First Reference	-1200 = 1190	✓
Year of Closure or Last Reference	1535-8 = 1530	×

12) Burford, Hospital of St John the Evangelist, Oxfordshire [Semi]

R. H. Gretton hypothesised that, given the hospital was in the patronage of John Giffard 'holding the manor' as recorded in the Assize Rolls of 1268, it was founded by a previous lord of the manor.[35] Gretton calculated that the most likely candidate would have been William, earl of Gloucester (d. 1183).[36] A recent study of Burford does not add any further information.[37] William inherited the title of earl in 1147 and died in 1183. The earliest evidence in this study was a close roll entry in 1226.[38]

This hospital was surrendered to the Crown commissioners by the master in 1538.[39]

	Database Entry	Historiography
Year of Foundation or First Reference	-1226 = 1210	✓
Year of Closure or Last Reference	1538 = 1530	✓

[31] Poornan, *The Royal Latin School, Buckingham*, pp. 10-12.
[32] Ibid., p. 167.
[33] Ibid., p. 170-2.
[34] *L&P*, vol. 16, p. 716.
[35] R. H. Gretton, *The Burford Records: A Study in Minor Town Government* (Oxford, 1920), pp. 257-8.
[36] Ibid., p. 10.
[37] A. Catchpole and R. Peberdy, *Burford: Buildings and People in a Cotswold Town* (Chichester, 2008).
[38] *Rotuli Litterarum Clausarum (1224-1227)*, vol. 2, p. 135.
[39] Gretton, *The Burford Records*, p. 264.

13) Calne, Hospital of St John the Baptist (& St Anthony), Wiltshire [Ancillary]

The chantry certificate stated that this hospital was founded by Lord Zouche. It is possible that this referred to Alan la Zouche (d. 1190). It is first recorded when Richard the Tanner quitclaimed a house to Ernest the Presbyter and the brethren in 1202.[40]

The *VCH* recorded a master occurred from 1535-48. The site and endowment were granted to a London gentleman in 1546.[41]

	Database Entry	Historiography
Year of Foundation or First Reference	-1190 = 1180	P
Year of Closure or Last Reference	1548 = 1540	✓

14) Cannock, Hospital of St Mary, Staffordshire [Ancillary]

This hospital is recorded in the Close Rolls in 1220.[42]

The *VCH* referred to arrears on a sheriff's role at TNA in 1287 (from 1230) and surmised that it did not exist at some point after this date.

	Database Entry	Historiography
Year of Foundation or First Reference	-1220 = 1210	✓
Year of Closure or Last Reference	+1287 = 1290	P

15) Castle Donington, Hospital of St John the Evangelist, Leicestershire [Semi]

The register of Bishop Hugh of Wells stated that the hospital was erected by 'J' sometime Constable of Chester.[43] This was John Fitzrichard, lord Halton.[44] The dates in the historiography range from 1535-47. The *VCH* date, based on the chantry certificate was entered into the database.

	Database Entry	Historiography
Year of Foundation or First Reference	-1190 = 1180	✓
Year of Closure or Last Reference	1547 = 1540	P

[40] A. E. W. Marsh and H. Brakspear, *A History of the Borough and Town of Calne: And Some Account of the Villages, etc. in its Vicinity* (London, 1904), p. 132.
[41] *CPR: 1548-1549*, p. 44.
[42] *Rotuli Litterarum Clausarum in Turri in Londinensi Asservati*, vol. 1, ed. T. D. Hardy (London, 1833), p. 417.
[43] *Rotuli Hugonis de Welles, Episcopi Lincolniensis, A.D. MCCIX-MCCXXXV*, vol. 1, part 1 ed. W. P. W. Phillimore, (London, 1909), p. 252.
[44] Frederick Suppe, 'John (d. 1190), Soldier and Landowner', *ODNB* (Oxford, Sept. 2004), https://ezproxy-prd.bodleian.ox.ac.uk:4563/10.1093/ref:odnb/15854 (25 May 2019).

16) Castleton (High Peak), Hospital of St Mary the Blessed Virgin or (Spital on the Peak), Derbyshire [Semi]

The hospital is said to have been founded by *uxorem domini Peverelle*.[45] The Peverels held the honour of Peverel/feudal barony of Peak until Henry II seized it in 1155.[46]

Le Spytle of Castleton is last noted in the Calendar of Patent Rolls in 1548. It was in the tenure of Thomas Savage who might have been related to the last officially recorded master, George Savage. The letter patent provides a useful account of the lands 'belonging' to the hospital at this point and noted that the chapel was annexed to the mansion.[47] George Savage occurred between 1536 and 1542.[48] The date entered into the database was 1548 on the basis that there was most likely an attendant priest, and definitely a site and endowment, and it is the last-known extant record of the hospital.

	Database Entry	Historiography
Year of Foundation or First Reference	-1155 = 1140	×
Year of Closure or Last Reference	1548 = 1540	×

17) Chesterfield, Hospital of St Nicholas, Derbyshire [Ancillary]

There is doubt as to whether the reference to this hospital in 1276 (concerning protection for the master and brethren at the hospital of St Nicholas) was an error and should have stated the hospital of St Leonard.[49]

	Database Entry	Historiography
Year of Foundation or First Reference	-1276 = 1260	✓
Year of Closure or Last Reference	+1276 = 1280	✓

18) Clyst (Clist) Gabriel, Hospital of St Gabriel the Archangel, Devon [Ancillary]

Orme and Webster's study of hospitals in Devon and Cornwall dated the foundation of this hospital as 1309-12 and attributed it to Walter Stapledon, bishop of Exeter. It also noted that it was funded from the estate of his predecessor, Thomas Bitton.[50] This study takes the view, in accordance with Watson's thesis, that the foundation process often took several years and has therefore concurred with Clay's date.

This hospital was united with the hospital of Warland, Totnes, and the College of the Vicars Choral in Exeter in 1509.[51]

	Database Entry	Historiography
Year of Foundation or First Reference	1276 = 1270	P
Year of Closure or Last Reference	1509 = 1500	×

[45] *Itineraria Symonis Simeonis et Willelmi de Worcestre*, p. 358.
[46] Edmund King, 'Peverel, William (b. *c.* 1090, d. after 1155), *ODNB* (Oxford, Sept. 2004), https://ezproxy-prd.bodleian.ox.ac.uk:2095/10.1093/ref:odnb/22076 (12 Apr. 2020).
[47] *VCH: Derby*, vol. 2, pp. 86-7; *CPR: 1548-1549*, p. 69.
[48] Ibid., p. 87.
[49] *PR: 1272-1281*, p. 187.
[50] Orme and Webster, *The English Hospital, 1070-1570*, p. 217.
[51] Ibid., p. 222.

19) Cookham (Cokeham) in Sompting, Hospital of [(St Mary the Virgin and) St Anthony, Sussex [Ancillary]

The founding document contained in the cartulary of the high church at Chichester stated that the founder, William Bernehus, was of Cocham. Bernehus incorporated a clause which gave the dean and chapter permission to 'institute a fit person' if the patron failed to present a candidate within twenty days of a vacancy occurring. The cartulary recorded in 1278/9 that the dean and chapter acted upon the instruction when the then patron, Sir Walter de la Hyda, failed to present a candidate.[52]

A licence was issued in 1351 for the prior and convent of Hernygham to appropriate the hospital of St Anthony, Coukham which is of their advowson.[53]

	Database Entry	Historiography
Year of Foundation or First Reference	1272 = 1270	✓
Year of Closure or Last Reference	1351 = 1350	✓

20) Cricklade, Hospital of St John the Baptist, Wiltshire [Semi]

The revised statutes issued by Bishop Hallam in 1415 stated that Warin founded the hospital prior to 1231.[54] Warin was a chaplain of Henry III.[55] Watson attributed the statutes to Richard Poore in 1225.[56]

In 1493 the bishop was patron, but the description of the site changed to the hospital 'in Cryklade priory' and the presentations ceased.[57] In 1535, it was recorded as a hospital.[58] In 1548, the lands and buildings of the late priory or free chapel were sold.[59]

	Database Entry	Historiography
Year of Foundation or First Reference	1225 = 1220	P
Year of Closure or Last Reference	1548 = 1540	P

[52] *The Chartulary of the High Church of Chichester*, ed. W. D. Peckham (Lewes, 1943), pp. 170-1.
[53] *CPR: 1350-1354*, p. 64.
[54] *Materials for a History of Cricklade*, ed. T. R. Thomson (Oxford, 1961), pp. 32-4.
[55] *CR: 1227-1231*, p. 487.
[56] Watson, 'Fundatio, Ordinatio and Statuta', p. 246.
[57] *Institutiones Clericorum in Comitatu Wiltoniae, ab Anno 1297 ad Annum 1810,* ed. T. Phillipps, vol. 1 (Middle Hill, 1825), p. 175.
[58] *Valor Ecclesiasticus*, ed. J. Caley, vol. 2 (London, 1814), p. 129.
[59] *CPR: 1548-1549*, p. 378.

21) Croxton, Domus Dei, Norfolk [Ancillary]

The hospital is known to be extant in 1250.[60]

Bishop William Bateman's register stated that the *domus dei* in Croxton was dependent on the hospital at Thetford in 1355.[61] This hospital possessed land in Croxton in 1335, but that is all that is known.[62] At this point, the hospital at Thetford was transferred to the prior and canons of the Holy Sepulchre, Thetford.[63]

	Database Entry	Historiography
Year of Foundation or First Reference	-1250 = 1240	✓
Year of Closure or Last Reference	1355 = 1350	×

22) Devizes, Hospital of St John the Baptist, Wiltshire [Ancillary]

The source for Clay's date of 1207 is unknown. A recent local study did not shed any further light on the matter.[64] The *VCH* date of 1314 referred to the first known presentation of a priest. However, this study has noted Henry III granted beams or timber for the chapel in 1232.[65] It seems likely that Clay had sight of a now unknown document as a market was granted to the town in 1228, and Devizes was a royal demesne.[66]

K&H stated that the hospital was not suppressed, but it was clearly sold to a London based gentleman with its endowment in 1550, and the chapel was noted as 'late'.[67] The hospital was in the king's gift in 1399.[68]

	Database Entry	Historiography
Year of Foundation or First Reference	1207 = 1200	P
Year of Closure or Last Reference	1548-1550 = 1540	P

23) Elleshaugh (Elishaw/Elshaw) near Otterburn in Redesdale, Not Dedicated, Northumberland [Ancillary]

The *Testa de Nevil* recorded the master of the hospital holding 100s of land in free alms of G. de Humframvill.[69]

The last collation by a bishop took place in 1534, and the master remained in post until 1544.[70]

	Database Entry	Historiography
Year of Foundation or First Reference	-1240 = 1230	✓
Year of Closure or Last Reference	1544 = 1540	✓

[60] C. J. W. Messent, *The Monastic Remains of Norfolk & Suffolk* (Norwich, 1934), p. 18.
[61] *The Register of William Bateman, Bishop of Norwich, 1344-1355: Volume II*, p. 166.
[62] *CPR: 1334-1338* (London, 1895), p. 158.
[63] *VCH: Norfolk*, vol. 2, p. 450.
[64] R. B. Pugh, *A History of Devizes* (Trowbridge, 2001).
[65] *CR: 1231-1234*, p. 43.
[66] Pugh, *A History of Devizes*, p. 112.
[67] *CPR: 1549-1551* (London, 1925), pp. 6-7.
[68] *CPR: 1399-1401* (London, 1905), p. 141.
[69] *A History of Northumberland in Three Parts*, part 3, ed. J. Hodgson (Newcastle, 1820), p. 213.
[70] *Fasti Dunelmenses*, p. 22; Hodgson, *A History of Northumberland in Three Parts*, parts 2 and 3 (Newcastle, 1820-32), p. 31.

24) Flixton, Hospital of St Mary the Virgin & St Andrew (Carman Spittel), Yorkshire [Ancillary]

This hospital is said to have been founded by a lord of Flixton in the time of King Athelstan for an alderman and fourteen brethren and sisters.[71]

In 1447, the alderman, brethren, and sisters requested the assistance of the king as they were unable to call upon the support of their founder (patron).[72]

	Database Entry	Historiography
Year of Foundation or First Reference	925x939 = 930	✓
Year of Closure or Last Reference	+1447 = 1450	P

25) Gateshead, Holy Trinity Hospital, Durham [Ancillary]

The founder and date of foundation is unknown. A grant by Osmund, son of Hamon, made a gift of land to the chapel. This has been dated to *c.* 1200 owing to a reference to Bishop Pictavia (1197-1208).[73] In 1226, Henry de Ferlington, constable of Durham, issued a confirmation of the gift of the vill of Kyo in free alms to fund a chaplain and to sustain three poor men to pray for the souls Henry, Simon, and his ancestors.[74]

The hospital was united with the hospital of St Edmund the Confessor by Bishop Farnham in 1248.[75]

	Database Entry	Historiography
Year of Foundation or First Reference	*c.* 1200 = 1200	P
Year of Closure or Last Reference	1248 = 1240	✓

26) Gateshead, Hospital of St Edmund the Bishop, Durham [Semi]

This hospital was appropriated to the nuns of St Bartholomew in 1448. In return, the nuns agreed to provide two chaplains for the chapel; to keep the chancel and buildings belonging to it in good repair; and to pay two pensions - one to the bishop and one to the prior of Durham.[76] A list of rented property belonging to the nuns, dated between 1489 and 1545, recorded the hospital rent as £12 which suggests that the hospital was still active.[77] The last-known master occurred in 1507. The hospital had its own entry in the *Valor Ecclesiasticus* and was valued at £6 2s 4d.[78]

	Database Entry	Historiography
Year of Foundation or First Reference	*c.* 1247 = 1240	✓
Year of Closure or Last Reference	1535 = 1530	P

[71] *CPR: 1446-1452*, p. 69.
[72] Ibid.
[73] J. R. Boyle, *Vestiges of Old Newcastle and Gateshead* (London, 1890), p. 297.
[74] *EEA 25: Durham, 1196-1237*, ed. M. G. Snape (Oxford, 2002), p. 251.
[75] *VCH: Durham*, vol. 2, p. 117.
[76] Ibid., pp. 118-9 citing Bourne, vol. 1.
[77] J. Brand, *The History and Antiquities of the Town and County of the Town of Newcastle upon Tyne* (London, 1789), p. 231.
[78] *Valor Ecclesiasticus*, ed. J. Caley, vol. 5 (London, 1825), p. 310.

27) Gedney, Hospital of St Thomas the Martyr, Lincolnshire [Ancillary]

John d'Ory reached an agreement with the abbey in 1256 to staff the hospital.[79]

This study concurs with the work of Miri Rubin and Dorothy Owen who both referred to this house as a hospital. The former noted its change of function from a hospital for five men to a site distributing alms following its absorption into Creake Abbey.[80] The latter noted that it was founded in the twelfth century and was a dependency of Creake Abbey until it disappeared from the historical record prior to 1345.[81] The year books of Edward III contain details of a legal action brought by the patron against the abbot for failing to provide the requisite services.[82]

	Database Entry	Historiography
Year of Foundation or First Reference	-1256 = 1240	P
Year of Closure or Last Reference	+1341 = 1350	✓

28) Glanford Bridge (Brigg/Wrauby/Wrawby/Paynell's Hosital), Not Dedicated, Lincolnshire [Ancillary]

A papal bull published by the bishop of Lincoln in 1236 contains the earliest reference to the hospital and a patron, and a dispute with Selby Abbey.[83] Watson dated the foundation charter as 1221.[84] K&H, Clay, and the *VCH* date the foundation to the reign of King John.

The *VCH* also stated that there were no masters in the episcopal registers.[85]

	Database Entry	Historiography
Year of Foundation or First Reference	1221 = 1220	P
Year of Closure or Last Reference	+1236 = 1240	P

[79] *Final Concords of the County of Lincoln*, vol. 2, pp. 145-6.
[80] Rubin, *Charity and Community in Medieval Cambridge*, p. 248.
[81] D. M. Owen, *Church and Society in Medieval Lincolnshire* (Lincoln, 1971), pp. 56.
[82] *Year Books of the Reign of King Edward the Third: Year XV*, pp. 448-51.
[83] Dugdale, *Monasticon Anglicanum*, vol. 6, part 2, p. 688.
[84] Watson, 'Fundatio, Ordinatio and Statuta', p. 308.
[85] *VCH: Lincoln*, vol. 2, ed. W. Page (London, 1906), p. 232.

29) Helston, Hospital of St Mary or St John the Baptist, Cornwall [Ancillary]

N. Orme and O. J. Padel suggested that the hospital might have been founded by Henry (senior) in 1220.[86]

The relatively recent work in the *VCH* stated that a deed of *c.* 1240 by Henry son of Henry Fitzwilliam, lord of Kellygren, confirmed his father's grant to the chapel at Menedklodou and the brethren serving the poor there.[87] By 1260, the chapel was documented as a hospital and relocated to a site in the vicinity of a bridge.

Orme's extensive work concerning this hospital provides a dissolution date of 1548.[88]

	Database Entry	Historiography
Year of Foundation or First Reference	*c.* 1220 = 1220	P
Year of Closure or Last Reference	1548 = 1540	P

30) Hemsworth/Emsworth, Hospital of St Mary Magdalene, Sussex [Ancillary]

Simple protection was issued for this hospital in 1252 for three years.[89]

	Database Entry	Historiography
Year of Foundation or First Reference	-1252 = 1240	✓
Year of Closure or Last Reference	+1252 = 1260	✓

[86] Orme and Webster, *The English Hospital, 1070-1570*, p. 193.
[87] *VCH: Cornwall: Religious History to 1560*, eds N. Orme and O. J. Padel (Woodbridge, 2010), p. 192.
[88] *VCH: Cornwall*, p. 194.
[89] *CPR: 1247-1258* (London, 1908), p. 98.

31) Hockliffe, Hospital of St John the Baptist, Bedfordshire [Ancillary]

The Malherbe family were patrons of the hospital in the thirteenth century.[90] The start date selected is that used by Watson.[91]

The *VCH* stated that the hospital was absorbed into Dunstable Priory after 1422.[92] In 1473, the hospital was granted by Edward IV to John Seymour a serjeant of the king's vestiary (*vestibularie*).[93] In the *Valor Ecclesiasticus* there is an entry listed under Dunstable Priory which is for Hocclyff, but it does not mention a chapel or hospital – although it does refer to a Thome Olbo'ne.[94] In 1540, the prior surrendered his house in Dunstable to the Crown.[95] The hospital was granted by the Crown to George Acworth of Potton, Bedfordshire, and Edward Buttler of London in 1545. At this time, the hospital was noted as being in the tenure of Thomas Osborne.[96] It seems, therefore, feasible that the priory was the custodian of the hospital prior to the suppression of religious houses.

	Database Entry	Historiography
Year of Foundation or First Reference	1218 = 1210	P
Year of Closure or Last Reference	1540 = 1540	✓

32) Hungerford, Hospital of St John the Baptist, Berkshire [Ancillary]

Clay stated that this hospital was founded by a king and the patron was the Duchy of Lancaster.[97] In 1232, Henry III granted protection to the hospital.[98] However, Norman Hidden speculated that as the chapel fell under the jurisdiction of the prior of Ogbourne as proctor of the abbey of Bec in Normandy (which had been granted the patronage of the parish church by the earls of Leicester in the early twelfth century), the vicar of the church and chaplain of the hospital might have been the same individual. Hidden also surmised that, as a result of the seizure of alien priory lands in the late thirteenth century and a large payment made by the abbot to retain the abbey's property, the hospital might have fallen into the possession of the Duchy of Lancaster at this time.[99] It is also possible that the hospital was founded by an earl of Leicester and placed under the custody of the prior of Ogbourne. This would explain why it was held by Simon de Montfort, earl of Leicester, and then descended to the Duchy of Lancaster.[100]

	Database Entry	Historiography
Year of Foundation or First Reference	-13th century = 1150	P
Year of Closure or Last Reference	1546 = 1540	✓

[90] *Registrum Rotuli Ricardi Gravesend, Episcopi Lincolniensis, A.D. MCCLVIII-MCCLXXIX*, ed. F. N. Davis and C. W. Foster (Lincoln, 1925), p. 192.
[91] Watson, 'Fundatio, Ordinatio and Statuta', p. 326.
[92] *VCH: Bedfordshire*, vol. 1, pp. 401-2.
[93] *CPR: 1467-1477*, p. 375.
[94] *Valor Ecclesiasticus*, ed. J. Caley, vol. 4 (London, 1821), p. 207.
[95] *VCH: Bedfordshire*, vol. 1, pp. 374.
[96] *L&P*, vol. 20, part 2, ed. J. Gairdner and R. H. Brodie (London, 1907), pp. 543-4.
[97] Clay, *The Mediaeval Hospitals of England* , p. 279.
[98] *CPR: 1225-1232*, p. 475.
[99] Hidden, 'The Hospital or Priory or Free Chapel of St John the Baptist in Hungerford', p. 100.
[100] *PR: 1272-1281*, p. 436.

33) Ivychurch near New Romney, Undedicated Hospital, Kent [Ancillary]

There is only one extant document which detailed a grant to Maud de Bello Campo, countess of Warwick and heiress of Richard son of John tenant in chief, seisin of lands and advowsons including the hospital.[101] This house was included within this sample as Clay recorded the date as 1229 in her appendix, but the accompanying footnote stated 1299 and is probably the aforementioned document.[102] K&H (1971) also stated 1229.

	Database Entry	Historiography
Year of Foundation or First Reference	-1299 = 1280	✓
Year of Closure or Last Reference	+1299 = 1300	✓

34) Kepier by Durham, Hospital of St Giles, Durham [Core]

The hospital was founded in 1112 by Bishop Ralph Flambard.[103]

This hospital was surrendered to the Crown, by a clerk and the masters and fellows in 1545, and was valued at £205 16s.[104] It was subsequently granted to John Cokbourne, lord of Ormeston in 1552.[105]

	Database Entry	Historiography
Year of Foundation or First Reference	1112 = 1110	✓
Year of Closure or Last Reference	1545 = 1540	✓

35) Killingwoldgraves, Hospital of St Mary Magdalene, Yorkshire [Ancillary]

Dugdale gave the earliest extant date at 1169.[106]

In 1547, the master and brethren granted the hospital and its possessions to the king's servant, Michael Stanhope, knight.[107]

	Database Entry	Historiography
Year of Foundation or First Reference	-1169 = 1150	✓
Year of Closure or Last Reference	1547 = 1540	✓

36) Lathbury, Hospital of St Margaret, Buckinghamshire [Ancillary]

This hospital was granted simple protection in 1252.[108]

	Database Entry	Historiography
Year of Foundation or First Reference	-1252 = 1240	✓
Year of Closure or Last Reference	+1252 = 1260	✓

[101] *CCR*: *1296-1302*, p. 288.
[102] Clay, *The Mediaeval Hospitals of England*, p. 298.
[103] *Fasti Dunelmenses*, pp. 45-6.
[104] *L&P*, vol. 20, part 1, ed. J. Gairdner and R. H. Brodie (London, 1905), pp. 27-8.
[105] *CPR: 1550-1553*, p. 360.
[106] Dugdale, *Monasticon Anglicanum*, vol. 6, part 2, p. 650.
[107] *CPR: 1547-1548*, p. 170.
[108] *CPR: 1247-1258*, p. 127.

37) Lechlade, Hospital of St John the Baptist, Gloucestershire [Semi]

Founded by Peter Fitzherbert and Isabella Ferrers/Mortimer prior to 1228.[109] The *VCH* has a date of -1246.

In 1472, Edward IV granted his mother a licence to convert the hospital or house into a perpetual chantry as it had fallen into decay.[110] In 1475, the bishop of Worcester appropriated the hospital to the church.[111]

	Database Entry	Historiography
Year of Foundation or First Reference	-1228 = 1210	P
Year of Closure or Last Reference	1475 = 1470	✓

38) Long Stow, Hospital of St Mary the Blessed Virgin, Cambridgeshire [Ancillary]

Sisters of the hospital held land in 1250.[112]

The patronage of the house was in Richard II's gift in 1392 when the wardenship was granted to John Sherewynd, clerk.[113] In 1414, the rector of Stowe held a tenement known as 'the house of the nuns of Stowe, cos. Cambridge and Huntingdon'.[114] It is possible that this is either the hospital or a tenement in the possession of the hospital. It is not listed in the *Valor Ecclesiasticus*.[115] Nor was it listed in the calendar of Patent Rolls between 1547 and 1553.[116] An earlier date of 1392+ could have been used.

	Database Entry	Historiography
Year of Foundation or First Reference	-1250 = 1240	✓
Year of Closure or Last Reference	+1415 = 1420	×

39) Longbridge, Holy Trinity Hospital, Gloucestershire [Core]

Founded by Maurice, lord Berkeley I (d. 1190).[117]

The *VCH* stated it was suppressed under the Act for the Dissolution of the Chantries. However, this is incorrect as the hospital and its lands were concealed from Henry VIII and his government until the reign of Elizabeth I.[118]

	Database Entry	Historiography
Year of Foundation or First Reference	1170x1189 = 1180	✓
Year of Closure or Last Reference	1561 = 1560	×

[109] *CR: 1227-1231*, p. 82.
[110] *CPR: 1467-1477*, p. 361.
[111] *VCH: Gloucester*, vol. 2, ed. W. Page (London, 1907), pp. 125-6.
[112] *Liber Feodorum: The Book of Fees, Commonly Called Testa de Nevill 1242-1293*, ed. H. C. M. Lyte, vol. 2 (London, 1923), p. 1233.
[113] *CPR: 1391-1396*, p. 37.
[114] *CFR: 1413-1422* (London, 1934), p. 84.
[115] *Valor Ecclesiasticus*, ed. J. Hunter and A. Spottiswoode, vol. 6 (London, 1834).
[116] *CPR: Edward VI, Index* (London, 1929).
[117] *A Catalogue of the Medieval Muniments at Berkeley Castle*, p. 565.
[118] *CPR: 1560-1563*, pp. 329, 357.

40) Lorwing, Undedicated Hospital, Gloucestershire [Ancillary]

In 1225, the patron, Thomas Berkeley I (d. 1243), son of the founder, transferred the hospital to the prior of Stanley St Leonard.[119]

	Database Entry	Historiography
Year of Foundation or First Reference	1170x1189 = 1180	✓
Year of Closure or Last Reference	1225 = 1220	✓

41) Lutterworth, Hospital of St John the Baptist [& St Anthony], Leicestershire [Semi]

An early antiquarian work quoted an unnamed source which stated that the manor of Lutterworth was held of the king for one knight's fee and that the hospital was given seven virgates of land of the fee by Rose and Nicholas Verdon.[120] The founding date used was as given by Watson.[121]

This hospital survived the seizure of chantry lands. The last-known master to be presented was in 1672 by Charles II.[122]

	Database Entry	Historiography
Year of Foundation or First Reference	1219 = 1210	✓
Year of Closure or Last Reference	+1672 = 1680	✓

42) Martin-by-Bawtry, without, Hospital of St Mary Magdalene, Nottinghamshire [Semi]

This house represents another example of a hospital which survived the suppression. It is a rare example as one of its masters, John Slacke, left an account of the hospital compiled for his patron in 1635.[123] It appears to have been refounded in 1390 but forfeited to the Crown in 1405.[124] The *VCH* made reference to the patronage being held by archbishops of York in the pre- and post-Reformation periods.

	Database Entry	Historiography
Year of Foundation or First Reference	-1200 = 1190	✓
Year of Closure or Last Reference	1635 = 1630	✓

[119] Smyth, *The Berkeley Muniments*, p. 69.
[120] J. Throsby, *The Supplementary Volume to the Leicestershire Views: Containing a Series of Excursions in the Year 1790, to the Villages and Places of Note in the County* (London, 1790), p. 216.
[121] Watson, 'Fundatio, Ordinatio and Statuta', p. 334.
[122] *Calendar of State Papers, Domestic Series, of the Reign of Charles II: Preserved in the State Paper Department of Her Majesty's Public Record Office*, ed. F. H. B. Daniell (London, 1897), p. 138.
[123] Thomas Hearne, *The Works of Thomas Hearne, M.A.: Volume IV*, pp. 391-438.
[124] *CPR: 1388-1392, Richard III*, p. 336; *CPR: 1405-1408*, p. 57.

43) Milton near Gravesend, Undedicated/Hospital of St Mary the Virgin, Kent [Ancillary]

The earliest reference noted to date is regarding a hospital in Gravesend in the Pipe Rolls of 1156.[125] It was refounded by Aymer de Valence, earl of Pembroke, in 1321.[126]

In 1524, Henry VIII granted Sir Henry Wyat a licence to found a chantry in Milton comprising two chaplains in the Church of St Mary, Milton, funded by the lands of the hospital and use of the 'mansion' formerly belonging to the master and brethren of the hospital.[127]

	Database Entry	Historiography
Year of Foundation or First Reference	-1156 = 1140	P
Year of Closure or Last Reference	1524 = 1520	✓

44) Mitford near Morpeth, Hospital of St Leonard, Northumberland [Ancillary]

This hospital is said to have been founded by the founder of Brinkburn Priory, William Bertram, and endowed with lands to support one keeper.[128] This study has not uncovered any further evidence.

K&H have stated that this hospital became dependent on Newminster Abbey.[129] A tenement known as the hospital of St Leonard was recorded in the possession of the abbey in 1536.[130] However, there was also a hospital at Morpeth known as Catchburn, and there appears to be some genuine confusion between the antiquarian accounts. The last-known date unearthed by this study is 1464 when Margaret Percy died seized of the advowson.[131]

	Database Entry	Historiography
Year of Foundation or First Reference	-1135 = 1120	P
Year of Closure or Last Reference	+1464 = 1470	×

45) Morpeth, Undedicated Hospital, Northumberland [Ancillary]

This hospital should not be confused with a later foundation at Catchburn by Roger Merlay.[132] In *c.* 1160, William de Merlay granted '*unam carucatam terrae domui infirmorum de Morpathe*' which was of ancient foundation, but its founders are unknown.[133] There is no further extant evidence, and it is possible that this house should not have been recorded as a hospital by K&H.

	Database Entry	Historiography
Year of Foundation or First Reference	-1160 = 1150	P
Year of Closure or Last Reference	+1160 = 1170	×

[125] *The Great Rolls of the Pipe for the Second, Third, and Fourth Years of the Reign of King Henry the Second, A.D. 1155, 1156, 1157, 1158*, ed. J. Hunter (London, 1844), p. 16.
[126] *VCH: Kent*, vol. 2, ed. W. Page (London, 1926), p. 221.
[127] *L&P*, vol. 4, ed. J. S. Brewer (London, 1870), p. 123.
[128] *A History of Northumberland in Three Parts*, part 2, p. 76.
[129] K&H, *Medieval Religious Houses* (1971), p. 291.
[130] *A History of Northumberland*, part 2, p. 77.
[131] Ibid., p. 44.
[132] J. Wallis, *The Natural History and Antiquities of Northumberland*, vol. 1 (London, 1769), pp. 286-7.
[133] T. Tanner, *Notitia Monastica: or, An Account of all the Abbies, Priories, and Houses of Friers Heretofore in England and Wales; and Also of all the Colleges and Hospitals Founded Before A.D. MDXL* (1695), p. 393.

46) Nantwich, Hospital of St Nicholas, Cheshire [Ancillary]

The hospital was granted simple protection in 1276.[134] This study has not uncovered any further evidence as to its foundation. The start date entered into the database concurs with the *VCH*, Clay, and K&H. This is based upon unsubstantiated local antiquarian accounts that the house was founded by the first Norman baron of Wich-Malbank.

This hospital was in the patronage of the Lovell family in the late fifteenth century before eventually falling to the Crown in 1495.[135] The hospital was suppressed in 1548.[136] In 1542, the master of the hospital, William Hill, leased 'all that hys ffree Chappell or Hospitall with all houses, messuages, tenements, lands, tythes, leadds, salt, walling, emoluments' to Raphe Wilbraham of Nantwich for the term of 21 years.[137] It could be argued that the hospital ceased to function at this point.

	Database Entry	Historiography
Year of Foundation or First Reference	*c.* 1084 = 1080	✓
Year of Closure or Last Reference	1542x1548 = 1540	P

47) Nesscliffe (Great Ness), Hospital of St Mary de Rocherio, Shropshire [Ancillary]

John le Strange III (d. 1276) appropriated the hospital to the nuns of Acornbury *c.* 1250.[138] It is not listed in the *Valor Ecclesiasticus.* The chapel listed in the 1971 version of K&H is probably that listed as the 'Nessestrange Vicaria de,'.[139] The last-known date noted in this study was 1258 when the hospital of Acornbury received a grant. This may not be the same hospital, and therefore the *c.* 1250 date decision stands.[140]

	Database Entry	Historiography
Year of Foundation or First Reference	-1250 = 1240	✓
Year of Closure or Last Reference	*c.* 1250 = 1250	×

[134] *PR: 1272-1281*, p. 187.
[135] *VCH: Chester*, vol. 3, eds B. E. Harris and C. R. Ettington (London, 1980); *A History of the Town and Parish of Nantwich, or Wich-Malbank, in the County Palatine of Chester*, ed. J. Hall (Nantwich, 1883), p. 50.
[136] *CPR: 1547-1548*, p. 348.
[137] *A History of the Town and Parish of Nantwich*, p. 51.
[138] *Antiquities of Shropshire*, ed. R. W. Eyton, vol. 1 (London, 1854), p. 276.
[139] *Liber Regis vel Thesaurus Rerum Ecclesiasticarum*, ed. J. Bacon (London, 1786).
[140] *Descriptive Catalogue of Ancient Deeds*, ed. H. C. M. Lyte, vol. 3 (London, 1900), p. 284.

48) Ospringe, Hospital of St Mary the Blessed Virgin, Kent [Core]

The earliest available primary source material relates to a grant of tithes in alms by Henry III to the hospital in order to improve (*ad emandationem*) the hospital.[141]

In 1516, Henry VIII granted the advowson of the hospital to St John's College, Cambridge.[142] It is not listed in the *Valor Ecclesiasticus*, and it is said to have become a secular institution on the death of master Robert Darell (fifteenth century).[143] By 1681, the hospital, 'where in former times, strangers, pilgrims had a 'Mazen due' (Maison Dieu) or house of entertainment', stood in ruins.[144] The hospital for the purposes of this study is taken to cease to exist in 1516 when its endowment was absorbed into the college.

	Database Entry	Historiography
Year of Foundation or First Reference	-1234 = 1220	✓
Year of Closure or Last Reference	1516 = 1510	✓

49) Ospringe, Hospital of St Nicholas, Kent [Ancillary]

The *VCH* suggested that references to this hospital are probably a mistake.[145] The evidence is based upon an entry in the Patent Rolls dated 1241 which merely stated that protection was granted to 'The Hospital at Hospring'.[146] In 1247, Henry III issued protection with a clause *rogamus* without term for the brethren of the hospital of St Nicholas without Ospringe.[147] For the purposes of this project, it is not unusual for hospitals to request protection of this nature. The entry stands.

	Database Entry	Historiography
Year of Foundation or First Reference	-1241 = 1230	✓
Year of Closure or Last Reference	+1247 = 1250	✓

[141] *CR: 1231-1234*, p. 492.
[142] *L&P*, vol. 2, part 1, ed. J. S. Brewer (London, 1864), p. 460.
[143] *Valor Ecclesiasticus*, vol. 6; *VCH: Kent*, vol. 2, pp. 222-4.
[144] *The Manuscripts of His Grace the Duke of Portland Preserved at Welbeck Abbey*, vol. 2 (London, 1893), p. 278.
[145] *VCH: Kent*, vol. 2, pp. 222-4.
[146] *PR: 1232-1247*, pp. 222-4.
[147] Ibid., p. 500.

50) Pelawe, Hospital of St Stephen, Durham [Ancillary]

The foundation date of this hospital is uncertain, but a record survives of a master occurring in 1260.[148]

The advowson of the hospital and the manor of Pelawe came into the hands of the bishop of Durham following its transfer from the Pelawe to the Elmedon families. It was then returned by the bishop to the Elmedon family in 1451 which is its last-known extant date. It is said that the hospital was absorbed into their landed estate.[149]

	Database Entry	Historiography
Year of Foundation or First Reference	-1260 = 1250	✓
Year of Closure or Last Reference	+1451 = 1460	✓

51) Perio/Peryho (in Southwick), Hospital of (St John the Baptist and) St Martin the Bishop, Northamptonshire [Ancillary]

The source for Clay's date of 1258 is unknown, but the Knyvet family held the manor of Southwick of the earls of Warwick from the late 12th century. K&H stated -1282.

The advowson of the hospital was transferred to a new college in Cotterstock, Northamptonshire founded by a clerk of the king and master of the hospital of St Leonard, York in 1338/9.[150] Unlike other hospitals which were absorbed into institutions, masters continued to be appointed to this hospital until 1518. The chantry is listed independently in the *Valor Ecclesiasticus* and was noted as a free chapel by the commissioners.[151]

The free chapel is also listed in the Patent Rolls of 1547 when it was specifically excluded from the grant of 'late chantry, college or rectory of Cotherstoke'.[152] By 1549, it was recorded as the late chapel when its endowment, or part thereof, was purchased by John Peryent, knight, and Thomas Reve, gentleman, John Hulson, serivener, William Pendred, founder, and finally the site to Ralph Sadleyr, knight, and Laurence Wennyngton, gentleman.[153]

	Database Entry	Historiography
Year of Foundation or First Reference	1258 = 1250	P
Year of Closure or Last Reference	1547-9 = 1540	×

[148] *Fasti Dunelmenses*, p. 80.
[149] E. Mackenzie and M. Ross, *An Historical, Topographical and Descriptive View of the County Palatine of Durham*, vol. 1 (Newcastle upon Tyne, 1834), p. 136; Durham Cathedral Archive: Register IV, 1451, http://reed.dur.ac.uk/xtf/view?docId=ark/32150_s15999n339g.xml f.85v (17 April 2019).
[150] *CChR: 1327-1341*, p. 449; C. Burgess and M. Heale, *The Late Medieval English College and its Context* (Woodbridge, 2008), p. 71.
[151] *VCH: Northampton*, vol. 2; *Valor Ecclesiasticus*, vol. 4, p. 293.
[152] *CPR: 1547-1548*, p. 176.
[153] *CPR: 1549-1551*, pp. 8, 13, 128, 130, 265, 269.

52) Portsmouth (by), Hospital of St Mary Magdalen (and St Anthony), Hampshire [Ancillary]

It is possible that this hospital should not be contained within this sample. Clay provided a reference for her data which is 'Pat. 1340' but the date given was 1253.[154] The only reference this study can locate in the Patent Rolls of this date relating to a hospital in Portsmouth appertains to the hospital of St John and concerns the appointment of a warden.[155] There is an entry in the Close Rolls dated 1340 which refers to the hospital of St Nicholas.[156] In any case, this does not explain the date of 1253. K&H stated that it merged with St Anthony by 1340. It is possible that Clay's original notes were incorrect but as uncertainty remains, the data has been left intact.

	Database Entry	Historiography
Year of Foundation or First Reference	-1253 = 1240	✓
Year of Closure or Last Reference	*c.* 1340 = 1340	×

53) Portsmouth, Domus Dei, Nicholas, Michael, John Baptist, Hampshire [Semi]

The *VCH* stated that the hospital was founded by Bishop Peter des Roches (d. 1238) but does not provide evidence. There is a reference in the Patent Roll of 1233 which stated that the bishop of Winchester was building a hospital in Portsmouth.[157] A confirmation charter was issued in the reign of King John (the *VCH* stated 1214, this study believes it to be 1215) which details a series of gifts made by a variety of donors to the hospital.[158] The first donor on the list was William of Wrotham, and this may account for Watson's suggestion that he was the founder.[159] William was a respected royal administrator in the reign of King John and is said to have worked closely with Bishop Peter des Roches when founding the hospital.[160] This may account for the subsequent interest by the bishops and disputes with the king.[161]

	Database Entry	Historiography
Year of Foundation or First Reference	-1215 = 1200	✓
Year of Closure or Last Reference	1540 = 1540	✓

54) St Briavels, The Hospital of St Margaret, Gloucestershire [Ancillary]

In 1256 simple protection was granted for seven years to the warden of the hospital.[162]

	Database Entry	Historiography
Year of Foundation or First Reference	-1256 = 1240	✓
Year of Closure or Last Reference	+1256 = 1260	✓

[154] Clay, *The Mediaeval Hospitals of England*, p. 293.
[155] *CPR: 1338-1340* (London, 1898), p. 440.
[156] *CCR: 1339-1341*, p. 637.
[157] *PR: 1232-1247*, p. 14.
[158] *Rotuli Chartarum in Turri Londinensi Asservati, Volume I, Pars I, ab Anno MCXCIX ad MCCXVI*, ed. T. D. Hardy (London, 1837), p. 202.
[159] Watson, 'Fundatio, Ordinatio and Statuta', p. 344.
[160] Brian Golding, 'Wrotham, William of (d. 1217/8)', *ODNB* (Oxford, Sept. 2004), https://ezproxy-prd.bodleian.ox.ac.uk:2095/10.1093/ref:odnb/30087 (11 Apr. 2020).
[161] *CCR: 1385-1389*, p. 480.
[162] *CPR: 1247-1258*, p. 490.

55) Seaford (near), Hospital of St Leonard, Sussex [Ancillary]

There is a certain amount of confusion concerning this hospital. A leper house was founded by Roger de Fraxeto, constable of the king, in 1159 which was dedicated to St James.[163] Clay also attributed this house to a founder with the same name which was dedicated to St Leonard. The *VCH* appears to have confused the two hospitals referring to St Leonard's as the leper hospital and St James as a hospital in the patronage of the Abbey of Robertsbridge. This study will only concern itself with references to the hospital of St Leonard.

The hospital received protection with a clause *rogamus* in 1256.[164] The *VCH* recorded it as receiving an additional endowment in 1172 and that it was founded in 1147 by the king's constable, Roger de Fraxeto.

The *VCH* recorded a grant of an indulgence in 1368 by the archbishop of Canterbury as the hospitals had been 'ruined by the incursions of the sea'. [165]

	Database Entry	Historiography
Year of Foundation or First Reference	1147 = 1140	P
Year of Closure or Last Reference	+1368 = 1370	✓

56) Seaton, Hospital of St Mary, Rutland [Ancillary]

Simple protection was issued to this hospital in 1271.[166]

	Database Entry	Historiography
Year of Foundation or First Reference	-1271 = 1260	✓
Year of Closure or Last Reference	+1271 = 1280	✓

57) Sheffield, Hospital of St Leonard, Yorkshire [Ancillary]

William Lovetot, lord of Hallamshire, founded this hospital in *c.* 1160.[167]

In 1522, a chaplain received a stipend of £6 p.a., and by 1583 the chapel had fallen into disrepair.[168] The hospital is not listed in the *Valor Ecclesiasticus* or the Patent Rolls of Edward VI.[169] Unusually for a hospital which survived for this length of time, the sixteenth-century patron is unknown.

	Database Entry	Historiography
Year of Foundation or First Reference	*c.* 1160 = 1160	×
Year of Closure or Last Reference	+1522 = 1530	✓

[163] SAS-M/1/331 'Foundation Charter of the Hospital of St James', 1160, http://discovery.nationalarchives.gov.uk/details/r/723af28f-c5f9-4b3c-bb69-fbd082c55e21 (3 July 2019).
[164] *CPR: 1247-1258*, p. 468.
[165] *VCH*: Sussex, vol. 2, ed. W. Page (London, 1973), pp. 105-6.
[166] *PR: 1266-1272*, p. 603.
[167] Foundation Charter of St Leonard's Hospital Sheffield, Sheffield City Council, http://www.pictureshеffield.com/frontend.php?keywords=Ref_No_increment;EQUALS;arc02793&pos=1&action=zoom&id=132479 (9 March 2019).
[168] *VCH: York*, vol. 3, pp. 330-6.
[169] *Valor Ecclesiasticus*, vol. 6; *CPR: Edward VI, Index*.

58) Sprotborough, Hospital of St Edmund, Yorkshire [Ancillary]

A charter dated 1272 authorised Sir Thomas Fitzwilliam of Sprotborough to establish a hospital for the reception and entertainment of pilgrims, travellers, and strangers.[170] Sir Thomas was lord of Emley and Sprotborough. The advowson was still held by the family in 1423.[171]

The chantry certificate of 1546 describes the hospital as 'Hospitall of Seynte Edmonde Called Seynt Edmondes Chappell in the Parishe of Sprotbrugh'.[172] A second certificate noted that the chantry of St Katherine had been moved from the hospital to the parish church.[173]

	Database Entry	Historiography
Year of Foundation or First Reference	1272 = 1270	×
Year of Closure or Last Reference	1546 = 1540	×

59) Stagshaw, Undedicated, Northumberland [Ancillary]

The hospital is said to have been founded by one of the Clavering lords of Corbridge in the thirteenth century, but the date and lord is unknown.[174] The manor was granted to the Robert son of Roger in 1204/5 and in 1293 is recorded as being held in the same family line. It is said that King John granted permission for a market, and it is just possible that this period witnessed the foundation of the hospital.[175] The earliest reference to the hospital concerns a burglary in 1293.[176] A tentative decision of 1205 was entered into the database.

H. H. E. Craster's account of Stagshaw hospital referred to an inquisition post mortem printed in Hodgeson's *Northumberland* and dated 2 Richard II (1373).[177] Land was annexed as an endowment to fund a chaplain, but no such chaplain was hired. Craster stated that it languished after the lay subsidy of 1296 when it was valued at £2 9s 4d. Craster hypothesised that the hospital's endowment became part of the chantry of St Mary founded in the parish church in 1374.[178] K&H have relied upon this date. The latest date proved by the present project is a passing reference to a grant *sicut iacet inter placiam hospitalis de Stainscau* in 1345.[179] A date of 1345 has been tentatively entered into the database.

	Database Entry	Historiography
Year of Foundation or First Reference	1205 = 1200	×
Year of Closure or Last Reference	+1345 = 1350	×

[170] https://historicengland.org.uk/listing/the-list/list-entry/1425243 (23 Sept 2017).
[171] *CCR: 1422-1429, Henry VI*, vol. 1 (London, 1933), p. 41.
[172] *The Certificates of the Commissioners Appointed to Survey the Chantries, Guilds, Hospitals, etc., in the County of York: Part I*, ed. W. Page (Durham, 1894), p. 155.
[173] Ibid., p. 156.
[174] Craster, *A History of Northumberland: Volume X, the Parish of Corbridge*, p. 73.
[175] 'Gazetteer of Markets and Fairs in England and Wales to 1516: Places, Corbridge', https://www.history.ac.uk/cmh/gaz/gazweb2.html (15 May 2019).
[176] Craster, *A History of Northumberland: Volume X, the Parish of Corbridge*, p. 73.
[177] Ibid., pp. 73-4.
[178] Ibid.
[179] Ibid., p. 439.

60) Stanemoor (Rerecross), Spital upon Stanemoor, Yorkshire [Ancillary]

This hospital is said to have been founded by Conan, earl of Richmond (d. 1171), before being placed in the custody of Marrick Priory in 1171.[180]

In 1543, the hospital's lands which were previously in the tenure of the prioress of Marrick were leased to John Uvedale.[181] The *VCH* recorded that the tenement entitled 'le spittell super Staynemoore' was also leased to John Uvedale in 1545.[182] Accounts for the nunnery in 1415/6 do not contain payment to the chaplain at Rerecross despite a declaration in the *Valor Ecclesiasticus* stating its value as £4 13s 4d per annum; nor do they contain reference to estate or rental income in that area.[183] It seems that the hospital and its endowment remained intact.

	Database Entry	Historiography
Year of Foundation or First Reference	-1171 = 1160	✓
Year of Closure or Last Reference	1545 = 1540	✓

61) Stockwell, Hospital of St Mary, Bedfordshire [Ancillary]

Protection with clause *rogamus* was issued in 1232 for the brethren.[184] Nothing else is known of this hospital.

	Database Entry	Historiography
Year of Foundation or First Reference	-1232 = 1220	✓
Year of Closure or Last Reference	+1232 = 1240	✓

62) Stoke-by-Newark, Hospital of St Leonard and St Anne, Nottinghamshire [Semi]

The local historian William Dickinson stated that the hospital was founded by Bishop Alexander and was based upon a charter contained in the registry of Lincoln Cathedral, a transcript of which was reproduced in the appendix.[185] It was refounded in 1322 with the consent of the archbishop of York at the request of the master.[186] It is not known why the patronage passed into lay hands, but it was in the gift of Edmund Deincourt in 1317.[187]

The patronage came into the king's gift in 1477 owing to Francis Lord Lovell being a minor.[188] The *VCH* states that it was finally suppressed in 1576.[189]

	Database Entry	Historiography
Year of Foundation or First Reference	1135 = 1130	✓
Year of Closure or Last Reference	1576 = 1570	✓

[180] J. Burton, *Monasticon Eboracense and the Ecclesiastical History of Yorkshire* (York, 1758), p. 271.
[181] *L&P*, vol. 18, part 1, ed. J. Gairdner and R. H. Brodie (Vaduz, 1901), p. 549.
[182] *VCH: York*, vol. 3, pp. 321-30.
[183] J. H. Tillotson, 'Marrick Priory: A Nunnery in Late Medieval Yorkshire', *Borthwick Papers*, 75 (1989), pp. 21-2.
[184] *CPR: 1225-1232*, p. 2.
[185] W. Dickinson, *The History and Antiquities of the Town of Newark, in the County of Nottingham* (London, 1819), pp. 171-2, p. 388.
[186] Dugdale, *Monasticon Anglicanum*, vol. 6, part 2, p. 735.
[187] *CPR: 1313-1317*, p. 651.
[188] *CPR: 1476-1485*, p. 14.
[189] *VCH: Nottingham*, vol. 2, pp. 176-7.

63) Stow on the Wold, Holy Trinity Hospital, Gloucestershire [Ancillary]

The foundation date of this hospital is difficult to ascertain. Tanner quoting Speed stated that it was founded in 1010 by Ailmer, earl of Cornwall, and was dedicated to the Holy Trinity.

This hospital is noted in the *Valor Ecclesiasticus* as a poor hospital housing paupers and chaplains with revenues totalling £25 4s and 4d.[190]

	Database Entry	Historiography
Year of Foundation or First Reference	1010 = 1010	✓
Year of Closure or Last Reference	1535 = 1530	✓

64) Stydd/Stidd near Ribchester, Hospital of St Saviour, Lancashire [Ancillary]

This hospital was acquired by the Knights Hospitaller in the mid-thirteenth century. It is unclear as to when it ceased to provide services of hospitality as there is evidence of wardens in the early fourteenth century. In 1535, a chaplain, Thomas Bradley, was noted in the chapel of Stede.[191] Earlier in 1501, a Nicholas Talbot appointed a priest to sing at Stidd, and in 1535 the bailiff was John Talbot.[192] It could, therefore, be tentatively suggested that the Talbot family might have been the patrons at this time.

	Database Entry	Historiography
Year of Foundation or First Reference	-1216 = 1200	✓
Year of Closure or Last Reference	1535 = 1530	×

65) Tilbury (East Tilbury), Hospital of St Mary, Essex [Ancillary]

The *VCH* data is taken from a suit dated 1233 which stated that the hospital was founded by Geoffrey Fitzpeter, earl of Essex, who died in 1213. By 1338, the advowson was held by Eleanor, late wife of the earl of Ormond.[193]

The *VCH* suggested the possibility that the hospital reappeared as the chantry of Stonehouse in East Tilbury, citing the chantry certificate.[194] This is unlikely as there were two chantries listed: one being Stonehouse, the other being a free chapel served by a priest.[195] In 1393, on the appointment of a warden by Richard II, the hospital was described as 'the free chapel otherwise called the hospital or chantry or Estilbury'.[196] Therefore, the free chapel listed was probably the hospital.

	Database Entry	Historiography
Year of Foundation or First Reference	-1213 = 1200	✓
Year of Closure or Last Reference	1547 = 1540	×

[190] *Valor Ecclesiasticus*, vol. 2, p. 436.
[191] *Valor Ecclesiasticus*, vol. 5, p. 68.
[192] T. D. Whitaker, *An History of the Original Parish of Whalley and Honor of Clitheroe in the Counties of Lancaster and York* (London, 1818); *Valor Ecclesiasticus*, vol. 5, p. 69.
[193] *CCR: 1337-1339, Edward III*, vol. 4 (London, 1900), p. 341.
[194] *VCH: Essex*, vol. 2, eds W. Page and J. H. Round (London, 1907), p. 191.
[195] J. E. Oxley, *The Reformation in Essex to the Death of Mary* (Manchester, 1965), p. 243.
[196] *CPR: 1391-1396*, p. 265.

66) Tonge (Puckeshall), Hospital of St James, Kent [Ancillary]

The Clay date of 1202 appears to be a typing error for 1252. The first reference is in the Kent Feet of Fines in 1252 as noted in the *VCH*. There might have been an earlier leper hospital, but it is thought that this early hospital ceased to function in *c.* 1201. There is also a possible earlier start date of 1239, but this cannot be substantiated either. Therefore, this study has used the K&H and *VCH* dates. A change to the overall start date in this case would not significantly alter the longevity debates.[197]

In 1557, the house or hospital and its lands was granted by the Crown as part of a package of lands and buildings purchased by John Parrott, knight, for £184 15s. The manor descended to the Duke of York before passing to the king following the death of the duke in 1460.[198]

	Database Entry	Historiography
Year of Foundation or First Reference	-1252 = 1240	P
Year of Closure or Last Reference	1557 = 1550	✓

67) Walsoken, Holy Trinity Hospital, Norfolk [Ancillary]

In 1390, a licence was granted to the chaplains of this hospital to celebrate mass in the chapel founded by Richard I.[199] This is presumably why Clay dated the foundation as pre-1200, and K&H relied upon this work.

This hospital was surrendered to the Crown by the 'master or keeper of the fraternity or guild in the chapel of Holy Trinity ...and the brethren and sisters of the same' in 1545 with its possessions: a clear example of a hospital despite the reference to a chapel.[200]

	Database Entry	Historiography
Year of Foundation or First Reference	1199 = 1190	✓
Year of Closure or Last Reference	1545 = 1540	✓

68) Werhale, Undedicated Hospital, Durham [Ancillary]

Bishop Bury recorded an *inspeximus* in 1344 of a grant of land in 1256 by Sir Marmaduke, knight, to the warden. This is contained in the published registers of Bishop Kellawe under *excerpta*.[201]

	Database Entry	Historiography
Year of Foundation or First Reference	-1265 = 1250	✓
Year of Closure or Last Reference	+1344 = 1350	✓

[197] Summerson, 'Repercussions from the Barons' Wars: a Kentish Inquest of 1264*', pp. 573-8.
[198] E. Hasted, *The History and Topographical Survey of the County of Kent,* vol. 6 (Canterbury, 1798), pp. 132-43.
[199] *CEPR: 1362-1404*, p. 376.
[200] *L&P*, vol. 20, part 2, p. 602.
[201] *Registrum Palatinum Dunelmense: The Register of Richard de Kellawe, Lord Palatine and Bishop of Durham, 1311-1316*, vol. 4, ed. T. D. Hardy (London, 1878), p. 357.

69) West Tarring, Hospital of St Mary, Sussex [Ancillary]

There is only one extant reference to this house dated 1277 which refers to the assize of *novel disseisin* at the behest of the warden.[202]

	Database Entry	Historiography
Year of Foundation or First Reference	-1277 = 1260	✓
Year of Closure or Last Reference	+1277 = 1280	✓

70) Whitchurch, Undedicated, Shropshire [Ancillary]

The evidence used by K&H is that stated in Dugdale. The evidence in the historiography is the thirteenth century.[203] It is difficult to provide a date for a house of this nature, a tentative date of 1250 was entered into the database in order to provide a general indication. It is thought to have been transferred to Haughmond Abbey before 1320 per K&H. The end date has been left as a fleeting reference of 1320 in accordance with K&H.

	Database Entry	Historiography
Year of Foundation or First Reference	-14th C. = 1250	×
Year of Closure or Last Reference	-1320 = 1310	×

71) Wootton Bassett, Hospital of St John the Baptist, Wiltshire [Ancillary]

Philip Bassett, justiciar of England, founded this hospital.[204]

In 1406, the advowson of this hospital was granted by Edmund, duke of York, to Bradenstoke Priory. At the same time, the master of the hospital granted the lands and other possessions to the priory in mortmain.[205] Nothing more is known of the hospital: it is not separately listed in the *Valor Ecclesiasticus*.[206]

	Database Entry	Historiography
Year of Foundation or First Reference	1266 = 1260	✓
Year of Closure or Last Reference	1406 = 1400	✓

[202] *46th Annual Report of the Deputy Keeper of the Public Records*, p. 272.
[203] Dugdale, *Monasticon Anglicanum,* vol. 6, part 2, p. 773.
[204] TNA, E 42/377, 'Ordinances made by Walter, Bishop of Salisbury, for a hospital to be founded at Wootton Bassett by Sir Philip Basset, patron of the church, and Th. de Gay, rector: [Wilts.]', 1266.
[205] *CPR: 1405-1408*, p. 227.
[206] *Valor Ecclesiasticus,* vol. 6.

72) Wycombe (High Wycombe), Hospital of St John the Baptist, Buckinghamshire [Ancillary]

John Parker's *The Early History and Antiquities of Wycombe* refers to a deed dated 1245 which bound the brethren and sisters to distribute specified alms each year to the poor and to pray for the soul of Adam Walder. The burgesses agreed to oversee and implement this agreement.[207] The present study has subsequently noted that an Adam Walder was also a burgess in 1237.[208] The hospital was certainly extant in the early thirteenth century and had close connections with the burgesses of the town. However, in this case the archaeological evidence must take precedence with reference to the foundation date and the founder remains unknown.

In John Parker's account of the history of Wycombe, he noted that the hospital was leased by the master to two gentlemen in 1548, and that they sold the hospital to the mayor and burgesses of the town who subsequently founded a grammar school.[209] The grammar school continues to operate today.

	Database Entry	**Historiography**
Year of Foundation or First Reference	*c.* 1180 = 1180.	✓
Year of Closure or Last Reference	1548 = 1540	✓

[207] J. Parker, *The Early History and Antiquities of Wycombe in Buckinghamshire* (Wycombe, 1878), p. 140.
[208] *Charters and Grants Relating to the Borough of Chepping Wycombe* (Wycombe, 1817), p. 9.
[209] Parker, *The Early History and Antiquities of Wycombe*, p. 142.

Appendix II: Maps of Hospital Locations

Microsoft product screen shots reprinted with permission from Microsoft Corporation.

Figure 16: Map of Hospital Locations (72 Hospitals)

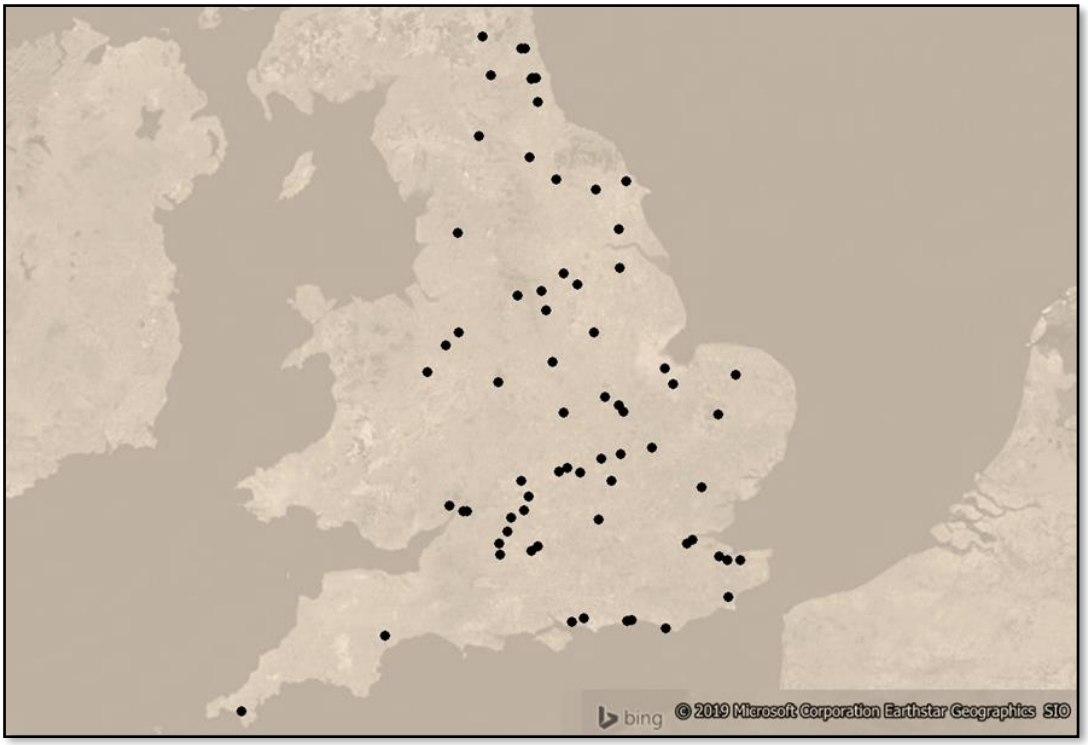
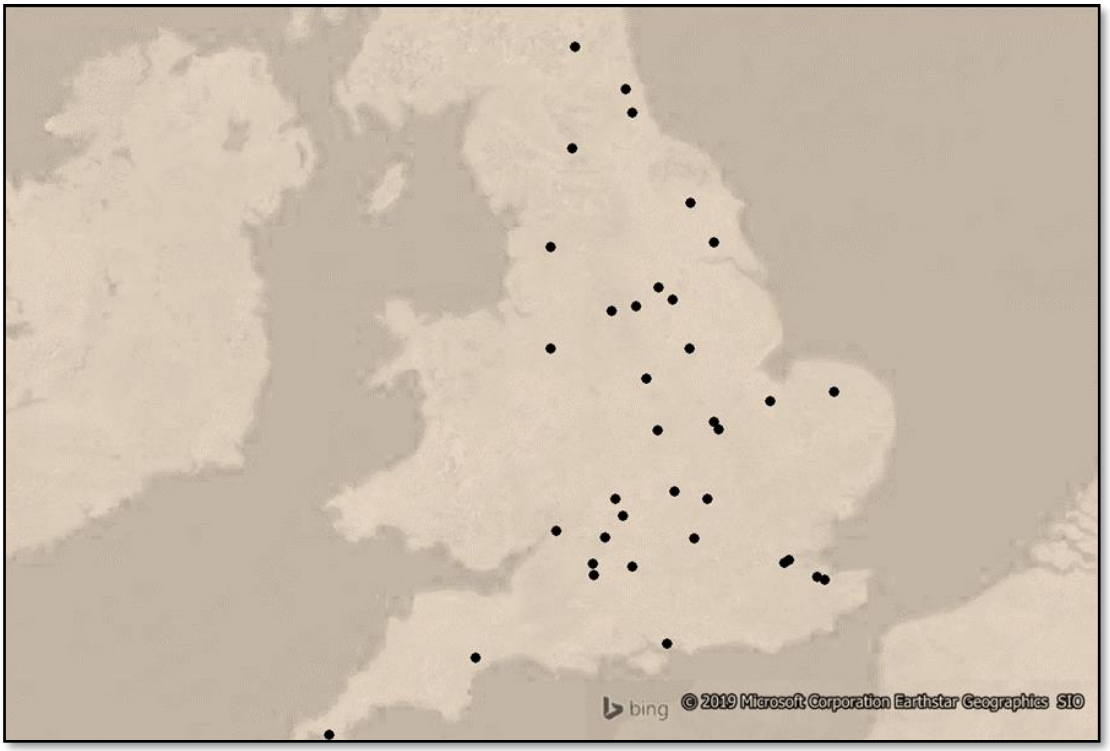


Figure 17: Map of Surviving Hospitals in the Sixteenth Century (36 Hospitals)



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